

**Mental Health and Healing with the Carrier First Nation:
Views of Seven Traditional Healers and
Knowledge Holders**

by

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of the Requirements for the Degree of
Doctor of Education

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Abstract

The Carrier First Nations people are the original inhabitants of Central Northern British Columbia. Along with First Nations throughout Canada, the Carrier people have endured years of hardship as a result of European colonization. Over time, this has resulted in erosion of traditional practices and decline in overall health. The focus of this research is the mental health of Carrier First Nations.

In present day, Western European mental health services are provided to Carrier people. There is ongoing concern that these services are not meeting the needs of the Carrier people because they are not provided from within a Carrier cultural framework. As a Non-First Nations mental health practitioner working in Carrier communities, the researcher has seen this struggle first hand.

In efforts to understand what culturally appropriate mental health services for Carrier people are, the researcher looked to Carrier people. Using an ethnographic framework, the researcher explored Carrier First Nation views of mental health and healing through discussions with seven traditional healers and knowledge holders who live and practice in Carrier communities. The resulting data provides a rich description of Carrier worldviews with respect to health and healing. It also describes the work of traditional Carrier healers, historically, as well as in present day. While this worldview is similar to other First Nations across the country, it is uniquely Carrier.

This research has implications for mental health practice in Carrier communities.

Keywords: First Nation; Carrier; mental illness; mental health; traditional healing

*To the Carrier people and
those who walk with them.*

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Table of Contents

Approval	ii
Partial Copyright Licence	iii
Ethics Statement.....	iv
Abstract.....	v
Dedication.....	vi
Acknowledgements.....	vii
Table of Contents.....	x
List of Tables	xiv
Introduction.....	1
Research Question	4
Research Rationale.....	5
Current Issues in First Nations Mental Health.....	5
Providing Mental Health Services in Carrier Communities.....	7
Research Process.....	15
Definition of the Research Topics.....	16
Dissertation Structure.....	17
Literature Review:	
First Nations Arrival to North America through to Present Day	19
Canada's First Nations: Pre European Contact	20
The Arrival of the First People.....	20
First Nations Pre Contact.....	23
Socio-Cultural Organization.....	23
Early Healing Beliefs and Practices.....	24
The Early History of Carrier People.....	27
Carrier Social Structure.....	30
Health, Healing and Spirituality of Carrier People.....	32
First Contact.....	35
Government Intervention in the Lives of Canada's First Nations People	38
The Indian Act of 1867.....	39
Child Welfare and Canada's First Nations.....	47
Health and Welfare of Contemporary First Nations Populations	48
Conclusion	53

Literature Review Part 2:

The Evolution of 21st Century First Nations Health Care	55
The Beginnings of Government Provided Health Care	55
The Decline of Traditional Health Practices	60
Current Day Health Care	63
Increasing self-governance.	63
Provincial Government Involvement.	66
First Nations Mental Health.....	67
Mental Health Funding for Programs.	70
The Tripartite Agreement.	74
Understanding Cultural Views.....	78
Worldviews and Mental Health.	81
Healing Models.....	84
Conclusion	88

Research Design

Research Design	89
First Nations Research Considerations	90
Methodology	96
Sampling.	98
Data Collection.	100
Data Analysis.	108
Conclusion	111

Presentation of Data

Presentation of Data	112
Carrier Worldviews of Wellness.....	115
Balance and Connectedness.	115
Absence of Mental Illness.....	115
Balance.....	117
Carrier Grief Process.	119
Loss of Spirit.....	120
Bad Medicine.....	124
Community.	128
Communal Social Structure.	128
Clan System.	130
Nature.....	132
Connection with Nature.	132
Mountains and Water.....	136
Plants and Herbs as Medicine.....	136
Animals.....	138
Spirit World.	141
Carrier Traditional Healers	144
On Becoming a Healer.....	144

The Work of a Healer	154
The Power to Heal.	154
Engaging a Healer.....	159
Plants and Herbs- Medicine.....	162
Talk/counsel.....	165
Dreaming.	167
Chanting/singing/drumming to Heal.	170
Water.....	173
Eagle Feather.	174
Predicting Future and Seeing Spirits.	176
Fast.....	179
Sweat Lodge.	183
Yuweepi Ceremony.	187
Conclusion	188
Discussion.....	190
Primary Findings.....	194
Carrier Worldviews of Wellness.....	194
Carrier Traditional Healers	198
Implications for Practice.....	201
Practice recommendations.	201
The Worldview Should Lead the Practice.	201
Use Interventions that Reflect the Worldview.....	202
Consider the Family and Community in Healing.....	204
Use the Natural Environment when Possible.	207
Consider the Spirit World.....	209
Practitioners Must be Endorsed by the Individual and the Community.	211
Inform Practice with Current Local Knowledge.....	212
Consider Combining Healing Interventions.	213
Policy Implications.....	213
Policy Should Involve Community Research Funding for Mental Health Practice.....	213
Policy Should Recognize Traditional Health and Healing Practice.	214
Policy Should Recognize the Interconnected Nature of Health and Healing.	214
Limitations and Areas of Additional Research.....	215
Conclusion	216

Conclusion	218
Epilogue	220
References.....	223
Appendix A. Band Council Approvals.....	248
Appendix B. Information Sheet for Research Participants	254
Appendix C. Informed Consent Form.....	256
Appendix D. Interview Guide	257

List of Tables

Table 1.	Communities of the three Carrier sub-regions.....	29
Table 2.	Codes, categories, and themes	113

Introduction

I attended a sweat lodge ceremony many times during my five years of working in Carrier First Nation's territory. I felt it was part of my job, as a mental health and addictions therapist, to participate in cultural ceremonies with staff and clients, at the cultural addiction treatment center where I provided contracted services. I was accustomed to the protocol that is followed in the ceremony, accustomed to the intense heat, and the pitch black darkness inside the lodge. I was familiar with the drumming and the songs that were sung during the four "rounds" which I learned to sing in the lodge, despite not understanding the words. Admittedly, my early experiences in the sweat lodge caused me some anxiety, particularly when the door flap was lowered and the steam began to rise. Over time however, I began to welcome the heat, the dark, and the feeling of comfort I had as I was seated on the ground, squeezed in-between any number of bodies, under a low structure made of willow, and draped with tarps.

This particular sweat lodge ceremony occurred in the fall of 2001; I entered this ceremony with a heavy heart. My father had died two weeks before of lung cancer. I had watched as this swift and painful disease claimed the greatest man I had ever known. I returned to work in central British Columbia, from my parent's home in Calgary, soon after his death. As is the way in First Nations' communities, family members of clients and staff alike are welcome to attend ceremony. On this day, my mother was visiting me from Calgary wanting to escape her own grief. Because she was interested in First Nations culture, she chose to attend this sweat lodge ceremony with me.

The ceremony began as it always did. The sweat lodge holder entered the lodge first and sat facing the door. At his word, the men, the warriors, smudged themselves with the smoke of sage and entered the lodge. They moved clockwise to take their seats to the left of the lodge holder. Once the lodge was “safe” the women and children were invited to enter, after smudging, to also move clockwise and sit to the right of the lodge holder. This low structure, no more than four feet high at its center, allowed little room for movement as the bodies were tightly squeezed into the perimeter of the small space.

Once appropriate direction was given to the participants by the lodge holder, we entered into the first of four rounds of the ceremony. Hot lava rocks were placed into the central fire pit, the door flap was ordered closed, plunging the lodge into complete darkness with only the glow of the lava rocks visible. The lodge holder poured water and herbs on the rocks, resulting in fragrant steam and intense heat. The participants then began to talk in turn, to the “creator, the grandfathers and, the grandmothers” out loud” or “in my heart”. After each participant had the opportunity to speak, we began to drum, shake rattles, and sing for the remainder of the round.

The Carrier say, people sometimes have mysterious experiences in the sweat lodge. I have heard people describe seeing faces in the glowing lava rocks, and others have talked about hearing the voices of their ancestors. I had never had any such experience, until this fall of 2001. Sometime during the second round, when I prayed “in my heart”, I became aware of what first sounded like wind high above me. As the noise grew louder, I thought it sounded like the flapping wings of a bird. I was perplexed by how this sound was being made. In my mind’s eye it seemed that the sound was that of a great bird circling down

toward me. I began to feel wind on my face. Then, much to my shock, what felt like large feathers began to heavily brush over my face and my seated body. The sensation was that of a great bird maintaining flight before me while flapping its wings in front of itself, over me. Startled, I drew my legs to my chest and put up my arms to cover my face. This fanning went on for several seconds, and then the sound of the wings faded away, circling upwards, only to return and repeat this same action several more times. Between this fanning, I had the distinct sense, based on sound and movement of air, that a great bird was circling high above me, impossible because the roof of the lodge was only a few feet above my head. As perplexed as I was at how this could be occurring, I remained silent, with my heart racing, and simply covered my head with my arms each time it did.

At the conclusion of the ceremony, I looked around the lodge before exiting to try and understand how the lodge holder was able to create the experience I just had. My assumption was that all participants in the lodge had the same experience as I did. There was such little space between the fire pit and those seated that it seemed an impossible task for him to maneuver around the lodge, fanning the participants with feathers. I had not seen his form pass between me and the glowing lava rocks. The only noise I heard came from above. How was he able to create the deafening sound? Logically, it was simply not possible for the lodge holder to move around the circle of people to fan us all with feathers and create the illusion of the noise I heard. However, I concluded that he somehow managed to pull off this feat of trickery because, the alternative was even more impossible to my English/Irish bred mind. I further concluded that his trickery was augmented by my distorted senses in the dark.

Regardless, I left the lodge with feelings of awe for the experience, and wonderment at the skill of the lodge holder. As we walked back to our cabin, I turned to my mother and referred to the experience to which she replied “What are you talking about? I didn’t hear or feel anything like a bird or feathers”. She then said that the only thing she heard that was odd was the sound of a man’s voice singing, coming from *behind me*. She had tried to figure out how and why, one of the men came over to the women’s side of the lodge and squeezed in behind me. Despite the turning in my stomach, I insisted that the noise I heard was so loud, she must have heard it. She maintained that she had not heard or felt what I did. Later, still unwilling to believe my experience was anything but clever maneuvering, I asked the lodge holder if he had used fans of feathers in the lodge, not wanting to elaborate on my experience or my thoughts of it, in case I insulted him. He only looked at me knowingly and said that it was the spirits who do the work in the lodge, not him. As I walked away from the lodge holder my skeptical thoughts faded into an abyss of an unknown world.

Research Question

After this profound sweat lodge ceremony experience, a desire was sparked in me to open my mind further to the culture I found myself working in. I was beginning to understand that Carrier First Nations’ healing practice was built on an epistemological framework that differed significantly from that of the Western European framework, in which I had been trained. I knew that I could not fully understand Carrier healing practice, such as the sweat lodge ceremony, because I could not look at it through a Carrier cultural lens. I did however want to come closer to a level understanding. Through this research I asked the question, “How do Carrier First Nations people conceptualize mental health and treat mental illness in traditional Carrier culture”.

Research Rationale

Current Issues in First Nations Mental Health.

Historically, First Nations around the world have governed themselves based on a worldview that incorporates an interconnection within self, and the natural and supernatural worlds (Dickason, 2009; Morrison & Wilson, 2004; Ray et al., 2010; Waldram, Herring, & Young, 2006). Over time however, First Nations' cultures were overshadowed and marginalized as "larger and more powerful nations moved across the globe in search of wealth" (Cohen, 1999, p. 1). Canada's First Nations were no exception. Since the time of first contact between Canada's First Nations and Europeans, there has existed a cultural dichotomy that has, over time, weighed in favor of the dominant European culture. The policies of the Dominion of Canada (under British & church guidance) implemented a paternalistic perspective toward First Nations people. These policies reflected a position that First Nations were incapable of independent governance, and implemented laws intended to protect, control, and assimilate First Nations into the developing Eurocentric culture (Dickason, 2009; Hill, 2009; Morin, 2011). Colonization in Canada occurred with little respect for its' first people. First Nation's traditions were largely disregarded and swept aside as static, archaic notions (Battiste, 2005; Hill, 2009). A parallel tendency to romanticise First Nations culture in literature, and later in film, leant itself to further disregard and exploitation (Littlefield, 1992). As colonization continued, First Nations lost much of their former ways of life. Indian Act policies, most notably the reservation system and residential schools, dictated a foreign way of functioning for First Nations. The reservation system restrained First Nations people from their traditional movement, while the Indian Residential Schools introduced a structured form of education that separated children

from their families, communities, culture, and language (Haig-Brown, 1988; McMillan & Yellowhorn, 2004; Tanner, 2009). As a result, the turn of the last century saw Canada's Indigenous populations in states of poor physical and emotional health (Cohen, 1999; Waldram, Herring, & Young, 2006).

In response to the health needs of First Nations people, the Canadian government began providing sporadic health care aid that developed into full medical services by the mid-1970s. By the mid-1990s, recognizing the poor emotional and mental health of First Nations, the federal government began offering mental health services on reserves (Auguste Solutions & Associates, 2004). Over time however, it became evident that the Western European models of mental health services being offered, mirrored the dichotomy between cultures that has haunted First Nation and European relationships. These services did not fully meet the needs of First Nations people (Kirmayer, Tait, & Simpson, 2000; Kishk Anaquot Health Research, 2006; Smye & Mussel, 2001).

Within the last two decades, Canada's first people have joined Indigenous people around the world in a process of reclaiming traditional views, practices, and political power. These movements involve goals of improving the health and wellbeing of First Nations people (Cohen, 1999; Czyzewski, 2011; First Nations Health Council, 2006.). Included in their efforts is the re-emergence of traditional philosophies and healing paradigms (Belanger, 2008; Crowshoe, 2005; Department of Justice Canada, 2008; First Nations Health Society, 2010).

Although First Nations in Canada share some similarities in their traditional worldviews and healing practices, each First Nation community has a unique culture

(Kinnon, 2002). While a general framework has its place in recognising general differences between First Nation and Eurocentric worldviews, individual First Nations communities further define their own culture (Dei, Goldin-Rosenberg & Hall, 2000; Morin, 2011). Therefore, national First Nation's knowledge should be augmented with local knowledge, to inform First Nation's mental health practice for specific groups (Kinnon, 2002).

Providing Mental Health Services in Carrier Communities.

I am a first generation Canadian, of English – Irish descent, practicing clinical social work in Carrier First Nations' communities. I moved from Calgary to Prince George in 1993 and began working in Carrier communities in 1994 after a First Nations colleague suggested I explore providing clinical social work in a specific Carrier community. At this time I knew very little about First Nations' culture and less about cross cultural clinical social work. I have lived in urban western Canada for most of my life.

My father was part of the child immigration movement and was relocated to Canada from Newcastle upon Tyne as a 10 year old boy. He was raised in a residential school on Vancouver Island until the school closed when he was 14 and he was placed in a foster home. By the age of 15 he was no longer seen as a ward of the government and was cast into the streets of Vancouver. By the time he reached the age of 17 he had grown tired of fending for himself and he joined the Canadian Air Force. Sadly, he never returned to his homeland except for one brief visit and he reconnected with his mother for a short period before her death. The only traces of his English ancestry were a faint accent that he never lost, and a tendency to promote the English "stiff upper lip" which, I'd grown to understand meant always keep your emotions under control. It was through his travel with the air force that he

met my mother in Northern Ireland. The young couple traveled with the air force and eventually were stationed back in Canada with a son who was born in Germany. I became the first of three children born in Canada.

My mother was close to her Anglican Irish family and I grew up knowing this extended family through many of their visits to us and ours to them. My mother never wanted to let go of her homeland in Northern Ireland. As a result, my siblings and I were told on two occasions to give away most of our possessions and to pack everything we wanted to keep into two suitcases. Although I'm sure these moves exhausted my parent's savings, we never remained in Ireland for more than a year on either occasion. My father was reluctant to raise his children in the heat of the Irish civil war of the time.

As a result, it was the Irish culture I was exposed to that had a stronger influence on me than my English roots. I grew up hearing stories of the "Banshee", a spirit woman who wailed out in the mist to warn of impending death. I remember stories of people who could heal by touch and see the future as being common. Seemingly factual stories of ghost sightings were told by adults and children alike. I also enjoyed stories about the surrounding location where my family lived. These involved stories of family experience and folk lore. My grandfather never learnt to drive a car and lived his 90 years within an area that he could get to on foot or on his bicycle.

When I was in Ireland, I had a sense of connection with the land, the family, and the culture. None the less, my older brother and I were left with a feeling of displacement between the two countries. We were referred to by teachers, schoolmates, and friends as the "Canadian kids" when we were in Ireland and the "Irish kids" when we returned to Canada.

As a result we had a conversation on the issue as young teen agers. We decided to identify ourselves from that time forward as Canadian because it was to Canada that we were most loyal. I also made a private pact as the result of my exposure to the Protestant – Catholic war to never again identify with organised religion.

I view this childhood exposure to extended family and Northern Irish culture as a valued experience. I have made many parallels to it during my work in Carrier communities. Most notable are the connection to a land that your family has inhabited for generations, large extended family, folk lore, healers, and the common belief in the spirit world as part of an everyday reality.

I began my professional work as a pre degree human service worker in Calgary working for a youth organisation at the age of 21. I then acquired a Bachelor of Social Work degree at the University of Calgary when I was 26 years old and then worked as a counsellor for youth probation services for the next four years. I relocated to Prince George and completed a Master's degree in social work in 1998. I worked as a child and family therapist before being invited to work in Carrier communities.

My practice had always been general, in that I did not specialise in any particular area or work with any specific therapeutic approach. My social work education dictated a person in environment, client centered approach. I had knowledge of family systems, crisis intervention, and all the usual theories one needed when working with people as a clinical social worker. I was comfortable with generalist practice approaches that included solution focused therapy, cognitive behavioural therapy, and a sprinkle of art therapy. I was aware from my training that building relationships was an integral part to engaging with clients.

When my colleague invited me to work in the Carrier community she cited a “good fit” as being the reason she thought I would work out. I recall focusing on building relationships with the community members once I started working in the community. I embraced the nature of the work that involved my getting out of the office and visiting people in their homes. I lived in the community from 2- 4 days per week and enjoyed learning Carrier culture through community members. I was quietly amused and pleased when I arrived at a client’s home, after several months of working in the community, and a young girl of five or so announced to her mother that “auntie” was at the door.

There was much work to do however. I was working in a community that had very little exposure to community mental health services. The stigma attached to mental health services was evident by the slow building of my case load. A need was also present. Mental health and addictions related problems were evident from the high rates of substance abuse and violence. During the first two years of working in this community, I provided support services for a significant number of people who were exposed to suicide and homicide. The result was that I furthered my training to include critical incident support services and post trauma intervention.

Thinking outside of my own cultural worldview and professional knowledge framework in efforts to understand and work with my Carrier clients has been a challenge. My experience is not unique. Working cross culturally has unique challenges for professionals and has been identified as being problematic for clients. North American mental health professionals, educated within the dominant Western European paradigm, can unwittingly and unintentionally further oppress First Nations clients by subjecting them to

culturally insensitive interventions (Duran, Firehammer, & Gonzalez, 2008). Duran et al. (2008) discusses the negative impact of these “well-meaning and good-hearted counsellors, psychologists, and social workers” (p. 288):

Operating from culturally biased views of mental health and what are considered to be appropriate intervention strategies, these professionals perpetuate various forms of injustice and institutional racism by imposing helping paradigms that are often incongruent with the worldviews, values, beliefs, and traditional practices that have been used to promote the psychological well-being of persons in diverse groups. (Duran, et al., 2008, p. 288)

I have had ongoing experiences in my work with Carrier people that support Duran’s thesis. By 1996, I widened my practice and became involved in providing services at an addiction recovery program run by Carrier Sekani Family Services (CSFS). CSFS is a First Nation health and welfare service provider that works on behalf of 11 First Nation communities in central British Columbia. The Addiction Recovery Program used Carrier culture coupled with psycho education programming as a way of helping those affected by addictions to enter into recovery. I was asked to provide mental health support on contracted bases. The traditional work at the center involved daily smudge, sweat lodge ceremonies, drum making, berry picking, fishing, and hunting. Addictions counselling staff and Carrier Elders provided workshops and talking circles on topics such as the impact of Indian Residential School. My contribution involved supporting this work, as well as seeing clients individually when staff or the client felt this additional support was needed. My role also involved reviewing each client file and signing it off. It was explained to me that as the

funding agent, First Nations and Inuit Health, Health Canada required that an approved mental health clinician provide these services to the center. Although I participated in the group sessions as a therapist, and I attended some of the traditional ceremony as a support person, these activities were generally led by the Carrier staff. I was asked to provide some workshops such as “Understanding Grief and Loss”. My practice was informed by clinical social work education. I was always aware that my presence was a requirement by the federal government as the funding source yet, my relationship with my colleagues was positive. They were always very willing to share information regarding their culture when I was willing to ask and listen. Over time my Carrier colleagues and I became involved in some combined interventions. For example, I would end a therapeutic relationship with a client by working with a medicine person in providing a ceremony for the client to mark the end of our work together but a continuation on their healing journey. I would also be invited by medicine people to provide emotional support to people during traditional ceremonies. These were often offered to people by the medicine person for trauma recovery.

My work from 1996, led to a contract in 2003 with CSFS to develop the agency’s first ever Mental Health Wellness Program for its 11 member Bands. In 2003, there were limited examples of culturally appropriate First Nations’ mental health services programs. Therefore, I based the development of this program on my practice to date and the limited literature available on First Nations’ mental health. Since 2003, CSFS’s program has evolved in response to need and new discoveries regarding the most effective services for CSFS’s communities. However, how to best meet the mental health needs of Carrier people from a culturally sensitive position was often debated by both the staff and residents in Carrier communities (Shawana, 2002).

Mabel Louie is the Health Director for Carrier Sekani Family Services (CSFS). She is also a member of Stellat'ten First Nation of the Carrier Nation, and recently served a term as their Chief. Ms. Louie and I have had a number of conversations regarding First Nations' mental health services over the years. The series of conversations illustrated a contrast between my professional practice and Carrier First Nation's culture. One clear repeated example involved issues of confidentiality and rights to privacy for community members. On occasion a family member, Band staff, or Band leader would approach one of my mental health staff about someone they were concerned about. Mental health staff would be asked to call this person or pay them a visit at their home. Frequently, this informal referral was not discussed with the person in question prior to providing a therapist with the information. It has been my professional opinion based on my training that this type of referral goes against policies of privacy and self-determination. The practice of knocking on someone's door offering counselling intervention based on the concerns of someone else is not usual practice. The only exception to unsolicited "house calls" is when we have been advised that someone is at risk of harm, as in suicidal or homicidal ideation, or child abuse. In all of these high risk cases the therapist would make a referral or go to a client armed with back up; police, ambulance, or child welfare social workers. In non-high risk cases, I would always ensure the potential client was aware of the referral and if not, my advice to the referring person was always to go and talk with the person first to see if they would like services. I advised my staff to operate within this policy framework, despite ongoing contrary expectations of our Carrier colleagues and community members. When I discussed this issue with, Ms. Louie, she insisted it should not matter whether or not the client was aware of the referral. If other family or community members were concerned about the individual then

the therapist should respond with or without the individual's consent. She suggested that my professional "ethics" were interfering with providing culturally appropriate service.

Culturally, she informed me, the community operates for the greater good of the whole. I struggled with this issue for a number of years because client self-determination and right to privacy were ingrained in me. They were social work values I believed in. Over time however, the lesson for me was that to work cross culturally, I needed the people I was working with to define aspects of my practice.

Using this example, I explored how professional ethics might be interfering with the provision of the most appropriate services within the local First Nations' culture. Consulted literature and First Nations' professionals with whom I worked, supported Ms. Louie's argument that professional boundaries that protect the privacy and the client's right to choose, do interfere with Carrier First Nations' traditional worldview of communal existence (Howell-Jones, 2005; Kirmayer, et al., 2000; Kirmayer, Simpson, & Cargo, 2003; McMillian & Yellowhorn, 2004). In this Carrier view individuals work for the greater good, and community need supersedes individual need. Therefore, it would be natural for community members to provide unsolicited help for each other. It was common, traditionally, for a community member to go to a person in power, such as a Chief or a known community healer, with concerns for someone else (Holyk et al., 2007). The consent of the individual would not have been a primary consideration.

Based on the preliminary information I gathered and my own experiences with Carrier culture, I went back to Ms. Louie with the idea for my research. I agreed that my practice was based on a Western European culture and that there were components that did

not fit with Carrier First Nations' culture. She agreed that exploring local Carrier knowledge with respect to mental health and healing for the purpose of informing culturally appropriate professional mental health service to Carrier people would be valuable. Through this dissertation I hope to contribute to the body of knowledge that informs current First Nations' mental health practice, specifically, for work with Carrier people in Carrier communities.

Research Process

First Nations research recommendations, described in more detail in the Research Design chapter, encourage researchers to ensure First Nation involvement and ownership of research conducted with them. I felt it was important therefore to involve Carrier people in the entire research process (Schnarch, 2004). The intended outcome of this work was to improve mental health services in Carrier communities. I was cognisant of the need for it to be useful to them. Therefore in addition to consulting with Ms. Louie, a respected Carrier woman, I talked with three Carrier Elders from three separate Carrier communities. I presented my idea and was met with a positive response. To maintain a strong Carrier First Nation presence throughout the research process, my thesis committee included Ms. Louie as a formal member of my committee. I will further address the issue of research ethics with First Nations as a non-First Nations person in the Research Design chapter.

To explore my research question, I went to Carrier First Nations' healers and knowledge holders and invited them to participate in this research. Using an ethnographic framework, I observed and talked with seven First Nations present day healers and knowledge holders who shared a wealth of information regarding their traditional worldviews and healing practices. I will discuss the choice for this research methodology in the Research Design chapter.

All of my participants spoke fluent English. They had varying degrees of command of Carrier language, ranging from fluent to limited understanding. Therefore, I did not feel it was necessary to bring a translator to my discussions with them. I will comment further on issues of language in the literature review and the discussion chapters.

Definition of the Research Topics.

The term “First Nation” is used throughout this dissertation as a consistent term to refer to Indigenous populations’ worldwide. This was the term that my Carrier academic advisor preferred I use. It should be noted however, that other terms used throughout history and in present day, including “Indigenous”, “Aboriginal”, and “Indian” appear in the text of this dissertation as direct quotes from other sources.

General definitions of mental illness and mental health are required for the purpose of this paper. The World Health Organization (WHO) provides definitions that are applicable at the global level. Mental illness, also referred to as a mental health or psychiatric “disorder” by the WHO, refers to a diagnosable condition that has the capacity to disrupt a person’s healthy functioning. As stated, “In order to be categorized as disorders, such abnormalities must be sustained or recurring and they must result in some personal distress or impaired functioning in one or more area of life” (World Health Organization, 2001, p. 21). There has been a relatively recent shift for mental illness to be understood and treated as part of a larger concept of mental health (Canadian Mental Health Association, 2013; WHO, 2001):

Mental health is more than the absence of a mental disorder. Mental health is the ability to think and learn, and the ability to understand and to live with one’s emotions and the reactions of others. It is a state of balance within a

person and between a person and the environment. Physical, psychological, social, cultural, spiritual, and other interrelated factors participate in producing this balance”. (World Health Organization, 2007)

Therefore, poor mental health can exist in the absence of mental illness.

Comparatively, mental illness can exist for someone who is considered to have good mental health. The concept here suggests that if a person is managing their mental illness positively and is maintaining an overall healthy balance, they are said to be practicing good mental health. These definitions and concepts will be used for the purpose of this dissertation. Mental “health” will refer to the full spectrum of global functioning, while mental “illness” will refer to diagnosable conditions.

Dissertation Structure

This dissertation is organized into seven chapters. The second chapter is the first of two literature review chapters. This chapter begins with the earliest available history of the First Nations who originally inhabited the North American continent. This serves to provide a general ontological overview of Canada’s First Nations’. The latter half of the chapter moves into exploring the history of European contact with Canada’s First Nations. Specific literature regarding Carrier First Nations is presented.

The third chapter is the second literature review chapter, presents an overview of the provision of health care services post colonization, with a focus on the history of government interventions and government provided health care. This chapter includes an examination of the history and development of the largest aboriginal-led health and social service provider in the region: Carrier Sekani Family Services (CSFS). An overview of current developments

in health, within British Columbia's First Nations, through the Tripartite Agreement, are presented. This agreement between the federal government, the province, and British Columbia's First Nations to provide First Nations' governed health, education, and social services, is the first of its kind in Canada and is set to be implemented in April 2013.

The fourth chapter presents the research design used for this dissertation. The chapter includes considerations involved in research with First Nations' people.

The fifth chapter uses participants' quotes and filed observation notes to illustrate the two primary themes that emerged from the data; Carrier views of Wellness, and Carrier Traditional Healers. The presentation of "Carrier Worldviews of Wellness" in the first half of this chapter, lays the foundation for a discussion of the second theme of "Carrier Traditional Healers". The later theme presents how Carrier people became healers and how they worked, and continue to do so today, amongst Carrier people.

The following chapter offers a discussion of the primary findings of this research and how they can be used practically in the area Carrier First Nation mental health practice. The dissertation concludes with a brief summary chapter.

Literature Review:

First Nations Arrival to North America through to Present Day

This chapter provides an overview of the arrival and early socio-cultural functioning of First Nations people in what is now Canada. This history will be explored from the perspective of the anthropological and archeological literature that is available, as well as from the recorded oral history accounts of First Nations people. As the focus of this research is on understanding First Nations' perspectives on what we now refer to as mental illness, mental health, and traditional healing practices, what is known about the early beliefs of traditional health and healing will be explored in this chapter. This information is crucial for understanding the epistemological foundation of the Carrier culture, specifically in reference to mental health. Mental health is presented as a part of overall health.

Following this rich description of the early existence of First Nations people, I will provide a summary of the effects of European contact. Understanding the impact of contact and Canadian government policy in First Nations people's lives is essential to understanding the social and mental conditions of First Nations people today (Morrison & Wilson, 2004).

It should be noted that I refer to the past tense in the following two chapters because I am reviewing the history of First Nations and Canada. This is not to imply that the beliefs and practices of First Nations people presented are not present today.

I will conclude the chapter with a summary of the current health and welfare status, with a focus on mental health, experienced by Canada's First Nations people.

Canada's First Nations: Pre European Contact**The Arrival of the First People.**

Literature is readily available regarding evidence and theories of how the continent of North America became populated. However, literature and general knowledge regarding the early socio-cultural functioning of these First North Americans is limited. There is more literature available on the topics of First Nations' culture and customs subsequent to the arrival of the Europeans. The reason for this, explains Dickason (2009) is that history is a “document bound discipline” and that in Western European modern day “if something was not written, preferably in an official document, it was not historical” (p. iii). This is also the reason why more attention is paid to the documented 15th century European arrival and less to the original European arrival of the Norse in 1000 AD (Dickason, 2009). The subject of this dissertation involves First Nation's traditional beliefs and practices. Therefore this literature review will explore Canada's first people from their origins, as well as after contact with the Europeans. An exploration of pre-contact history is important because “to understand Native cultures, it is essential to begin studying them from their origins” (Williamson & Roberts, 2004, p.4). Due to the fact that there is no written history from the time the First Nations began populating North America to the arrival of the 15th century Europeans, literature is based upon archeological and anthropological findings. It is also based upon teachings that have been passed down, and recorded in modern day, to younger generations through the First Nations' traditions of storytelling or oral history (Carter, 1999; Williamson & Roberts, 2004). It should be noted that, as could be expected of literature pertaining to pre-document history, the literature is not collectively conclusive and is sometimes conflictual (Carter, 1999; Dickason, 2009). Furthermore, literature pertaining

specifically to the regional pre contact history of the Carrier people is very limited (Fiske & Patrick, 2000).

The majority of contemporary anthropologists agree that North America's First Nations, collectively referred to as Paleo-Indians, came from the continent of Asia (Dickason, 2009; Goebel, Waters, & Rourke, 2008; Morrison & Wilson, 2004). There is some debate in the literature however, regarding the method and the time of this migration (Carter, 1999; Dickason, 2009; Ray, et al., 2010; Wright, 1995). The most popular theory is that migration came by way of a land bridge, referred to as Beringia, which existed intermittently across the Bering Strait 75000 to 15000 years ago. A less popular theory suggests that migration may have come, by boat, via the Pacific Ocean. Theories regarding the time line for this migration are also debated, with migration occurring anywhere between 15,000 to 50,000 years ago (Dickason, 2009; Goebel, Waters, & Rourke, 2008; Ray, et al., 2010). Other theories suggest migration occurred over time, in at least three separate streams (Morrison & Wilson, 2004).

These early people resided along the North West coast of the continent and eventually spread both south and east, as glacial melting allowed (Morrison & Wilson, 2004). It is beyond the scope of this thesis to discuss the existing archeological and anthropological evidence of these migration theories, or the debates surrounding them, within this literature review. However, there is general agreement that the First People of North America were *Homo sapiens*, or fully modern human beings, and that they had established settlements throughout North America about 11,000 years ago (Dickason, 2009; Goebel, Waters, & Rourke, 2008; Morrison & Wilson, 2004).

First Nations' people have their own traditional oral history of their origin. Traditionally, many First Nations' groups believed that they did not migrate to North America, but that they originated here (Carter, 1999; Dickason, 2009; Williamson & Roberts, 2004). Williamson and Roberts (2004), state that while these "creation stories" bear some similarities across Canada they are unique to each First Nation (p. 5).

Canada's First Nations people's value a legacy of oral tradition that provides an account of each group's origins, history, spirituality, lessons of morality, and life skills. Stories bind a community with its past and future, and oral traditions reach across generations, from elder to child. They bear witness to how women and men were created and populated the land. These descriptions of genesis are as varied as the religions of the First Nations, but all maintain that life began on the North American continent. (The Applied History Research Group, University of Calgary, 2000)

The Carrier people have specific creation stories. Stories that explain the creation of light, fire, and water are passed down through storytelling and also exist in pictograph form on cave and cliff walls throughout Carrier territory (personal communication with François Prince, February 27, 2013). I repeat one such story with permission from the Carrier man who shared it with me. The creation of light, I was told occurred as the result of an old man by the name of "Jiza". He was originally the only person on earth who possessed light. In this story, men and animals banded together to tire and trick the old man into releasing his hold on the light. Ever since this time, light belongs to all people.

Regardless of how the original people came to live in the north-western part of the continent, by creation or migration, literature informs us that this part of Canada has been inhabited by First Nations longer than any other part of Canada (Furniss, 1993; Morrison & Wilson, 2004).

First Nations Pre Contact

Socio-Cultural Organization.

Canada's First Nations people are believed to have first existed as small extended family groups of traveling egalitarian societies (Dickason, 2009; Morrison & Wilson, 2004; Ray, et al., 2010; Wright, 1995). These groups of 15 – 20 individuals may have traveled alone, moving as the environment dictated, to acquire food and shelter, and may have periodically joined with other small family groups. The survival of these early groups of people was dependent on cooperation and the use of individual skills for collective benefit. Their greatest asset was not possessions, as they would have had very few, but was knowledge of how to survive in their environment. All members of a group, including children and the elderly, had a role in the functioning and survival of the group. Roles were based on ability (Dickason, 2009; Morrison & Wilson, 2004; Ray, et al., 2010).

