From Benzos to Berries: Treatment Offered at an Aboriginal Youth Solvent Abuse Treatment Centre Relays the Importance of Culture

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First Nations and Inuit youth who abuse solvents are one of the most highly stigmatized substance-abusing groups in Canada. Drawing on a residential treatment response that is grounded in a culture-based model of resiliency, this article discusses the cultural implications for psychiatry's individualized approach to treating mental disorders. A systematic review of articles published in *The Canadian Journal of Psychiatry* during the past decade, augmented with a review of Canadian and international literature, revealed a gap in understanding and practice between Western psychiatric disorder–based and Aboriginal culture–based approaches to treatment and healing from substance abuse and mental disorders. Differing conceptualizations of mental health and substance abuse are discussed from Western psychiatric and Aboriginal worldviews, with a focus on connection to self, community, and political context. Applying an Aboriginal method of knowledge translation—storytelling—experiences from front-line workers in a youth solvent abuse treatment centre relay the difficulties with applying Western responses to Aboriginal healing. This lends to a discussion of how psychiatry can capitalize on the growing debate regarding the role of culture in the treatment of Aboriginal youth who abuse solvents. There is significant need for culturally competent psychiatric research specific to diagnosing and treating First Nations and Inuit youth who abuse substances, including solvents. Such understanding for front-line psychiatrists is necessary to improve practice. A health promotion perspective may be a valuable beginning point for attaining this understanding, as it situates psychiatry's approach to treating mental disorders within the etiology for Aboriginal Peoples.

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Highlights

- There is significant need for peer-reviewed, culturally competent, psychiatric research specific to diagnosing and treating First Nations and Inuit youth who abuse substances, including solvents.
- A health promotion perspective may assist clinicians in bridging the gap between Western and Aboriginal understanding and practice regarding substance abuse and mental health, thereby improving outcomes.
- The practice of storytelling illustrates the disjuncture between Western and Aboriginal responses to healing, and may be a valuable tool for knowledge transfer in the clinical setting.

Key Words: *substance abuse, addiction, volatile solvent abuse, mental health, Aboriginal, youth, treatment, storytelling*

> This is why I tell these stories over and over again. And there are others. I tell them to myself, to friends, sometimes to strangers. Because they make me laugh. Because they are a particular kind of story. Saving stories, if you will. Stories help keep me alive. But help yourself to one if you like. It's yours. Do with it what you will. Cry over it. Get angry. Forget it. But don't say in the years to come that you would have lived your life differently if only you had heard this story. You've heard it now.[1]

Beginning in the 19th and well into the 20th century, Aboriginal ceremonies, traditions, and activities were discouraged and at times criminalized through Canadian government legislation, policy, and practice (for example, the Indian Act).[2] This response was part of a comprehensive attempt to assimilate Aboriginal Peoples into the contemporary Canadian mosaic, and resulted in the erosion of their traditional ways of life.[3,4] Consequently, the health and well-being of First Nations and Inuit are negatively affected, demonstrated by their marginalized social and economic status, poor nutrition, and high rates of violence and substance abuse.[5]

Traditional Aboriginal understandings and approaches to addressing problematic substance use and mental health issues have historically been at odds with conventional biomedical approaches.[6,7] Specific to substance-related diagnoses, Health Canada's First Nations and Inuit Health Branch, in partnership with First Nations and Inuit communities and organizations, moved toward closing this gap with the development of 56 NNADAPs in the 1970s. Most of these treatment centres were developed with an emphasis on Aboriginal understandings of healing in conjunction with conventional approaches to substance use treatment. Alongside NNADAP, a network of 9 youth solvent abuse–specific residential treatment centres has been established, starting in 1996.