Pre-contact leaders achieved leadership status through their ability to motivate and provide for their group (Dickason, 2009; Morrison & Wilson, 2004; Ray et al., 2010). In very early times, there were no formal leaders. Leadership was often flexible and situational depending on the task on hand. Even once more formal positions of Chiefs existed; these positions were based upon skill and were conditional. As Dickason (2009) notes:

The power of Chiefs depended on their capacity to provide for their followers, as well as their power of persuasion: perhaps most importantly of all, they were expected to set an example for their people. Chiefs, instead of gaining wealth through their possessions, could end up the poorest of the group because of the continual demands made on their resources. (p. 25)

Individual group members were free to make choices but it was understood that the survival of the group and its members superseded any individual desire. The worst form of punishment was to be cast out from the group, as this banishment from the collective would most likely mean death (Dickason, 2009). This was particularly true in the climatically harsh conditions of north central British Columbia, where cooperation for survival of these First Nations' groups was paramount (Wright, 1995). As hunters and gatherers, survival was dependent on knowledge of the environment and the resources it offered (Dickason, 2009; Morrison & Wilson, 2004; Ray et al., 2010).

Early Healing Beliefs and Practices.

The beliefs and practices of early First Nations in maintaining individual health and community wellness were embedded in daily living (Dickason, 2009; Morrison & Wilson, 2004; Ray et al., 2010; Waldram, Herring, & Young, 2006). First Nations maintained an interconnected view of physical, spiritual, and emotional health. Similarly, the maintenance of a healthy state of being was interconnected with relationships with the physical and the supernatural worlds, as explained by Waldram et al. (2006):

Aboriginal medical systems, like all such systems throughout the world, are built upon coherent, rational understandings of the universe and people's

place within it. ‘Rationality’ must be understood to be a culture specific notion... Inherent in any group’s medical system are ideas about how disease is caused, what one can do to avoid the disease, and what types of treatment are called for. In general, Aboriginal people in Canada saw disease as the product of both natural and supernatural causes. (p. 129)

Treating an illness involved a combination of herbs, plants, and the spirit world (Waldram, et al., 2006; Waldram, 2008; Wright, 1995). First Nations Healers would specialize in a particular form of healing. Waldram, et al. (2006) suggested that there were “basically three types of healers; herbalists, medicine men, and shamans. The differences between them... is the degree to which spiritual assistance is required in the healing” (p. 133). The herbalist was the most skilled in the uses of medicinal plants and herbs, while the shaman held the strongest connection to the spirit world.

The use of the supernatural through ceremony was commonplace amongst First Nations people (McCormick, 2000; Waldram, et al., 2006; Waldram, 2008; Wright, 1995). One such ceremony, the “Shaking Tent”, is described by Waldram, et al. (2006):

The shaking tent ceremony had a variety of functions. Communication with the spirit world was integral to all ceremonies, and through such contact the Shaman, among other things, was able to predict the future (such as the weather, where game might be found, or that a sickness would soon arrive), locate lost objects, and diagnose the cause of illness. Characteristically, the shaking tent itself was small, often conical lodge made of branches and skin covering in which the shaman was seated or knelt... the shaman would sing

and invite his spirit helpers, and indeed any spirits, to enter the lodge. When they did so, the lodge would often shake violently, back and forth. The people outside would then hear a succession of voices of the spirits as they entered and communicated with the shaman. They were not the voices of the shaman however, and sometimes were in a language unintelligible to those on the outside (often considered an ancient language). (pp. 138-139)

Reference to the “sweat lodge” ceremony is also frequently found in the literature and is noted by Waldram, et al. (2006) to have been more common than the shaking tent ceremony. The sweat lodge was essentially used to cleanse the body and mind and to pray to the creator (McCormick, 2000; Waldram, et al., 2006). While the exact rituals performed when using the ceremony may have differed in various regions, the basic process involved a covered lodge into which hot rocks were placed. When the rocks were sprinkled with water, and sometimes herbs, the resulting steam enveloped the participants inside the lodge, thus causing them to sweat (Waldram, et al., 2006). The sweat lodge, like the shaking tent, involved a combination of nature (herbs, rocks, and water), prayer, and presence of spirits.

Of course, there is no way to determine the effectiveness of early traditional healing on either the body or the mind. Archeological evidence offers limited information regarding the kind of physical illnesses that were experienced by early First Nations (Waldram, et al., 2006; Wright, 1995). Through the examination of limited human remains and feces, it is concluded that “fungal, bacterial and parasitic infections afflicted pre contact people to varying degrees, depending on local socio-ecological conditions” (Waldram, et al., 2006, p. 46).

By the time the first Europeans, the Norse, reached the North Eastern coast, approximately one thousand years ago, a majority of North American First Nations estimated to be approximately 200,000 resided along the North Western coast of the continent. A second primary group, estimated at 60,000, inhabited the area now known as Southern Ontario. A remaining estimated population of 250,000 to two million were thinly scattered throughout the rest of Canada (Dickason, 2009).

Over time, these groups developed differing linguistic dialects (Morrison & Wilson, 2004). Again, it is beyond the scope of this thesis to present the literature regarding the history of these classifications or the debates of linguist professionals. However, Paleo-Indians, who resided in the North Western part of the continent, and some who migrated to the southern states, were eventually given the linguistic group name ‘Athabaskan’, also sometimes spelt “Athapaskan”, by European linguists in the 18th century (Morrison & Wilson, 2004). This linguistic group was eventually divided into three geographical groups; the Northern Athabaskan, the Pacific Coast Athabaskan and, the Southern Athabaskan. The Carrier belongs to the Northern Athabaskan language family (Morrison & Wilson, 2004). Many members of this larger language group, although differing in their dialects can usually understand some of what is said amongst members of the Athabaskan language family (Furniss, 1993).

The Early History of Carrier People.

Paleo Indians share a similar early developmental history. Over time however, subgroups of extended families established areas of residence and travel, based on food sources. According to Morrison and Wilson (2004), the people of central British Columbia

were given the name “Carrier” after first contact with Europeans. Prior to this, they had no collective sense of socio-political unity. They described themselves as ‘Uda Ukelh’. This is translated as meaning “people who travel by boat on water in the morning” (Furniss, 1993, p. 3). This name has been shortened to ‘Dakelh’ or ‘the people’.

Early Carrier lived as small extended family groups, similar to other early First Nations peoples. This extended family unit was the group with whom people traveled and lived with, and was central to social existence. Family groups had patterned seasonal activity (Fiske & Patrick, 2000; Morice, 1904; Morrison & Wilson, 2004; Wright, 1995). Generally, groups traveled to areas containing lakes, rivers, and streams for fishing during the summer months of July through September. Berry gathering and hunting large game occurred in the late summer and fall seasons. Once winter set in, groups would move to areas that supported ice fishing and snaring of small game. Late winter and early spring was generally the harshest of the seasons with winter stores of food often exhausted, deep snow that made movement more difficult, and game sparse. During these times, groups may have looked to other kinship groups for assistance or trade (Fiske & Patrick, 2000; Morrison & Wilson, 2004). By early spring, groups would begin to forage for plants and small game such as water fowl, beaver, and squirrel (Morrison & Wilson, 2004).

These early groups, although independent extended family units, had a network of social connection to each other (Furniss, 1993; Morrison & Wilson, 2004). Intermarriage and socialization were common. Groups would occasionally band together to make a stronger unit to accomplish a raid. They would also meet to trade goods or participate in social events (Carter, 1999; Fiske & Patrick, 2000; Morrison & Wilson, 2004). Over time,

extended family groups were identified by each other based on the geographical area in which they primarily lived. According to Morrison and Wilson (2004) many of these early groups maintained their stability over time, and still exist today in their original area, with their original identifying names. The suffix “whot’en” meant ‘people of’; this term was sometimes abbreviated to “t’en” which is reflected in the names of contemporary Carrier communities such as Nadleh Whut’en, Wet’suwe’ten, and Stelat’en.

Early groups of Carrier, described as “Bands” in the literature, had no formal or permanent leaders. Over time however, the Carrier began to organize into social and political structures. They eventually developed into three subgroups identified post contact as Southern, Central, and Northern Carrier. The Southern Carrier developed differing social and political systems than the Northern and Central Carrier.

The distribution of the 20 communities within these three sub groupings is outlined in Table 2.1. There are now three distinct Carrier dialects among the three Carrier subgroups (Furniss, 1993).

Table 1. Communities of the three Carrier sub-regions

Lower or Southern Carrier: Ulkatcho, Cheslatta, Lhoosk’uz Dene, Nazko, Red Bluff
Central Carrier: Lhedli T’enneh, Sakuz, Nak’azdli, Tl’azt’en, Takla Lake, Nadleh Whut’en, Stelat’en, Wet’suwe’ten, Yekooche
Northern Carrier: Hagwilget, Morrice Town, Nee Tahi Buhn, Skin Tyee, Babine Lake, Burns Lake

The Carrier people remained located in their present territory of what is now known as north central British Columbia (Adam, Holyk, & Shawana, 2003; Furniss, 1993; Morrison

& Wilson, 2004). Today, Carrier territory covers 500 square kilometers in the North Central region of the province. There are 22 Bands, or First Nations groups, that are identified as being Carrier. Although Carrier people are part of the Athabaskan language family, and share some similarities with other First Nations, each Band varies in their social and political structures (Adam, Holyk & Shawana, 2003; Furniss, 1993; Morrison & Wilson, 2004).

Carrier Social Structure.

While it is difficult to ascertain exactly when the Carrier people began to organize themselves into the social structures that exist today, Morrison and Wilson (2004) state that it was most likely sometime in the last two decades of the 18th century. Social structure refers to the way in which the Carrier people governed relationships between individuals and how they managed collective group functioning as a society.

The exact development of socially structured societies is debated in the literature. Morrison and Wilson (2004) indicate some anthropologists argue that matrilineal organization was the original social structure for Northern Athabaskan. Others claim that bilateral kinship was the original form of social organization and that the Central and Northern Carrier adopted the matrilineal form of organization, along with political hierarchy and potlatch systems, from their western neighbors, the Git'xsan (Morrison & Wilson, 2004). In the Git'xsan Nation, social hierarchy and status were believed to be associated with the need to position groups for economic success both through trade and natural resources. Central and Northern Carrier are said to have become aware of the benefits of the Gitxsan's hierarchical structure in matters of trade and rights to hunting and fishing grounds, and therefore adopted this structure (Morrison & Wilson, 2004). Higher status groups came to

have increased rights. Titles and crests were bought and earned by houses and these were then displayed on totem poles, ceremonial regalia, and on tattoos of individual house members (Morrison & Wilson, 2004). While early post contact literature, mainly written by male Europeans, indicated it was primarily men who held positions of leadership and healing, oral tradition that has been recorded in the literature suggests that these positions could belong to men or women (Carter, 1999; Fiske, 1996). Over time, therefore, political and leadership structures evolved differently within the larger Carrier groups (Morrison & Wilson, 2004).

By the time Europeans were recording the social structure of the Carrier people after contact, Southern Carrier group organization was based on bilateral kinship centered on extended families consisting of brothers, their wives and children, and married sons' families. Each group, known as a sedeku, was associated with hunting, fishing, and gathering territory. Women usually joined their husband's family group, although family groups and adult children could choose to join another extended family group for a variety of social or environmental reasons. These groups based leadership on the historical Athabaskan tradition of informal and situational leadership. The family leader, referred to as the detsah would generally be the eldest male sibling of an extended family group and would lead, as long as his recommendations were seen as sound (Morrison & Wilson, 2004).

In contrast, Central and Northern Carrier social and political organization was based on matrilineal descent groups and hereditary leaders (Furniss, 1993; Morrison & Wilson, 2004). In a matrilineal structure, children became members of their mother's clan. Central and Northern clans were further divided into houses. 'Houses' were political governing

groups that may be related. Each house was led by a hereditary chief. The Northern and Central Carrier are the focus of this dissertation.

Potlatches were important ceremonies in the social and political function of the Central and Northern Carrier (Adam, et al., 2003; Fiske & Patrick, 2000; Morrison & Wilson, 2004). Potlatches, referred to as “Balhats” by the Carrier, were held by clans to solidify political status and to commemorate special events such as deaths, marriage, and the inheritance of names. Food and other items of value were given to potlatch participants as a form of payment to people for witnessing the business occurring in the potlatch. Members of each community were connected by extensive kinship ties which served as a framework for the inheritance of trap lines and the exchange of goods and services.

The traditional economy of the Carrier was based on wildlife including fish, caribou, moose, bear, marmots, and beaver (Furniss, 1993; Wright, 1995). Carrier people also gathered and traded berries and plants. They used trade routes to exchange food and hides with each other. These routes became known as Grease Trails because many of the things traded involved animal grease or fish oil. The Carrier had extensive trade ties with neighboring groups such as the Git’xsan and Sekani (Furniss, 1993; Morrison & Wilson, 2004).

Health, Healing and Spirituality of Carrier People.

Similar to other Canadian First Nations people, Carrier people held a belief that all things were interconnected (Furniss, 1993; Hall, 1992; Morrison & Wilson, 2004). This belief was intertwined with all functions of life. Maintaining health and being prosperous in hunting was believed to be dependent on balance and respect of the physical and spiritual

space in which the individual existed. Carrier people believed that all things had a spirit. As Morrison and Wilson (2004) state:

While survival depended on practical knowledge, it was also important for people to live according to certain standards of conduct. The Carrier believed that all animate and inanimate objects in the world had a spirit. People's survival depended on their ability to maintain balanced relations with all the spirits in the land; if they did not, animals would not give themselves to hunters. Balanced relations were kept by living according to ethical standards and by performing rituals. These ethical concepts were encoded in oral traditions, which served as primary educational devices for children's moral training. (p. 212)

Each man and woman would make effort to gain personal power that was used to gain favor of the spirit world, particularly in success of hunting. "Duyun" the Carrier word for power was necessary for success (Furniss, 1993, p. 48). Duyun was gained and maintained by people through observing certain rituals and respect for the environment. One such ritual, the sweat lodge was a widespread practice of Carrier people. Carrier hunters would participate in a sweat to purify their bodies in preparation for a hunt (Furniss, 1993). Furniss (1993) explains that an alternate way of gaining Duyun or preparing for a hunt was for the hunter to cleanse his body by walking through smoke produced by burning juniper boughs.

All of Carrier livelihood, health, and wellbeing followed this concept of living in harmony with the natural environment. Children were taught to respect their environment

including the spirit world. If an individual was disrespectful to the spirits, he or she may invite ill health. Furness (1993) discussed this aspect of spirituality as it related to health:

When a person became sick, he or she was first treated with herbal medicines. All adults knew how to prepare and use these medicines. Some illnesses, though, could not be cured easily. If the person did not recover in a reasonable amount of time, he was believed to be suffering from a spirit illness. This could be because the person has violated some ritual, or had acted disrespectfully toward the spirits. (p. 61)

In cases when a person could not be cured through the use of herbs, a medicine person would be called in to help. Medicine people were men or women who were thought to have high levels of Duyun or power (Furniss, 1993; Hall, 1992). Power came from both knowledge of herbs and a connection with the spirit world. These people, referred to as Duyunne, had power to heal by herbs and by spiritual power. Both Furniss (1993) and Hall (1992) suggest that Duyunne were both respected and feared in earlier Carrier culture. When a person had a particularly strong relationship with a spirit, they were referred to as Nelhjun (Furniss, 1993). Nelhjun were powerful enough to manipulate the spirit world to kill or cure people. Nelhjun could be either men or woman and could come to their position at any time from childhood through to the later years of their lives, through a variety of pathways, as described by Furniss (1993):

Both men and women may become Nelhjun. In earlier times a person could make a deliberate attempt during the puberty ritual to acquire an especially strong relationship with one or several animal spirits. Others might have these

powers come to them spontaneously. Still others might have these powers passed down to them from other Nelhjun. Through adulthood, the person further refined and developed his or her power, until finally they became recognized as full Nelhjun. Some people had their power come to them in their elderly years. (p. 61)

Historically, Carrier people negotiated a way of life with their environment and spirit world (Fiske & Patrick, 2000). They had established social and belief systems that guided their daily lives. Inevitably, travelers from outside of the country would make contact with the First people of North America and would result in a dramatic change to their way of life.

First Contact

As briefly mentioned in the introduction of this paper, the first documented European contact with North America's First Nations occurred in the 10th century with the Norse. This contact, and subsequent failed attempt at settlement, occurred in the North East coast of what is now Canada (Dickason, 2009). Documented history indicates that the American continent was then left largely untouched by non-First Nations until 1492, when a Spanish expedition lead by Italian born Christopher Columbus, landed on the islands off the coast of South Eastern North America, in what is now known as the Bahamas and Cuba (Morrison & Wilson, 2004). Columbus himself made subsequent voyages across the Atlantic and by his fourth visit, reached the mainland of the Americas, specifically, Central America. This discovery sparked interest and increased travel to America by Europeans. In 1497, a second Italian, John Cabot, this time leading a British expedition, is believed to be the first European, after the Norse, to reach the eastern coast of what is now Canada (Morrison & Wilson, 2004). It is beyond the scope of this paper to summarise the subsequent conquests

and settlements of Europeans in the Americas after contact by Columbus and Cabot.

However, it will suffice to say that this contact was the beginning of European movement throughout America that would dramatically change the lives of First Nations.

It took almost 300 years from the time of John Cabot's arrival to the time of the first European contact with Carrier people (Carter, 1999; Morrison & Wilson, 2004). Alexander Mackenzie was the first European to travel into Carrier territory, beginning in 1793 (Carrier Sekani Tribal Council, 2011; Morrison & Wilson, 2004). He was followed by Simon Fraser, who established trading posts in the area from 1805-1807. In 1807 Simon Fraser built an 83 mile road from Ft. St. James to Ft. McLeod, which was the first colonial developed road in the territories. Mackenzie and Fraser wrote journals describing the First Nations they encountered. Later, as contact and trade became more established, missionaries added to this documentation. Once such missionary, Adrian Gabriel Morice, arrived in Carrier territory sometime around 1885. He is credited with documenting the most comprehensive ethnographic and linguistic material of the Carrier people (Morrison & Wilson, 2004).

As Europeans began trading with the bands in this area, they identified the smaller family bands as collective groups (Fiske, 1996; Morrison & Wilson, 2004). It is likely that it was the Carrier's neighbours to the North, the Sekani, who gave the central British Columbia First Nations the name "Carrier" that the Europeans used to refer to the collective group (Furness, 1993; Morrison & Wilson, 2004). Members of a Sekani Band acted as guides for Mackenzie's first journey into Carrier territory (Morice, 1904; Morrison and Wilson, 2004). According to Morrison and Wilson (2004), "Carrier" is an English translation of the Sekani word "Aghel", translated into English as meaning "the ones who pack" (p. 203). Several

bands of the time had descriptive names for their neighbors. Had Mackenzie approached the Carrier people from another direction, thus traveling through an alternate group of First Nations, the traders would have likely been provided an alternative descriptive name (Morrison & Wilson, 2004).

Furness (1993) indicated that there are two primary theories to the coining of the name Carrier. The first, she indicated, is reflective of the fact that the Sekani had horses to carry their possessions, the Carrier did not, and instead Carrier carried their possessions themselves, on their backs and in canoes. The second theory which, appears more commonly in the literature, indicates that the name was given as a result of the custom of Carrier widows carrying the cremated remains of their husbands on their backs for four seasons, after which time a grieving ritual would be conducted to release the woman of her burden and end her period of mourning (Fiske & Patrick, 2000; Furniss, 1993; Helm, 1981; Jenness, 1937). As previously mentioned, Carrier people identified themselves to foreigners as Dakelh (Furniss, 1993).

Today, the name “Carrier” appears most commonly in the literature to refer to the First Nations of north central British Columbia. Carrier people recognize that they have similarities with the larger group of Athabascan speaking people. This acknowledged relationship causes the Carrier people to sometimes refer to themselves as part of the Dene Nation, an Athabascan term translated to mean the people of the original group of North Americans (Furniss, 1993).

Government Intervention in the Lives of Canada's First Nations People

The arrival of Europeans would radically change the way in which all First Nations people lived in the Americas (Haig-Brown & Nock, 2006; McMillan & Yellowhorn, 2004; Shewell, 2004). It is beyond the scope of this dissertation to provide details regarding the specifics of European migration, or the conflicts and alliances that occurred from first contact to eventual British rule in 1763 (Belanger, 2008; Aboriginal Affairs and Northern Development Canada, 2011). Nor, will it give opinion of conflicting interpretations found in the literature regarding British and Canadian government policies concerning Aboriginal people. As indicated by Belanger (2008):

One mere chapter cannot explore the history of the past four centuries, from the eras of peace and friendship treaty-making between sovereign nations based upon mutual respect and military alliances through the decades of racism and oppression or the more sporadic attempts at rebuilding a sense of partnership (p. 39).

This section will instead provide a factual overview of primary government interventions that affected the lives of First Nations who resided in what is now Canada. It is reasonable to infer however, that government policy, whether one has the opinion that it was developed based on good or ill will, was created with First Nations people as the subjects rather than willing partners of its development (Shewell, 2004). It is also reasonable to conclude that government policy contributed to the devastating impact on the health and wellbeing of Canada's First Nations (Belanger, 2008; Haig-Brown, 1988; Haig-Brown & Nock, 2006; Shewell, 2004; Tanner, 2009). As Shewell (2004) summarizes:

The strategy for dealing with Indians and their lands, as articulated by the Crown, assumed a de facto sovereign-subject relationship. This assumption carried with it two implications. First, Indians were not considered self-determining peoples; instead they owed their continued existence to the Crown's pleasure. Second, the First Nations' own history as independent peoples was moribund; their future now lay within western civilization, however that history unfolded. (p. 7)

From time of first contact, First Nations and European relationships ranged from cooperation to conflict (Belanger, 2008; Haig-Brown & Nock, 2006; Shewell, 2004). By 1763, the so called "Seven Year War" or "French Indian War" saw conflict and alliances on the Eastern side of the continent amongst First Nations, French, and English. This conflict came to an end when Britain prevailed (Shewell, 2004). The Royal Proclamation of 1763 outlined relationships between First Nations and the new British rulers in matters primarily pertaining to land and European settlement (Aboriginal Affairs and Northern Development Canada, 2012; Library and Archives Canada, 2006). While the Canadian government maintains that the proclamation was intended to foster positive relationships with First Nations; it also acknowledges the inherent paternalistic attitude of British rulers toward First Nations people.

The Indian Act of 1867.

Due to war, disease and, starvation, First Nations populations had been reduced significantly from first contact to time of confederation in 1867. In the first available reliable statistical report in 1871, First Nations' represented only 2.8 percent of the general Canadian

population (Shewell, 2004). First Nations had become a minority population in Canada and government control over them continued to increase. Efforts to amalgamate all previous legislation concerning First Nations people into one resulted in the Indian Act of 1876 (Cote, 2001; Makarenko, 2008). The Indian Act of 1867 was a key piece of Canadian legislation that is arguably a watershed mark in First Nations' history. Primary features of the Indian Act will be described here and include government dictation of First Nations' membership, political systems, application of the Reserve system, and the implementation of Residential Schools. These social policies are important to understanding the cultural and community anomie and the resulting high rates of alcoholism, suicide, and social suffering amongst First Nations people.

To begin, the Indian Act of 1867 determined who could be seen as "Indian" in the eyes of the government. Under this Act, anyone thought to be part white or "Half Breed" would be considered white. The Act dictated the status of women, in particular. The European view of women holding a subservient position to men was in contrast to traditional First Nations' views where women were valued as the "givers of life" (Boyer, 2006, p.8). Under the Indian Act however, if a First Nations woman married a non-First Nations man, she would lose her First Nations status. Any non-First Nations woman, who married a status First Nations man, would be considered a Status Indian. (Canada in the Making, 2005a; Canada in the Making, 2005b; Henderson, 2012).

The potlatch, discussed previously in this chapter as an important political and social gathering amongst Canada's First Nations, including the Carrier, was outlawed in 1884 through an amendment to the Indian Act. This is said to have occurred as a result of the

desire of religious sects, primarily the Protestant and Catholic Churches, and the federal government, to further control and assimilate First Nations (Fiske & Patrick, 2000; Haig-Brown & Nock, 2006; Shewell, 2004). With this move, the government abolished the structure the Carrier used to officially interact with one another on the issue of leadership and social relationships (Shewell, 2004). This act was not amended again to allow the potlatch system to occur until 1951 (Aboriginal Affairs and Northern Development Canada, 2012).

The reservation system, also implemented under the Indian Act, was a set of legal and administrative provisions that led to the sedentarization of Aboriginal people across the country (Tanner, 2009). Through this system, First Nations people were forced into government dictated geographical boundaries that caused great damage to their former ways of living, and weakened the functional socio-political systems of First Nations (Dickason, 2009).

Canadian anthropologists have debated whether reserve communities constitute 'real' communities. There is also discussion in the literature regarding how reserve culture has contributed to negative social and health experiences among its residents (Carstens, 2000). This may be the result of a lack of self-determination amongst its residents;

In the debate about reserve social structure, one common theme has been to suggest that this form of society (and, by implication, the social problems of its members) has been strongly influenced by the government control found there, as well as the generally corrosive influence of mainstream Canadian society, towards which Reserves seem to be on their way to becoming a marginalized component. (Tanner, 2009, p. 432)

Therefore, the concept of the reserve as being a government imposed place of residence in and of itself, contributes to development of marginalisation. The reserve system has been described by some as a case of social engineering, or centralized social planning, with little to no attention paid to the local practical knowledge or way of life (Tanner, 2009).

Another social planning initiative that was a direct outgrowth of the Indian Act was the development and implementation of the Indian Residential Schools, mandated in 1879 (Kirmayer & Valaskakis, 2007). This would set the wheels in motion for what was to become a widespread forced European style education of Canada's First Nations people. This movement is blamed with being a primary contributing factor to the present day state of emotional and social problems experienced by First Nations people (McMillan & Yellowhorn, 2004; Haig-Brown, 1988). The Canadian government of the time viewed Aboriginal people "as uncivilized and hence unable to exercise rights as citizens in a democratic polity" (Kirmayer & Valaskakis, 2007, p. 6). "The *Bagot Commission Report* (1844) argued that reserves in Canada were operating in a "half-civilized state" and that in order to "progress towards civilization Aboriginal people needed to be imbued with the principles of industry and knowledge through formal education" (Kirmayer, et al., 2000, p. 9). Thus began the active process of assimilation, reinforced by the Davin Report (1879), which recommended a policy of aggressive civilization. Many residential schools were run by religious groups, primarily the Roman Catholic and Anglican churches. Based on European schools models, they were designed to indoctrinate First Nations children to the language, values, customs, and ethics of "white society" as wholly as possible (Haig-Brown, 1988; Kelm, 1998). By 1884, it became mandatory for all First Nations school aged children less than 16 years to attend government-mandated schools (Archibald, 2006).

Pointing (1997) discusses how the residential school format was believed to be an effective model to accomplish the objective of bringing First Nations people into Western European culture. He describes what an earlier academic, Erving Goffman, calls the 'Total Institution'. Pointing (1997) gives a description of a total institution and argues that this was the intended function of the Indian Residential Schools. "A total institution is a confining formal organization usually intended to forcibly change people's behaviors and self- concept by means of the rigid structuring of daily routines and assault upon personal dignity and autonomy" (p. 5).

There are many accounts of forced assimilation in the Indian Residential Schools (Haig-Brown, 1988; Kelm, 1998; McMillan & Yellowhorn, (2004). Students were forbidden to speak their languages or practice cultural rituals, brothers and sisters were separated, and contact with parents was limited. There are also accounts of harsh treatment of students; they were expected to do physical labor to assist in the operations of the schools and corporal punishment was used regularly (Haig-Brown, 1988; McMillan & Yellowhorn, 2004). Many children were exposed to infectious diseases in residential schools and improper segregation of ill children promoted spread of disease and inefficient medical attention impeded recovery (Kelm, 1998).

Formal strict educational environments were a complete contrast to the way First Nations people were living prior to the Indian Residential Schools (Haig-Brown, 1988). As identified by McMillan and Yellowhorn (2004):

First Nations People collided with modernity with little to buffer, filter or mitigate the experience. They lost traditions, languages, and life ways. Yet,

they were expected to embrace modernity and thrive in its various forms without vocations, skills, or worst of all, hope. (p.316)

This collision had a devastating impact on First Nation people's sense of cultural belonging and has negatively affected the feelings of self-worth on every generation since (Pointing, 1997; Thomas & Bellefeuille, 2006).

Lejac Indian Residential School was situated in the heart of Carrier territory, on highway 16 east of Fraser Lake. Many Carrier children attended Lejac during its operation from 1922 through 1976. The exact number of students who attended is unknown (Fiske, 1996; Indian Residential School Survivors Society, n.d.).

In response to growing concern over substandard education for First Nations children in residential schools, the federal government made the decision in 1971 to close all residential schools as soon as it was possible. Although the majority of Indian Residential Schools were closed by 1980, the last Indian Residential School in Canada did not close until 1996 (Archibald, 2006). Within ten years after Canada's decision to close the residential schools, a landslide of allegations of physical and sexual abuse of former residential schools students occurred (Archibald, 2006). These allegations, which were followed by legal proceedings, resulted in the Canadian government and the churches involved in running residential schools, to take accountability for the damage they had caused First Nations people as result of the schools.

In 1972 the National Indian Brotherhood released a paper titled Indian Control of Indian Education (Assembly of First Nations, 2010). This paper reviewed the history of Canada's First Nations education under federal government policy. The paper identified

errors in these policies and made a statement that First Nations were moving forward with control over the education of their future generations with expected cooperation of the federal and provincial governments. In the 2010 follow up paper, the Assembly of First Nations reported ongoing success with the 1972 plan. At the time of the report there were 518 schools located in reserve communities that were under the control of First Nations administration (Assembly of First Nations, 2010).

In 1993, the Anglican Church formally apologized to First Nations people for the part the church played in the support of residential schools. In 1998, both the United Church and the Canadian government offered similar apologies (Government of Canada, 2010). By this time, it was generally accepted that the abuse endured by students was widespread and included sexual, physical, and verbal abuse, substandard food, and harsh labor. In addition, the very philosophy of the residential school to assimilate children into European society was recognised as being damaging. This included removing children from their families and communities, limiting contact with parents and forbidding the children to speak their language or observe any cultural practices (Haig-Brown, 1988; Kelm, 1998; McMillan & Yellowhorn, 2004).

In 1996, the Royal Commission of Aboriginal peoples report was released (Aboriginal Affairs and Northern Development Canada, 2010b). This paper provides an overview of the history of the Canadian Government and First Nations' relationship. It is a direct account of the historical circumstances that contributed to a failure in fostering a positive relationship between First Nations and the government. It also reviews the negative

and harmful outcome for First Nations. The paper called for a spirit of renewal and renegotiation between Canada and First Nations.

In 1997, the Canadian government released its document, *Gathering Strength-Canada's Aboriginal Action Plan*, that outlined the government's planned response to counter the damage done through colonisation including, the Indian Residential Schools (Minister of Indian Affairs and Northern Development, 1997). In November 2005, the federal Government of Canada announced it was releasing two billion dollars for Indian Residential School compensation. A large portion of these dollars would be awarded directly to Residential School Survivors as compensation payments (Weber, 2005). The remaining portion of the budget would be used to fund community driven healing initiatives, provide direct mental health counseling to survivors, and fund the "Truth and Reconciliation Project". This project involves recording survivors' stories and informing the general public, through these stories, about the plight of First Nations in the residential schools. At time of writing this dissertation the Aboriginal Healing Project had completed its mandate for funding community healing initiatives. The Truth and Reconciliation project was ongoing.

Interestingly, the Government of Canada made an attempt to remove factors of the Indian Act that identified First Nations' people as different from the remainder of Canadian citizens. The so called White Paper was produced by in 1969 by Minister Chrétien under the Trudeau Government (Aboriginal Affairs and Northern Development Canada, 2010a). This paper called for the removal of special considerations to Canada's First Nations people, citing that they should be assimilated into general Canadian society. This paper was met

with rejection by the First Nations community who feared such a move would cause a further loss of First Nations culture (Steel, 2003).

Child Welfare and Canada's First Nations.

The federal government passed the responsibility of the welfare of First Nations children to the provinces in 1951 (Milner, 2001). The role provincial child welfare services played in the lives of Canada's First Nations is complex. I will provide only a brief overview here, but note that it represents another important layer of government and First Nations' relations.

By 1951, many First Nations' families had experienced at least one generation of residential school involvement, depending on residence in various parts of the country. Former residential school students had minimal parental role models and suffered from the effects of childhood separation from their families, abuse in the schools, and loss of cultural identity (Alston-O'Conner, 2010; Haig-Brown, 1988). This, coupled with the other negative effects of colonization, resulted in provincial government concern regarding the ability of First Nations to safely parent and care for their children. Therefore, acting under their newly federally sanctioned authority, provincial child welfare authorities went onto reserve and assessed child safety. The agents of the provinces, primarily child welfare social workers, disregarded reservation based factors such as culture and poverty (Alston-O'Conner, 2010; Blackstock, Brown, & Bennett, 2007). The provinces followed what is known as the life and death policy whereby they only intervened when they assessed that a child was in imminent risk of harm (Hudson, 1987). This meant that intervention to strengthen the family unit and parenting skills were not offered. Instead intervention was provided only when removal was

the only perceived option. This intervention resulted in the removal of thousands of First Nations children from their homes, some permanently, in what literature now refers to as the “Sixties Scoop”. This term was coined by Patrick Johnston (1983) who was a researcher with the Canadian Council on Social Development at the time (Alston-O’Conner, 2010; Milner, 2001). In 1959, one percent of children in care were First Nations. As a result of the Sixties Scoop, one in four First Nations’ children were removed from their families and by the late 1960s up to 40% of children in care were First Nations. This is a significant percentage considering First Nations represented only 4% of the entire Canadian population at that time (Alston-O’Conner, 2010). As of 2010, 8% of British Columbia’s children were First Nations, yet 52% of children in government care were First Nations (Kozlowski, Sinha, Hoey, & Lucas, L. 2011).

By the early 1980s Canada’s First Nations became increasingly concerned regarding the high numbers of their children who were being removed from their families and communities (Blackstock, Brown, & Bennett, 2007; Hudson, 1987). As a result, First Nations began to take a more active role in the care of their at risk children. This decade saw movement across the country towards First Nations agencies receiving levels of delegation to providing child welfare services to First Nations children. At the time of the preparation of this document, there were 22 First Nations agencies in some level of delegation in British Columbia representing 148 First Nations Bands (Province of British Columbia, 2013).

Health and Welfare of Contemporary First Nations Populations

The 2006 Canadian census, the most recent full census done regarding First Nations people, recorded 1,172,790 Canadians identified as First Nations. This included 50,485 Inuit and 389,785 Métis people (Statistics Canada, 2006). It is noteworthy that the number of

people identifying as First Nations has been increasing steadily since 1996. The 1996 census report of First Nations people indicated 139,655 British Columbians identified themselves as First Nations. In 2001, this number had increased to 170,000. BC Stats posts a caution on its website informing the reader that this rise is not due to natural population increase but is most likely due to increased comfort with First Nation identification (Province of British Columbia, 2011a). In British Columbia today, there are approximately 196,075 residents who identified as First Nation (Province of British Columbia, 2011a). Of this number, 110,550 were registered under the Indian Act. This number represents 4.4% of the entire population of British Columbia.

While the First Nations population of British Columbia is less than 5%, the First Nations population of the less populated half of the province, Northern BC, is almost 20% (Province of British Columbia, 2011a). Of approximately 51,055 on reserve resident's province wide, approximately 15,095 are living on reserves in Northern British Columbia. There are 198 First Nations communities in British Columbia, with 48 of these communities located in the Northern half of the province (Government of Canada, 2012). The overall health status of First Nations people is consistently reported as being poorer than the rest of the Canadian population (Bailey, Calloway, Gebremarian, et al., 2002; Clark & Riben, 1999; Health Canada, 2009; Kendall, 2001). For example, in 1990 Health Canada reported that First Nation females had a life expectancy that was 6.8 years shorter than the general Canadian female population; males had, on average, reduction in life of 7.4 years. In the year 2001, this range had decreased only slightly for females to 6.6 years and little more for men to 6.1 years (Auguste Solutions & Associates, 2004). Chronic disease, life threatening illness, and accidental death are reported as being more prevalent in First Nation

communities (Bailey, et al, 2002; Clark & Riben, 1999; First Nations and Inuit Regional Health National Steering Committee, 1999; Health Canada, n.d.; Kendall, 2001). Bailey, et.al, (2002) reported that diabetes is three to five times higher amongst First Nations people when compared to the general Canadian population. The Province of British Columbia's Provincial Health Officer reported that heart disease is 8% higher in BC's First Nations populations and high blood pressure is 10% higher (Kendall, 2001). Most reports on First Nations' health mention that poor living conditions such as housing shortage, poverty, low educational levels, and general effects of colonization directly affect health status (Bailey et al, 2002; Clark & Riben, 1999; Health Canada, *n.d.*; Kendall, 2001).

Literature regarding the mental health status of First Nations and Inuit populations is scarce (Auguste Solutions & Associates, 2004; Corrado & Cohen, 2003; Smye, 2004). As stated in the introduction of this document, discussions of mental health in this dissertation include the spectrum of diagnosable chronic and severe mental illness to non-chronic mental health problems. There is no conclusive data that provides evidence that rates of severe and chronic mental illness, such as schizophrenia, amongst Canada's First Nations are different than that of the general population (Kirmayer, McDonald, & Brass, 2001; Reading, 2009). However, it is generally accepted that "common mental health disorders (depression, anxiety, post-traumatic stress disorder) are epidemic in Aboriginal communities" (Kirmayer, et al, 2001, p. 12). This appears to be a result of issues associated with colonisation. Literature suggests that general mental health concerns, such as social and emotional wellness, amongst First Nations need more attention. As Smye (2004) indicates, "Instead of thinking about mental health problems as medically defined disorders, many Aboriginal caregivers and policy analysts believe that it is more appropriate to focus on the social and mental health

issues that pose the most serious threat to the survival and health of Aboriginal people and their communities” (p. 6). These issues are generally identified and include poverty, violence, low self-worth, cultural identity, suicide, substance abuse, and sexual abuse (Corrado & Cohen, 2003; Kirmayer & Valaskakis, 2007; Smye, 2004). These social and emotional conditions are directly related to the events of colonization, “It seems clear that intensive interactions with colonizers, settlers, and the economic, technocratic and bureaucratic institutions of Canadian society have been major determinants of the social distress experienced by Aboriginal communities today” (Kirmayer & Valaskakis, 2007, p. 2).

As evidence of the direct negative impact colonization has had on First Nations, the Aboriginal Healing Foundation (AHF) published information regarding the mental health status of Indian Residential School (IRS) survivors (Corrado & Cohen, 2003). This report presented findings of a 2001 research project that examined the mental health status of 127 British Columbia IRS survivors. All of the 127 subjects had been involved in litigation with the federal government or church groups regarding residential school. The data was gathered through a secondary data analysis of clinical case files. Most (85%) of these files existed due to a court ordered psychological evaluation conducted during the course of the IRS settlement litigations. The research showed that 93 subjects’ files contained a mental health diagnoses. The most common diagnoses were Post Traumatic Stress Disorders (PTSD) at 64.2%. This was followed by substance abuse disorder at 26.3% and then major depression disorder at 21.1%.

Issues associated with colonization and current conditions on reserve are blamed for high suicide rates (Chandler & Lalonde, 1998; Chenier, 1995). Canadian First Nations’

suicide rates are reported as being 3.3% times higher than the national average (Chenier, 1995). First Nation youth suicide, in particular, is seen as an urgent issue in Canada (Health Canada, 2012a). Overall rates of youth suicide are seven times higher than in the general youth population, and 11 times higher among Inuit people. Inuit youth suicide rates are cited by Health Canada (2012a) to be amongst the highest in the world.

Substance abuse has long been identified as contributing to the poor mental and physical health of First Nations people. Alcohol abuse specifically has been a topic of focus, “in the area of Indigenous mental health, no other topic has dominated the research and discourse as much as alcohol and none has generated such a combination of perverse curiosity and genuine concern” (Kirmayer & Valaskakis, 2007, p. 315). Recent information suggests that First Nations living on reserve report abstinence more frequently than the general Canadian population. The national average of adult Canadians who drink any alcohol was 79.3%, while First Nations populations reported a 65.6% consumption rate. However, of those who did report they drank alcohol, twice as many First Nations people reported that they are heavy drinkers (Health Canada, 2009). A 2007 federal report showed that a significant number of on reserve residents reported substance abuse as being a primary problem in their communities. The majority of this population, 73%, reported alcohol was a problem and 59% reported that drugs were a problem (Chansonneuve, 2007). This same document reported that alcohol related deaths amongst First Nations were almost twice the rate of the general population and death due to illegal drug use was three times higher than the general population. Denis Wardman, of the First Nations and Inuit Health Branch, Health Canada has identified that prescription drug abuse amongst Aboriginal people has

joined illegal drug use as a significant concern (Wardman, Khan, & el-Guebaly, 2002; Wardman & Khan, 2004).

Problems with drug and alcohol abuse have been identified as a primary reason for people accessing mental health services through Carrier Sekani Family Services (Holyk, Heaney, & Adam, 2007). The report, which involved 170 clients from on-reserve bands in the Carrier and Sekani territories, indicated that 20% of people attended mental health services for addictions issues, 15% for depression, and 7% for loss and grief issues. Suicidal ideation occurred in 6% of all mental health intakes for the 2007 calendar year.

Conclusion

The history of Canada's First Nations is a progression of an ancient people through to present day. Carrier First Nations, presently located in central northern British Columbia, represent the descendants of Canada's earliest inhabitants, living in their original location. Available literature illustrates how early Carrier not only survived in the harsh climate of northern Canada, but had a culture rich in family relationships, social organization, and a worldview that involved a connection with the environment and the greater universe, as they understood it. It is also clear that First Nations had a distinct worldview and structure for managing issues of health and wellness.

The manner in which European colonization and assimilation efforts occurred is accepted as being the catalyst for the modern troublesome social and health status of many of Canada's First Nations:

Although mental health problems are reflections of ordinary human vulnerabilities and can be found in every population, the elevated rates of

suicide, alcoholism, domestic violence and the pervasive demoralization seen in many Aboriginal communities can be readily understood as both direct and indirect consequences of this history of colonization, cultural oppression, loss of autonomy, dislocations and disruption of traditional lifeways, and connection to the land. (Kirmayer & Valaskakis, 2007, p. 41)

The following chapter provides an overview of the development of services aimed at improving the health and wellbeing of Canada's First Nations and First Nation rise to reclaim culture, and with it, health.

Literature Review Part 2:

The Evolution of 21st Century First Nations Health Care

This chapter contains the second part of the literature review of this dissertation. In this chapter, I will present a review of the literature specific to modern day health and healing issues amongst Canada's First Nations. This begins with a chronological summary of government provided health care services, which, began in the late 1800s. The evolution of these services paralleled the decline of First Nations' health and healing traditions. It is necessary to provide an overall summary of 'health', and not just 'mental' health services because, mental health services are intertwined with the evolution of all government provided First Nations' health services. However, whenever possible, mental health services will be referred to specifically and where appropriate, I will make specific reference to health services in Carrier territory.

The latter half of this chapter will explore the primary contemporary issues described in the literature regarding First Nations' mental health services. This chapter will conclude with a review of the current First Nations movement of reclaiming traditional ways of knowing.

The Beginnings of Government Provided Health Care

Federal government policies of health care for Canada's First Nations evolved through an attitude of reluctant responsibility (Waldram, Herring, & Young, 2006). Its development is intertwined with the ideologies that drove policies of assimilation during colonization. Its beginning dates back to the late 1800s. Shortly after confederation, between 1871 and 1921, the federal government signed a number of treaties with Canada's

First Nations. A majority of these pertained to issues of land and access (Canada in the Making, 2005b; Waldram, et al., 2006). In the later part of the 1800s, many First Nations were suffering ill health due to disease and starvation. The impact of colonization, including the introduction of diseases new to First Nations and a decline in previous hunting and gathering activity, contributed to this state of ill health. As was discussed in the previous chapter, traditional health and healing practices were diminishing due to developments associated with colonization (Hill, 2009).

The Plains First Nations, in particular, were impacted by the disappearance of the buffalo, a primary food source. As a result, Treaty 6 of 1876, an agreement between the Crown and the “Plain and Wood Cree Indians and other Tribes of Indians at Fort Carlton, Fort Pitt and Battle River with Adhesions” involved agreements aimed at improving health (Duhamel, 1964). Specifically, Treaty 6 included promises of provisions of tools, seed, fishing nets, and livestock to aid in acquiring and cultivating food and, “access to a medicine chest” that “shall be kept at the house of each Indian agent for the use and benefit of the Indians, at the discretion of such agent” (Duhamel, 1964, para 25). Treaty 6 was the only numbered treaty that refers specifically to provision of medical care (Waldram, et al., 2006). This provision however, has been a source of controversy between the federal government and First Nations for decades:

The question of whether a treaty right to free comprehensive medical services exists for status Indians is one of the most controversial areas in Aboriginal health care. While the courts have ruled in favor of the Federal government’s view that no rights exist, treaty language written in the last century, speaks of access to a medicine chest, in reference to a

government commitment to provide health resources. Many Aboriginal organizations argue that the spirit and intent of the medicine chest clause means that Aboriginal people have a right to be provided with the best possible medical care available at the time (Kendall, 2001, p. 86)

Therefore, First Nations have maintained that the “medicine chest” clause entitles all of Canada’s First Nations, and not just the Plains First Nations with whom the treaty was signed, to accessible, modern, publicly funded, health care. The federal government has largely denied this claim. However, the government could not deny the ill health of the First Nations population post contact, and did historically provide some level of medical care to First Nations throughout the country (Waldram, et al., 2006).

The Department of Indians Affairs, established in 1880, had a mandate to provide First Nations with “medical assistance and food rations in times of ‘famine and pestilence’” (Waldram, et al., 2006, p. 187). Indian Agents acted on behalf of the Department to enforce and carry out policy. As most Indian Agents did not have any specialized training in medicine, they were providing basic aid. In the early days of confederation, treaty negotiators and Indian agents would sometimes travel with physicians who would also provide sporadic medical services to First Nations in need (Waldram, et al., 2006).

The North West Mounted Police were also involved in providing food to starving First Nations and helping manage other health issues such as quarantine during an infectious disease outbreak. The RCMP would arrange for physicians to provide free medical services to those First Nations who could not afford to pay for service. First Nations who had the means for payment were directed to local resources (Waldram, et al., 2006).

Starvation and infectious disease continued to ravage reserve communities into the 21st century (Waldram, et al., 2006). In response, the federal government moved to explore ways to address the issue and appointed a Superintendent of First Nations Health in 1904. This superintendent, Dr. Peter Bryce, was a strong advocate for improved health services for First Nations but the majority of his proposals were denied by the Department of Indian affairs based on cost (Waldram, et al., 2006). He was successful however, with his proposal that nurses be hired for several prairie Indian Residential Schools that were experiencing child death rates as high as 35 percent from infectious disease, primarily tuberculosis (Waldram, et al., 2006).

By 1927, Dr. Bryce's successor, Dr. E.L. Stone, noted that tuberculosis continued to rage at epidemic rates amongst First Nations, particularly those in Western Canada. Like Dr. Bryce's efforts however, "The cost of medical services remained an issue throughout Stone's tenure. His efforts to deal with the tuberculosis problem and other communicable disease, and to expand the scope and magnitude of medical services, were hampered by a lack of funds" (Waldram, et al., 2006, p. 193). During Dr. Stone's appointment, the cost allocated per capita for First Nations populations was half that of the remaining Canadian population (Waldram, et al., 2006).

Eventually, movement to improve the health of First Nations people occurred through increased levels of government assistance. "In 1935, there were eleven medical officers employed full time and eight Indian agents with medical training. Another 250 physicians were employed part time" (Waldram, et al., 2006, p. 193). The first nursing station was opened in 1930 on a Manitoba reserve. By 1946, there were 27 full time and 700 part time

physicians, 24 field nurses and, 16 sanatorium hospitals operating by the federal government to address the health issues of First Nations (Waldram, et al., 2006). By 1970, the majority of sanatorium hospitals had closed due to a significant reduction in cases of tuberculosis and other infectious disease. Also at this point in history, over 100 First Nations' nursing stations and health centers existed on reserves throughout the country (Waldram, et al., 2006).

As medical care became more structured in the country, First Nations reminded the government of the medicine chest clause. First Nations maintained that the clause of 1876 entitled them to mandated, publically funded, medical care. The federal government opposed this position and a debate on the subject continued throughout most of the 20th century. After decades of controversy, much of which was played out in the courts, the federal government received the judicial ruling that it was not legally obligated to provide medical services to First Nations. However, the government has chosen to do so as a matter of policy. As policy, versus law, the government is free to alter, or discontinue, the provision of service (Waldram, et al., 2006).

Today, health centers are located on most reserves and, specific to each clinic, federally funded services can include nursing, scheduled medical doctor visits, scheduled dental visits, drug and alcohol counseling, and mental health services (Kendall, 2001; Waldram, et al., 2006). First Nations living on reserve, can also access the usual provincial medical services available to all Canadians through Canada's universal health plan, implemented in 1971 (Waldram, et al., 2006). Through the health plan, provincial governments are responsible for administering medical services to all Canadians under federal guidelines (The Council of Canadians, n.d.). Provinces individually determine direct

costs to their citizens. At the time this document was being prepared, British Columbians paid a maximum premium of 121 dollars per month for families of three or more, with a combined annual income over \$30,000 (Ministry of Health, n.d.). Status First Nations persons, living on or off reserve, can register for provincial medical coverage through the federal government. The federal government then provides payments to Provincial Ministries of Health to include, free of charge to First Nations populations, all provincial general health care services (Kendall, 2001, Smith, 2007).

In addition to on reserve medical services and universal provincial coverage, status First Nations individuals are eligible for the federally provided Non-Insured Health Benefits (NIHB) program, established in 1974. NIHB provides medical services that are not available through the provincial medical plans and includes, some prescription and non-prescription medication, eye care, dental care, prescription eyewear, transportation costs associated with accessing provincial medical services, and access to private crisis counseling services (Assembly of First Nations, 2006; Auguste Solutions & Associates, 2004; Health Canada, 2012b; Smith, 2007).

The Decline of Traditional Health Practices

As discussed in the first literature review chapter, policies in the Indian Act, most notably the reserve system and the residential school significantly changed the ways of life of First Nation people. First Nations' traditional ceremonies, "such as potlatch, dancing, and traditional funerals and burials" were outlawed (Shewell, 2004 p. 15). With the erosion of this traditional way of life came an erosion of traditional health and healing practice (Waldram, et al., 2006). Healing practices, involving herbs, plants, and the spirit world, were frowned upon by those non-First Nations who were involved in administering components of

the Indian Act or religious teachings to First Nations. This resulted in a reluctance to practice traditional healing openly:

There was a time when many details of aboriginal medical practice were considered communal knowledge and freely provided to inquisitive outsiders, to the point where some have been allowed to witness and documented various healing activities. By the end of the first quarter, of the twentieth century, there appears to have been a shift in this attitude of Aboriginal healer, and a period commenced in which the traditions went underground, shielded from the watchful eye of government administrators, missionaries, and legal authorities. (Waldram, et al., 2006 pp. 126-127)

As physicians and missionaries traveled amongst First Nations, they witnessed traditional healing practices, most of which they did not understand or support (Waldram, et al., 2006). Indeed, an account of a physician, who provided medical care to First Nations between 1955 to 1957, noted, “seeing patients ‘with wounds dressed in obnoxious concoctions of bear grease and assorted unidentifiable ingredients’ that he then treated ‘in a more orthodox manner’” (Waldram, et al., 2006, p. 186). First Nations’ spirituality, an integral part of health and healing practices, was discouraged by Missionaries who were attempting to bring Christian teachings to the First Nations. This further assisted in eroding traditional lifeways (Grant, 1984; Nock, 1988).

The federal government, responsible for overseeing improvements in First Nations health, aligned with physicians and missionaries in their lack of support of traditional healing practice (Waldram, et al., 2006). The government saw traditional medicine as impeding,

rather than helping improve, First Nations health in that “the persistence of traditional Indian medicine, based on ‘ignorance and superstition’...was still seen as a road block in the delivery of medical services, especially in remote areas” ((Waldram, et al., 2006, p. 194).

Interestingly, even though there was an overall sense of a perceived barbaric and superstitious view by Europeans regarding traditional healing, there are some reluctant accounts in the literature of the effectiveness and power of these practices:

Even representatives of the Canadian government from time to time were forced to acknowledge the efficacy of Aboriginal medical practice, as did Dr. George Orton, medical officer for Manitoba, in 1891, writing that the healers ‘who by experience in the use of vegetables and other remedies in the treatment of wounds and diseases handed down from generation to generation doubtless have been the means of saving many lives and relieving much suffering. (Waldram, et al., 2006, p. 127)

Even more interesting are the accounts of spiritual healing intervention recorded in the field notes of some early Europeans. This example caused its writer to develop a respect for First Nations’ use of the spirit world in their religious and healing tradition:

George Nelson was a trader with the Hudson Bay Company in northern Saskatchewan in 1823. A devout Christian....amazingly Nelson actually seemed to be converted after observing many so called ‘performances’ by ‘conjurers’. For instance, in describing a ceremony known as the ‘shaking tent’...he wrote ‘I have almost entirely converted myself from these foolish ideas of ghosts and hobgoblins, but I assure you in truth that I more than once

felt very uneasy'. At the conclusion of the shaking tent ceremony, Nelson was humbled: 'I am fully convinced, as much so that I am in existence, that Spirits of some kind did really and virtually enter [the shaking tent]... (Waldram et al., 2006, p. 128)

A hundred years of First Nations' and Canadian government relationships, resulted in the evolution of government provided health care that, today, is administered through the federal department called the First Nations and Inuit Health (FNIH). The later part of the 1900s however, was to see a shift amongst First Nations from a position of passive recipient of government health care services to that of active administration and application. The most significant moves were toward First Nations self-governance in health care, increased provincial government involvement in First Nations health, and a re-emergence of traditional healing practices. These developments will be reviewed in the next section.

Current Day Health Care

Increasing self-governance.

Shifting attitudes toward First Nations' control over First Nations' issues, including health care, began to emerge in the 1980s. First Nation demand for increased control over health services began to affect the way health services were administered (Waldram, et al. 2006). In 1986, FNIH launched the Health Transfer Program (Government of Canada, 2012; Kendall, 2001). This program initialized a movement toward increasing First Nations self-governance of health services. The Health Transfer Program would allow health funding to be transferred from the federal government to First Nations' Bands, for management of on reserve health services (Kendall, 2001; Lavoie et al, 2005). The aim of this program was to

allow Band governments more ownership and flexibility, within federal guidelines, in the use of federal funds to meet their community members' health and wellness needs (Auguste Solutions & Associates, 2004). Under this agreement, First Nation Band leadership could directly hire health service providers and manage health programs. By 2002, half of British Columbia's First Nations Bands were in a health transfer agreement (Kendall, 2001).

In 2005, the federal government introduced the Contribution Funding Framework (CFF) to the Health Transfer Program. The CFF was developed to offer First Nations even more flexibility and control of health funds. The CFF allows Bands to enter into health services agreements of up to ten years long versus a maximum of five years in the previous funding model (First Nations Health Council, 2010). In addition, unlike the previous health transfer models where most of the control remained with the federal government, Bands could "apply for the highest level of self-control (flexible transfer funding)...following a capacity assessment done collaboratively between the recipient and FNIH, a recipient can apply for the most appropriate model based on their capacity and abilities" (First Nations Health Council, 2010, p. 4).

Some Bands have chosen to group together for ease of providing health transferred services and maximizing funds. In British Columbia's Carrier Territory, such a grouping exists in Carrier Sekani Family Services (CSFS), established after health transfer in 1990 (Shawana, 2002). CSFS provides culturally relevant and community-based services grounded in its mission statement: "With the guidance of our Elders, Carrier Sekani Family Services is committed to the healing and empowerment of Aboriginal families by taking direct responsibilities for health, social and legal services for First Nations people residing in

Carrier and Sekani territory” (Carrier Sekani Family Services, 2011a, home page). Bands within the territory that CSFS covers, can choose to contribute some of their health dollars back to the agency to receive a variety of community health services. CSFS also provides services independent of Band contributions, with additional funding from the federal and provincial governments, as well as from a variety of grant funding sources. CSFS has offices within easy access to its eleven member Bands. Offices are located in Prince George, Vanderhoof, and Burns Lake (Shawana, 2002). CSFS programs are as follows:

- Health Programs
 - Nursing
 - Early Childhood Service
- HIV/AIDS
- Homecare
- Mobile Diabetes
- Tele health
- Patient Liaison
- Youth Development
- Non-Insured Health Benefits
- Mental Health and Addictions
 - Adult Mental Health
 - Child and Youth Mental health
 - Addictions Recovery Program
 - National Native Alcohol and Drug Abuse Program Mentorship
- Family Support Program
 - Bridging
- Home Support
- Community Linkages
 - Child and Youth Skills
 - Life Skills

- Child and Family
 - Child Welfare
 - Family Preservation
- Family Justice
- Research and Development

In addition to providing services on reserve to member Bands, CSFS's off reserve services are available to any First Nations person regardless of Band membership. A Board of Directors represented by Chief and council members of Carrier and Sekani Band councils govern CSFS (Carrier Sekani Family Services, 2011b).

Provincial Government Involvement.

During the last decade, the provincial government of British Columbia, previously uninvolved in what was seen as a federal jurisdictional matter has joined in the effort to improve the overall health of Aboriginal people (Kendall, 2001). The Province of British Columbia recognized a need to make provincial services more culturally friendly and to coordinate health services for those populations living on reserve and accessing off reserve provincial health services. The province has implemented policy that supports education of its staff regarding Aboriginal culture in an effort to better meet the needs of Aboriginal patients (Kendall, 2001).

According to Kendall, (2011), another identified area of concern has been the lack of coordination regarding a transition from hospital to First Nation community. In response to this, the Ministry of Health allocates funds to the regional health authorities to fund Aboriginal Health Liaison Workers. The goal of this program is for the liaison worker to support First Nations people who receive services in a provincial hospital facility to

coordinate aftercare services with on-reserve family and home community medical services. Follow up rates for Aboriginal people returning to reserve after accessing a provincial mental health service are particularly low. As reported by the BC Provincial health officer (Kendall, 2001):

A well-coordinated range of follow up services is particularly important for mental health clients, because many mental illness are long-term and require specialized care and support. ...Low rates of follow up can indicate a lack of community services to support those with mental illness, or that there are problems with coordination between hospitals and the community system. (p. 91)

Attention to the health needs of First Nations people in Canada evolved slowly. Attention to the mental health needs of all Canadians, including First Nations, followed a similar pattern.

First Nations Mental Health.

The primary care service model for the mentally ill in Canada during early colonisation was that of the institution (McLaren, Menzies & Chunn, 2002; Reaume, 2000). As acknowledged by the Mental Health Commission of Canada (2009), “For too long, people who have been given a diagnosis of mental illness have been seen as fundamentally different. There was a time – not that long ago even in Canada – when they were sent away and locked up never to be seen again” (p.6). These institutions, based on a European model, were initially implemented in eastern Canada, and moved across the country with colonization. British Columbia’s care of the mentally ill “officially began with the opening in 1872 of the

Victoria Lunatic Asylum in traditional Songhees First Nations territory on the north shore of the city's inner harbour" (Menziés & Palyst, 2006, p174).

Care of the mentally ill began a shift from the institutional paradigm to a more humanitarian community based model in the mid-1960s (Graham, 1964). A wider definition, and a more positive view of mental illness, began to emerge. The Canadian Mental Health Association was instrumental in this shift through their 1963 report, "More for the Mind". As summarized by Graham (1964):

In essence, it asks for a new deal for the mentally ill, for the hospitals in which they are treated, and for those charged with carrying out such treatment. It asks that mental illness be approached in "the same organizational, administrative, and professional framework as physical illness". And it claims for psychiatric services: medical integration, regionalization, decentralization, continuity of care and co-ordination. (p. 1130-1131)

Significant changes have occurred since the 1960s in the way mental illness is viewed and treated in Canada. It is now generally understood that individuals with diagnosable mental illness can live productive lives, sometimes with assistance, in society (Standing Senate Committee on Social Affairs, Science and Technology, 2006).

Today, one in every five Canadians will experience a diagnosable mental health related problem in their lifetime (Mental Health Commission of Canada, 2009). However, attention and resources allocated to mental health in Canada do not reflect prevalence. For example, in 2006, it was noted that Canada was the only G8 country that did not have a mental health strategy (Standing Senate Committee on Social Affairs, Science and

Technology, 2006). The “Mental Health Commission of Canada” was therefore created with its primary role being to develop a mental health strategy for Canada (Mental Health Commission of Canada, 2009). The release in 2009 of the commissions’ report titled “Toward Recovery and Well-Being: A Framework for a Mental Health Strategy” remains in a draft stage (Mental Health Commission of Canada, 2009). The federal funding allocated to mental health is reflective of the limited position it holds on the political stage. Less than 5% of Canada’s overall health budget is allocated to mental health services (Jacobs, et al., 2008).

As mentioned in the first chapter of this dissertation, the prevalence of mental health related problems in First Nations communities is disproportionately high to that of the general population (Corrado & Cohen, 2003; Kirmayer & Valaskakis, 2007; Smye, 2004). It is difficult to ascertain the prevalence of diagnosable mental illness amongst First Nations due to a lack of documentation but it is understood to be higher than that of the general population (Schmidt, 2000). In 2001 the federal government looked specifically at mental health issues amongst First Nations and began to implement a plan to address these issues. The plans were outlined in a report titled, “Report on the health of British Columbians” (Kendall, 2001). Since that time, federal government funding has been made available to address mental health related concerns in First Nations’ communities as discussed below.

Today, there are streams of funding for First Nations mental health through the federal and provincial governments. Many are awarded through proposals written in response to a funding grant offered by the provincial and federal governments. This paper will not list the various grants that have been available. There are however, two ongoing federal programs specific to on reserve populations and one federal program specific to off

reserve populations. The Brighter Futures and Building Healthy Communities program funding is available for on reserve service, while the Crisis Mental Health Program serves off reserve populations. In addition, there are two limited programs specific to residential school survivors; the Aboriginal Healing Foundation (AHF) and the Indian Residential School *Resolution Health Support Program* (Auguste Solutions & Associates, 2004; Health Canada, n.d.; Kendall, 2001). All of these programs are described below.

Mental Health Funding for Programs.

The Brighter Futures initiative was introduced in 1992 as a direct response to the 1991 report on Aboriginal mental health. Program goals included a wish to “promote the development of healthy communities through community mental health programs” (Auguste Solutions & Associates, 2004, p. 25). Within two years of the Brighter Futures initiative, there was a second response, primarily due to a growing concern regarding high rates of youth suicide. The federal government initiated a supplement to the Brighter Futures project, called Building Healthy Communities. Both the Brighter Futures and Building Healthy Communities programs subscribe to the same conceptual framework and are part of the health-transferred program. Program funding can be utilized to support a variety of mental health related wellness initiatives including direct counselling, as well as a variety of prevention and education services.

The dollars allocated to a community are rated according to community population. On reserve populations in British Columbia, range from 50 to 2,500 with an average size of 500 (Kendall, 2001). Because funding allocations vary, and band councils govern the programs, programs implemented on reserve will also vary. For example, some of the

smaller communities may not have sufficient funding, to hire a qualified mental health professional to conduct counselling services. These communities may instead offer an occasional workshop or employ “community counsellors or wellness workers” to provide services (Auguste Solutions & Associates, 2004, p. 42).

In the Auguste Solutions & Associates, 2004-evaluation report on the Brighter Futures and Building Healthy Communities programs, the following types of programs were listed as being implemented: counseling services, information and awareness programs, crisis intervention and, general wellness programs. Specific services included: individual and family counseling, educational workshops, support groups, sharing circles, and crisis intervention services. The report indicated that only 20% of communities have an established clinical mental health program. Of this 20%, there were a mix of professionals and paraprofessionals providing services. There are no standardized sets of minimum qualifications for on reserve mental health staff (Auguste Solutions & Associates, 2004; Health Canada, 2006; Shawana, 2002). A further 25% employed only paraprofessionals to conduct general mental health services. The remaining 55% of communities did not have staff dedicated to mental health services. They instead relied on sending community members out to external resources. Most communities were reported to lack an established critical incident response plan to deal with crisis events such as suicide or accidental death. They would instead rely on “ad hoc” responses to a crisis after the event (Auguste Solutions & Associates, 2004).

Through the Non-Insured Health Benefits program, any status First Nation person living off reserve can access crisis mental health counseling when a public service is not

available (Health Canada, n.d.). Through this program, individuals can access a private mental health practitioner for up to 20 sessions. The practitioner must meet FNIHB qualifications of being a Masters level registered social worker, psychologist or, psychiatrist (Health Canada, 2006).

The Aboriginal Healing Foundation (AHF) and the Indian Residential School Resolution Health Support Program (IRS RHSP) are the most recently implemented federal mental health programs. The AHF was launched on March 31, 1998 (Aboriginal Healing Foundation, 2013). This program's goal is to address the widespread emotional damage experienced by First Nations' people through the Indian Residential Schools by funding community based projects. This proposal driven funding option for healing initiatives was open to any First Nations' Band or service body (AHF, 2006). The Aboriginal Healing Foundation had commitments to fund existing projects into the year 2012 but is no longer funding new projects (AHF).

The Indian Residential School Resolution Health Support Program (IRS RHSP) assists individuals and families cope with the emotional impact of the IRS. This program provides professional counseling services, as requested, to any person negatively affected by the Indian Residential Program. This service is open to people living on or off reserve. Health Canada has established minimum criteria for mental health professionals working off reserve directly for the government. Providers must have a minimum of a Master's degree with experience (Health Canada, 2006).

In 2002, Carrier Sekani Family Services conducted a health programs evaluation (Shawana, 2002). This evaluation preceded, and was the catalyst for, the development and

implementation of CSFS's Mental Health Wellness Program. This earlier report indicated that some of CSFS's eleven member reserve communities independently hired or contracted mental health service providers with their Building Healthy Communities and Brighter Futures contribution dollars. Carrier Sekani Family Services acknowledged the absence of a coordinated set of standards for on reserve mental health professionals (Shawana, 2002). Before this evaluation, CSFS did not provide mental health services to its member Bands.

Similar to the findings in the Auguste Solutions & Associates (2004), CSFS noted that the level of qualifications of mental health providers was one of the weakest components:

One of the most startling trends is that the delivery model does not support quality care from licensed therapists. In many communities mental health services are being delivered by persons that do not have the requisite qualifications...First Nations authorities and FNIHB are exposed to potential liability because of service from unlicensed, unregistered and unqualified service providers. (Shawana, 2002, pp. 128-129)

The report called for an immediate "revamp" of community mental health programs to include mandatory qualifications for clinical services providers and a termination or job duties change for all non-qualified providers. This revamp was recommended to include the development of standards, ethics, and program guidelines that support a professional, coordinated service from within a First Nations' culture. These recommendations lead to the implementation of CSFS's Mental Health Wellness Program in October, 2003. Bands wishing to participate in the program allocate their mental health dollars to CSFS (Holyk et

al., 2007). Through the program, a registered mental health professional was assigned to each community. The therapist would then work with Band leadership, as well as community wellness workers, to provide ongoing weekly service. These services included prevention and educational services such as workshops, as well as direct counselling services. I was involved in the development of this program and continue to be involved in its management. Without a model of any on reserve service, or a comprehensive understanding of First Nations traditional healing culture, the program was developed based on the kind of counselling services offered in urban areas of British Columbia and, essentially involved direct individual, couple, and family counselling.

Five years after the implementation of the Mental Health Wellness Program, a report was released based on research that explored community members' opinions of CSFS's mental health program. This report indicated that the program is having a positive impact on the communities it serves but that "there is much work to be done" (Holyk et al., 2007). This report identified that a lack of funding was a barrier to recruitment and retention of qualified professionals. A primary recommendation was that the program should include traditional healing practice.

Since this report, there have been several changes in the program. The agency integrated its mental health and addictions services and now offers the "Mental Health and Addictions Program" (CSFS website, Programs, Mental Health, para. 1).

The Tripartite Agreement.

In 2004, an 18 month long process started between the federal government and Canada's First Nations aimed at exploring ways to bring the standard of living of First

Nations in line with the rest of Canadians. This process concluded in Kelowna, British Columbia in November of 2005 and “produced an ambitious ten-year plan to close the gap between Aboriginal and non-Aboriginal Canadians” (Patterson, 2006, para. 1). This plan became known as the Kelowna Accord, and as a result of this Accord, the Canadian government “pledged \$5.85 billion over five years to improve the socio-economic conditions of Aboriginal people. The overall plan was to bring the standard of living for Aboriginal peoples up to that of other Canadians by 2016” (Patterson, 2006, para. 2). The responsibilities for developing and implementing this plan were shared by “the governments (federal, provincial and territorial) and Aboriginal peoples” (Patterson, 2006, para. 4). Improved health care services was one of the primary intended outcomes of the accord that also included better education, housing, economic opportunities, and general improved relationships between levels of government. Unfortunately, only 72 hours after the accord plan was completed in Kelowna, the federal government responsible for implementing this accord, led by Paul Martin, collapsed. The subsequent federal election saw Stephen Harper’s Conservative party take office. The new government did not move forward with the plan claiming that funds had not been secured nor had the plan been formally endorsed (CBC News Online, 2006; Patterson, 2006). Two years later, after demands by First Nations leaders, the Kelowna Accord was resurrected in what is known as The Kelowna Accord Implementation Act, passed by the federal government (Department of Justice, Canada, 2008). The Act states, “The Government of Canada shall immediately take all measures necessary to implement the terms of the accord, known as the “Kelowna Accord” (Aboriginal Affairs and Northern Development Canada, 2011). The Act further dictates that:

At the end of the fiscal year beginning on April 1, 2007, and at the end of each of the next four fiscal years, the Minister of Indian Affairs and Northern Development shall prepare a report reviewing the progress made by the Government of Canada in fulfilling its obligations under the Kelowna Accord during that fiscal year. (Aboriginal Affairs and Northern Development Canada, 2011)

The 2010-2011 report published by the Federal Government lists progress that has been made in in all areas involved in the Kelowna Accord (Aboriginal Affairs and Northern Development Canada, 2011).

At the same time the Kelowna Accord was agreed upon, British Columbia's First Nations made an independent agreement with the Province of British Columbia and the Canadian government. This agreement was known as the "Formative Change Accord" (First Nations Health Council, 2006.). This accord focused specifically on improving the health of British Columbia's First Nations.

Today, the tripartite work of the three levels of government has resulted in the development of the First Nations Health Authority (FNHA). Through the FNHA, British Columbia is entering into a time of historic development with the shift of the responsibility of First Nations' health from Health Canada to the First Nations Health Authority. The FNHA is scheduled to take this responsibility beginning in July 2013. The document "A Path Forward, BC's First Nations and Aboriginal People's Mental Wellness and Substance Use-10 year Plan" outlines a starting framework for moving into the new age of First Nations directed health specific to mental health (First Nations Health Authority, BC Ministry of

Health, & Health Canada, 2013). The document is the first of its kind in the province and its existence will “transform systems and improve capacity to better meet the needs of First Nations...” (First Nations Health Authority, BC Ministry of Health, & Health Canada, 2013, p.5). The document clearly states that First Nations’ mental health services should be strengthened to reflect culture.