We begin our paper by introducing different conceptualizations of mental health and substance abuse in Western and Aboriginal world views. Then we draw attention to the serious gap in understanding and practice between these 2 world views. Using a traditional Aboriginal method of knowledge translation—storytelling—front-line experiences from people working in a culture-based youth solvent abuse treatment centre in Canada relay the difficulties with imposing conventional psychiatric diagnosis–based responses onto First Nations and Inuit youth. This leads into a discussion of how psychiatry can best capitalize on its growing debate regarding the role of culture in care offered to First Nations and Inuit youth who abuse substances. To conclude the paper, we discuss the significant need for increased peer-reviewed, culturally responsive, psychiatric research specific to diagnosing and treating Aboriginal youth who abuse substances, including solvents. A health promotion perspective is suggested as a possible beginning point for attaining this understanding. It situates psychiatry's individualized approach to treating metal disorders within the etiology for First Nations and Inuit.

Abbreviations used in this article

DSM	Diagnostic and Statistical Manual of Mental Disorders
NNADAP	National Native Alcohol and Drug Abuse Program
SUD	substance use disorder

Treating Solvent Abuse Among First Nations and Inuit Youth in Canada

Solvent abuse is the deliberate inhalation of fumes or vapours given off from a substance for its intoxicating and mind-altering effects.[8] Solvents are a large and diverse group of chemical compounds located in hundreds of household and industrial products, including paint thinner, glue, gasoline, and correction fluid.[9] The health effects of inhaling can be acute, and include frostbite and burns,[10,11] brain and nerve cell damage,[12,13] and sudden heart failure.[14,15] The social effects are equally destructive, and include poor academic performance,[12,16] decreased mental wellness,[17,18] and problem behaviour, such as delinquency.[19]

The 2004 Canadian Addiction Survey found that 1.9% of males and 0.7% of females aged 15 years and older reported the use of an inhalant in their lifetime.[20] The majority of people (67%) reported first using inhalants when aged between 12 and 16 years.[20] Research and practice have indicated higher rates of solvent abuse among youth experiencing disenfranchised life conditions and at younger ages. This has been documented among street youth, inner-city youth, and some First Nations and Inuit youth living in select rural and remote areas of the country.[21,22] Solvent abuse among First Nations and Inuit youth has been linked to high rates of poverty, boredom, loss of self-respect, unemployment, family breakdown, and poor social and economic structures.[23]

Most youth who enter into the residential solvent abuse treatment centres in Canada have extensive histories of mental, physical, social, and spiritual abuse and disconnection.[24,25] These are the same youth who, in the conventional biomedical view, would most likely receive psychiatrist-supervised care. The solvent treatment centres focus on a culture-based model of resiliency, which is a strength-based approach to treatment. This holistic model of resiliency is understood as:

> [A] balance between the ability to cope with stress and adversity [that is, inner spirit] and the availability of community support [that is, relations with the collective community].[23, p 7]

Key in this model is recognition that a person's inner spirit and community cannot be disentangled from one another, as is commonly done within a Western world view. A person's inner spirit is intertwined with their family, community, and the land and cannot be understood apart from them. For example, among the Dene people, a person's addiction is seen as shared by all

community members. Everyone in the community shares the responsibility and has a duty to contribute to the person's healing.[26]

Recent work on Aboriginal youth resilience supports this holistic understanding.[27,28] To illustrate, Iarocci et al[29] propose that psychiatry's individualized understanding of resiliency needs to include an understanding of families, communities, and broader society to account for culture, social context, and ecological environment. Numerous non-Western cultural traditions assume a sociocentric concept of self, which likewise views the individual as a relational, interdependent entity,[30] and which is in sharp contrast to the conventional biomedical view of an egocentric self that characterizes people as unique, separate, and autonomous beings.[31] Gladwell[32] has criticized this individual-centred view with numerous examples of the ways in which individual behaviour is better explained by social networks and forces than the common assumptions of individual effort or blame. Within an Aboriginal worldview, people cannot be conceptually separated from their community.

The stories shared in this article originate from the Nimkee NupiGawagan Healing Centre in Muncey, Ontario. The centre opened in 1997 and is a 4-month residential, gender-based treatment program for First Nations and Inuit adolescents. Its 12 treatment beds are funded through Health Canada's First Nations and Inuit Health Branch. As a cultural program, assessments, counselling, and programming begin from a place of respect that focuses on the strengths of Aboriginal youth, families, and communities. The centre's name translates in English into Thunderbird's Necklace; the Thunderbird's Necklace is a rainbow of colours and the rainbow symbolizes "the aura of a cleansed Creation which comes from the cleansing waters of the Thunderbeings."[33] The cleansing work of the Nimkee NupiGawagan Healing Centre is to promote the true colours of the spirit of the youth and to have them shine.[33]

Psychiatry's Response to Aboriginal Peoples Mental Health and Substance Abuse

Although the DSM-IV-TR has arguably received most attention for responding to mental health and addictions, it has come under scrutiny by some as being conceptually Western-based and laden with value judgments.[34,35] A foremost example is psychiatry's historical recognition of indigenous peoples as "primitive" and "inherently opathological."[36, p 105] Within Canada this is possibly most notable in that "mental health research has paid scant attention to the role culture plays."[31, p 48]

The DSM includes 17 categories of SUDs and defines SUDs as "anything that is ingested in order to produce a high, alter one's senses, or otherwise affect functioning."[37] SUDs are divided into 2 categories: substance abuse, which is a pattern of substance use leading to significant impairment in functioning, and substance dependence, which is the more serious diagnosis and includes, in addition to substance abuse, "continuation of use despite related problems; . . . increase in tolerance . . . ; and . . . withdrawal symptoms."[37]

A debate within psychiatry that illustrates its reliance on an individual medicalized model of understanding is the efficacy of a categorical, compared with a dimensional, classification system of disorders. Discussions about adding a dimensional component to the DSM has been ongoing for many years,[38] with dimensional measures gaining influence since the publication of the DSM-III-R in 1987.[39,40] A categorical diagnosis is based on a binary distinction—an individual is either positive (has the disorder) or negative (does not have the disorder). Although there is recognition that there may be overlap between disorders, the focus is on diagnosing specific mental disorders. In contrast, a dimensional diagnosis is based on 3 or more categories or traits, with people placed on a continuum of traits from minimal to extreme.

Helzer et a1[40] offer a model for creating dimensional diagnoses for substance abuse disorders, with particular focus on alcohol use disorders. They argue that substance abuse and dependence are best viewed on a continuum rather than as 2 discrete disorders. Advantages for the incorporation of dimensional classification into substance abuse disorders can include compatibility with neurobiological research, potential to address and measure polysubstance use and comorbidity with other DSM disorders, ability to provide a uniform approach within addiction studies, and promise to create population norms that are sensitive to gender, ethnicity, and culture.[40] Thus a dimensional classification may be able to account for information not provided by a categorical diagnosis alone.[41]

Despite psychiatry's individualistic traditions, there has been movement away from focusing strictly on the reduction of psychiatric symptoms and toward greater understanding of individual experiences of meaningful living.[42,43] This includes discussing the role of culture within the discipline, in particular in preparation for the DSM-5.[39] For example, the most recent version of the DSM-IV for the first time includes a section on cultural variations for DSM disorders. It identifies 5 distinct aspects of the cultural context for assessing and caring for mental illnesses. For example, the clinician is advised to explore cultural explanations for the diagnosable illness. Scholarly reaction has been mixed. Whereas Manson[30] identifies it as a step forward in acknowledging the role of culture in defining and treating mental illness, others[44] counter this with concern over the implied universality of the DSM categories. According to Kirmayer and Minas,[44] the DSM-IV "introduces cultural considerations as just minor qualifications to what are presumed to be culture-free diagnostic categories."[p 439]