The Aboriginal worldview highlights concepts of wholeness, balance, the importance of relationships with family, community, ancestors, and the natural environment. An individual’s identity, status, and place in the world are tied to the family, and to ones’ ancestors’ traditional territory and the community. Each of these elements has implications for the design and delivery of healing programs. (First Nations Health Authority, BC Ministry of Health, & Health Canada, 2013, p.6)

In summary, mental health services for First Nations are evolving through political and practical movements within First Nations and between levels of government. There is vast area for development. As this evolution takes place, it is valuable to understand the foundational features of First Nations culture, when developing and offering mental health services with First Nations. It is also valuable to understand local traditional healing practice when working within First Nations communities and with traditional healers. The next section explores First Nations’ cultural views and how they influence issues of mental health and healing.

Understanding Cultural Views

There exist generalizations of First Nations' culture and how these differ from that of the generalized Western European based culture. Duran (2006) refers to this practice of generalizing First Nation's culture as "cultural or tribal glossing". "Glossing" refers to the assumption that all tribes are exactly the same culturally. Although there are many similarities, there are differences in language, religion, and other aspects of culture that need to be considered when working with Native people (p. 7). Duran (2006) warns that cultural glossing can have a negative impact when working with specific First Nation groups when the cultural identity of a group is assumed, versus explored. In this section, I offer a general and somewhat simplified presentation of First Nations and Western European worldviews as a point of reference to illustrate some of the fundamental differences between the cultures. However, I hold a position that the specific uniqueness in individual First Nations' groups should be explored by practitioners working in a particular community. This is a primary goal in this dissertation.

Traditionally First Nations people and Europeans have viewed the world differently (Hammerschlag, 1988; Maher, 1999; McCormick, 2000; Tsey, 1997). Eurocentric thought is more concerned with the physical world and tends to view the world and our place within it objectively:

The greater menaces to Aboriginal thinking are the assumptions that drive the search for knowledge in the Western world. One assumption is that the universe can be understood and controlled through atomism. The intellectual tendency in Western science is the acquisition and synthesis of total human knowledge within a worldview that seeks to understand the outer space

objectively. In the process, Western science, the flagship of the Western world, sought answers to the greatest questions concerning our existence and our place in the universe by keeping everything separate from ourselves.

(Ermine, 1995, p. 102)

Traditional First Nations' worldviews, on the other hand, put emphasis on understanding the interrelationship between all things within the physical world and the metaphysical realm (Cheney, 2002; Hammerschlag, 1988; Little Bear, 2009; National Aboriginal Health Organization [NAHO], 2008). Through this understanding, all components of a human being, physical, emotional, spiritual, and mental, interact within a person, and are connected to the outer world of community, nature, and the supernatural world. Therefore, rather than viewing self as living "in" the environment, traditionally, First Nations' people view themselves as living "with" their environment. The synergy of all of the elements involved, will impact existence. First Nations' knowledge is derived from this understanding of the world. Through this subjective worldview, knowledge cannot be separated from experience in that "there can be no detachment from the knower to the known" (Gegeo & Watson-Gegeo, 2001, p. 62).

The issue of language should be addressed here in this discussion regarding understanding cultural views. Language is recognised as being intertwined within the social fiber of culture (Baloy, 2011; Kelly, 1991). So much so that a field of study referred to as "language ideology" exists and is defined as a "mediating link between social structures and forms of talk" and refers to "the social connections people make with their own or others' languages, dialects, or language variations" (Baloy, 2011, p. 517). According to Kelly

(1991) there are 11 First Nations language dialects across Canada. Interestingly 7 of these dialects are in British Columbia and include Athabaskan, Tlingit, Haida, Tsimshian, Wakashan, Salish, and Kootenay.

Through the processes of colonization and primarily the experiences involved with the residential school and child welfare many First Nations lost the ability to speak their language (Baloy, 2011; Clearsky. 2011). Loss of language resulted in a loss of some of the culture that could not be expressed in its true form in a foreign language. As discussed by Kelly (1991), “Language is an important vehicle for cultural expression, for it is largely through language that unique cultural experience is shared. It is well known that some concepts do not translate easily from one language to another” (p. 141). Therefore the ability to adequately explain life and existence, as experienced by a people, was lost (Hallet, Chandler, & Lalonde, 2007).

Loss of language and its resulting loss of culture have been directly linked to wellness. Hallet, Chandler, and Lalonde (2007), conducted a study in British Columbia on the rates of youth suicide in communities that had varying degrees of First Nations language ability amongst its members. They found that the communities with the highest rates of members who spoke their language had the lowest rates of youth suicide.

First Nations people are recognising the full impact of the implications of a loss of their language:

An important question that must be addressed by everyone whose ancestral language is under siege is: What do you lose when you lose a language? The short answer is that you lose your culture. There is an indexical relationship

between language and culture. Language is culture and culture is language.

(Kirkness, 1998, p. 93)

In response, First Nations are making moves to revitalise their language. They recognise the importance of language and its link to culture and wellness. First Nations language revitalisation efforts are occurring in schools, in reserve communities, and in urban centers (Baloy, 2011). Information technology is playing a role in language revitalisation in modern day. The First Peoples Cultural Council is a First Nations-run corporation that supports the revitalization of Aboriginal language (First Peoples Cultural Council, 2013). This group has developed an interactive webpage that includes a map of the various languages of British Columbia's First Nations, games, and an English- First Nations translator. Carrier languages are included in this project.

Worldviews and Mental Health.

As a result of differing worldviews, traditional First Nations' understanding of health, including mental health and illness, differs from that of Western European society (Hammerschlag, 1988; Maher, 1999.) In traditional First Nations' culture, issues of health are not separated as being an independent ailment of the body, spirit, mind, or emotion. Instead, illness is believed to be the result of an imbalance between all parts of the individual, the environment, and possibly with the overall universe, as discussed by Maher (1999):

The traditional health beliefs of Aboriginal people are interconnected with many aspects of Aboriginal life such as the land, kinship obligations, and religion. The sociomedical system of health beliefs held by Aboriginal people places emphasis on social and spiritual dysfunction causing illness. This

approach emphasizes that individual wellbeing is always contingent upon the effective discharge of obligations to society and the land itself. A person's social responsibilities and obligations may take precedence over their own health because of the priority given social relationships in this model. (p. 230)

There is belief in First Nations culture that illness can be caused by a malevolent spirit despite an individual's best efforts to maintain balance (Hammerschlag, 1988; Maher, 1999). In these cases, harmful supernatural beings act on their own to cause harm to a person. In addition, people can use the supernatural to intentionally cause harm to others. Therefore, "sorcery and supernatural intervention are part of the perceived reality of Aboriginal life, and in Aboriginal society explanations in terms of sorcery are often used" (Maher, 1999, p. 230).

The Western European world, in contrast, tends to understand and explore illness as having a tangible cause. Physiological causes are typically explored to explain illness (Van Uchelen, Davidson, Quressette, Brasfield, & Demerais, 1997). The human spirit, or supernatural involvement, is rarely considered (Hammerschlag, 1988). Although the symptoms of an illness will be similar amongst human beings, the understanding of the origin of an illness, and its treatment, will differ within specific cultures. It may be helpful to view illness as a result of interplay between the organic biological makeup of a human being, and cultural experiences and beliefs. In the area of mental health, this can be understood and explored through a distinction between "mind" and "mentality" and the interplay between the two (Hwang, 2005).

Diagnosable mental illnesses have similar symptomology worldwide (Kastrup, 2011; Kleinman, 2004). However, some symptoms may be more or less pronounced as a result of cultural influence. In the case of depression, as example, globally people will express having symptoms related to a lack of happiness, motivation, energy, and interest in life. Culture will affect more specifically, how these symptoms are manifested. In some cultures, symptoms of suicidal ideation will be more prevalent in people with depressive disorder than in those cultures where suicide is not culturally acceptable. This understanding lends itself to a concept of “one mind, many mentalities” where “psychological functionings or mechanisms of the human mind are the same all over the world, but that people may evolve various mentalities in different social and cultural environments” (Hwang 2005, p. 8). Indeed, the Diagnostic and Statistical Manual for Mental Disorders, fourth edition, text revised, has been criticized in recent years for its exclusion of cultural consideration in its diagnostic criteria (Kastrup, 2011; Kleinman, 2004). Many cross cultural practitioners recognize that symptoms, and their expression to practitioners, will vary between cultures. In response, the DSM V, released in May 2013, has included provisions for culture and its effect on symptoms and diagnoses (Warren, 2013).

Therefore, the presentation of symptoms and treatment of illness, in a general First Nations’ paradigm, will involve interconnection of the entire person who is suffering, the environment, the spirit world, and the healer (Hammerschlag, 1988; Van Uchelen, et al., 1997). Natural substances such as herbs and plants are used, along with ceremony, such as the sweat lodge, to encourage healing. Asking the assistance of the creator or spirits through prayer is a common practice in First Nations’ healing protocol (Maher, 1999). However, it is

the worldview of interconnectedness and not the tools themselves that is the primary factor in First Nations' healing tradition.

Healing Models

With the movement toward self-governance in health and healing, First Nations began to express dissatisfaction with Western European based services and began advocating for service models based on their traditional culture. First Nations traditional health practices began to re-emerge when “a degree of cautious openness regarding healing began to emerge in the 1980's” (Waldram, et al., 2006 p. 127). With this re-emergence came the concern that because Western European mental health interventions are based upon Western worldviews and illness based models, these interventions are in contrast with First Nations worldviews (Kirmayer et al. 2000; Kishk Anaquot Health Service, 2006; Smye & Mussel, 2001). As stated by Smye and Mussel (2001):

Although most recently there has been gradual shift to family-focused and community based care, the mental health system remains aligned with an illness service model. Even where illness service models used across Canada reflect a more holistic, multidisciplinary and multi-sectorial approach to health, generally this development within western society, does not fully reflect the holistic approaches of Aboriginal traditions nor does it acknowledge the socio-political and historical context of Aboriginal health.

(p. 8)

First Nations groups in Canada are therefore shifting toward traditional models of healing practice. However, generations of traditional practices that were “displaced and actively

suppressed by successive generations of Euro-Canadian missionaries, governments and professionals” have caused this re-emergence of traditional healing practice to be clouded and at times confusing (Kirmayer & Valaskakis, 2007, p. xxiv). This clouding may be due, in part, to a disconnect between the healing activities and the cultural beliefs they were traditionally embedded within. As a result of years of colonisation activities and the resulting assimilation, many First Nations people “do not identify with the belief system embedded in traditional healing practices such as sweat lodges, false face healing rituals or other indigenous healing methods. “These ceremonial practices would be as foreign to highly acculturated Aboriginal people as it would be to non-Aboriginals who have no context in which to decipher what is transpiring in the ceremony” (Hill, 2009, p. 30).

Through efforts to revive traditional healing, First Nations and those who work with them, have attempted to identify more closely what traditional healing is. As noted by Waldram, et al., “Traditional Healing has become a ubiquitous term these days, yet no succinct and agreed upon definition exists” (2006, p. 237). It is possible that the very nature of First Nations’ healing practice may prevent it from acquiring a succinct definition. Traditional healing practice does not contain a global standard of practice because healing practices are embedded in local beliefs and culture. Traditional healers are taught through informal structures and are locally endorsed. This is in contrast to modern world medicine where formal education and licensing of practitioners exists, as do standardised treatment protocols. A modern world physician can lose his or her license to practice medicine if standards of practice are disregarded. Traditional First Nations healers are not formally regulated (Waldram, et al., 2006). However, the absence of standardized protocol for the training and practice of traditional healers does not mean that traditional practice is void of

mechanisms to ensure good practice. First Nations' healing practice is based on historical knowledge that has evolved over generations to promote health and healing. Good practice is regulated informally by the community. Any healer, who is identified as practicing in an unskilled or harmful way, would be ostracized by the community members (Waldram, et al., 2006).

There is evidence of growing attempts at developing services and approaches that reflect local traditional healing culture in many First Nations communities in Canada (Crowshoe, 2005; Kirmayer et al. 2000; Smye & Mussel, 2001). Canada's National Aboriginal Health Organization (NAHO) offers a Tool Kit that contains "tools a person, community, or nation can use to help maintain traditional knowledge. Each example can be changed to fit your community's needs, and in a way that supports the vision of your community" (Crowshoe, 2005, p. 10). Through initiatives such as this, local knowledge and culture are supported as the foundation for traditional healing.

British Columbia's First Nations Health Society (FNHS) also recognizes the importance of locally embedded First Nations healing traditions. The FNHS released a 2010 document that explored current health and wellness practices and opinions in British Columbia's reserve communities. The purpose of this project was to acquire a snapshot of how traditional models of wellness were being used in health and mental health services and, if there was a desire to increase the use of traditional models in these areas. The FNHS hopes that the tripartite process will support communities in developing program models that include traditional practices (FNHS, 2010). This document titled, "Best Practices of Traditional Models of Wellness Scan" found that approximately 50% of the 123 community

health centers involved in the study had traditional health models in practice at their centers. Likewise approximately 50% of respondents used traditional methods of healing. A majority of respondents, (91%) felt that traditional practices models should be part of health and wellness services in their community health center (FNHS, 2010).

The 91 respondents involved in the research echoed similar philosophies to those found in the literature concerning First Nations wellness. Respondents stated wellness involved a holistic state of being that meant “taking care of oneself spiritually, physically, emotional, and mentally” (FNHS, 2010, p. 14). The types of traditional healing methods used in British Columbia communities that were identified by participants as desirable healing methods, involved:

Cultural sharing

Medicine gathering

Gathering berries

Fishing

Hunting

Healing circles

Camping

Sweats

Drum classes

Language classes

(FNHS, 2010, p. 14)

Conclusion

In this chapter, I presented a review of the available literature regarding the evolution of government provided, First Nations health, including mental health, services in Canada. Due to issues associated with colonization, this evolution paralleled a decline in traditional First Nation healing practice. Over time, government provided services, primarily based on modern Western European philosophy, were identified as lacking appropriate cultural content and philosophy. As a result, many first Nations across the country today are revitalizing traditional health and healing practice. Each First Nations' group has their own unique culture, and therefore, a unique philosophy regarding health and healing. The Carrier people in north central British Columbia share this journey. The following chapters present my exploration into Carrier First Nations health and healing philosophy and practice, as described by seven traditional healers and knowledge holders.

Research Design

Through this research, I was seeking a deeper understanding into how Carrier people traditionally understand and treat mental health related conditions. As such, this research explored the primary question: “How did Carrier First Nations people conceptualize mental health and treat mental illness in traditional Carrier culture?”. This chapter provides a description of the research design. It involves both First Nations’ research considerations and academic research recommendations. Following a summary of research considerations for conducting research with First Nations people, I present the overall methodology of ethnography that was used in this study. The primary data collection tools of ethnographic interviews and observation will be discussed. The chapter concludes with a presentation of content analysis as the methodology that was used to analyze the data. First however, it is important to be clear regarding my professional position as it relates to this research.

I am a non-First Nations clinical social worker involved in overseeing mental health and addictions services to Carrier First Nations communities. My practice with Carrier people led me to explore this research topic. The research participants were referred to me by Carrier people. None of these knowledge holders or healers involved in my research was supervised by me in my work. On occasion, we have interacted with each other in our healing work as colleagues. I have had the privilege of providing mental health services in Carrier communities for the past 18 years. My professional relationship with the communities I work with gave me, I believe, an advantage in connecting with the traditional knowledge holders and healers. My professional relationship with them did not, in my opinion, influence the information provided to me.

First Nations Research Considerations

It is becoming increasingly apparent in the literature that First Nations research requires specific considerations. Non-First Nations researchers have been accused of taking a paternalistic approach to their research involving First Nations people, by paying little attention to the needs and rights of the First Nations' populations involved (Castellano, 2004; Denzin & Lincoln, 2005; Kenny, 2004; Schnarch, 2004; Smith, 1999). As stated in a Royal Commission Report:

In the past, research concerning Aboriginal peoples has usually been initiated outside the Aboriginal community and carried out by non-Aboriginal personnel. Aboriginal people have had almost no opportunity to correct misinformation or to challenge ethnocentric and racist interpretations. Consequently, the existing body of research, which normally provides a reference point for new research, must be open to reassessment. (Chenier, 1995, p.1)

Current literature on the subject contains information that suggests non-First Nations researchers critically examine all aspects of their research practice including ideology, levels of First Nations involvement, and the research design itself to ensure its cultural appropriateness (Schnarch, 2004; Smith, 1999).

Research conducted from outside of a specific cultural lens can misrepresent the data (Smith, 1999). When research in a First Nations culture is conducted using a Western European lens, that knowledge carries with it the assumptions, values, and theories of that culture. The researcher will hold preconceived ideas that are embedded in his or her culture.

This worldview can prevent researchers from objectively viewing a phenomenon in First Nations' culture. To counteract this occurrence, Smith (1999) called for a decolonizing of methodologies. To do this, she said, researchers must be aware that the very framework of research methodologies was built upon the dominant Western European culture and that research for First Nations people must be reinvented. Smith's (1999) position is echoed in the Government of Canada's document "A Holistic Framework for Aboriginal Policy" (2004):

Aboriginal research must begin with a serious examination of the historical and political influences that have guided research up to this point. Any holistic framework for Aboriginal policy research will only be legitimate if it employs the holistic attitude to which it subscribes. This integrity is the foundation that will bring and form the research act. (p. 4)

A landmark meeting that launched many of the Canadian developments in First Nations Research protocol was hosted by the Royal Commission on Aboriginal Peoples at the Nakoda Lodge in Alberta in September of 1992. This meeting involved a gathering of 80 First Nations people who were involved in research. During the meeting, a First Nations' Elder encouraged his people to take on the challenge to govern the direction of First Nations research. In response to general comments that First Nations people had been "researched to death", he responded, "If we have been researched to death, maybe it's time we start researching ourselves back to life" (Castellano, 2004, p. 98). Since this time, First Nations people are increasingly involved in advising researchers and policy makers, as well as conducting research themselves (Schnarch, 2004; Smith, 1999).

Today there exist funding and research bodies that provide guidelines specific to ethical research with First Nations people. The Tri-council policy statement on ethical research includes a guide specific to non-First Nations people who conduct research with First Nations. The Tri-council is comprised of the Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council (NSERC), and the Social Sciences and Humanities Research Council (SSHRC). The Tri-council's three core principles for ethical research with humans are concern for persons, concern for welfare, and justice. These core principles are reviewed in a First Nations' context in the statement. The Tri-council strongly encourages respectful practice for non-First Nations' people who are engaged in research with First Nations' people. Although the specifics of the statement are too involved to review here, they generally promote a culture of building a trusting, respectful relationship for research that will benefit and belong to the people with whom the research is conducted (Government of Canada, 2013b).

The National Aboriginal Health Organization also outlined a set of principles that are recommended to guide research with First Nations people (Brian Schnarch, 2004). These principles, known as "OCAP", are described by Schnarch (2004) as First Nations Ownership, Control, Access, and Possession of research. Schnarch stated that OCAP is "a political response to tenacious colonial approaches to research and information management" (p. 80). He further stated that "OCAP has become a rallying cry to many First Nations and should be a wakeup call for researchers ... OCAP is changing the way research is done" (p. 80). In his article, he outlined 30 "recurring grievances" that First Nations groups have made regarding researchers and research of their populations. These grievances contain themes of a lack of respect for participants, a lack of knowledge of participants' culture, lack of consultation,

poor ethical conduct, and limited First Nation's control over the research being done (p. 82). OCAP principles attempt to provide researchers with guidelines aimed at avoiding such practices.

According to Schnarch (2004), ownership refers to the "relationship of a First Nations' community to its cultural knowledge/data/information" (p.81). Schnarch stated that ownership is different from stewardship; the researcher can manage and store information, but it is still "owned" by the First Nations group. Control refers to the right of First Nations people to oversee all aspects of a particular research project being conducted in their community from conception through to completion (Schnarch, 2004). Access means that First Nations people should be able to gain access to research data and information that was gathered from them (Schnarch, 2004). Schnarch suggested that a standardized protocol regarding access be developed. Possession of research data was described by Schnarch as something that is not essential, but as something that First Nations people can exercise if they choose. He reminds that possession is different than ownership, but that possession can protect ownership if necessary. Schnarch is clear that OCAP is not a definitive prescription but is instead an evolving set of principles that should guide the researcher and First Nations groups to mutually positive research practice.

The National Aboriginal Health Organization (NAHO; 2007) provides templates for data use agreements that they recommend should be made between the researcher and the community. The content of these agreements will be specific to each First Nations community but can include issues such as data storage, First Nations review of the analysis

for misinterpreted results due to a lack of cultural knowledge and final review of the document.

While some literature contained information regarding general principles for change in the area of First Nations research, such as OCAP, other literature contained concrete recommendations for preferred methodology and methods in First Nations' research. While the research question is the predominant factor in deciding on a methodology qualitative methodology is identified as having a stronger fit with First Nations than quantitative methods. Qualitative research is more reflective of First Nations oral traditions and has a way of allowing participants to maintain control in the research process, which is a primary concern expressed in First Nations research literature (Kenny, 2004; NAHO, 2007; Smith, 1999). According to Kenny (2004), the author for the Government of Canada's A Holistic Framework for Aboriginal Policy Research,

Qualitative research is appropriate for researching the lives of First Nations peoples precisely because the purpose of qualitative research is to reveal the identities and stories of the people and the meaning of these stories, giving the viewpoint of the participants in the research (section 8, p. 1).

Specific qualitative methods are identified in the literature as being preferred for First Nations research. Methods that focus on oral communication, relationships, community involvement, and traditional talking circles are viewed as culturally appropriate. Therefore, participatory action, focus groups, and interviews are recommended most frequently in the literature (Castellano, 2004; Kenny, 2004; NAHO, 2007; Schnarch, 2004; Smith, 1999).

The literature is also clear that the results from First Nations research should be used to benefit the First Nations group involved. This recommendation appears to be in response to past practices of taking information that benefits the research group, while giving nothing back to benefit the First Nations' community (Schnarch, 2004; Smith 1999).

As a non-First Nations researcher, I was very cognizant of the literature specific to conducting research with First Nations' people. Research ethics described by the Tri-council involved building a trusting relationship with the people with whom the non-First Nations researcher would be working. I was fortunate in that I had been working in these Carrier communities for a number of years prior to conducting this research. I suspect that my pre-existing relationships with Carrier community members assisted me in gaining entry as a trusted researcher.

I involved First Nations members throughout my research. I spoke with three Carrier Elders and one Carrier leader during the development of the research question. The Carrier Elders were from the three separate Carrier communities of Nadleh Whut'en, Stelat'en and Saik'uz. The Carrier leader, Mabel Louie, has served a term as Chief for her community and has held leadership positions in the area in First Nations health. Ms. Louie later joined my academic committee to help guide this research and has been involved with the entire process. As will be discussed later in this chapter, my research participants were involved with providing feedback to the data and edits to the results chapter. I communicated with Band councils in the communities where I hoped to conduct the research. The execution of this research has attempted to honor the recommended protocols for First Nations research,

while meeting academic expectations. The amalgamation of these recommendations for use in this study is outlined in the research methodology.

Methodology

To explore the research question, it was necessary to gain insight into Carrier cultural views and practices. I looked to the field of ethnography to frame this work. I chose ethnography because I felt it was best suited to the nature of enquiry, which, was to enter into the natural environment of Carrier culture and “understand people’s perspectives” on the topic of Carrier mental health and healing (Hammersley, 2006, p. 4). I felt this approach lent itself to the exploratory nature of my inquiry as an outsider looking for an insider’s perspective. While etic concepts of First Nations culture with respect to mental health and healing exist and guided the development of my research question, a research methodology that supported an emic approach was preferable to explore the insights of the healers and knowledge holders in Carrier communities (Bala, Chalil, & Gupta, 2012; Chen, 2010).

There is some debate in the literature regarding what makes a research study “ethnographic” (Koro-Ljungberg & Greckhamer, 2005; Wolcott, 1990). Traditional ethnography requires that a researcher participates “overtly or covertly, in people’s daily lives for an extended period of time, watching what happens, listening to what is being said, asking questions-in fact collecting whatever data are available to throw light on the issues that are the focus of the research” (Hammersley & Atkinson, 1983, p1). However, some contemporary ethnographers suggest that traditional ethnography has evolved over the years. Wolcott (1990) suggests that what makes a study ethnographic is less about time spent in the field and more about its processes and the product of that process. He states “the research process deserves the label ethnography only when the intended product is ethnography.

Therefore, Wolcott (1990) suggests that a claim to be “doing ethnography’ is also a proclamation of intent” (p. 47). The product of ethnography, Wolcott (1990) argues requires an underlying rationale of cultural interpretation.

Similar considerations are raised by Hammersley (2006). He acknowledges that ethnography has roots in the field of anthropology. In its infancy, the field of ethnography required its researchers to spend extended periods of time living amongst the group being studied. However, this has evolved over the years, and modern ethnographers focus more on the purpose of this type of inquiry versus the means by which the information is gathered. He makes it clear however that the data gathered should come directly from the culture being studied. A definition is offered by Hammersley (2006), who, like Wolcott, suggests that ethnography should put more emphasis on purpose than activity:

I will take the term to refer to a form of social and educational research that emphasises the importance of studying firsthand what people do and say in particular contexts. This usually involves fairly lengthy contact, through participant observation in relevant settings, and/or through relatively open-ended interviews designed to understand people’s perspectives...As ethnographers, we typically insist on the importance of coming to understand the perspectives of the people being studied if we are to explain, or even to describe accurately, the activities they engage in and the courses of action they adopt. (p. 4)

Ethnography, therefore, is being used as an appropriate approach for research in the social sciences when a researcher seeks to explore an insider’s cultural worldview (Hammersley,

2006; McNamara, 2009; Robertson & Boyle, 1984; Shaffir, 1999). “Ethnography is concerned with the context of discovery, rather than verification, and leads to descriptions and interpretations of cultural phenomena. Ethnography is a means for gaining access to the health beliefs and practices of a culture” (Robertson and Boyle, 1984, p. 43). Intentions of the ethnographic research to “discover” through observations and dialogue, honors considerations of First Nations research; the participant has the control of showing and explaining their worldview.

I live and work in Carrier territories and was able to conduct this research in these communities. As recommended by Wolcott (1990), the process of my research flowed from the intended ethnographic result of my research; a cultural interpretation.

Sampling.

I approached eight First Nation Band councils in Carrier territories and requested that they enter into a research partnership with me, by permitting me to seek out traditional healers and knowledge holders in their communities who were willing to share their knowledge. I initially sent out letters to each Chief of these communities and followed the letter up with a phone call. Leadership provided their support in writing (see appendix “A”). Seven of these Bands granted me permission to work in their communities. I advised that each community could use the information results of this research, as is appropriate under the OCAP recommendations (Schnarch, 2004). Entry into the communities was granted without discussion. I simply presented the outline for the research and was granted permission. I have no way of knowing if this ease of entry was due to communities being familiar with me or if another factor was at work.

I used purposeful and snowball sampling to gather participants. Purposeful sampling occurs when research participants are selected “according to criteria determined by the research purpose” (Tuckett, 2004, p.53). Snowball sampling occurs when existing participants refer the researcher to other possible participants (Brewerton & Millward, 2001).

My research required participants from Carrier communities who possessed knowledge regarding traditional Carrier health and healing practices (Brewerton & Millward, 2001). These criteria dictated a purposeful sampling strategy. When I approached community leadership to partner and grant me access to traditional healers and knowledge holders, I asked them to refer me to anyone they felt was a traditional healer or knowledge holder. I also asked my First Nations committee member to direct me to anyone she thought might meet my criteria. I followed up on all of these referrals. Four individuals responded positively to my request. Snowball sampling occurred when I was referred to additional traditional people by my existing research participants. Snowball sampling was very useful as traditional healers do not advertise and they are only recognized by peers and members of their communities as knowledgeable and skilled people.

In all, seven traditional healers/knowledge holders, from the five Carrier Bands of Burns Lake; Nadleh Whut'en; Stellako; Saik'uz; and Nak'azdli, participated in this research. There were four women and three men. Four of the participants were very active well known healers in Carrier communities. The remaining three were well known for their knowledge of traditional Carrier culture. As outlined in my informed letter of consent to research participants I offered a cash honorarium to all participants. I was reminded during my first interview with my first participant that it was proper protocol that I also offer tobacco as the

traditional way to ask a healer for help or information. I therefore offered a pouch of tobacco to my subsequent participants as a way of traditionally requesting information.

All of my participants consented to my acknowledging them as being contributors to this research. However, through the informed consent form, I made a commitment to my participants that I would make every effort to protect the anonymity of their specific contributions to this data. Carrier healers and knowledge holders are well known in the area. For this reason, I list all of the people who assisted me with this research together and I do not specifically identify which ones are research participants. In addition, any description of the participant who provided a specific quote, would risk identifying the contributor. In the 'Presentation of Findings' chapter, I will use a code, instead of names, to represent each participant. Direct quotes are identified by the letter 'P' for 'participant', followed by a number 1 through 7.

Data Collection.

My data collection phase for this research occurred between November 2010 and October 2011. To begin, I set up an initial interview with each participant. Eight interview guide questions were designed to prompt the research participants to discuss factors involved in the primary research question (see Appendix E). Questions were purposely open ended to allow for a maximum of exploratory related information (Frankel & Devers, 2000). These initial interviews ranged in time from two to four hours. Each of the interviews was recorded on a digital recorder. These recordings were transcribed into text in preparation for data analysis. One initial interview was conducted in my Prince George office due to issues of convenience for the participant. The remaining initial interviews were conducted in Carrier

communities. All but one initial interview was conducted individually. In this interview, the participant asked if two other participants could sit in on the interview with her, due to her concerns that she could not translate Carrier concepts into English. These initial interviews, occurring from November 2010 through May 2011, provided me with an orientation into concepts of traditional Carrier mental health and healing.

Because initial interviews were tape recorded, these events were set up in a way that allowed privacy and a quiet environment. The one interview that was conducted in my Prince George office, took place in my board room seated at the table. The participant brought to life his description of traditional medicine when he produced medicine from his pocket. He allowed me to handle and smell the medicines as he described them.

Two initial interviews took place in the homes of the participants. One participant described how she used prayer when she collected the medicine from the forest and then spent hours preparing it in her kitchen. She described how she was frequently visited by spirits. She sees the spirit of people who are about to die or have recently died. She also described how ancestral spirits use her home to meet and discuss issues. It was an interesting experience to sit with her, in her living room, and hear these descriptions. This participant is a very friendly and practical woman. There were no indicators of embellishment for dramatic effect, just practical talk about how the spirits are there to help her in her work and how they go about their own business to do theirs. The interview took place in the middle of the day and her living room was bright. Perhaps these factors caused my experience to lack any level of the fear that might come with talk of ghosts. My experience was that of being

aware of a connection beyond the physical world while I sat in this place that is frequented by spirits.

A male participant also invited me to his home for the initial interview. His home was situated in a forested area, approximately 2 hours' drive from Prince George. My 11 year old son was ill on this day and was home from school. I phoned the participant to reschedule the meeting. He instead invited me to bring my son and stated that his own three children were also home from school ill. On arriving, my son was quickly taken by his wife and settled on the couch in the living room to watch a movie with the other children. My participant and I sat at his kitchen table while his wife went about her daily chores that included caring for all four children. I was aware from my previous experience with Carrier people that communal care of children is common. This seemingly natural act of including my child in this care was a hands on experience of Carrier culture.

Three initial interviews were conducted at the same location on the same day. This location, Ormond Lake, is on the traditional territory of the Nadleh Whut'en people, and is their traditional fishing land. It will be described in greater detail below, and is a place where I spent time observing a healer's work later in the data collection phase. Two of the participants were from the community of Nadleh Whut'en while the third was from the community of Stellat'en. I was able to set up the interviews at this location for all three participants who were at the site for various reasons. The site has a main cabin and several small fishing cabins located on the site. The three participants were interviewed in the main cabin that is on location. The structure is made of logs and is quite rustic. It has a kitchen and a common area. Two participants were interviewed separately in the kitchen. The third

participant was interviewed in the common area, but she asked if the other participants could join us because she was concerned she may not be able to translate Carrier concepts to English. The final initial interview was also conducted at this site on a different day.

The summer, and early fall provided opportunities for me to meet with participants', talk more with them, and observe them in their traditional work. I traveled to each community a minimum of two times from June, 2011 through October 2011. Most trips into community lasted a full day. My work in Carrier territory takes me into the communities frequently and has done for years. In efforts to protect the integrity of this research, I recorded observations and discussions as "data" only during the formal data collection phase of this dissertation. I explicitly stated to my participants when my communication with them was related to my thesis. During my travel into communities during the data collection phase, I had the privilege of being part of a variety of experiences and conversations that offered me further glimpses into the world of traditional Carrier healing.

I observed one participant at his modern day counselling job in a helping center, where he incorporated traditional work in his practice. This program, which offers services to men who are recovering from addiction allowed him flexibility in his work. He is a known healer in his community. His place of work is located on reserve in a rural area. The center is essentially a converted house. It has a kitchen, dining area, a common area, and laundry facilities. What used to be bed rooms were converted into offices and private counselling rooms.

Although his formal title of "counsellor" did not represent his traditional healer status, he described working from within a traditional Carrier healing philosophy while

incorporating his addictions knowledge gained though his formal education. He regularly used the natural environment, including the forests, mountains, and nearby lake, in his work. He showed me how the facility contains a smoke house and a woodworking shop in the yard for participants' use. He informed me that in traditional healing culture, Carrier people look to nature to aid in healing because, nature is a powerful healing tool. He therefore took his clients into the wilderness frequently, to hunt, fish, or just spend time in nature. The smoke house was used to smoke fish and meat and the wood shop was for the clients to make traditional items such as drums. This connection with the natural environment is in itself healing. He regularly used talking circles a traditional, communal sharing of thoughts and problems, and prayer. He incorporated his knowledge of addiction models, including the Twelve Steps and Harm Reduction, in his work.

Another participant showed me how her home reflected her position as a traditional healer. She is known for her ability to use herbs and plants as medicine to heal. She showed me how she brought things from nature into the house and how she used them to keep in balance with the environment and the spirit world. She showed me a "bundle" containing branches from a tree and a knife that were placed under the mattresses in the house. These bundles protected her, and any overnight guest, from ill energy or bad spirits which, she referred to as bad medicine.

One participant took the time to show me some of the natural substances that he referred to as Indian Medicine, used in his healing work. He explained the uses of these medicines, informing me that some of them have a variety of uses. The particular

preparation of a medicine, along with the appropriate prayer and assistance from the spirit world, aids in the effectiveness of the medicine.

During the summer months, I had the privilege of attending one Fast ceremony over two full days and a sweat lodge ceremony during another day. Four of my seven participants were present for these ceremonies and I spent several hours, observing them and talking with them during each event. Each participant had a different role to play during these ceremonies. The entire Fast event was actually six days long, even though the Fasters fasted for a maximum of four days. Each day involved prayer, smudging, singing, and drumming. I understood these behaviors to be part of the daily routine of a traditional person and those involved in traditional ceremony.

The sweat lodge and Fast ceremonies I observed occurred on the traditional lands of the Nadleh Whut'en. This is the location where an annual Fast for the Carrier people is held and sweat lodge ceremonies are held weekly throughout the summer months. It is centrally located in Carrier territory. This traditional gathering place and fishing village is known as Ormond Lake, and is a sacred place for Carrier people. During my data gathering phase, four of my seven participants were involved with traditional work at this site. I have observed two of my other participants, during other times providing traditional work at the site.

In the 17 years that I have worked amongst the Carrier people, I have heard legends regarding the significance of the Ormond Lake area. I will share this here, with permission from a Nadleh Whut'en Band council member, neither as a contribution to the gathered data, or as one claiming the right to tell Carrier Legend, but instead to provide a background to this site as an interesting data gathering location on the topic of traditional healing.

Ormond Lake is situated approximately 20 km from the village of Nadleh Whut'en. It is accessible by logging roads. Carrier people have told me that they have gathered together on the North bank of the lake to hunt and fish for generations. Carrier people continue to camp at the site in cabins that have been built and maintained by generations of Nadleh Whut'en people. In previous years there was a teepee erected every spring on the site. I am informed that this structure will no longer be used because the Carrier people did not use a teepee as a dwelling. It will instead be replaced by a pit house, the traditional Carrier dwelling. Carrier Sekani Family Services also operates a seasonal cultural healing addiction recovery program at this site.

I have heard several versions of a legend that explains why the site is a sacred place. Essentially, the legend involves a story of a time, long ago, when a group of Carrier people were camped on the shores of the lake, one summer. A female member left the group one day and canoed across the lake. Some stories say she simply left the group on errands of her own, while others say she left after a premonition that something bad was going to occur at the site. Some of the later versions say that she tried in vain to warn the Chief and convince him to move his people away from the site. When she returned the next day, she found that all of her people had been massacred, presumably by an enemy First Nation group. To properly deal with the remains of her loved ones, she engaged in the difficult work of gathering the bodies together. When she had done so, she burnt their remains. She then left the site and went into the nearby mountains to mourn her people for the rest of her life.

Today, a large mound exists in the center of the traditional camp that is said to contain the cremated remains of the people. A small altar made of branches is built each

spring on the top of the mound. Offerings of food are carried up the mound and placed on the alter as offerings to the spirits of the dead. I am told that the singing and crying voice of the survivor of the massacre is sometimes heard from the banks of the lake as it drifts down from the nearby mountains. Because of the sacred nature of the site, and the mountains, people entering the area for the first time each year, follow a protocol of smudging charcoal under their eyes as a sign of respect to the spirits. As a by-product of its tragic and spiritual history, Ormond Lake is said to be a powerful place of healing. It is known to be occupied and protected by spirits. Indeed, over the years I have been witness to many modern day stories of spirit activity and a few unexplained events of my own.

In addition to in person contact, I communicated with participants via telephone and email when I wanted further information or clarification on data. I communicated with each participant a minimum of three times during the data collection phase. With the exception of the initial interviews, all of my discussions and observations were recorded, by written hand, as data for this research (Castellano, 2004; Kenny, 2004; NAHO, 2007; Schnarch, 2004; Smith, 1999; Spradley, 1979). The results of the data gathering phase generated over 300 double spaced pages of text.

After the data collection phase was completed, I sent a copy of transcriptions of interviews and observations to each participant. I asked them to make notes of any information that had been transcribed incorrectly, and to add anything they felt needed more information or clarification. This was a very important part of the data collection process. I wanted to ensure that I was taking steps to maintain the integrity of the data, particularly due to the fact that it was collected by a non-Carrier researcher. The feedback given by

participants was relatively minor, and related primarily to clarification of words misheard on the tape recorded transcriptions.

During the process of writing the Presentations of Data chapter, I occasionally contacted participants to ensure I was properly representing the data. For example, I contacted two participants to ensure I understood the Carrier concept of “bad medicine”. The literature described it as something that was caused independently by a bad spirit. I understood my participants’ descriptions as it was caused by people who manipulated energy. They confirmed that my understanding was correct.

Once the presentation of the findings chapter was completed, it too was sent to the participants for review. Sadly, one of my participants died of cancer in September of 2011, and did not have the chance to read the results chapter. All remaining participants responded positively to the format and content of the chapter.

Data Analysis.

The resulting text, which became the data for this research, was analyzed using content analysis. Content analysis involves a process of examining the transcribed text from, in this case, interviews and observations, and organizing the text into units of meaning (Elo & Kyngas, 2008; Graneheim & Lundman, 2004; Krippendorff, 2004; Mayer, 2000; Morgan, 1993). I felt that due to the fact that this research is both cross cultural and is exploring an area in which little is formally known outside of that culture, I would focus on gathering manifest concepts from the data. To attempt to explore latent concepts as a non-native researcher was, in my opinion, breaching researcher bias issues as were discussed in the

section of this chapter concerning First Nations research. In this case, I would be searching for meaning in the text and interpreting the data through my Western European lens.

My intent was to allow the transcribed text to speak for itself by allowing the participants' words to communicate research results (Graneheim & Lundman, 2004; Mayring, 2000; Stemler, 2001). A deductive approach can be used in content analysis when the researcher has predetermined categories. However, I used an inductive approach because I wanted the themes to emerge directly from the data (Elo & Kyngas, 2008; White & Marsh, 2006).

The process of content analyses, involves a series of back and forth movements between parts of the text and the whole in a manner that is reminiscent of grounded theory (Glaser & Strauss, 1967; Graneheim & Lundman, 2004; Morgan, 1993). Forms of content analysis can be used for both qualitative and quantitative analysis, the most significant difference in the methodology is the orientation of overall research design. Morgan (1993) explained that qualitative and quantitative content analysis differs in how codes a primary method used to organize the data are developed and used. Quantitative researchers will count codes to support the strength of the presence of themes. As the overall research design is qualitative in nature, my use of content analysis methodology flowed from this orientation. After reviewing a number of possibilities in the literature outlining the specific steps to conducting qualitative content analysis, the processes described by Graneheim and Lundman (2004) and by Elo and Kyngas (2008) were the most applicable to this research. Both of these works described using content analysis in social science research. I have outlined the process I conducted below.

My transcribed recordings and notes produced over 300 pages of text. To start the process of analysis, I read through the text several times. My initial read through was to gain a sense of the text in its entirety. During my second read, I highlighted concepts that emerged from the text. During my third read, I made notes in the margins commenting on basic concepts that were included in the highlighted text. This process is referred to as “open coding” by Elo and Kyngas (2008), and the concept word I wrote in the margin is referred to as a “code”. These highlighted concepts, words, sentences, or phrases are referred to as meaning units (Graneheim & Lundman, 2004; Elo & Kyngas, 2008).

At this point in the process, a document was developed which organized all highlighted meaning units under a specific code. As some meaning units were relevant to more than one code, they were placed under all applicable codes. As meaning units can include sentences or paragraphs, the next step was to reduce these longer statements into condensed statements that closely resembled the original text (Graneheim & Lundman, 2004). To accomplish this task, the meaning units were all reread and condensed. I bold typed the primary meaning parts of a larger paragraph or sentence.

Through this process of placing condensed meaning units under codes, larger categories began to emerge. A category is a group of content that shares a commonality (Graneheim & Lundman, 2004; Mayring, 2000). All data relevant to the research question was placed into a category. This process and the resulting categories represent an overall descriptive level of content (Graneheim & Lundman, 2004).

The development of themes, or main categories was the final step in this qualitative process (Elo & Kyngas, 2008; Graneheim & Lundman, 2004). A theme is described by Graneheim and Lundman (2004) as:

A recurring regularity developed within categories or cutting across categories . . . threads of meaning that recur in domain after domain. . . . We consider a theme to be a thread of an underlying meaning through, condensed meaning units, codes or categories on an interpretive level. (p. 107)

Conclusion

This chapter summarized the process I engaged in to explore my research question. Literature about First Nations' and social science research considerations was consulted to guide this research design. The overall methodology of ethnography was presented in this chapter as the framework used in this research. This framework attempted to honor a culturally sensitive research approach. The primary data collection tools of interviews and observation flowed from this culturally sensitive, ethnographic framework. The chosen data analysis method of content analysis supported the inductive and qualitative nature of this research. The resulting themes, supported by their codes, will be presented in the "Presentation of Data" chapter of this dissertation.

Presentation of Data

The data for this dissertation consists of transcribed interviews and field notes with seven Carrier First Nations knowledge holders and traditional healers. This data was analyzed using the process of content analysis. In all, 37 codes were developed from the data. The codes were then further grouped into larger descriptive primary categories. In all six categories emerged. All of these categories have been placed into one of two primary concepts of “Carrier Worldview of Wellness” and “Carrier Traditional Healers”. The categories within the Carrier Worldview of Wellness theme are “Balance and Connectedness”, “Community”, “Nature” and “The Spirit World”. The categories within the Carrier Traditional Healers theme are “Becoming a Healer” and “The Work of the Healer”. I have provided a visual guide for the reader (Table 2). It should be noted that not all codes are identified under a subcategory title but are contained in the description of the theme. To identify each code under a separate title would upset the flow of this chapter.

I have chosen to use both titles of *traditional healer* and *knowledge holder* for the participants of this research. Even though all seven participants were recommended by someone who identified them as practicing traditional Carrier healing, they would not necessarily identify themselves as a practicing healer. I understood this to be the result of a code of humbleness that is expected of traditional Carrier healers to help ensure their gift of healing is not abused. The term knowledge holder therefore is respectful to the participants’ possession of traditional knowledge while not making the assumption that they identify as a healer.

Table 2. Codes, categories, and themes

CODES	CATEGORIES	MAIN THEMES
Communal social structure	Community	Carrier Worldview of Wellness
Clan system		
Absence of mental Illness	Balance and Connectedness	
Balance or holistic		
Carrier grief process		
Loss of spirit		
Bad Medicine		
Connection with Nature	Nature	
Mountains		
Water		
Plants and herbs as medicine - tobacco		
Animals		
Belief	Spirit World	
Creator		
Prayer		
Spiritual		
Identified by the Spirit World	Becoming a Healer	
Identified by Elders		
Teaching	The Work of a Healer	
Healing through knowing self		
Healing power		
Engaging a Healer		
Plants and herbs		
Talking/Council		
Dreaming		
Drumming/chanting/Singing to heal		
Eagle Feather		
Spirit World/Creator		
Predicting/knowing future		
Seeing spirits		
Ceremony		
Fasting		
Ritual/protocol		
Smudge		
Sweat lodge		
Yuweepi		
Modern day		

It should be noted that the term healer in this dissertation refers to a person who used or uses traditional Carrier healing methods. This was the term most often used by participants. This term, as well as the terms medicine man and medicine woman, were also identified as acceptable terms by my First Nations advisor/committee member. The participants accepted these terms and also added the terms helper and doctoring to further describe the position and practice of the traditional healer.

Although I set out to seek insight into the traditional views with regards to how mental health was viewed and mental illness was treated, it was evident through the results of my research that mental health, or illness, for Carrier people cannot be considered independently from physical or spiritual health. Therefore, I take the reader through descriptions of Carrier views as they relate to overall functioning in the world, while attempting to focus on mental health.

The questions contained in my interview guide were phrased in a way that asked about Carrier philosophy of mental health and healing practice in a historical tense. However, participants' responses reflected a disregard for time in their descriptions of traditional views and healing practice. They used words that described both past and present tense in response to my questions. I was at first concerned that my participants misunderstood my questions and that the conversations I had with them would not lead me to the insight I was looking for. Through my experience involved in data collection I came to believe that this disregard for tense may be indicative of the Carrier philosophy of existence; it is not linear. Nor is traditional healing practice static or archaic. It is ever evolving through interplay of historic knowledge and present practice.

This chapter starts with a description of the categories that fall under the first primary concept of “Carrier Worldviews of Wellness”. These categories provide a description of traditional Carrier concepts, as described and demonstrated by the participants, of living in harmony with each other and the greater universe. This concept is essential to understanding concepts relating to Carrier health and healing. The chapter then moves into the second primary concept of Traditional Carrier Healers. This section describes how someone became a traditional healer and what activities were involved in being a healer. This chapter uses a large number of direct participant quotes to illustrate the findings of this research.

Carrier Worldviews of Wellness

Balance and Connectedness.

The concepts of balance and connectedness were central to descriptions provided by my participants. They described concepts of traditional health and healing against a backdrop of a general Carrier worldview of balance and connectedness. These general concepts are discussed in this section.

Absence of Mental Illness.

When asked the question “Historically, what might have been considered a mental health wellness related concern” participants quickly informed me that the concept of “mental health” did not exist in traditional Carrier society. As clearly stated by P2:

A long time ago we didn't have mental illness in the sense of how it's classified today. Even when I read about history, about our history, or what I learned from the elders and things like that, there was never really a concept of mental illness.

He recalled the teachings of his father, who spoke directly to issues of mental health as a First Nations advisor, regarding current First Nations mental health issues:

My dad used to tell me too, he said at one point there was no people around who were considered, I remember him saying too at a meeting in Prince George, at a mental health meeting at the friendship center, he was telling people that when Simon Fraser and Father Morice and them were up here, there was no mention at all of anybody being mentally ill or retarded or whatever, you know, crazy. There was never any mention of that. (P2)

P3 responded to this query by recalling her experiences in early childhood, “it was all the same thing. Like, I don't think we were even aware of mental illness. You know, I never heard my parents talk about somebody being mentally sick.” P4 was definitive in informing me that concept of mental illness simply did not exist in early Carrier society, when I asked how someone might get help for a mental health related problem:

Interviewer: In the old days, traditionally, if a person felt somebody needed doctoring or needed help, would they just, put out that communication that someone needed to come out and help your sister or brother or friend who was mentally ill?

Participant: There is no mental illness. (P4)

There were suggestions that emerged from the data, that mental health related problems came with colonization, as was indicated by one participant when he recalled the opinion of his father: “He said a lot of this started, um, these problems I guess you would say started after the white man came, you know, alcohol and different things like that, influences

or whatever. Values and priorities changed, you know and the concept of wealth came in there you know” (P2).

The data showed that there was no concept of “mental health” or illness in traditional Carrier culture. Instead, Carrier people viewed themselves as living life favorably if they maintained a state of balance within self, and between self and the greater environment.

Balance.

In this philosophy of balance, Carrier people recognized the various aspects of self; mind, emotion, body, and spirit, but believed that they always operated interdependently:

They are all related, either mental, your emotional, your spiritual, and your physical, they are all interrelated. You can't separate anything from your different aspects of your life. You can't separate yourself, the way you can separate your mental from your physical when you look at them specifically, but they are all intertwined, and they all intertwine, and one impacts the other.

So, in our way, we try to keep balance in those four areas. (P7)

This overall balance within oneself and the universe was described as being pivotal to maintaining wellness:

Participant: There's always a balance. Big thing is you have to find balance, right. Balance for people to, to live. The balance of life. You know, in order to reach our harmony, you know, we have to get that balance first.

Interviewer: So balance is about being overall well?

Participant: Ya. Holistically well. You know they talk about holistically well. You know you have to be good, sound in the mind and body and in the spirit. You know it's like, say for instance, before you can play a piano you, you know, to get good music out of it you have to tune it first. (P7)

Likewise, a person's illness was not identified as having a particular origin or identification but was instead attributed to the individual being out of balance within oneself:

Interviewer: So, how would people then, in the old way, identify being unwell, not saying "they're mentally ill" or "physically ill", they would just say "not well"?

Participant: "Not well" and it's just one of those areas there that they are referring to usually. We don't look at it personally. I don't look at someone's unwellness as a sickness or anything. I just, you're wounded in some way. And have to find a way to heal that wound because it impacts you collectively as a person in those four areas. So, it's a process, where you are continually reflecting on yourself, working on what you need to work on. (P1)

This participant indicated that in his work as a healer, he looks for the "wound" a person is suffering from. This wound may be physical, emotional, mental, or spiritual. A lack of balance that caused this wound may not be something that an individual has direct control over. It may be an imbalance that occurred as the result of an ignored protocol, or of an

event that occurred prior to the individual's birth. One participant described these teachings from his father:

My dad used to say that when people who had something wrong with them, was that they were out of balance in some way. Whether that was something that was happening in their life at the time, or if it happened before they were born. It used to be that the Indian people believed...that if somebody did something wrong, or something was wrong in their life, it carried, not only if it was emotional, mental thoughts to whatever, it carried into the physical.

(P2)

As identified overall balance was important to Carrier people. Grief was a concept that was identified as a natural condition that needed to be managed to maintain balance.

Carrier Grief Process.

Grieving was processed by early Carriers through ritual that helped the grieving person accept the loss. As discussed in the first literature review chapter, the Carrier may have gotten their name from the ritual of carrying the remains of their dead during the grieving period. Carrier philosophy regarding death reflected their worldview of connectedness. They believed the spirit never truly died:

As Indian people, the grief stuff right? Grief wasn't an ongoing process for us. We had no time for that. That is why they call us Carrier's right? The Carrier people come from a practice of carrying our dead for that cycle of one year, you know. We put ashes in a bag around our neck or whatever and pack

them around. You get used to the idea that they are right there, they are not gonna come out of the bush or anything.

We had a belief that when people died we were going to see them again you know, they are just going somewhere else and there are different levels of death or, you know, after life or whatever you want to call it and some of them come back as animals or other people. (P2)

Death of a loved one may involve a traumatic event. With or without death, exposure to a traumatic event could cause someone to lose their spirit.

Loss of Spirit.

When a person is met with significant grief or trauma, imbalance may result that can cause a person to “lose their spirit”. This notion of loss of spirit was explained:

Participant: Some people that lose their spirit, they’re little bit off the wall.

Then you call them by water, you call them by name.

Interviewer: You call their spirit back?

Participant: Yeah. Totally different person after they do that to ya. You’ll go in a deep sleep and when you’re in that deep sleep, that’s when your, whatever came out of you, ... your spirit, or your soul or whatever, you want to call it. Yeah. They done that to me and you can stand by the water cause when something traumatic, when something happens to you; your spirit goes back to the water.

Even notice every reserve you go to they're, they're um their graveyards are by water? (P3)

P3 had the experience of losing her spirit and going through a ritual of calling it back. She has also worked with others, as a healer, to call their spirits back. Both ritual and water were used during this event. P4 described the loss of spirit and recovery that occurred to her family member:

Participant: They say; when you see, you lose your ghost, or you see somebody's ghost, or you lose your ghost, you lose your soul or something, you lose your, if you get scared or if you are really traumatized, you lose your soul, I guess that's what it is. And, what they used to do is, the older people, they would call them back. So, bring their soul back home.

Interviewer: So, would they have strange behavior when they lost their spirit?

Participant: Yep. They would eventually just sleep all the time. I remember my cousin (name of cousin), he would just sleep most of the day. Wouldn't eat, hardly eat, just was pretty well just, there was nothing they could do, he was just dying. And, they did that to him.

Interviewer: And, did he come back?

Participant: Yep.

Interviewer: He did?

Participant: Mmmhmm. He said he just felt cold water splashed on him one day. I guess when the spirit returned.

Interviewer: So, did they only have to do that one time for him or several times to get his soul to come back?

Participant: Sometimes they will know. Sometimes they will have to do it two more times or until it does. I remember those stories like that. They always had those older people. Those people, like I was never scared of them. They were people that I trusted, like when I was growing up. (P4)

Another participant also discussed the ritual involved in calling back a spirit although; she had some difficulty expressing this to me in English. She asked another participant to help translate. She described the process that she witnessed when her mother a Carrier healer performed it. It involved using an article of clothing that would have a person's essence on it to help bring the spirit back. She described that the ritual can take place anywhere a person was believed to have lost their spirit. At the conclusion of the ritual however the person must sleep undisturbed and the clothing used in the ritual was burned. She explained:

Interviewer: Is there a certain ceremony to call your spirit back?

Participant 2: Yes.

Interviewer: Oh, so they would do a very specific thing to do that?

Participant 2: Yes.

Interviewer: Oh, okay.

Participant 2: It's really hard to say in English

Participant 4: Yeah, she does a thing with, like if you get scared and you lose your spirit, something that you use a long time, like a t-shirt or something. It's got your, will you translate (asks other healer in the room)?

Participant 4 (translating Carrier for P2): It has your essence, because you have been wearing it for a while. She did that to one of my granddaughters. That's what she has been wearing for a long time, that one, you burn it.

Interviewer: And that calls the spirit back. Then you burn it?

Participant4: Yes. We have some people that take them out where you have been frightened and they call their spirit back.

Interviewer: Like, literally call it? Verbally call it back?

Participant 4: Yes. And you have to be in a room by yourself, no distractions and when you feel something, you don't move. You just lay there. Otherwise you will scare your spirit away.

Interviewer: So, you call it back in the forest? And then after you go into a dark room?

Participant 4: Well, you don't do it like, somebody can come to my house and call my spirit back.

Participant: And then after there is not supposed to be any dogs or...

Participant 4: Something to scare the spirit away. No distractions.

Interviewer: Oh, okay. And then it comes back?

Participant 4: Yes. And then when they go to sleep, after they get home, you
make sure you don't wake the person up and she has to sleep.

Wake up whenever they get it back.

Interviewer: Just let them sleep until they are ready then?

Participant 4: Yes. (P2, P4)

The concept of losing one's spirit due to fright or trauma appeared to be well known to the participants. Based on their descriptions, it was the job of the healer to perform the ritual to help the afflicted person regain his or her spirit.

Bad Medicine.

The concept of "bad medicine" was introduced by the majority of the participants as being a possible cause of someone's imbalance. Bad medicine was described as the use of energy to cause harm. People who used this energy to cause harm were said to be practicing witchcraft or were bad healers. Therefore, to have the abilities of a healer did not guarantee the individual would choose to use this gift for good:

Participant: There's always been bad medicine out there. There is bad
medicine because it's been passed down...generation thing that's
been passed down.

Interviewer: So what is bad medicine?

Participant: Bad medicine is a person who practices witchcraft that can alter...energy. (P1)

Although the majority of participants indicated that bad medicine was used intentionally to cause harm, one participant indicated that bad medicine can occur unintentionally, if someone who has healing power is hurt by someone else. Her description suggested that she could not control her energy if she was at risk of harm; almost as if it could become an independent agent and cause harm:

Participant: If you accidentally do something to me, you know, startle me, or do something; I can unconsciously dream about you and hurt you.

Interviewer: Oh. So, in a bad way then people can dream?

Participant: Yeah.

Interviewer: So, you can dream about me and hurt me in my dream also, or in my waking world?

Participant: In your waking world.

Interviewer: Oh, okay. So, you can make me ill?

Participant: Yeah.

Interviewer: Is that what they call bad medicine? Is that another word for that, or no?

Participant: Some people used to do that on purpose, but I don't want to hurt you. But, I can, or my grandchildren, like if they startle me or something like that. (P3)

I wondered if bad medicine was credited with inflicting conditions that might be seen as diagnosable mental illness today. The participant responded that bad medicine can alter the mind but that he knows how to rid people of bad medicine through the use of traditional medicine:

Interviewer: In the old days when people would present with what we would know today as say, schizophrenia, how would they see that?
Would they see that as imbalance or as bad medicine or?

Participant: Well you know for instance, somebody playing with mind games. Head games, trying to play with your mind...you know like with a, the ah, altering the mind...but there is a medicine that I, that was passed on by our, you know, by our family which gets rid of that. Gets rid of that bad medicine, bad energy so, when you mix the herbs. (P1)

Participants who mentioned bad medicine discussed how, as healers, they need to protect themselves from bad medicine. There was an indication that healers, who use their power to heal, did not practice bad medicine. This use of energy to harm was described by the majority of the participants as something that was not used by healers who used their power to heal, with the exception of the one participant who stated she could unintentionally harm someone. Bad medicine was practiced primarily by people who were bad healers. The participants indicated that the danger of bad medicine was very real and that medicine people should be well versed on how to protect themselves from bad medicine as well as how to

help others be healed from it. P3 showed me how she protected not only herself but any overnight visitors who slept in her home:

There are some bad healers too. You got to watch out for them. They can play with your mind...there are ways to deal with people like that. My mom never knew how they done stuff, but her granny taught her how to break them. They're very powerful people too. You'd better watch for them and some of them are known. Different reserves practice that. They don't know what they're dealing with or how bad it is to do things like that to other people. It catches up with you because people know how to break it. We use stuff like the rose bush. You want to see mine? (P3)

As mentioned earlier, P3 then took me into her bedroom where I helped her lift up her mattress. Under the mattress were a cloth bundle that held a knife, and a branch that the participant told me was from a rose bush. She said that bad medicine will often be put on a person when they are defenseless in sleep. The rose bush protects and the knife will cut the bad medicine off.

My participants did not provide not any explicit descriptions on how someone could use bad medicine. In her last quote on the subject, a participant indicated that her mother was never taught how to use bad medicine, but only how to "break" it. Therefore, the knowledge regarding how to use bad medicine was never passed on to her.

The concepts involved in the category of Balance, provided an overview of the Carrier philosophy of interconnectedness. Community is the next category that will be discussed.

Community.**Communal Social Structure.**

The family, and the overall community, were described as being important parts of the social structure of Carrier people. This is illustrated in this participant's statement, in reference to community being vital to basic survival:

Well, see, they were so close, the community, they used to look after each other too. Like they got that first moose, [it went] right around, their first fish and stuff, it went right around. They helped everybody in their community.

They took care of everybody. Now it's changed. It's different. (P4)

According to the participants, when someone needed help of any kind, the first line of responsibility was the family's to take care of the family member but, the larger community would also respond, as necessary. The following participant indicated that in Carrier communities, social ties were close, and help would often arrive before it was requested. She provided the following response when I asked: "Who in the community, or family, would be responsible for taking action with a person who showed concerning behavior? Who would they go to?"

Participant: The family would know of it, they would be helping.

Interviewer: They would be doing it?

Participant: Yeah. And then, pretty soon there is a parade of people just standing there.

Interviewer: Just happened?

Participant: Yes. (P4)

This same process was echoed by P2 who talked about the interplay of family and community to take care of each other. This participant responded to the same interviewer question stated above:

At that point, it's up to the individual families, but the community would get involved. Usually the parent would approach an elder, and an elder would talk to an elder, and it would end up being collective decision making at the end of the day. I think it still happens today in a subtle way. It's very subtle, but it's there yet. It's just been ingrained in us, biologically ingrained in us.

(P2)

This subtlety of communal care was clear in another participant's comment on the subject of interpersonal support. He indicated that all community members, elders, family, friends, and healers would have the natural responsibility to help one another through difficult times:

If you're feeling sorrow or you're feeling anger there was somebody there to help you through that, you know, to say, 'Okay, well, tell me about that'. And then explaining the anger process to them, what happened to them, why you feel that way and then a way out of it. So there were always people around to help them through um, so they are not stuck you know. (P2)

Family and community support then was described as an important natural support system for Carrier community members.

Clan System.

The natural support system was formalized through the clan system by the central and Northern Carrier people as was discussed in the literature review chapters of this dissertation. The clan system is a structure whereby individuals are placed into a grouping at birth. Children were placed into their mother's clan. Membership in a clan would dictate who would be responsible for taking care of individuals in a time of need, independently of immediate family. As illustrated by one participant:

The clan system...if somebody's husband died and she was a certain clan then those clan members would come. The elders would sit with that person and then they would hire other people from other clans who would do the work and basically the clans were there to support the people through this stuff and people who had been through this themselves who had already gone through the grieving process or whatever and they were there to help them.

(P2)

One interview with a participant was conducted during a fast held in a traditional camp in a forested area. A fast is a ritual involving abstaining from eating or drinking for up to four days for the purpose of exploring oneself or gaining a spiritual connection. The fast ceremony will be discussed further in "The work of the Healer" section of this chapter. There were several people involved in this process. This ceremony can involve being on site for a week or more preparing for the four day ceremony. The fasters were required to remain in a designated area, away from the general camp area for the fasting duration. There were a large number of supporters moving around the camp who were there as cooks, medics, and

personal supporters. These people did not fast but were there to support the medicine man and the fasters. During our conversation, the participant and I were sitting alone in a tepee so that we could have some quiet for our discussion. A young child of five or six would frequently come into the tepee and listen for a few minutes to her grandfather's discussion with me. This participant referred to this environment we were in as an example of a traditional Carrier community:

When you look at this right here, this is a real form of community, because it's a collective community here, a lot of children and you don't, we don't discourage children from anything. We believe that as they run around and play, they are watching us and learning it. So, the more they are exposed to this type of activity, the more they will become comfortable...it's all about the people. It's about all of us collective. You know, someone might be sick in here, one of us might have a story, it gives an answer, and then you, they are able to start dealing with that. So, it's all about the community and we are all part of the community. And, we don't say it's just for the Indian people either, it's whoever comes into the ceremonies are treated as brothers. We are all human beings, you know? We have many commonalities. It doesn't matter to us what colour you are, what blood you have. But, you have to respect our way when you come in there. We don't tell you to drop what you believe in, but just respect what we do, and maybe you will be shown that that it's a good thing. (P7)

Participants indicate that collective community was seen as an important part of overall Carrier existence. The family, and then the community as a whole, would collectively be responsible for the health and wellness of all of its members. The community was instrumental in teaching its children about the ways of the society. This was exemplified in the young child who came into the teepee to sit and listen as she pleased.

Individuals, as part of communities, strived to function in balance and connectedness with each other and the larger natural environment, as illustrated in the following pages. The next section illustrates how nature was important to Carrier existence and wellbeing.

Nature.

Connection with Nature.

Participants explained to me that for Carrier people being connected to the natural environment was an essential part of traditional life. One participant was a healer who works with herbs, plants, and the spirit world. She told me that everything in nature has a purpose. She showed me how she had placed rocks in the windows of each room of her house. She explained “they keep me grounded” (P3). The statement from another participant indicated that the power of nature for Carrier people is not something that can be easily explained:

Interviewer: So, what is it about being in nature, in the bush, that helped feeling better?

Participant: Something, it's just, it's all around you, and it's -- I don't know -- just that good feeling. (P2)

Simply being a part of nature was described as necessary for Carrier people to maintain wellness and to regain balance. The location of the fast that I observed, for example, in the natural environment of the forest was an important factor for healing ceremonies. One participant illustrated this when he reiterated the traditional teachings of his father, who informed his son that a balance with nature, helped maintain a connection with spirituality and ultimately, balance within one self:

My dad used to say that when people were out of harmony, or out of sync with nature you know, because the Indian people, our Carrier people, the elderly people, the land, the bush is our connection with the spirituality of the culture of those kinds of things. We're bush people, basically. If you bring somebody out into the bush and they don't feel ok, then they're lacking something, right? (P2)

This same participant recalled his father's story of being restored to balance through an interaction with nature and the interpersonal support of his grandfather after returning from an Indian Residential School. Recognizing that his grandson was unwell, the grandfather took it upon himself to help his grandson in the traditional way by taking him into the forest. The community where I met with this participant is the same community where his father and grandfather would have lived. It is a reserve community that is located on a large lake surrounded by forest and mountains. To go "into the bush" would not have required considerable travel:

I remember dad used to say, when people are lacking that connection, you need to find a way back. He said that when he came out of residential school

he was very angry. His grandfather, my great-grandfather, took him out into the bush and they built a sweat and they stayed there about four days or something with, you know. And uh, he said that everyday he'd go have a sweat and they would go sit in the bush and fast and his grandfather had another little lean- too there and he would sit there and he'd pray and he would sit there with his grandfather and talk to him about what happened, things like that. After about four days of doing this he would start to feel better....so it helped him in the sense of regaining his uh, peace. I would feel like this. It is where I belong right, and it seemed like I was at peace...I would come back to the land and I would feel ok. (P2)

Participants indicated that a connection to the natural environment includes the ability to communicate with the greater universe. This belief dictates that if you ask the greater universe for something you need, it will happen. One participant described this in regard to her thoughts about the weather:

You know, the other day it was 34 degrees and my relatives are going to that fast, and yesterday was to be even hotter, and I thought, 'Hmm, I'm going to order some cooler weather and rain', and towards evening that same day you heard thunder and we had a little rain, and we had a little rain last night, and it just got cooler. I ordered it and it came. You know if I tell somebody that, they are going to laugh at me. (P4)

This participant explained that she was able to cause a change in the weather because there is a connection between all things. She described this connection as a universal energy. She

was clear that Carrier traditional worldviews of being connected with this universal power had no basis in modern ideas of religion. This conversation took place within the context of a discussion regarding how hunters prepared themselves for hunting using an individual sweat lodge and smudging:

Interviewer: They were individual sweats?

Participant: Yes. That was our practice. Yes. And then the smudging, we did smudging for the men to smudge their weapons and themselves, usually with a spruce bow, and that is just to take, to disguise their scent from the animals. Because animals can smell them. So, we disguised it.

Interviewer: And, would they pray as well before they went hunting?

Participant: Oh yeah. We didn't call it prayer.

Interviewer: What did you call it?

Participant: Oh, I don't know, that's your word.

Interviewer: Well, it's a Christian word isn't it?

Participant: Yes. You just communicate with universal energy, you know?

Interviewer: Okay.

Participant: Like prayer, that's your word, it's not ours. It was just a daily thing with us.

Interviewer: So, it was a way of being, not a way of practicing?

Participant: Just being. (P4)

Mountains and Water.

The mountains and bodies of water in particular, were identified as holding power for healing. A participant who remained very active in her position of healer in a family line of healers stated:

We done healing with a lot of people in the mountains with the drum, the water, because everything around you is very powerful, eh. The mountains are very powerful, the water, especially the ocean water. Mom said the ocean water is very powerful if you want to pray for anything bothering you, it will heal you. (P3)

Plants and Herbs as Medicine.

Elements in nature, such as plants and herbs, as well as the natural environment itself, are seen as important to Carrier health and wellbeing. Participants informed me that plants and herbs were traditionally used for both medicine and prayer. While these medicines were used by traditional healers in their work, participants indicated that all Carrier people had a basic knowledge of the uses of plants and herbs as medicine.

Interviewer: So in the old days, would they have usually, at least one medicine person or healer in each group?

Participant: Well every family member had their own knowledge of medicines...even to this day, they still do. (P4)

Knowledge, regarding which plants and herbs could be used as medicine, would be taught by families to younger generations:

Participant: Our people always believed that for every sickness that there is, you can go into the forest and get something to help you for it.

Interviewer: And would that be just anybody that would be able to go and gather medicine, or would that have to be a traditional healer?

Participant: It could be anybody. It's usually handed down. (P4)

A participant illustrated this point of daily use of plants and herbs for usual ailment as well as for spiritual trouble when he reached into a pouch and gave me a small piece of an organic material he identified as a root. This root, he explained, had multiple purposes. It could be used to treat a child for fever, treat anxiety, and could provide general “protection” from bad energy.

In Carrier worldview, plants and herbs were to be respected. Certain prayers and rituals had to be observed when taking and preparing medicine. For example, “Tobacco is one of the first medicines that was given to us to use as a, you know, to replace whatever we are taking from mother earth and again to use as, to barter, you know to get information” (P1).

Sage and sweet grass were gathered and used sometimes with other herbs or tree fungus. The herb would be placed in a bowl of natural material, such as a shell, and would be lit. The smoke would then be used as an energy and spiritual cleansing agent for a house or person referred to as a smudge. Participants informed that smudging was also done when a hunter wanted to prepare for a hunt. Not only was the ritual done to prepare the hunter through cleansing his mind the smoke from the smudge would cover the scent of the hunter. In modern day, smudge is used prior to a number of events including a sweat lodge

ceremony, a fast, and sometimes a talking circle. Some participants advised me that they smudged each morning to prepare for their day.

I observed one smudge during my data gathering phase prior to a sweat lodge ceremony. At the start of the ceremony, a smudge bowl was placed on a mound of dirt outside of the sweat lodge. Before entering the lodge, each person bent or knelt before the smudge bowl and “washed” their hands in the smoke. Some people washed the smoke over their heads and down their bodies.

Animals.

Animals were described by participants as being a part of the natural environment that helped maintain health and wellness both as a source of food, and as spirit guides. Participants informed me that Carrier people traditionally could communicate with animals. All of the participants in this research still believed and practiced this. Participants described how animals were to be respected and treated, as they too had a place in the universal order. To disrespect an animal might negatively impact a person’s survival. A participant shared a story with me regarding her son, who understood and practiced this traditional belief:

Participant: Why do you think that moose disappear when it's hunting season? It's reading the people's minds. People are coming. They are gonna hurt me. But, he will, if I need him for food, a moose will give himself to me. He's reading my mind. I need food. That person needs food, I better give my life to that person. Yeah. And, we weren't allowed to make fun of animals in any way, shape or form. You don't laugh at animals. You don't make fun of them because they are part of me.

Interviewer: That's respect for all things, then, as well. That was part of it?

Participant: Yes. My son reminded me about that, you know. The moose, knowing your thoughts. If you are gonna go out and get a moose, you don't say, "Oh, I'm gonna go get a moose today." No. You just think about you need food for the winter. You don't think about, "Hmm, I want to get a moose because I need him for the winter." You don't think like that, you just think about the food that you need for your family. And, the moose will give himself to you. Make that sacrifice. Give his life so you will have something to eat. My son, he was out hunting, and he met this other hunter. Not Native. They stopped and talked about hunting and blah, blah, blah, and he said, "I want to get a great big moose. A moose with a great big rack. That's what I'm hunting. I'm gonna come out here every day until I get a moose with a big rack." And, my son said he was standing there just smiling and looking at him, "You're not gonna get it. Nope. Because that moose heard you". Anyways, the guy drove away. About five minutes later, a moose with a great big rack passed the side of the truck in front of my son's car. And my son said he just sat in his truck and just laughed out loud at that. It was so funny. He wasn't looking for moose with a great big rack. He just wanted, (pause)

Interviewer: And he let him pass by?

Participant: Yeah. And the moose knew that. The moose knew that my son wasn't gonna harm him. That's just the way it is. The way it is. (P4)

The same participant described how she communicates with nature's creatures. She shared a story about a bird that flew into her house causing her grandchildren concern. They called to their grandmother to help:

One day, we got a hummingbird in the house. "I got a hummingbird in here!" And they were chasing it around. I said, "No. Stop. Stand still, and tell the hummingbird that you will put it out where it sings." "Grandma, it can't understand." I said, "Yes it can. You didn't even have to talk to him with your voice. Talk to him with your mind. Tell him you are gonna put him out. Put him back outside where he's safe." And, of course, they couldn't. So, I went over there, and I said, "okay, watch." And, I verbalized it. You know. But, he was just flitting all over the windows, and I was telling it you, know, "I'm gonna put you outside where it's safe. Please be still. Stay in one place, so I can put you out." He got to the bottom of the window and he just stayed there. And I just caught him, and then I put him outside on the railing. Put him down, and I told him, I said, "I'm setting you free." (P4)

In Carrier tradition, a person may have a particular animal present itself to them, in a dream or vision, for the purpose of acting as a guide to that person. Participants informed that young people of 14 or 15 years old would go out on their own and would fast for a spirit guide and that at times. One participant described it this way:

Spirit guides are even some animal spirits. Usually when a person is dreaming about a bear or a dog or a whatever, or a wolf or anything chasing you that if you, you know if he stopped, the animal, the spirit would talk to you. And if it should talk to you then that animal spirit would be your guide. (P2)

This essence of “just being” in connection with the natural environment is evident throughout the Carrier worldview. The natural environment including people, plants, herbs, animals, water, land, weather, and what was described as universal energy, was essential to Carrier health and wellbeing. Nature has practical uses, such as animals for food and herbs for medicine yet there was also a more abstract benefit that being in a natural environment provided for Carrier wellness. The final category contained in this theme of “Carrier Worldview of Wellness” describes the spirit world as being essential to Carrier people.

Spirit World.

Carrier traditional beliefs, as described by the participants in this project, consider the spiritual world as a very real aspect of the natural environment. There are four codes that directly contributed to the development of this category Belief, Prayer, Creator, and Spirit. The notion of spirit was described as being inclusive of each person’s own spirit, the spirits of those who have died, referred to as the ancestors or grandfathers and grandmothers, as well as the creator:

It is, ah, the belief, ya? The belief in the creator, the holy one, you know. The grandfathers, some would call it the guardian angels. And then again, we have the grandmothers, grandfathers. We all have those you know. Like even the, regardless of which church you belong to, you know, you believe there is a guardian angel always watching over us and this is true. (P1)

The notion of spirit was described by one participant as being central to existence. His description of the spirit world echoed the overall Carrier worldview of holistic balance:

Everything's gotta come back to one thing. It's the spirit. It works with everything in all aspects just like the mineral, water, air, fire. There is that devil they talk about...you know in our traditional ways, we don't, so there is no devil or heaven or hell or God. It's more. Well, we have the spirit world.

(P1)

The belief in a creator was identified as central to daily life. The healers I interviewed stated that they spoke to the spirit world daily. They described involving the spirit world as necessary in preparing and giving thanks for the healing work they do. Although some of the participants used the word "prayer", P4 stated that this is an English word. She indicated that there was not a Carrier word that described the ongoing relationship a Carrier person had with the Creator. Indeed, P4, and other participants, described a daily relationship with not only the creator, but with all things in the spirit and natural worlds:

Prayer is first and foremost. First thing, we thank the creator for giving us our life again. This beautiful; our spirit, you know, passes through the night, you know, and all the air and water and fire and the animals and all the things that sustain us. And also for the old ones that have walked ahead of us, who left a trail for us to follow. When you just, you know, like laying our trust in the creator, putting ourselves in the hand of our creator. (P1)

Another participant, who heals with plant and herbs, indicated that she prays to the spirit world as part of the process in gathering and making her medicines, "I pray everywhere I go. I pray for people when I go gathering medicines. I pray when I prepare it...to pray every day. You have to be thankful for what's out there" (P3).

Not all Carrier people today are comfortable with the spirit world, as one participant reminded another in a joint discussion of three participants:

One time, remember that old store in front of your mom's house, where that store used to be? My granddaughter was working there, and I was playing Bingo at that time, and she used to come to the Bingo Hall just down the road. She would take the car and go home, and then when Bingo is over she would come pick me up. And one day she decided to walk home, and the store is right here, and she had to go right past the graveyard, and as soon as she got even with the graveyard, she heard men drumming and singing. And, she started running. She looked that way, on this side, Angeline's house was dark. So, she started running, and as soon as she got past the graveyard, she didn't hear the drumming and singing no more. She said it was men's voices singing in Carrier. And I told her, `` (name of granddaughter), you're supposed to stop and listen. They are giving you a song." They give her a song, her own personal song. And she was too scared to stop and listen. She said, "Grandma, I was so scared. How am I going to stop and listen?" And then the next day we went to see her mom, and she heard them too. She said that was her dad and she named some other people. She said that was them singing for her. (P4)

Traditional Carrier life was balanced and connected to the natural environment and the greater universe—including family, community, nature, and the spirit world. If people listened to the messages of spirits and maintained balance with each other and the greater

environment, they would be expected to be well in their life. However, if balance was not maintained, or if someone had the power to cause ill will to another, imbalance or illness might have resulted.

Carrier Traditional Healers

The next section shifts into descriptions of the traditional Carrier healer. The traditional Carrier healer was instrumental in Carrier communities with helping community members maintain balance, as well as treat those who could not. This section will illustrate the participants' explanations of how people became healers and the type of work a healer did, and still does.

Healers were identified as those who had an ability to heal people from a physical, emotional, or spiritual ailment. They were also described as people who had the ability to know the future, and sometimes see into the spirit world. All would use a combination of self, nature, and the spirit world to heal people, or to give advice for the greater good of the community. Some Healers might have all of these abilities while others, only one. Healers used a variety of tools in their work including plants and herbs, dreams, visions, and spiritual or universal energy.

Participants indicated that healers came to their positions as the result of a natural ability, referred to by the majority of participants as a 'gift' from the creator or the ancestors. These gifts could not be taught, but they could be nurtured.

On Becoming a Healer.

Two primary pathways were described through which someone would become a healer in Carrier tradition. The first was to be identified by the watchful Elders in the

community as someone who displayed a gift as a healer. The second was to become aware of one's gift through interaction with the spirit world. Either way, a healer was thought to possess a natural ability and once identified would have their skill enhanced through others who held knowledge. In Carrier tradition, Elders played a vital role in overseeing the functioning of the village. They had the skill of observation and would talk with each other to decide who would be the best candidate to fill a needed community position:

Participant: You know, back in the day, the elders were trained to observe their community. It wasn't just one elder saying you are gonna do this. It was a reflection, or a combination of different elders getting together and saying, "Oh this person is gonna be a good politician. This person is a great hunter. This person is gonna be a healer." Because the child or the person will show them by their actions. So, the actions speak pretty loud. So, people hone in on that and try to develop that special little gift they have, and then we see where it goes.

Interviewer: So, it was very communal?

Participant: Very communal. It's all done around and with the community because it's the community that is gonna be impacted, so they have to have that input into it. If I want a good doctor, I want to make sure that person is a good doctor. If you spend time observing them, through the course of time you know. And there is a collective discussion amongst the elders that this person is gonna be a great politician, let's groom him for it. So, there is a lot of

grooming that's going on. Not so much now, but it's coming back.

(P4)

When a person had experiences with a gift of healing, or with the spirit world that indicated some healing ability, the individual might have then gone to an Elder or other medicine person for guidance. This experience would be understood and supported as was the case of one participant:

I seen them (spirits) after they pass on. My mom, more or less said, `you pray for them. They come to you for help. ` To make them go across, you know? I done that when I was probably about 15 the first time. I got so frightened, I woke up my Mom. I was doing my homework by a coal oil lamp, eh. This guy that was buried was standing there smiling at me. I woke up my Mom and told her what I'd seen and she said "you pray for him because he come to you for help". "Ok", I tell her, so I did. (P3)

Not all healers calmly accepted their gift of being able to communicate with the spirit world. A participant described discovering his ability to communicate with spirits, after one frightening experience that was the first of many connections with the spirit world:

Participant: One of my sisters in law died, and when she died I was having this dream. I was sitting down in the grave with her, and she was lying in the casket, and I was sitting beside her in the grave, and I was talking with her and she was telling me about her kid and stuff like that...It was like I was physically there. I could smell her, I could, you know, feel it and everything, and uh scared the hell out

of me actually. I didn't understand what it was all about and then it started happening on a regular basis.

Interviewer: with her specifically, or other people?

Participant: well, other people. (P2)

This participant went to talk to his own father and another healer about this experience. The other healer was a man who is known to be able to communicate with the spirit world. The participant described how this healer understood the participant's gift and helped the participant feel comfortable with his gift through explaining his own gift of being able to communicate with the dead:

He has this gift. And he told us of helping people get from, when you die, there's a place you go he said, it's sort of like what a catholic would call purgatory right? It's like in between space, hey? Whether you were gonna go, wherever you're gonna go in the afterlife and (name of healer) said he would get calls, sometimes by these people, either from the other side, or relatives would come over who had a dream about whoever had died, and they were stuck somewhere and (name of healer) was able to go to the other side. To the middle ground and he would be able to go there and talk to them and help them through it. He would go into a trance, or whatever, and he would go right out. Or physically he was right there, and he would go there and would help them get through to the other side. (P2)

The connection with this healer gave the participant the confidence he needed to be able to accept his gift of communicating with the spirit world. He now accepts his gift as a responsibility he has to prepare his family or community for change:

I'll see people. People, before somebody dies. I'll have a dream about them, somebody dying...I asked (name of other healer who goes into the spirit world) about this...he said what that means is that 'you have a gift of seeing things before they happen' and the reason for that, he said, is that in every community there should be people who are going to be prepared for when things happen, because when things like that happen, whether it's in your own family or not your own family, he said, you need to know. People, somebody, needs to know these things are going to happen...so you're prepared, you're ready. You know in case you need to help. (P2)

P3, also an active medicine woman, recalled that this tradition of being identified by the Elders of the community as a healer was in fact her own experience. She came from a line of healers. As a child, she was taught not only by her mother but by many Elders in the community. Her education started when she was young. Although she did not indicate why this was. I had the sense that because she was identified by the Elders at a young age, their immediate and ongoing teaching was a natural process. Her memory of this childhood experience is as follows:

Interviewer: So are most healers born with that gift?

Participant: Yeah, they been, more or less, passed on.

Interviewer: There's always been healers in your family?

Participant: Well, that's the way I was raised. My mom learned from her Grandmother and my mother taught me since I was very young, but not only taught by her, I was taught by other elders that I had to live with before I reached puberty...my mom always said it was a gift and you don't abuse it, eh. I was raised with different elders. And when I was growing up, I often wondered why that was happening, and one of them told me that when my mother leaves, somebody has to take her place and I guess they choose me. (P3)

This same participant discussed how the Elders helped her enhance her gift of healing:

Participant: When I was very young, like I said before, before entering puberty, I was raised by different Elders on the reserve...I have a picture of this lady that taught me many things. Taught me how to talk to the wind, bring the rain. And she made me sleep with people that were passed on in the graveyard. I wasn't scared, I slept with her there and she said you're gonna get help from the other side in what you do for your people when you work for them. Said they're gonna pass their, their knowledge on to you when you're sleeping and not to be frightened....I must have been about 9, 10 years old.

Interviewer: Pretty young to sleep in a graveyard.

Participant: Oh yeah. When my Mom done the same thing, she went through the rituals of that, things like that when she very young. My Mom

said I'm the one to take over for her... Said 'I watched all my children grow up. Me and your Dad talk about it. After we're gone who's gonna take care of everything and chose you'. Then they told me to do all these crazy things before puberty.

Interviewer: They chose you out of the kids because you showed the gifts

Participant: Probably. That's what that little old lady told me. 'You're chosen. That's why we're teaching you.' (P3)

This tradition of having the younger generations ready to move into healer positions as the Elder healers die was experienced by another participant. He tells his story about how he was chosen as a healer by his deceased ancestors. His father later explained to him that there must be at least one person in every generation that is given healing gifts to help the community:

I was 27 years old. I was staying there (at his father's cabin home), and it was over a hundred years old and my grandfather used to live there um in the 1900s before the 1900s. I was staying there...I was sleeping and I woke up in the middle of the night ...I could hear somebody talking, at first I heard somebody walking in the old cabin, and I was in the addition, and I listened and I could hear him walking, just walking by the steps you know. Just somebody wearing boots right, and it scared the hell out of me; you know, something's here, right. And all of a sudden inside my head, I heard someone talking...I heard somebody walking first, I heard somebody walking and whistling, they were whistling a tune, not specifically, just whistling, but

anyways I heard this voice inside my head and uh they said ‘this is your ancestors. At some point the spirits are gonna come to you, so don’t be scared of them, but when they do come to you he said, uh it’s gonna be a good thing. Don’t be afraid when they come’...I didn’t understand what it meant. About two months later, I went to my dad and asked him I said ‘dad a couple of months ago’’ I said, ‘I was sleeping out there and somebody was out there whistling, talking to me’. He says ‘Really?’ So I told him what happened and he said ‘I didn’t want to say anything to you, to any one of you kids,’ he said, ‘but in our family, in every generation’ he said, ‘one person hears the whistling’, he said. ‘The person who heard it is gonna come to him and tell him... because he was the one who heard the whistling in his family...you are going to be needed’, he said ‘and they’re gonna turn to you for help’, or whatever. He wasn’t specific; he didn’t say what it was. But he said ‘every generation has that person in his family, he said someday somebody is gonna come to you and tell you the same thing’. (P2)

Two other participants discussed, during the initial joint interview identified in the methods chapter, how they as Elders, had identified a young woman in their community who showed signs of being a dreamer, a type of healer who can see the future, or receives healing direction in dreams. They also observed however that she was not ready to accept the responsibility of the gift because she was using substances. This was a barrier to nurture her gift:

Participant 4: Like we have got this young girl on our reserve, she does that, she dreams, but she's not ready yet.

Interviewer: So, no one really taught her, she just had the ability?

Participant 6: She's just got that. Maybe if she quits the bad stuff, she can start cleaning up and stuff like that. Interferes with her gift, I guess. Well, actually, I think she's scared of it; she doesn't want to do it. I think that's why she does her, yeah. I think I would be too, you know.

Interviewer: Her gift would be more spiritual.

Participant 6: Hers is spiritual. She dreams about people and she knows things are gonna happen. But, like I said, she's scared of it. She don't want it. (P4 & P6)

The responsibility of the individual to use whatever skill they had for the greater good of the community was stressed by one participant. He indicated that a healer's gift was as important as that of a good hunter. His description illustrated an essence of accepting an individual role for the wellbeing of the greater community:

Interviewer: You said that 'people who have gifts', or 'Elders who see that people have gifts', when you say 'gift', does that usually mean healing gift?

Participant: Any type of gift. Anything. You can be a good hunter. You can be a great dreamer, someone that is able to look into the spirit

world, and do whatever you need to be done. Depends on the person's gift. When I talk about gifts, we do have real healers. I mean people that can diagnose you and get a potion that can straighten out that sickness. So, I mean there is powerful enough people. I mean, you know that lady in Stoney Creek, Sophie? She had a gift of the plant. A lot of people went to her for different ailments, and she was able to help them, through just the traditional stuff that she still does. It doesn't do you any good to have a special gift or be taught a certain lesson, and just keep it to yourself. You have to share what you learn. That's one of the understandings that we have as pipe holders, is you have to share what you learn. It's a process. A beautiful process. (P7)

All of the participants agreed that the ability to work as a healer, with herbs or with spirits, was a gift and was something that could be developed through teaching by others who had the knowledge. Even though most people knew how to use plants and herbs for everyday ailments only healers with a natural gift could use the plants and herbs for more serious conditions. This was explained by one participant: "You know a lot of people know the medicines, you know, know the stuff we teach them, but they cannot, they cannot do the healing. I often wonder, you know, there's just special people that can do it" (P3).

It was clear then, that healers came to their positions as a result of a natural gift. Their identification and mentorship was a responsibility taken on by other healers and the Elders in the community. Healers also understood that they had a responsibility to use their

gift to help others. The next section describes how healers worked among their communities, starting with a description of how, according to the participants, the healer's understanding and use of self in their healing work was vital to the success of their work.

The Work of a Healer

Being a Carrier healer, involved a natural ability that once accepted was nurtured. The life work of a healer involved the use of self, as well as a combination of practices that involved herbs, plants, dreams, and the spirit world. Individual healers had specific skill and some focused on the use of some practices more than others. Ceremonies were described as important to all healers. Healer specializations, practices, and ceremonies will be presented in this chapter.

The Power to Heal.

Participants indicated that their ability to work as a healer required a personal commitment. They must be physically, spiritually, mentally, and emotionally healthy to take on the responsibility:

Participant: I need to be healthy in order to help somebody. If I'm not in the mood or in a good mood, cranky mood or whatever, I don't do, I don't see people, I don't make medicines. When I get myself well balance again and that, then I do medicines and work with people.

Interviewer: So you know when you are out of balance

Participant: Oh yah.

Interviewer: You feel it?

Participant: Yeah, when I don't feel good, I don't do anything. I get prepared every time we go out to do something. My Mom say you have to be clean, your mind, your body, spirit, be well balanced when you do things for other people.

Interviewer: So you take care of yourself.

Participant: Uhuh, you have to. You're no good to anybody if you're not well. That's what she always taught me, make sure, that's why I say enchynochylo; take care of yourself, don't get lost. (P3)

In addition to being personally well, it was important for the healer to believe in the power of his ability and his tools. P1 who uses herbs and plants, among other things, in his healing work described how his personal connection with elements in the larger universe was essential in his healing work:

Participant: When I'm treating people with traditional herbs and you know, it comes in with the spiritual form of a person, starting with the mind. You have to have an understanding, you know, to have a belief system in order for, you know, like for the herbs to work.

Interviewer: So that individual would have to have that belief system?

Participant: Yeah, more or less, well yes, I guess, as well as myself. So there was a way to fix things, but it wasn't just with the medicines, the spirituality and the belief right, you know. The belief that this is going to work. One of the greatest healers is our mind. The mind is one of the healers....as long as the mind is healthy then, you

know, the healing process will take over...all the senses are connected to the spiritual part of our, you know, of our spirit, the mind and the body...it's a mystery...any First Nation, non-natives, as long as they believe in the spiritual part of oneself ...it's easy for a person to heal. (P1)

Equally necessary to a healer's belief in their own power, was the belief of the person being helped. According to the participants, belief is powerful and can promote wellness or invite negativity, as stated by one participant, "It's up to you to allow that belief system. If you believe, you know, this is a bad omen, somebody's going to die or whatever, it will actually happen, if you believe it" (P4). The belief in the power of the healing treatment being performed therefore, could impact the success of the treatment:

Participant: I do, the actual traditional healing like say for instance ah using herbs and you know, for like for a person who has say, prostate cancer. There's medicine that we use you know that you'll ah, get rid of the prostate cancer. And there's quite a few people who are walking today because they believe that these medicines will work and does work.

Interviewer: Believing it's going to work? Would that combine prayer as well?

Participant: Exactly...prayer is first and foremost. (P1)

This participant reminded me, however, that healing power should be respected:

You know about medicine...it's amazing how you can feel the, you know, the ah energy flow...at first they (elders) are kind of reluctant to talk about it...but usually when you talk about ah, ah, you know ah some medicines, for instance, especially the, you know. The real powers like this medicine that I talked about, you know, ah they start into the specifics, you would have to light a candle for the energy safety, just for the safety of a person. You know, to ah, not to ah, be offensive to the spirits. (P1)

Respect for healing power was evident throughout discussions with the participants; it was woven into all they did with respect to their healing work. For example, the rituals followed while gathering and preparing the medicine were as important as the substance itself, "I pray for people when I go gathering medicines. I pray when I prepare it...to pray every day. You have to be thankful for what's out there" (P3).

To facilitate belief in the power of the healer, the individual and the community as a whole would need to have basic trust in the healer. While a healer might be thought to be powerful his or her intent to use power needed to be trusted. In addition the individual should feel that they are being heard and understood by the healer. Therefore, the relationship the individual had with the healer was of great importance.

Healers would gain the trust and build relationships with people based on past experiences and the opinions of others. A healer's worth and respect was in large part dependent on the community. One participant recalled the healers known to her when she was a child; "Those people, like I was never scared of them. They were people that I trusted,

like when I was growing up” (P6). P1 identified that the healer was not involved in advertising his or her skill. The healers’ value as a healer was determined by the people:

Interviewer: So, how do people come to you and how would they come to a healer in the old days?

Participant 1: They know. They know by word of mouth. We don’t tell anybody we do this or that. They just hear about it and they go to who they trust eh? Because there are a lot of different healers out there. They know who I am and that I’m not going to try and deceive them...that is where the respect comes in you know...it always works together in a part of healing. (P1)

This same healer indicated that the person being helped must be made comfortable to share things with the healer, and to feel that he or she is being believed. Traditional healing can involve issues of the paranormal or spirit world. Without trust in the healer, the individual may not be comfortable sharing unusual or frightening experiences:

Once you understand the spirit, you know, the healing, you know you have to believe. It’s just like if a person comes to you and says, ah, you know, I hear these (noises)...you really have to understand what they are talking about...a person opens up and builds that trust (P1).

Building relationship involves not only creating a feeling of safety, but honouring that trust in ensuring safety for the individual. As noted earlier, traditional medicine and the power of the spirits can be dangerous if they are not respected and used properly. In traditional healing, managing the safe use of these elements is the job of the medicine person:

Interviewer: A lot to consider isn't there to be safe and appropriate?

Participant 1: Yes, that's the first and foremost, safety. And that's the same thing with our ways of counsel. Make a person feel safe. Same thing with our traditional ways. And pipe ceremony and smudging ceremonies; I don't force anybody. (P1)

Another element of building a healing relationship is being available to the person in need whenever possible. Even traditional healers have days when they don't feel like making themselves available to help others. However, one participant noted that it is her duty to be available to people for as long as they need her to be:

Interviewer: So as a healer you have all of these people coming and asking you. Do you always say "yes" or do you find sometimes you find you get too busy?

Participant 3: I don't know. I want to say "oh I have too much to do. I have too much to do". But it all seems to fall into place. Sometimes I'll sit here half a day and listen to somebody talk to me about everything, eh? And all really what's bothering them and they feel a lot better about it after they leave. (P3)

Engaging a Healer.

Participants indicated that in order to keep their people strong, family, community members, and particularly the Elders, would have been aware of the functioning of individuals, as part of the whole community. When someone was in need of the services of a healer, they would ask for help directly or, as was more often indicated by the participants,

family members would ask for help on behalf of an individual. People would know, through word of mouth, who in the village or the area was identified as a healer. Participants indicated that when calling a healer there were no concerns of privacy or confidentiality in getting someone the help needed:

Interviewer: In the old days, traditionally, would it have been acceptable for the community to, if you are worried about the individual, there wasn't that confidentiality thing going on? If you felt somebody needed doctoring or needed help, would you just, yourself, put out that communication that someone needed to come out and help your sister or brother or friend?

Participant: The family would know of it, they would be helping.

Interviewer: They would be doing it?

Participant: Yeah. And then, pretty soon there is a parade of people just standing there`

Interviewer: Just happened?

Participant 4: Yes. (P4)

It was also explained that, part of being a skilled medicine person simply knew through intuition, dreams, or requests from the spirit world, that they were needed. P4 talked about how a healer would come to her village when she was a child. She described how this healer would travel and respond to telepathic requests for help:

Interviewer: So, if somebody had unusual behaviour, problematic behaviour, would that be treated normally with some kind of ritual or traditional kinds of practices?

Participant 4: Yes, that was the job of the medicine man.

Interviewer: And, did each community usually have one, or each area had one?

Participant 4: Yeah. When I was young, we had a traveling medicine man. I don't know where he was from. He used to come to our village once in a while, and he used to visit Mom and Dad.

Interviewer: So, he wouldn't be called upon, he would just sort of wander around and visit?

Participant 4: Well, you could call him. (Participant touched her head).

Interviewer: Ah, oh with your mind? So, you would say in your mind you needed help and he would come?

Participant 4: Yeah.

Interviewer: Okay. So, sort of telepathy was something that was used. If you wanted someone you just thought about it and it would come to you?

Participant 4: mmm (nods) (P4)

Participants noted that the relationship a community and an individual had with a healer was important. Once engaged and trusted traditional healers combined their personal

skill with a variety of elements and ceremony. The next pages contain the participants' descriptions of what elements and ceremonies were used, and what is still in use in present day. This discussion starts with the use of plants and herbs described as medicine by the participants.

Plants and Herbs- Medicine.

Plants and herbs were described as items that were not only used regularly for everyday household use to prevent and treat illness, but were also used regularly in a healer's work. Plants and herbs were used for a variety of purposes from cleansing a dwelling or person, in the way of a smudge, offering thanks to the creator, protection against bad medicine, and to heal sickness. Use of plants and herbs for medicine was the most basic use of these substances, "Our people always believed that for every sickness that there is, you can go into the forest and get something to help you for it" (P4). She warned however, that there was a certain protocol to be observed when gathering medicines to avoid inviting damaging, versus healing, power of the herbs:

Interviewer: So, is there a, when you collect medicines, is it just knowing what to collect, or is there also a spiritual part to collect them?

Participant: Usually, you would be able to know when to collect them, and then like....

Interviewer: Is there a time of day or a time of year?

Participant: No. Well time of year and you are also supposed to leave something, of your own, behind, like tobacco, know these days we leave tobacco, but I don't remember being with grandma, when

they used to collect medicines, I don't remember if they did. If they would leave anything behind. They must have, (name of well know Carrier healer) says they do. There are so many questions that I want to ask now with all of our people gone, and Mom used to be the one that did that. Grandma used to do this, Mom, and she would be the one to tell me. And Dad, he can't remember, so can't ask him. They say if you mess around with it, something bad might happen to you. That if you don't use the medicine right, or if you don't mix it right. (P4)

Herbs are used regularly in Carrier culture for Smudging. As previously described, smudge was used by people to mask their scent when hunting, or to cleanse their bodies and minds when praying. This same mixture is used to cleanse a house of bad energy and spirits, “There’s also cleansing, cleansing the houses with smudge, you know, like sweet grass and with whatever we use like, you know, for me I use sweat grass and sage. Mountain sage and then fungus, you know, willow fungus” (P1). Participants described how the tobacco plant was used as a sacred offering to thank mother earth for what they had taken from the earth, and also to offer to the spirit world or healer when seeking help, “Tobacco is one of the first medicines that was given to us to use as a, you know, to replace whatever we are taking from mother earth and again to use as, to barter, you know to get information” (P1).

This same participant, who regularly uses plants and herbs in his healing, provided a summary description of how these substances fit in with the overall holistic Carrier view:

They (herbs) have colors. The red is ah, represented like you know the red the colors come from the beaver caster. When you dry beaver caster, we use that a lot in our medicines, beaver caster and then another herb that we use. It is just a black...it's got a Latin name, usually all these medicines have a Latin name...it is called a "Small Love Root" and its black, the root is black and then another, ah a white color is a Solomon's `Seal and grows abundance around, even around Ormond Lake ...and then there is the rat weed and that's yellowish. I don't know if I carry it, I used to always carry it (pulled a root out from a pouch). I'll give you this part here (hands me a piece of root). You chew on it a little bit. It's good for anything its good for anxiety...gets rid of colds as well. You know anxiety...chew on it just a little bit.

These four medicines, grinding it in a grinder you know...these four piles...red, white yellow, black. Those are the four sacred colors. You know the red nation, the black nation, the yellow nation, and the white nation okay? Now we say, in prayer, we say these medicines working in unison allows this person to walk on mother earth in a good way so he can remember who he is and not forget who he is and also to get rid of all the bad medicine that might be projected toward him or his family, he can use it in a smudge and put it on a hot rock. We can put it in a sweat as well. You know and you can inhale it and it gets rid of all the bad energy and gives you clarity. Sometimes it might take more than one, you know, one session.

It's hard to get this (showing me a root) this is rat root here....well it's a muskrat...that's where our medicines come from. They looked at the animals and when they are sick, what do they eat? What do they do? Some of the medicines are ah, "visioned". Like when you are fasting, you know you ah fast fasting for medicine this will come to whatever, the medicine will come to you. That's a good medicine. (P1)

Talk/counsel.

Participants stated that healers would sometimes simply talk at length with the people they worked with. They indicated that in a traditional way, healers did not concern themselves with the passage of time in their healing work. Instead they might take hours or sometimes days to allow the person doing their healing work to process that which was bothering them:

The way we do treat people, in our way, sometimes takes days sometimes takes hours. We talk like you and me are doing. Talk about everything. How many children they have, what they are doing now, just the way. What's bothering them and lay it all out, hey? Really important for our people, that's why ah we have circles and talk about whatever happening in your life and if you need help with it, we go and help. I found we have been doing that for many years....I do a lot of counseling in my own way too. In our own traditional way. But it's mostly talking and listening is most important. Sometimes I'll sit here half a day and listen to somebody talk to me about everything eh. And all really what's bothering them and they feel a lot better

about it after they leave. But I don't do 15 minutes per patient like a doctor.

No, no, we get it all out and dealt with before we let them go. (P3)

P2 indicated that talking with the person in need helped the healer to further understand what was wrong, and how they could help. There was a sense of innate ability of healers have to really look inside a person to understand what their problem was. He had some difficulty concretely describing the ability some healers had to do this:

Participant: I don't know exactly how to describe it, but there was a power to help people right?

Interviewer: Through Herbs?

Participants: Through herbs and through talking with them and uh, a lot of it I think was uh, knowledge you know about how to speak to people and how to listen...she'd always have an answer you know...then with the medicines she was very powerful with the medicines. She could cure a lot of things. (P2)

The importance of relationship between the healer and patient was identified. P2 shared his opinion that relationships in helping transcended all cultures and was certainly present in traditional Carrier helping work:

We look at it as you know counselling or whatever you want to call it today.

It's the same thing we used to do with before, talk about things, talk about problems....I think you know when you talk about this, and I guess it goes across cultures too sometimes being there for somebody is more important than trying to solve all their problems. (P2)

Talking was often combined with other methods of healing. An example was given of how a man was taken out into the forest with his grandfather, a healer, when he was suffering from his experiences at residential school. The natural environment, the sweat lodge ceremony, talking, and patience with the healing process through time, were identified as working in combination with each other:

I remember dad used to say when people are lacking that connection you need to find a way back....he said that when he came out of residential school he was very angry. His grandfather, my great-grandfather took him out into the bush and he built a sweat and they stayed there about four days or something with you know and uh, he said that everyday he'd go have a sweat and they would go sit in the bush and fast and his grandfather had another little lean- to there and he would sit there and he'd pray and he would sit there with his grandfather and talk to him about what happened, things like that. After about four days of doing this he would start to feel better....so it helped him in the sense of regaining his uh peace. (P2)

Conversations between Carrier people was therefore a usual way of helping each other in the community.

Dreaming.

Participants described dreaming as another medium used by traditional healers. Dreaming had a variety of uses for various healers. P3 indicated that dreams could be an overall useful tool to healers as a means to stay informed, "they say your dreams tell you about a lot of things that's going on, hey. Sometimes it comes to you in your dreams what's

happening”. P2 said that dreaming informed him that there was a death pending, “I’ll see people, people before somebody dies. I’ll have a dream about them. Somebody dying, you know?”

Dreaming occurred with some healers, as a way of discovering what was wrong with a person and to know how to perform a cure. The practice of dreaming about illness and cure is described below by P3:

Participant: Yeah. Oh, okay, that's what medicine man uses, or medicine people, they dream about it. They call them dreamers.

Interviewer: So, how does that work, the dreamers, they dream about the illness, or?

Participant: Yeah. I would say so. They can dream about ways to heal somebody that come to them in a dream. (P3)

Another participant recalled this same practice of healers dreaming about someone who needs their services before the person comes to them:

Participant: There are medicine people. And, I remember really there was one lady, I think, but most of them used to live in Stellako or Stoney Creek. Somebody got sick, like mentally, like lose their ghost or something they say, they take them to, they think they are getting like bad medicine or something. They used to take them to either these places like I think there was only one in Nadleh though. But, I can't remember. That's the only part of the mental part, these old

ladies or these men that would dream about them. They would dream and they would say what's wrong with you.

Interviewer: So, they wouldn't necessarily be called, they would dream that somebody needed them?

Participant: They usually dream, they will bring that person there, and they will, sometimes, they will say; I dreamt about you, that you were gonna come to me. Or stuff like that. And they will talk to them and then -- I don't know a lot of the people, but they usually talked to them, and then they will say come back tomorrow, or bring them back, if it's a kid, and they will dream about them, and see.

Interviewer: So, in between they would dream about them and think about how to doctor.

Participant: Yes. That's the thing I remembered. (P6)

P1 shared his knowledge of a healer who works with dreams and touching to diagnoses and heal people:

There is a person, a specific person that would be a, what do you call it, a dreams keeper, ah you know. Some would even display touching, you would you know, how you felt, there was an elder in Takla...she used to do that. She could just by holding your hand she could tell you what's ailing you or what's troubling you. And she was blind.

A modern day dreamer was recalled by P4. This person told police where to find the bodies of two community members on two separate occasions. One person had drowned in a river and the police were searching for several days for his body. The second victim had disappeared. After the medicine woman dreamed of his location, she told police and his murdered body was found. Three participants were in the room during the discussion. The dreamer in question was the mother of one of the participants of this research who was in the room during the interview:

Participant: Remember somebody that drowned, was it, in the Nadleh River
that came to your mom and she told them where to look.

Interviewer: Oh.

Participant: And they found them.

Interviewer: Really?

Participant: Yes.

Participant: They shot him (another man) and dumped his body in a well, in
an old well. Her mom told them where to look and they found
him.

Interviewer: And she would know through her dreams?

Participant: Yes. (P4)

Chanting/singing/drumming to Heal.

Participants described how voice and music, particularly chanting, singing and drumming, are used regularly in Carrier healing work. Indeed, music was, and still is, used

in traditional daily life. As P2 explained, the purpose of music was not to tell a story through lyrics. It was used to express emotion instead:

Indians a long time ago, see a lot of these songs that we have, were not songs a long time ago...it was more, um, noises to express emotions. I've got a tape of my grandmother and she was singing...but there's no words in the song, she's its emotion, you know, she's playing on the drum...she's got structure to it but it's ah, there're no words. And you know, she's just singing and it sounds, and it's just beautiful. The reason for it is because we needed to, you know, express, you know, how you feel because we weren't ah, the kind of society I guess who sat down and talked about our problems. (P2)

While some of the information found in the literature and presented in the literature section of this paper, described early First Nations' healers using animated theatrics, only one participant described her memories of a medicine man that used this in his healing work:

Participant: He would do drumming and dancing, chanting, and like right now I have a sore knee. I remember my brother; I don't know what he had. You know, later on, I'm thinking he probably had some kind of fever.

Interviewer: Arthritis?

Participant: Something. And, he was bedridden for years and years. And, that medicine man cured him.

Interviewer: And he did that through chanting and drumming and...

Participant: And, like you know he would rub my brother's legs, both of them, and he would be mumbling and chanting and singing, and blowing it away. (P4)

Singing and drumming is used along with Carrier ceremonies. The sweat lodge is a ceremony that involves both singing and drumming. The sweat lodge ceremonies I have participated in involved drumming and singing. The prayer and song that occurs in the lodge was described by one participant as mysterious. Sweat lodge participants can sing along to songs they don't know in the lodge, but cannot recall the tune or the sounds when outside of the lodge. Traditional Carrier songs do not involve actual words, but rather they involve sounds, presumably, to express emotion, "You pray, you know and then one song there they were singing along there you know, you know it's amazing. You can sing along and when you're outside you can't sing, you know so it's sort of a mystery itself" (P1).

P3 described using drumming and singing in her healing work. She described an amazing event where her elderly mother had suffered a stroke. Her mother had stopped breathing. Instead of calling an ambulance, she gathered generations together and drummed for her mother:

Participant: I got my um, my daughter, my niece, they started drumming for their grandmother. And my youngest grandchild came, or my oldest grandchild, my first born grandchild came and she started drumming for her Granny. Next thing you know my Mom was singing with them. My brother just could never get over it, he said that we lost my Mom, but him I know, she didn't have no pulse, no heartbeat, come on Mom get up.

Interviewer: And no one call the ambulance.

Participant: No, You just trusted you could do it. (P3)

During this discussion, this participant told me that I was also a healer in Carrier communities. She offered to one day teach me how to drum and “heal people with it”.

Water.

As discussed in the “Carrier Worldview” section of this paper, water is seen as having healing properties. Carrier healers use water to heal. Water was described as having cleansing properties. Although the healers indicated that mental illness did not exist in traditional Carrier worldview, one healer acknowledged that water is particularly valuable when helping someone in modern day heal from mental health related conditions, including trauma:

Participant: They have lots of ceremonies...they do brushing off with water and evergreen some people do that. With mental illness, I don't know I, I mostly use water. Bring them to the water and clean them with fresh running water. Or if they have something really, something really hurt them or have a trauma situation, we do the spiritual thing with them...like I said you have to see it in order to write about it.

Interviewer: So when its mental illness or something that's bothering somebody, the water cleanses the spirit as well as the mind and the body?

Participant: Uhuh (yes). I can only do one a day, because it really takes a lot of energy. My mom more or less told me, “don't do more than one

in things that you do with people when they have real problems with their mental well-being”. (P3)

This same participant instructs that water is essential to life and has healing properties. Its healing power exists when we use it every day, “Use stones and dip them in the water to cleanse yourself, give you peace of mind. If you can’t pray, go drink glass of water every morning of your life. Without it you die...We can heal your body without everything from nature eh” (P3).

Two other participants, P4 and P5, in a joint interview tried to explain to me how water is also used as a type of vehicle to aid in healing versus it having healing properties in and of itself. Since colonization, some modern day Carrier healers have combined religion with tradition. The mother of P5, a healer, uses holy water in her work. The participants explained that sometimes the substance used in healing tradition was more ritualistic to enhance healing power. P4 reminded me how drumming and singing was like a conduit for power and belief:

Participant: You know she does traditional healing work, but she uses holy water. Remember I told you about the drumming and the singing?

Interviewer: Yes.

Participant: Same thing. (P4)

Eagle Feather.

The eagle was described as a sacred animal to the Carrier people. The eagle feather is frequently used by Carrier people in the smudging ceremony. I observed this ritual in my

work. The feather, or often a fan made out of several feathers, is used to fan the smoke of the smudge and to brush the smoke over an individual. The eagle feather fan can also be used to brush the bad energy off of an individual. P3 recalled the importance of an eagle feather in her work with her dying mother. She described how using the feather together with prayer, strengthened her power to ease her mother's pain:

Participant: You ever been in when you know somebody's going to die they have that, they have that funny breathing? My Mom started that, just a very last day and I use a feather on her, an eagle feather, she taught me that years ago. I watched her when she done it for my Dad. I done it for my Auntie and I done it for my Mom now. And I done it for another lady. That's how I earned my eagle feathers. I used to have them and my Mom, I done it to her twice. Brush them over with the whole body. So they wouldn't fight for their breath, it's painful when you fight for your breath eh. When my Mom passed on, that's it.

Interviewer: The rattle stopped?

Participant: No rattle, no nothing. That's it. Real gently like, she had no more, like blowing out a candle. I said that's what I wanted for my Mom, I said, die peacefully. You see it's hard to see people when they have a death rattle they call it, to die that way so she taught me how to do it.

Interviewer: So that feather that uses the energy, the creator and prayer, that's what you bring to her?

Participant: Yeah. And a lot of different ways of healing in that way but the most powerful is the belief in prayer and have faith.

Interviewer: And that's prayer to ancestors, creator?

Participant: We pray to everybody eh. There you say your own thing. We don't tell you how to pray. (P3)

Predicting Future and Seeing Spirits.

All of the participants indicated that healers had a connection with the spirit world. The existence of spirits, and the part they played in a healer's life, in all traditional Carrier life, was common place. The existence of spirits was accepted naturally by the participants. All of the participants were sensitive to the spirits and the messages they brought. P3 is able to predict death due to her connection with spirits, including ones that are preparing to leave the body, and the ones that have recently left:

Participant: I see people before they are going to die. I can't look them in the eye, but when they look at me, then their eyes change. And I stay away from people when they're going to die. I don't know why, but it does happen. Like my mom said that um your spirit leaves your body before you go eh. Sometimes they can see it walking about when you're at home. And then people come and visit me when they pass on.

Interviewer: Do they come into your house.

Participant: Ahha (yes).

Interviewer: And you see them? Is that before the pass on or just after?

Participant: On no, before. Before.

Interviewer: You see their spirit walk before then?

Participant: Yeah. (P3)

In addition to this participant predicting death when she sees a change in someone's eyes, or sees their spirit walking before death, she experiences spirits meeting in her home when a local death is imminent. P3 is a prominent healer in Carrier communities:

Participant: You know what happens to me when somebody is gonna die, the spirits they gather in my basement and they have a meeting or something, because I can hear voices.

Interviewer: Oh, in the basement?

Participant: In my basement.

Interviewer: And, is that when someone close to you is gonna die?

Participant: Anybody close by.

Interviewer: How long do they stay down there?

Participant: I just listen to them for a while and then I go to sleep and then when I wake up there's no voices.

Interviewer: Does it frighten you?

Participant: Oh no. I know it's spirits. Probably my relatives, my brother, Paul, they congregate in my basement. One time I heard a chair downstairs. I opened the door to my basement and I said, "Whoever is down there, clean the basement!" The spirits are lazy. (P3)

P5 comes from a line of healers who can predict the death of others. Her mother is well known in Carrier communities as someone who knows when someone in the community is going to die:

Before she goes to sleep, she -- something happens. Like she's in bed, and she's praying, and then somebody comes into the room and she always has this. She says 'Guess who came to me last night?' She knows before that somebody is going to die (P5).

As is consistent with the Carrier worldview, healing work involves a combination of the spirit world, ceremony and, protocol. P7 discussed how he seeks guidance from the spirits in his healing work. The way he communicates with the spirit world is dependent on the information he needs:

I rely a lot on ceremony when, you know, sometimes you don't have the answers. So, you have to go into the spirit world to try to find something, ask for help for some of these answers. We believe that the creator will provide. As long as you follow all of the procedure to get there. You just can't go out and say, "I need an answer for this." You know, you have to do certain things; you have to offer up tobacco. If it's really serious, fast for a day. (P7)

Use of Ceremony was described by all of the participants as a primary tool of the healer. Smudging, discussed earlier in this paper, was described as daily protocol, and was usually involved in all ceremonies as a way of grounding oneself and clearing the mind. Ceremonies discussed by the participants included the fast, the sweat lodge, and the yuweepi ceremony. Participants indicated that some ceremonies that are practiced in Carrier communities are believed to be adaptations of traditional ceremony that have evolved over time or have been borrowed from other nations.

Fast.

At the fast I attended, the attending medicine man was one of my participants, P7. He stated that the practice of fasting has been part of Carrier tradition for “centuries” (P7). Another of my participants, P4, was there as a supporter. A supporter is someone who is a friend or family member of the person who has chosen to participate in the Fasting ceremony. The supporter does not fast but they are present on site throughout the days of the ceremony. They are permitted to accompany the medicine man each evening to place the participant into his or her hut, and can also be there to let them out in the morning.

P4 indicated that the fast we were attending was an adaptation of Carrier tradition because there were a number of woman as well as men who were fasting:

Participant 4: Something like this today, the fast. That's not traditionally a Carrier practice. It is and it isn't. Because we don't fast. I've never heard of women fasting...But, the men, when, let's see, when they want to get a name, a special name or something like that. Or, they go off, like, go out, go across the lake, and go up that mountain.

And, make a shelter, and stay up there until they have a vision.

They fast and pray.

Interviewer: And, they do that alone?

Participant 4: Yes.

Interviewer: As a young boy or as a teenager?

Participant 4: As a young boy.

Interviewer: A young boy, so like 8 or 9?

Participant 4: Um, 15.

Participant 4: Yeah, they would go off by themselves.

Interviewer: Okay. And fast for that time until they had their vision?

Participant 4: Or if they need help. And, they will find their protector. (P4)

P1 stated that healers need to fast from time to time themselves to strengthen their knowledge:

It's hard to get this (showing me a root) this is rat root here....well; it's a muskrat...that's where our medicines come from. They looked at the animals and when they are sick, what do they eat? What do they do? Some of the medicines are ah, "visioned". Like when you are fasting, you know you ah, fast, fasting for medicine this will come to whatever, the medicine will come to you. That's a good medicine. Fasting needs to be lead, you know, by a traditional healer. (P1)

The fast ceremony I attended was a group event where several men and women attended the ceremony for up to six days. The event was held on a reserve, at a traditional location, by a lake. I attended the fast on days two and three. Each of the fasters had come to the community with at least one support person. The organizers had at the camp two cooks and one medical doctor. Each faster would have discussed previously their reason for their wanting to attend the fast with the medicine man, who would be in attendance for the entire ceremony. Each person, together with their support person, built a small hut made out of willow branches and then covered the hut with a tarp. I observed these huts. They were large enough only for its occupant to sit up or lay down. Men and women fasted in separate areas of the forest, all within several minutes' walk from the main camp. The first night of the fast, the medicine man led a sweat lodge ceremony for the fasters, their supporters and any other support people who wished to attend. At the conclusion of the sweat, close to sundown, each of the fasters was lead to their individual huts by the medicine man. Their supporters were able to walk beside them while the remainder of us followed behind, with appointed people playing the traditional Carrier drum. Each faster was "drummed" into their hut. The medicine man then "tied" each faster into their hut using binder twine; essentially a piece of twine circled the hut and was tied across the door. This was more ceremonial, than a true barrier to leaving the hut. Each faster was permitted a sleeping bag for warmth, but were prohibited from having any other comfort items or food or water. Once all of the fasters were tied into their huts, they were left alone for the night. Each morning, the medicine man untied the twine, permitting the fasters to exit the hut. For the remaining days, individuals could fast for up to four nights. They were permitted to live in the area around their hut. They did not eat, drink, or interact with anyone. Although I did not remain for the

conclusion of the ceremony, I was present when some of the fasters concluded their time of fast (two women chose to fast for a total of two nights). When they exited the forest, they attended another group sweat lodge. It was protocol that the fasters received the first plate of food at the evening meal. P7 discussed the purpose of the ceremony. He stated that some people come to a fast to heal from a physical, emotional, mental or, spiritual injury. The job of the medicine man during was to guide the faster through the process:

Interviewer: So, how would you then help somebody to become well?

Participant: Well, first you have to get to the point where you understand yourself. In order to help yourself, you have to understand yourself and know yourself and to know what needs to be fixed. So, that's one of the things we do is fast. There's many things that we do, but one of the things that we do is fast. It gives people time to sit down on the grandmother of the earth to reflect on themselves. You know, in this day in age there is so much going on and there's lots to do, and you never take the time out to nurture yourself. So, to get to know yourself, so when you sit down on the Earth, grandmother, for four nights, you start to understand yourself. Because the wheels of the earth, life, are continually rotating through your mind process. So, I mean it's a reflection and you start to see where you need to fix whatever you need to fix sickness, I don't know if I like to use that word. You nurture what needs to be -- the wounded part of you. We don't look at --

personally, I don't look at someone's unwellness as a sickness or anything. I just, you're wounded in some way. And have to find a way to heal that wound because it impacts you. Collectively as a person in those four areas. So, it's a process, where you are continually reflecting on yourself, working on what you need to work on. (P7)

Sweat Lodge.

Although the sweat lodge was a ceremony that was used within the fasting ceremony, it is also a ceremony in and of itself. The sweat lodge was identified as being a Carrier tradition:

Interviewer: The sweat lodge. You said you used the sweat lodge. I've heard different people say "it isn't Carrier", that "it is Carrier"?

Participant: Oh ya, it's our culture...they probably did it different in different (places)...there used to be family sweats, family or individual. They would go out, for example, on the trap line, um, in the fall time or spring...they would have a sweat out of the village...and build a sweat and they stayed there for a day and they would sweat all day long and the purpose was to get rid of the smell of the town or the human. You know village smell I guess you would call it. Get rid of that and then also cleanse your emotions and your mind mentally, you get rid of all this negativity or any problems that were happening or whatever would happen there. Get rid of it all

and when you go out there you not only cleaned physically but you're emotionally, mentally and spiritually clean. (P2)

P1 discussed how ceremony can be adapted. The basic purpose of the ceremony needs to be respected, as does the creator, when adapting a ceremony to meet current need:

The sweat I run faces east. There's certain ways, you know? I couldn't place it east because there was a fence...so I made some calls...consulted with them...and pray and tell the creator you're not accustomed to this and you need guidance for the purpose of no one to be hurt here and no harm comes to anyone who comes here. That only healing will take place, you know. (P1)

The purpose of the sweat was primarily to cleanse the body and the mind, different configurations of groups may sweat together. Sometimes hunters would sweat together to prepare for a hunt, or families might sweat together to maintain holistic balance. The sweat lodge ceremony I witnessed during the data gathering phase was a co-ed group sweat. The lodge itself was a dome shaped structure made out of willow branches. It was approximately twelve feet in diameter and roughly five feet high at its highest point in the middle. It was covered with several tarps with an opening, facing east, that would be covered during rounds. Approximately ten feet east facing the door, was a fire pit that was used to heat lava rocks. Between the fire pit and the lodge was a mound of dirt, where a smudge bowl was placed. Most sweats are four rounds long, the number is in keeping with the Carrier tradition of honoring the four directions; north, south, east and west and the four colors of the human race; red, white, yellow, and black.

At the beginning of the ceremony, the medicine man entered into the lodge first and was seated directly opposite the door. When he was ready for the participants to enter, he gave the word to the door man that he is ready. The door man, there were two on this occasion, is responsible for keeping the fire going to heat the rocks, to open and close the door, and to bring the lava rocks into the lodge on demand of the medicine man. Men always enter the lodge first. The reason for this is that, as the warriors and protectors of the community, they are expected to clear the way, to ensure the safety of the woman and children. All people entering the lodge must remove their shoes and smudge at the door. Men can go in shirtless, but woman must be modestly covered from neck to ankles, wearing either a modest nightgown, or shorts and tee shirt with a towel covering their legs. Shorts and a tee shirt can be worn, but a large towel should cover her legs. All people must move into the lodge in a clockwise direction. The men were seated to the medicine man's left and the women to the right. Once all people were seated, the medicine man called for a certain number of lava rocks, which were carried by the doorman on a pitch fork. The rocks were placed into the pit in the middle of the lodge. The medicine man then called for the doorman to close the door. Once the door was closed, water and herbs were sprinkled on the hot rocks, producing heat and fragrant steam. The sweat lodge is expected to be pitch black inside. Four "rounds" occurred during which participants sang, drummed, shook rattles, and prayed. At the conclusion of each round, the medicine man called for the door to be opened. A period of time, perhaps fifteen minutes, was spent talking between rounds. P2 discussed how according to his teachings, families had sweats regularly:

You have sweats you know, every couple of days or whatever. It wasn't really like structured in a sense of how they do it now...they just went in and

ah, sang and you know, sweat and you know, do a couple of rounds for however long or whatever or maybe one great big long one or something like that and he (participant's father) said Indians a long time ago, see a lot of these songs that we have, were not songs a long time ago...it was more, um, noises to express emotions. (P2)

The sweat lodge, like all Carrier ceremony, has protocol to be followed. P1 discussed how a woman should behave in a sweat lodge:

If you ever go into a sweat co-ed, don't let a man touch you ever in a sweat. Don't allow a person to touch you, other than, you know, ah the woman that is sitting beside you...cause that's the safest place for a woman...and its men who have to respect that and ah, I always talk about women, especially who have been abused you know, that ah, I start teaching our men about respecting you know the gifts of a woman the gifts being the caregiver and usually I'll ask a woman that is sitting cross legged, you know, that's not protocol. You being the giver of life you have to respect yourself by sitting in a modest way. You have to wear a cover too. Yeah you know, cover your legs. (P1)

This same participant who has been a sweat lodge leader for many years discussed the unexplained spiritual presence that existed in the sweat lodge. He discussed how people can sing songs they didn't previously know and how some see pictures in the hot rocks:

You pray, you know and then one song there they were singing along there you know, you know it's amazing. You can sing along and when your outside you can't sing, you know so it's sort of a mystery itself...It's a mystery itself

it like...sometimes when we roll the rocks you can visualize something, a wolf or a sign, or a face...and I usually tell them people like I said whatever you see the other person beside you is not going see the same thing. (P1)

Sometimes sweat lodge participants find the sweat lodge too hot. P1 will instruct people how to make it through the intense heat and steam, "I got them to hold sage, and told them this was to comfort you and also if you feel like it's gonna get too hot for you, try and breath and it sort of gives you energy you know ah, so you can breathe".

During this interview, I told the participant about the experience I had while in a sweat lodge, years previously, as relayed in the introduction of his document. This participant explained to me that what I felt was eagle feathers being used by spirits in the lodge:

Interviewer: So those were eagle feathers I felt?

Participant: Eagle feathers like a fan and you know, they (spirits) were coming in to doctor you... to heal you at your time of your loss or whatever, eh. Sometimes they will give you this energy to be able to cope with your loss...give you strength because sometimes its spiritual connection with our spirit and your belief system. It's not there to hurt you never. (P1)

Yuweepi Ceremony.

Only one participant mentioned what he referred to as a "Yuweepi" ceremony. He acknowledged that it was not thought to be traditional Carrier practice, but that it used the

power of the spirits, and invoked mystery for the people who were there to ask for healing or answers:

A Yuweepi ceremony. I guess it's more like a Lakota tradition...where they darken the room and then they, they sort of ah, bring the spirits, like it's a, just like sweat lodge where the sprits come...they darken all the room and they bring in, you know, it's like a tradition...where they tie a medicine man on a buffalo robe and then the ceremony is being done like with all this chanting and you know, after its done this person that's all tied up, all those ropes are neatly put in front of him and he's sitting there more or less, people are asking for prayers. Ask him for help....the thing is, here we go again we have to believe it in order for it to work. (P1)

Conclusion

This chapter illustrates how Carrier people viewed health and wellness as an overall state of being that was interconnected with the environment. Family, community, nature, and the spirit world were equally important components to the existence of Carrier people. Balance in all of these things was what was believed to keep a person and an entire community well.

Although all traditional Carrier people had knowledge of the use of plants and herbs as medicine, the need to maintain harmony with nature, and the need to respect the spirit world, traditional healers were people who were gifted to have strong healing powers. These powers were thought to be given to the individual through the higher power of the spirit world. Some healers were descendants of healers. Once discovered, healing powers were

nurtured, and further knowledge was taught by established healers and community Elders.

The reputation of all healers was dependent on the opinion of others. Healers did not advertise their skill or claim expertise.

Carrier healers used a variety of elements from nature, ceremony, and the spirit world in their work. This knowledge and its processes are embedded in traditional teachings although, participants indicated that protocol has evolved, and is altered, to meet current need. The overall essence of ceremony and healing tradition is embedded in Carrier worldviews.

Discussion

The intent of this research was to explore traditional views and treatment of mental illness with Carrier First Nations. The two literature review chapters provided a foundation for this data, through a review of the available historical accounts of First Nations in general, as well as Carrier people. The literature review contains evidence that suggests traditionally Canada's First Nations', share similar ontological and epistemological frameworks (Hammerschlag, 1988; Maher, 1999; McCormick, 2000; 1999; Tsey, 1997). Today, many First Nations are returning to their traditional beliefs. While generalizations of First Nations' worldviews, referred to as cultural or tribal glossing by Duran (2006), can be useful for understanding First Nations culture generally, literature indicated that culture is locally unique within individual communities. Even though this uniqueness may be subtle, information contained in the literature informs that for communities to regain and maintain wellness, they should establish their own cultural identities (Kirmayer, et.al. 2000). Therefore, I went directly to the Carrier healers and knowledge holders to seek this knowledge. This data has implications for the way in which mental health practice is offered in Carrier communities in present day.

This discussion chapter combines the primary findings of the data, with existing literature on the topic, to inform a discussion of Carrier mental health and healing and how services might be improved upon to better serve Carrier populations. First however, I will discuss some items that are embedded within this research and its results, namely that of culture, language, and my journey as a non-First Nations researcher. These items are highlighted as considerations to the reader while reviewing this chapter.

In review, I am a non-First Nations researcher. I am a First Generation Canadian of English-Irish descent who has worked in Carrier communities as a clinical social worker for a number of years. The “lens” with which I see the world will always be reflective of my culture and my personal and professional experiences. I was not raised in Carrier communities and my involvement with the community is as a professional. While I have several strong working relationships, I am not part of the Carrier community. My professional boundaries are quite rigid which I suspect is a reflection of my Western European culture and education. Yet, it seems I have given enough of myself to enjoy a comfortable place amongst the Carrier people. My goal in my work, and in this research, is to do the best job I can for the people I serve. To date I have spent almost 20 years of my life working with Carrier people. While this work has had its challenges, it has also been very rewarding. One of the most challenging tasks has been to help develop mental health and addictions services where none have existed before within an environment of Carrier cultural sensitivity. I see this research and its results as an extension of this work.

As I went through the process of this research, I was very conscious of the issues and challenges associated with non-First Nations researchers conducting research with First Nations. I was aware of the criticism that I might face under these circumstances. It is a difficult thing to help people understand that I take no ownership of Carrier culture. My reality is that I have spent years negotiating my way through Carrier communities searching for the best way to do my job. My contribution here is to offer insight to new and existing non-Carrier practitioners in hopes that they can take something from my experiences and the contributions of these research participants so that their work is informed better than mine.

I entered into this research relationship with Carrier people as an outsider, looking for an insider's information. The experience has added to my professional repertoire of information in ways that cannot easily be articulated. The most profound finding for me is that culture has many layers which cannot be discovered during a single research endeavor. In fact, I offer that these layers cannot be discovered in an entire life time by an outsider. Although I knew, through literature and personal communication, that Carrier people pass knowledge through a practice of oral history, I did not understand the intricate nature of this process before this research project. Carrier ways of knowing are a complex interplay of knowledge shared between and within generations through overt and subtle daily experience.

Carrier people have ways of maintaining health and treating illness. They have been doing so for their entire existence. This knowledge cannot be articulated in a single communication. Like all Carrier knowledge it is taught over a life time and through generations. The most valuable lesson for me is to remember to listen to what is being said and to watch people around me even when I do not think there is anything valuable going on.

The issues of culture and language are noted as factors in how information was expressed and understood in this research. I took steps to ensure that the research ethics were forefront in this work. The Carrier community had a voice in the development of this research. The participants were involved from data collection through to analysis. In my opinion the most valuable efforts I took were sending both the raw data and the analysis chapter to each participant for feedback and approval. Though this process, I could be reasonably sure that the information contained in this document was representative of my participants.

The factor of language is a complex issue involved in collecting data for this research and the resulting product. Through the process of colonisation, many Carrier people, along with all of Canada's First Nations, lost some ability to understand and speak their traditional language. This loss is well documented in the literature and falls on a continuum across the nation, within communities, and between individuals. As discussed in the literature chapter, the understanding and expression of culture is embedded within language (Kelly; 1991; Kirkness, 1998). Therefore, there will be concepts within the Carrier culture that my participants cannot fully represent because they have been lost over time due to a loss of language. Further, due to my very limited ability to understand the Carrier language, those participants who could speak the language translated concepts into English for my understanding. Some of the deeper meanings may have been lost in this translation. This was evident in two occurrences in the data gathering stages.

During one interview, a participant requested that two other participants sit with her during the interview because she was not sure she could translate all concepts into English. She did, in fact, struggle with translating a concept during her description to me regarding the ceremony involved in calling back a person's spirit.

The second example occurred during a discussion regarding communication with the creator. Although several of my participants had used the word "prayer" during their discussions with me regarding their communication with a higher power, one participant rejected the term when I used it. Although she did not provide an alternate term, it was clear from the conversation that the English word did not describe that which she was discussing.

I hope the reader will consider these items as threads that run through this research and its results.

The remaining chapter is structured into three sections. The first section summarizes and discusses the primary findings of the data. The chapter then moves into a discussion of implications for modern day practice in mental health with Carrier First Nation communities. The chapter concludes with suggestions for further research.

Primary Findings

Carrier Worldviews of Wellness.

The data indicated that Carrier people view the self, body, mind, and spirit as being interdependent. The data also show that Carrier people hold a philosophy that they live interdependently with their community, the environment, and the spirit world. Primary categories that emerged from the data regarding Carrier Worldviews of Wellness were “Balance and Connectedness”, “Community”, “Nature”, and “The Spirit World”.

According to the Carrier traditional worldview, balance and connectedness are primary concepts. While I used the terms “mental illness” and “mental health wellness” in the interview guide that was used during the interviews with participants, it was evident from the data that any term that separates *mental* health from the health and wellbeing of the whole person is not one that would be used by traditional Carrier healers and knowledge holders when describing their worldview. There is no separation of mental from emotional, physical, or spiritual wellness, and instead they are seen as interconnected. Traditionally, there was no concept or word for mental illness. Therefore, data primarily described overall health and wellbeing issues, versus mental health specifically.

Data indicated that Carrier people practiced prevention and maintenance for good overall health, as well as intervention for ill health. Data showed that traditional Carrier beliefs held that to prevent ill health, and to maintain overall wellness, an individual should maintain balance within oneself and between themselves and their environment. Individuals were not seen as functioning independently and were instead affected by the community they lived in and the natural environment that includes the spirit world. What was most striking in these descriptions is the way in which Carrier people incorporated health, nature, and the spirit world with daily living. There was no distinction made regarding a time to focus on health, spirituality, sustenance, or community. They were all intertwined in general existence and were seen as having equal weight or balance.

If a person was out of balance in any way, sickness of the body, mind, or soul would occur. Manifestation of symptoms that focused on any part of a person's being, would not necessarily dictate that illness was localized in that part of the self, or that it was organically caused. This was illustrated by a participant when he described how a medicine man would explore a patient's symptoms from an interconnected perspective. I asked him if a medicine man would consider a person's symptoms and interpret a physical or mental illness:

It's just one of those areas there that they are referring to usually. We don't look at it personally. I don't look at someone's unwellness as a sickness or anything. I just, you're wounded in some way. And we have to find a way to heal that wound because it impacts you collectively as a person in those four areas. (P1)

Interestingly it was suggested that ill health might actually result from events that occurred prior to an individual's own life time that affects them in present day.

Imbalance or illness of any kind might also be the result of bad medicine. Bad medicine was described by the participants as a phenomenon that occurred when a person intentionally, or unintentionally, used energy or power to harm others. This Carrier description of bad medicine, as the result of a manipulation of energy, is slightly different from descriptions found in the literature. Literature indicates that beliefs in other First Nations' communities of negative "sorcery and supernatural" intervention involves malevolent spirits (Maher, 1999, p.230).

These insights illustrate how the Carrier people conceptualized their existence. Individuals are greater than themselves, in that their existence is interdependent on people and events of the past, as well as present day.

The data showed that there is a need for Carrier people to have a strong connection to other people and the larger community. Literature indicates that from the very early days of North American First Nations people, there existed interdependence on community that was integral to survival. In the early days of the Carrier, the harsh environment of north central British Columbia dictated that small Bands of Carrier relied on each other to survive. When a Band did not have good fortune in hunting or gathering, they could have survived only through the grace of another Band. Carrier communities were structured through the clan system and the Bah'lats. Both of these social and political structures were instrumental in helping individuals, families, and the entire community for the greater good. While participants indicated that this collective practice has eroded somewhat since colonization,

there still appeared to be an essence of collective existence. In a collectivist community, a member's philosophy and functioning flows from this collectivist perspective (van Uchelen, 2000). Emotional attachments are valued as is cooperation between members for the greater good. The Bah'lat is active today in many Carrier communities (Fiske, 1996).

The data illustrated how community members would be involved in assisting other community members who appeared unwell. It was common for any concerned community member to call upon a healer on behalf of someone else, or for the healer to arrive unsolicited because he or she knew they were needed.

The importance of the natural environment in the lives of traditional Carrier people was clearly identified in this dissertation. Descriptions of its importance were all encompassing. Nature provided shelter, sustenance, medicine, and a place to heal. The participants provided descriptions of Carrier beliefs in the ability to communicate with the weather and animals in order to work with the natural environment for survival and wellness. This concept echoes the overall Carrier philosophy of existence; there was an interrelationship with the natural world that Carrier people tried to live in harmony with.

Presently, according to the participants, nature continues to be vital to the health and wellbeing of Carrier people. Modern day healers use herbs and plants to heal. Other healers described using the natural environment, including forests and lakes, as a place to work with people.

The participants' descriptions of interactions with the spirit world are fascinating concepts and crucial to understanding the Carrier worldview. Carrier people see themselves as having a connection and an existence beyond physical life. The participants spoke about

how the spirit world, the creator, ancestors, and guardians', affected everyday life. The existence of the spirit world was discussed as being factual. Carrier people relate to the spirit world on a daily basis. The spirit world is seen as integral to healing work. It was commonplace, and still is, according to the participants, for Carrier healers, to consult and call upon spirits to assist with healing. It was also common for some of the participants interviewed, to see the spirits of the deceased. One participant even described how a Carrier healer could himself enter into an area of the afterlife to help spirits pass through to the spirit world.

The concepts identified in the data and discussed in the theme of the Carrier Worldview of Wellness, illustrate the philosophy of existence of Carrier people as described by the participants. This framework of existence set the background for understanding the elements involved in the traditional work of a Carrier healer.

Carrier Traditional Healers

Based on the information shared by the participants regarding traditional Carrier healing practice, the development of knowledge involved in healing echoes the worldview of Carrier people. Concepts of illness, health, and healing are based on an interconnected worldview that incorporates self, community, the environment, and the spirit world. Carrier healers were taught and practiced traditional healing from within this same philosophy.

The selection and education of traditional Carrier healers, traditionally and currently, differs considerably from that of the Western European world. In the Western European world, an individual makes a decision to become a "healer" in a specific discipline, and then applies to the appropriate post-secondary school. Their success in acceptance to a school,

and the completion of a degree, is based on intellectual, situational, and financial abilities. The decision to become a medical doctor, social worker, psychologist, naturopath, etc., can be made and accomplished independently of one's family and community. To possess a natural aptitude for healing may not be a primary consideration for choosing a profession in the Western European world. Carrier healers in contrast, were chosen to become healers based on an innate gift of healing. As discussed by participants, community Elders would make selections of community members to fill any number of positions in the community to ensure its overall healthy functioning. The selection of a healer therefore, was based on observations of a person's natural ability.

Sometimes a person was chosen to be a healer by the spirit world. Some participants indicated that the natural gift of being a healer was passed on within families. Not all those who had the ability to be a healer would choose to become one. Occasionally people who had a gift of healing were afraid of their power.

The training of a selected healer was provided by healers and knowledge holders within the community. There was no formal educational process that the selected healers experienced. They were taught, over time, by any number of community members who held such skill and knowledge. Knowledge of how to use their gift of healing may also have come from the spirit world, when a healer would ask for guidance. Sometimes rituals were required, such as fasting, for a healer to increase knowledge or healing power. The education of traditional Carrier healers was always described as an ongoing teaching and learning process that involved verbal communication as well as practical exposure by the knowledge holder to the new healer.

All of the concepts identified in the section of Carrier Worldview of Wellness were central to the healer's work. Traditional healers used plants, and ceremony to promote healing, and all of their interventions involved the spirit world. Therefore, channeling energy, both natural and spiritual, was integral to a healer's power. The participants described "prayer", as it is referred to in present English language, as an ever present communication healers had with the creator and the general spirit world. All Carrier people were identified as having this connection, but healers had the gift of a connection strong enough to promote healing. In contrast, Western European "healing" professionals do not typically involve nature, ceremony, or the supernatural world in their work.

Once a healer began practicing in a Carrier community, a good healer was "known" and endorsed by the community. This was an important concept, as not all healers were good at what they did, and some may practice "bad medicine". Building relationship and trust in a healer were described as being important. An individuals' belief in the healer's ability to heal, coupled with the healer's belief in himself to heal, was believed to have had an impact on the success of the healing intervention. This practice is partly in contrast to Western European professionals. A Western European professional can gain entry into a profession based on his/her credentials. However, remaining in a position and being seen as a good practitioner will be based in part, on performance and reputation, similar to Carrier healers.

Carrier healers were described as having specializations. These included specializing in using herbs and plants as medicine, communication with the spirit world, dreaming, seeing into the future, and touching to diagnose and heal. A pivotal feature of all of these specializations however, appears to be the interconnected worldview that all healers had.

There was an explicit thread of connectedness to nature, the spirit world and community running through all of the descriptions of traditional healing. Western European practitioners also have areas of specialization in the overall health field. However, only those who specialize in religious or spiritual practice will have an explicit divinity component in their practice.

Implications for Practice

The purpose of this dissertation was to explore Carrier traditional concepts of understanding and treating mental illness. The intended result of this dissertation was to inform mental health practice and professionals, with regards to working in Carrier communities. I suggest that the results of the data gathered for this dissertation offer implications for mental health practice in Carrier communities. I offer a discussion of implications both from micro and macro perspectives, specifically in the areas of direct practice and policy. Policy recommendations are timely as the Canadian government shifts responsibility for health services to British Columbia's First Nations newly formed First Nations Health Authority. The direct practice recommendations refer specifically to mental health and wellness professionals who are working in Carrier communities. This chapter concludes with comments regarding limitations of this research and suggested areas for further research.

Practice recommendations.

The Worldview Should Lead the Practice.

The Carrier worldview of existence, and therefore concepts of health and healing practice, is that of an interconnected view. For those practicing mental health in Carrier

communities, the Carrier worldview concept should be a point of reference. The whole person, family, community, natural environment, ancestors, and the spirit world are involved in maintaining health, acquiring illness, and treating health problems. Concepts of unconnected “mental” illness have no place in a traditional Carrier worldview. Mental health practitioners should therefore work with clients within this "wide angle lens".

On intake, practitioners should ask clients about their whole world, and not just about the “presenting problem” or “diagnoses” that caused them to seek help. This whole world exploration would involve the clients’ present day situation, family, community, and spiritual beliefs. Because the Carrier worldview involves a concept that transcends present time, questions regarding a client’s existence within generations may also be valuable. According to Duran (2006), questions regarding past generations may help a client understand the impact of intergenerational trauma due to colonization. A cautionary note should be made that not all people of Carrier descent, particularly those who were not raised in a Carrier community, will share the traditional Carrier worldview.

Use Interventions that Reflect the Worldview.

When working with Carrier clients, mental health practitioners should consider interventions that include the whole person, community, nature, and the spirit world. Once a practitioner understands the Carrier First Nations’ worldview, she can choose therapeutic approaches that are most suited to help with the client’s problem, but are also reflective of the Carrier worldview and are similar to traditional ways of healing.

According to McCormick (2009), therapies that help the clients reflect on their existence in relation to others and the environment, are recommended:

Each form of therapy is based on tacit models of the person and associated cultural values (Kirmayer, 2007). Although the dominant theories of counselling emphasize individualism, for many Aboriginal peoples, relational notions of the self that connect the person to others (sociocentric), to the natural world, and to the spirit world are important. (p. 342)

As such, group therapies and family systems approaches are identified as appropriate for use with First Nations clients (McCormick, 2009). These approaches use social interaction and modeling behaviors as tools to help people make change in their lives or to cope with a mental health related issue. This recommendation is consistent with the Carrier worldview of social existence and interaction. Social interaction therapeutic interventions should be promoted, as appropriate, when offering mental health intervention in Carrier communities.

There are recommendations in the literature that suggest that nonverbal therapies are appropriate with First Nations people. The Aboriginal Healing Foundation suggests that alternative “energy based” therapies such as Reiki, be used with First Nations (Archibald, 2006, p. 65). Energy based therapies would fit with the Carrier belief in the manipulation of universal energy. The Aboriginal Healing Foundation also recommends that therapies involving the arts be used with First Nations. Music has a traditional place in Carrier healing culture. Drumming and singing were used in ceremony; they were also used as a means to express emotion:

Indians a long time ago, see a lot of these songs that we have, were not songs a long time ago...it was more, um, noises to express emotions. I've got a tape of my grandmother and she was singing...but there's no words in the song,

she's its emotion, you know, she's playing on the drum...she's got structure to it but it's ah, they're no words. And you know, she's just singing and it sounds, and it's just beautiful sound to it eh...the reason for it is because we needed to, you know, express, you know, how you feel because we weren't ah, the kind of society I guess who sat down and talked about our problems.

(P2)

Hammerschlag (1988) reminds mental health practitioners to continually reach outside of their comfort zone and realm of knowledge in effort to creatively work with First Nations' clients from within their clients' worldview.

Consider the Family and Community in Healing.

The data suggests that traditionally Carrier people were very communal. The greater good of family and community was seen as interdependent on the health and wellbeing of individual members. Traditionally, the healer would commonly be called upon by someone other than the person in need. The mental health professional in today's world should therefore establish referral streams and confidentiality protocol that fit with this worldview. This is not to suggest that the professional should disregard his or her ethical responsibilities with regards to confidentiality. It does suggest however, that guidelines be put in place to support a community's traditional need to care for its individuals for the greater good. For example, indirect, informal referrals from community members to a community mental health worker can be followed up by the professional through an informal "visit" to the person in question. The referral source could facilitate the first informal meeting. A formal intake would not be processed unless the potential client consented to service. It should be

noted, that this type of informal referral process would be practical for reservation community based practitioners, but perhaps not for those who are working in the Western European environment.

It is not uncommon for practitioners to receive calls for service for a family in the event of a crisis such as a traumatic death. These calls may come from family, as well as non-family members. A contemporary practitioner may be too quick to dismiss the majority of these calls, particularly if they are from extended family or non-family members. The Carrier worldview would instead support that the practitioner understand the need for people to assist other community members, and should therefore hear concerns, and assure the referral source that the people in question will be seen as requested.

The community at large should also be considered in some situations. In close communal environments, death, both natural and traumatic, and other social crises such as family violence, will impact the larger community. Knowledge of events will spread quickly. The community at large should be seen as both an ally to the practitioner, and as containing potential victims. For example, I recall arriving in a community late one night after being called to provide support after a tragic triple fatality. I was not familiar with the community or the families involved. On arriving on scene with a colleague, we were met by close to a hundred people standing around in groups. My colleague asked how we would know who the families of the deceased were, and how we would know who needed our help. I informed her that we would simply say who were, and the community would take care of the rest. On exiting my vehicle, I went up to the first group of people and simply introduced

myself. My colleague and I were then immediately caught up on a “wave” of people, and were quickly deposited into a living room of distraught family members of the deceased.

Although this group of immediate family members was our immediate and primary concern regarding this event, we also needed to consider the dozens of people who were outside of this home. They were in attendance, because they were impacted. In addition, in First Nations communities the first responders are frequently volunteer community members. Amongst the people outside, there were community members who had witnessed first-hand the aftermath of this tragic event. This is in contrast to larger urban communities where first responders would have their own support systems, and would most likely not know the victims.

The community at large should also be considered when planning capacity building activities aimed at improving the overall mental wellness in a Carrier community. As a communal people, providing prevention and education to the larger community can be valuable. It can be assumed, based on the practice of communal care of members, that any number of family and community members will informally become involved in a situation regarding the mental health and wellbeing of an individual. Therefore, the more educated the average community member is regarding issues pertaining to mental illness, and mental health, the more likely it is that an individual experiencing difficulties will be identified and helped to the appropriate resources. A common complaint in the communities I have worked with is that the people who need the information on mental health related topics, because they are experiencing related difficulties, are not usually the people who attend the workshops. It is advisable, based on this research that workshops are provided that

acknowledge this. The workshop information should include how to identify problems in others, and strategies for helping, including getting someone to professional services.

Use the Natural Environment when Possible.

The natural environment was identified as important to Carrier wellness and healing. Participants discussed how Carrier people have a strong connection to the natural environment because they were historically “bush people” (P2). Not only did they use elements from the natural environment for medicine, just being in the forest and mountains was itself powerful. As was summarized by a healer who takes people outdoors into the mountains to do healing work with them:

We done healing with a lot of people in the mountains with the drum, the water, because everything around you is very powerful, eh. The mountains are very powerful, the water, especially the ocean water. Mom said the ocean water is very powerful if you want to pray for anything bothering you, it will heal you. (P3)

Therefore, interventions should be offered that involve nature. Western European interventions can easily incorporate the natural environment. This may be as simple as the practitioner getting out of his or her office with a client, and taking a walk in a natural environment, such as a forest or park. It may also involve having natural elements in the office, such as rocks or eagle feathers. Clients may choose to handle these natural items as a way of connecting to the natural environment.

I have seen examples of incorporating nature with mental health work. A colleague of mine, for example, used the natural environment with a client while doing grief work.

This therapist worked with her client in her office and in a nearby forest over a period of several months. In her office they talked about his grief and the associated symptoms. At times she would take him into the forest to walk and talk. On more than one occasion, she encouraged him to ventilate his feelings by shouting out his grief to “the spirits” and to “nature”. Toward the end of their therapeutic relationship, she encouraged him to write a letter to the deceased. She then took him back to the forest where he smudged, then burned the letter to send it to the spirit world. The client described a healthy expression of grief through this process. He described to his therapist that involving the natural world in various expressions of his grief, helped him to feel a connection to the greater universe and the spirit of the deceased, thereby experiencing a recovery of mind, body, and soul.

In my work in the city, I have used the natural environment to assist in therapy. For example, I used visualization with a residential school survivor who was experiencing an anxiety related disorder. In sessions, I led my client through a visualization exercise that involved him being in a forest. I encouraged him to focus on the experience of being in a forest through all of his senses. Understanding that water is considered a healing element for Carrier people, I would often have him visualize sitting by a stream and using the water to wash away feelings of anxiety. This client reported a significant reduction in his symptoms and an increased ability to self-soothe during periods of increased anxiety.

A Carrier healer I work with uses rocks, mineral, and water in her group work with Carrier clients. She places a bowl of salt water in the center of the group and instructs clients to take turns holding a rock while they talk. The rock is held by the client to increase a

connection to the natural world, and also signifies the holder has the floor for speaking.

Once each person has spoken, they wash the rock off in the bowl of salt water, cleansing it.

Consider the Spirit World.

It is not appropriate, in my opinion, for the Western European mental health practitioner to include religion in a session unless the client introduces the topic. However, based on the Carrier worldview, it would be valuable for the professional who works with Carrier people, to consider that the client may endorse a worldview that includes spirituality, and that questions regarding this belief be asked when appropriate. In modern day, the Carrier client may not introduce issues such as bad medicine, or spirits, as having an impact on the client's health to a non-First Nations practitioner, because the client knows such concepts are often disregarded by Western European Western European societies. In the Western European world, we generally do not blame spirits or universal energy for ill health. The First Nations' client may do exactly that. The data clearly showed that spirituality is a vital factor to the Carrier worldview. Asking a client about his or her beliefs in this realm is valuable, as is keeping an open mind in respect to this subject. An open mind and non-judgmental attitude will help the First Nations client share what he or she believes is involved in their illness, and what might help or hinder recovery. Involving the spirit world in mental health practice with First Nations people is supported in the literature (Archibald, 2006; Kirmayer & Valaskakis, 2007; Sollod, 1993).

I have had Carrier clients tell me about experiences where they saw the spirit of a loved one, or dreamt about seeing a deceased loved one, and what they believed this sighting meant. I have also had clients describe frightening supernatural experiences that they

believed were caused by someone using bad medicine against them. Had I closed my mind to these Carrier beliefs, I would not have been able to build relationship with my clients, or effectively open up discussions regarding the concerns that brought them to my office.

Disregarding these beliefs would close the door to effective healing work.

I have also had clients who described “surreal” sensations of being outside of their bodies after experiencing a traumatic event. Some had accompanying experiences of seeing the spirit of their deceased loved one and some had feelings that their own spirit was already in the spirit world. Rather than talking about usual symptoms of trauma and grief that could explain these symptoms, I would instead listen to my clients’ descriptions from a non-judgmental position. I knew that the “loss of spirit” belief was common amongst Carrier people. By aligning with clients, we can explore what interventions best fit with their symptoms, based on their understanding of their cause. In these “loss of spirit” cases, it has been beneficial to combine Western European trauma therapy with the services of a traditional healer. For example, the therapist might provide usual trauma intervention to the client aimed at supporting the client in ventilating the experience, and providing psycho educational information regarding usual stress response symptoms. The traditional healer might perform a ceremony where the spirit is called back into the body.

The spirit world can also be considered as an ally to healing. If a client believes in the power of their ancestors, other spirits, and the creator, it might be valuable to encourage the client to ask for strength and guidance from these higher powers. The Fast ceremony described in the presentation of data chapter of this dissertation described how Carrier people would seek spiritual guidance through this ceremony. Supporting clients in attending

ceremonies such as the Fast, as well as simply supporting clients in receiving spiritual support, is recommended based on these findings. Some Western European interventions that use God, such as Alcoholics Anonymous, or energy, such as Reiki, can be incorporated using the language of Carrier spirituality. For example, Duran (2006) makes a parallel between the First Nations' perspective of getting emotional strength from a creator or spirit world and the successful model of Alcoholics Anonymous (AA). In the AA model, members are encouraged to surrender themselves to their addiction to their higher power, commonly referred to as God. God will then support them through to recovery (Alcoholics Anonymous, 2001). AA modeled support groups in Carrier communities can replace the word God with another word that is acceptable for Carrier people.

Practitioners Must be Endorsed by the Individual and the Community.

Traditionally, Carrier people define who their healers are, at a local level. They use local knowledge to teach healers how to heal, and then locally endorse who they feel are trusted and successful healers. Therefore, practitioners coming into Carrier communities should not do so with the opinion that their professional degree alone will gain them the trust of Carrier community members. In Western European counselling work, the therapeutic relationship has long been identified as being a primary factor to successful intervention (Lambert & Barley, 2001). However, this reference is to individual clients versus an entire community. Building relationship with the entire community, as well as individuals, is perhaps the foundation to positive work in Carrier communities. The research in this dissertation suggests that the healer must be locally endorsed to be successful. Therefore, considerable time and strategies should be employed by the mental health practitioner to

build relationships with community leaders, Elders, other healers, and clients. Relationship building should mirror how traditional healers were involved in the community and can include walking, talking, and engaging in traditional activities such as berry picking and fishing. This engagement will promote a practitioner's acceptance into a community.

Inform Practice with Current Local Knowledge.

Although this data provides cultural guidelines for work in Carrier communities, it should be remembered that Carrier healing tradition is the result of a blending of local historical knowledge with ongoing experience. It is a changing and evolving process, and may differ slightly between Carrier communities, and may change over time within Carrier communities. Therefore, it is advisable, based on this research, for practitioners to seek the ongoing direction of community knowledge holders to help inform their work. Knowledge holders may be Elders, other healers, and general community members. Some examples involve asking if bad medicine is seen as being active in a particular community and if so, what kinds of traditional interventions are performed and by whom?

Knowledge holders may also be valuable resources for protocol information such as, what is the proper protocol for facilitating a group intervention; are circles opened with a prayer or a smudge? Should a practitioner regularly cleanse a therapy room by smudging? Is it appropriate for a non-native practitioner to have smudge materials available for clients to smudge before or after a session? All of these questions, if asked with sincerity, will increase the practitioner's First Nations' knowledge base, as well as help build relationship with the community through demonstrated respect for traditional, local knowledge.

Consider Combining Healing Interventions.

The participants indicated that in fact, today there is a place for both Western European Western European and traditional healing models in Carrier communities. Literature supports the idea of amalgamating the best of traditional healing practice with Western European tools (Archibald, 2006; Kirmayer & Valaskakis, 2007; Smye & Mussel 2001). This combination can occur in a collaborative fashion where a non-First Nations practitioner works with a client alongside a traditional healer. Such combination might also occur if a single healer was educated in both Carrier healing tradition as well as Western European practice. An example of this was provided in this dissertation through the descriptions offered by participant two (P2) who works as an addiction counsellor and combines his traditional practice with his contemporary education. It is imperative, that any combining of interventions, particularly if conducted by a non-Carrier practitioner, be done with the support and guidance of traditional healers.

Policy Implications.***Policy Should Involve Community Research Funding for Mental Health Practice.***

As discussed in this paper, First Nations in North America share similar history and culture however, they also differ based on geographical location, social structure, and specific beliefs. As examples, the teepee, a structure often associated with First Nation people, was removed at a traditional camp by Carrier people to be replaced with a pit house, the traditional Carrier structure. Bad medicine in Carrier culture was described by the participants as negative energy that can be manipulated and used against a person. The literature review suggested that the concept of bad medicine in other First Nations culture is

understood to be the work of spirits. Plants and herbs used in ceremonies and in healing practice by specific First Nations will logically differ based on availability in a given region. The micro level recommendations provided above are the result of research conducted with a specific First Nation. As illustrated here, an understanding of Carrier culture can promote culturally competent mental health services. Therefore, FNHA should build into its budget opportunities for First Nations communities across British Columbia to define their own worldviews and approaches to mental health and healing. This policy could also exist nation-wide for the benefit of all First Nations.

Policy Should Recognize Traditional Health and Healing Practice.

Carrier people clearly have traditional ways of maintaining and treating health and wellness through work with traditional healers and ceremony. Funding agreements should allow for communities to develop their own health and wellness programs that can include both qualified professionals, as well as traditional healers. Funding should also allow for traditional ceremony. Communities will need to develop their own ways of identifying and compensating their traditional healers, based on their unique practice. Once the funding health authority provides this autonomy, traditional health and healing activities can become part of a community's health and wellness work plan.

Policy Should Recognize the Interconnected Nature of Health and Healing.

As identified, health and healing in Carrier communities involves a combination of the interconnected existence of individual to family, community, and the greater environment, including the spirit world. Therefore, to see mental health and healing activities only in the form of direct counselling type services would be inadequate. Health

and healing activities should be seen through a wider cultural lens. For example, promoting events that involve communal activity, such as a fall fishing camp that supports good mental health.

Limitations and Areas of Additional Research

There are two primary limitations in this research. First, there are 22 Carrier First Nations Bands located over a wide geographical area of 77,000 km. A primary factor repeated throughout this dissertation is also a primary limitation of its data results; although Carrier people have many similarities across Bands, not all beliefs and practices are the same. Equivalence of healing practices cannot be assumed across all Bands. Nor can the worldviews of individuals be assumed to be that of the general Carrier population. This data is based on the knowledge of seven people from five Bands. Therefore, there were 17 Bands that were not represented in this data. So while much of the data can be generalized to the other 17 Carrier Bands, this should be done with caution and respect for the Bands not represented and individuals living in the communities.

Secondly, this research was exploratory in nature, and its results are relatively tentative. This research provides insight into the worldviews of Carrier people as described by seven healers and knowledge holders, from which implications for practice were inferred. However, it does not provide a specific “road map” for mental health practice with Carrier people.

Both of these limitations provide guidance toward areas for further research, a next step whenever possible for research endeavors (Fisher, 2010). Further research is needed to gather information regarding specific worldviews in other Carrier communities. I also

suggest that further research is needed to provide empirical evidence to support specific culturally appropriate mental health interventions.

The literature contains a variety of ideas for Western European mental health practitioners to alter interventions based on general worldviews of First Nations people, for First Nations people. Much of this literature leaves it up to the practitioner to select suggestions from the literature or to be creative with their skills. As Western European mental health intervention is becoming more established in Carrier communities, and traditional Carrier healing practice is gaining popularity, research specific to the success of these interventions would provide guidance to their use. Carrier people, or those designated by Carrier people, could then showcase empirical evidence for the success of practice. Culturally sensitive practice can then be supported as interventions that can be evaluated and valued on a similar basis as Western European practice (Wilson, 1989).

Conclusion

To understand the necessity of the existence of culturally appropriate mental health practice, it is essential to understand the worldviews of First Nations, and how these contrast with the Western European view. Local Carrier First Nations' worldviews and healing practice have been discussed in this chapter, to inform contemporary mental health practice in Carrier communities. The implications for practice involve both the general conduct of the practitioner as well as suggestions for interventions with clients. This discussion chapter essentially suggests that the modern day practitioner join the Carrier community, in providing mental health services through understanding Carrier people, and their history of healers, health, and wellbeing knowledge. As stated by McCormick (2009), "To be clear, the

profession of counseling is ancient because Aboriginal people have sought out guidance and ‘counseling’ from expert helpers in their communities for a long, long time” (p. 337).

Conclusion

Through colonization, First Nations worldwide were forced to largely abandon traditional life ways and accept the health services of the Western European culture. Today, First Nations around the world are reclaiming traditional ways that are beginning to inform health, including mental health, services (Maher, 1999; Poonwassi & Charter, 2001; Tsey, 1997).

Through this dissertation, I explored how Carrier First Nation people traditionally viewed and treated mental health related concerns. Since first contact with Europeans Canada's First Nations have experienced an erosion of their traditional ways of life and with it, a decline in their overall health. There is a shift in Canada and throughout the world; First Nations' people are reclaiming their traditional worldviews and with it their traditional practices in an effort to improve health and reclaim heritage. While there are general concepts of First Nation's worldviews and healing practice there are unique aspects embedded within each individual Nation. Through this dissertation, I have explored what seven traditional First Nations healers in Carrier communities described as traditional views and practice of mental health.

A review of the literature placed this research topic within context. The literature explored Canada's First Nations in general, from their earliest existence, through to colonization. A post colonization review demonstrated how First Nations people were marginalized under European rule, resulting in a decline in overall health. The literature review focused on health, and specifically mental health, status and the evolution of formal services. A primary thread running through this literature review involved understanding the

ontology and epistemology of First Nations people as it relates to general beliefs of existence and health and healing knowledge. This understanding is crucial when considering how Carrier people view and treat mental health related issues, and how it differs from that of Western European thought.

British Columbia, and indeed all of Canada, is currently experiencing a shift in how First Nations mental health is being managed. First Nations are involved in developing mental health related services that are more suited to their culture. With this comes a need to explore what role culture has in services. The second half of the literature review explored this development.

The data for this dissertation was gathered using an ethnographic framework and analyzed through content analysis. Seven healers and knowledge holders shared their knowledge regarding traditional health and healing practice amongst Carrier people. A primary thread of the data indicated that mental health was, and is not, viewed or treated separately from the health of the whole person. There was evidence, however, that modern day Carrier healers have incorporated current knowledge in their practice. This was evident in the case of P1 who talked about treating cancer, and P2 who combined traditional Carrier healing practice with addictions education. A second primary thread was how Carrier people considered their existence, and their health and healing practice, within the larger context of community, and the natural and supernatural worlds.

It has been clearly identified through this dissertation that traditional Carrier views of mental health and illness are fundamentally different from current Western European Western European models. It has also been identified that Carrier people had, and still have,

a culturally specific manner of choosing and educating traditional practitioners, as well as how practitioners are supported in their practice.

Through this dissertation, I hoped to contribute to the growing body of knowledge involving First Nations' mental health practice. Therefore, the discussion chapter explored how the findings of this research can be used to inform mental health practice with Carrier people.

Epilogue

I joined two Carrier men, known Healers in Carrier communities, who were in a forested area on reserve preparing for the ceremony we were about to host. A fire had been lit. Both men had red colored markings below their eyes. One of the men approached me and applied a streak of the same powder substance under both of my eyes. As he did so, he said "to protect you". We then sat and discussed, in quiet tones, our plans for the ceremony. The ceremony was being held to assist a client with whom I had been working. This adult female had been diagnosed with a severe and persistent mental illness several years ago. She and I were working on developing strategies to help her effectively live with this mental illness. We were also working on helping her to recover from historical trauma. The people who were involved in perpetrating her traumatic experiences were dead. The traditional ceremony we offered her, was designed to assist this woman to "let go" of her shame, anger, and sadness associated with her traumatic experiences. I had instructed her previously to take time to prepare a letter, to bring with her to the ceremony, which expressed the events and feelings she wanted to work on.

Once our client arrived, armed with a paper plate full of food, as the medicine men had instructed, we began the ceremony with each of us smudging with sage. We then stood in a circle around the fire, which that had been built into hot and active flames. One of the medicine men began to speak. He addressed the “grandfathers” and the “creator”, explaining to them that we were there to help “heal” the woman who was with us. He asked these spirits to help us in this work.

As I had been taught by Carrier healers over the years, through example and practice rather than verbal instruction, I opened my mind to the spirit world and focused my thoughts on our client. On cue from one of the medicine men, our client began to read her lengthy letter to the fire. As she read, her emotions mounted, as did the level of her voice. I had not previously heard, in our therapeutic sessions, some of the things she expressed. Some were so atrocious, that I had a moment of doubt that she was providing an honest account of her experience. I privately wondered if her mental illness had played a part in fabricating stories with regards to her childhood abuse.

Strangely, as she talked and cried, the crackling noise of the fire, and the flames themselves, seemed to increase. As I watched and listened, I became aware that the crackling noise of the fire was no longer coming from just the fire. It was coming from all around us. There was rustling wind and crackling noises coming from the perimeter in a rapid, loud, circling pattern. I had the distinct feeling that the air was charged with intense energy. After the client’s letter was read, it was placed into the fire along with an offering of tobacco and the plate of food. The strange noise and the leaping flames remained until the last of the offerings were consumed.

Once the flames died down and the noise settled, we talked with our client until we were satisfied she was ok. Once she left, the medicine men and I prepared to leave. One of them turned to me and said “You can be sure she spoke the truth. The spirits would not have been here if she did not”. After years of working in Carrier territory, I did not question how the medicine man knew my thoughts. I did not question the feasibility of spirits being responsible for what I heard or felt during the ceremony. Instead, I looked through my “Carrier lens” and simply accepted the knowledge of the medicine man and thanked the spirits for their help.

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Meyer/Western Basin, and Northern Algonquian cultures (Vol 3).

Appendix A.

Band Council Approvals



CHESLATTA CARRIER NATION

P.O. Box 909 • Burns Lake, B.C. • V0J 1E0
Phone 250-694-3334 • Fax 250-694-3632



October 13, 2009

To: Simon Fraser University research Ethics Review Board

On behalf of the Cheslatta Carrier Nation I wish to inform you that our community supports Christina Dobson Berzzoni's Doctor of Education dissertation research project "An Ethnographic Study of traditional Healers' Concepts of Mental Health Wellness and Healing in Carrier Sekani Territory" I understand that she will be seeking our traditional healers from our community as well as other communities, to inform her research. She has advised me of the risks and benefits of this research for our community.

We look forward to seeing the results of Christina's research which, she has informed us will be provided to us in her final dissertation document.

Sincerely:

Chief Corrina Leween
Cheslatta Carrier Nation
October 13, 2009

NADLEH WHUT'EN INDIAN BAND

November 15, 2009



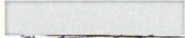
To Simon Fraser University Research Ethics Review Board

On behalf of Nadleh Whut'en First Nation I wish to inform you that our community supports Christina Dobson Brazzoni's Doctor of Education dissertation research project "An Ethnographic Study of Traditional Healers' Concepts of Mental Health Wellness and Healing in Carrier Sekani Territory". I understand that she will be seeking out traditional healers from our community, as well as other communities, to inform her research. She has advised me of the risks and benefits of this research for our community.

We look forward to seeing the results of Christina's research which, she has informed us will be provided to us in her final dissertation document.

Sincerely,

NADLEH WHUT'EN FIRST NATION


Chief Martin Louie

P.O. BOX 36, FORT FRASER, B.C. V0J 1N0 — PHONE: 690-7211 - FAX: 690-7316



LHEIDLI T'ENNEH BAND

"THE PEOPLE FROM THE CONFLUENCE OF THE TWO RIVERS"


November 5, 2009

To Simon Fraser University Research Ethics Review Board

On behalf of Lheidli-T'enneh First Nation I wish to inform you that our community supports Christina Dobson Brazzoni's Doctor of Education dissertation research project "An Ethnographic Study of Traditional Healers' Concepts of Mental Health Wellness and Healing in Carrier Sekani Territory". I understand that she will be seeking out traditional healers from our community, as well as other communities, to inform her research. She has advised me of the risks and benefits of this research for our community.

We look forward to seeing the results of Christina's research which, she has informed us will be provided to us in her final dissertation document.

Sincerely,


Chief Dominic Frederick

Main Office:
Phone: (250) 963-8451
Fax: (250) 963-6954
Toll Free: 1-877-963-8451

Mailing Address:
1041 Whenuan Road
Prince George, B.C. V2K 5X8

Treaty Office:
Phone: (250) 963-8480
Fax: (250) 963-8490
Toll Free: 1-877-963-8480

Chief Fred Sam
Nak'azdli Band
PO Box 1329
Fort Saint James, BC
V0J 1p0
250-996-7171 (phone)
250-996-8010 (fax)

To Simon Fraser University Research Ethics Review Board

On behalf of Nak'azdli Band I wish to inform you that our community supports Christina Dobson Brazzoni's Doctor of Education dissertation research project "An Ethnographic Study of Traditional Healers' Concepts of Mental Health Wellness and Healing in Carrier Sekani Territory". I understand that she will be seeking out traditional healers from our community, as well as other communities, to inform her research. She has advised me of the risks and benefits of this research for our community.

We look forward to seeing the results of Christina's research which, she has informed us will be provided to us in her final dissertation document.

Sincerely,



Date December 2, 2009

OCT/13/2009/TUE 04:59 PM

FAX No.

P. 001

**Saik'uz First Nation**

720 Patrick Street
Vanderhoof, BC V0J 3A1
Phone: (250) 567-9293
Fax: (250) 567-2998

October 13, 2009

Christina Dobson Brazzoni
Brazzoni & Associates
301 - 1705 Third Avenue
Prince George, BC V2L 3G7
(F) 1.250.563.5496

Dear Christina:

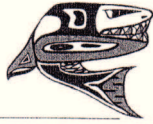
Re: Intellectual Property Agreement

This agreement is between Saik'uz First Nation (Aboriginal Nation) and Christina Dobson Brazzoni (researcher). This agreement has been made to guide the intellectual property rights of the information that will be gathered through research for the purpose of C Brazzoni's Doctor of Education dissertation degree through Simon Fraser University.

As stated in the Canadian Institute of Health Research (CIHR) Guidelines for Health Research Involving Aboriginal People "Community and individual concerns over, and claims to, intellectual property should be explicitly acknowledged and addressed in the negotiation with the community prior to starting the research project. Expectations regarding intellectual property rights of all parties involved in the research should be stated in the research agreement".

The agreement is as follows:

- 1) All individual participants of this research will be provided an "informed consent form" (see attached). A participant will not be identified in the dissertation document without his/her explicate written consent.
- 2) The knowledge shared through this research proposal will be included in C. Brazzoni's doctoral dissertation. This dissertation will be presented to the Academic community.
- 3) Participants and a Saik'uz designate from the community will be provided a copy of the dissertation. Saik'uz First Nation reserves the right to use this information for the benefit of their community's mental health services.
- 4) All dissertations are published by the degree granting University upon successful acceptance of the dissertation. This published document will be housed in Simon Fraser University and possible other libraries. There is no monetary gain for either party in this process.



STELLAT'EN FIRST NATION

BOX 760, FRASER LAKE, B.C. V0J 1S0 – PHONE (250) 699-8747 – FAX (250) 699-6430
www.stellaten.com

Stellat'en First Nation

To Simon Fraser University research Ethics Review Board

On behalf of Stellat'en First Nation I wish to inform you that our community supports Christina Dobson Brazzoni's Doctor of Education dissertation research project "An Ethnographic Study of Traditional Healers' Concepts of Mental Health Wellness and Healing in Carrier Sekani Territory". I understand that she will be seeking out traditional healers from our community, as well as other communities, to inform her research. She has advised me of the risks and benefits of this research for our community.

We look forward to seeing the results of Christina's research which, she has informed us will be provided to us in her final dissertation document.

Sincerely, 

Stellat'en First Nation

Date Oct 6/09

Appendix B.**Information Sheet for Research Participants**

Name of Research: An Ethnographic Study of Traditional Healers' Concepts of Mental Health Wellness and Healing in Carrier and Sekani Territory

Principle Investigator: Christina Dobson Brazzoni

Phone number (toll free to Prince George) [REDACTED]

Email: [REDACTED]

Aboriginal Advisor: Mabel Louie, Stelat'en First Nation

University Thesis Committee: Adam Horvath, PhD; Glen Schmidt, PhD

Affiliation: Simon Fraser University

Purpose of research:

As a non-native mental health therapist, who provides services to Carrier Sekani people, I am seeking a deeper understanding into how Carrier Sekani people traditionally view and treat mental health related conditions. I hope that this research will assist me, and others like me, in providing support services that are culturally sensitive.

What will the participant be asked to do:

I will ask you to meet with me for a maximum of three times to share your knowledge and opinions regarding Carrier Sekani mental health wellness and healing. I will ask you the questions included on the attached "Interview Guide" but of course, I am interested in hearing anything on the subject that you think is valid. I will come to your home or meet you where it is most convenient for you.

All of our conversations will be tape recorded. These tapes will be transcribed into text and used to inform this research. After the information is "analysed" and written up in the format required for this dissertation, I will provide you with a copy and ask that you read it and provide any feedback to help ensure the information is accurate and valid.

Potential benefits and risks: Potential benefits include contributing to information that may be used to inform improved mental health service to Aboriginal, and specifically, Carrier Sekani communities.

Potential risks: there are no known risks associated with participating in this research.

How was participant chosen: Your name was provided to me by someone who identified you as a traditional healer or knowledge holder.

Voluntary nature of participation: it is completely voluntary for you to choose to meet with me. You have the right to withdraw at any time.

Honorarium: I understand that your time and knowledge are valuable. You will be paid an honorarium of \$75 each time you meet with me.

How anonymity is addressed: You will be asked to indicate on the attached “Informed Consent” form if you would like your name and or home community/Band included in the document. If you do not wish to be identified, all identifying information will be omitted from the thesis document.

How confidentiality is addressed: there will be two to three other knowledge holders who will be participating in this research. Information will be grouped together for presentation in the final document. Your comments will not be identified as being yours.

Information access and storage: the tape recordings and transcriptions will be kept locked in my Prince George office. My Aboriginal Advisor and my Thesis Committee will have access to this information. The results of this information will appear in my final dissertation document. The results may also appear in other publications. The original data will be destroyed after five years.

If you have any *questions* about this research please contact Christina Brazzoni at [REDACTED] or [REDACTED]

If you have any *concerns* or *complaints* about this research you can contact:

Simon Fraser University
Office of Research Ethics — Director,
Dr. Hal Weinberg
778-782-6593
hal_weinberg@sfu.ca

Appendix C.**Informed Consent Form**

Name of Research: An Ethnographic Study of Traditional Healers' Concepts of Mental Health Wellness and Healing in Carrier and Sekani Territory

Principle Investigator: Christina Dobson Brazzoni

By signing this consent you agree with the following:

- The purpose of this research has been explained to you.
- You understand that participation is completely voluntary.
- You understand you have the right to withdraw at any time without a reduction in the honorarium.
- You understand that because others in this group will hear you and see you, your participation and comments are not confidential.
- Your name will not be used in the final document or any other publications to protect your identity from the general population.
- The focus group session will be tape recorded.
- The information from the focus group will be stored in a locked cabinet at my Prince George office for a period of five years, after which it will be destroyed. Your Chief and Council have the right to a copy of the data in keeping with Aboriginal Research rights to Ownership and Possession recommendations.
- This research is guided by an Aboriginal Advisory Committee as well as an academic advisory committee.
- Due to the topic of research, your community's mental health therapist is aware that I will be conducting these groups and is available to you if necessary. I have arranged to have these groups on the days she is in community. She can be reached by calling the health center.

I agree with the above statements and give my informed consent to participate in this process.

Signed: _____

Date: _____

Witness: _____

Appendix D.**Interview Guide**

An Ethnographic Study of Traditional Healers' Concepts of Mental Health Wellness and Healing in Carrier and Sekani Territory

I am interested in a deeper understanding of Carrier Sekani traditional philosophy of mental health.

1. Historically, what might have been considered a “mental health wellness” related concern. Was there a distinction in physical, emotional, mental, spiritual or social functioning?
2. Who in the community/family would be responsible for taking action with a person who showed concerning behavior? Who would they go to?
3. Were situations handled confidentially or was more emphasis placed on the good of the whole community?
4. Did most communities have a “medicine man/woman” or “healer”?
5. How did a person attain this status?
6. What types of conditions/situations would these medicine men/women or healers treat?
7. In Carrier Sekani Territories, what methods of healing were used?
8. You are a traditional healer. How, in modern times, do you as a healer view and treat mental health related issues?