Just as there has been little attention paid to culture within the DSM specifically, and psychiatry generally, there too has been minor attention allotted to the abuse of solvents. A 2000 Viewpoint article[45] in the Canadian Psychiatric Association *Bulletin,* describing a solvent-using client, solely mentions that "solvent abuse had contributed to his intellectual problems as well as exacerbating his psychotic disorder."[p 88] Similar to the medicalization of substance abuse within psychiatry generally, the documentation of solvent abuse that exists likewise focuses on diagnosing the individual with little attention toward

broader etiological factors or cultural context. For example, the work of Duggal et al[46] relays the case of a male aged 18 years, referred to as P, who started sniffing gasoline when aged 6 years. Although the authors briefly mention the desirability of a holistic approach (including family history and premorbid temperament), their psychiatric-informed response was dominated by pharmacological interventions.

The story of a client's experience at the Nimkee NupiGawagan Healing Centre relays a first-hand account of the need for cultural understanding in psychiatric diagnosis of a First Nations youth who abuses solvents. Pseudonyms are used in this story, and throughout our paper's stories, to protect anonymity.

> *Story from the treatment centre.* Cory is typical of many of the youth admitted to Nimkee's Healing Centre. She is 14 years old and has been abusing solvents for nearly 3 years as a way of coping with pain and trauma in her life. Within 72 hours of arriving at Nimkee, like all youth, Cory was sent for a mandatory physical and psychological assessment within the Western medical system. This is the first time Cory has travelled away from her land, territory, language, and people; naturally she is very quiet and shy. She is also experiencing the physical manifestations of detoxifying from the solvents she used before her admittance. As often happens with the youth at Nimkee, Cory's assessment identifies her as high risk and depressed, and consequently she receives a prescription. This was a common occurrence for youth at Nimkee 5 years ago. Today, with mutual cooperation between Nimkee and the Western health services system, including sharing Aboriginal and Western world views with one another, the general practitioner and the psychiatrist do their assessments at the treatment centre. They try to address assessment issues through Nimkee's cultural ways (for example, Elder) before medication is prescribed.

Method

A search was initiated to identify literature published in *The CJP* from February 1998 to June 2008 that addressed the treatment and healing of Aboriginal Peoples for mental health and substance abuse-related issues. We chose to focus on *The CJP* because of its Canadian focus, psychiatry orientation, and impact factor (3.026 in 2007). The search terms included: Aboriginal, First Nation, Indian, Métis, Inuit, Eskimo, indigenous, North American Indian, mental health, mental wellness, psychiatry, addiction, substance abuse, and derivatives thereof. We excluded letters to the editor, book reviews, editorials, biographies, and articles that were only marginally relevant. From a total of 118 articles in *The CJP*, 12 were selected as satisfying the selection criteria noted above. Most were retrieved from a 2000 issue, in which Aboriginal mental health was highlighted. Given the small number of articles, an additional search of 15 years prior was conducted, with a total of 10 additional articles selected. However, these articles were significantly dated and so contributed little to our paper. We then conducted a larger search of the Canadian and select international literature with Academic Search Complete and available federal and provincial government documents. Academic Search Complete is a comprehensive, scholarly, multidisciplinary full-text database, with more than 5300 full-text periodicals, including 4400 peer-reviewed journals, and abstracts for more than 9300 journals, and a total of 10 900 publications, including, for example, monographs, reports, and conference proceedings. We investigated the same terms listed above, and added the terms solvent, volatile, and inhalant abuse. A limited number of documents were identified.

Results

A prevalent finding within the Canadian literature was a significant gap in understanding and practice between Western psychiatric diagnosis–based and Aboriginal culture–based approaches to treatment and healing for substance abuse specifically (including solvent abuse) and mental health problems generally. This result centres on disparate understandings of mental health and wellness. Very little literature was uncovered specific to solvent abuse. We described above the major differences between Aboriginal and Western psychiatric world views: holistic understanding of mental wellness that accounts for community relations, compared with classification based on an individualized medical understanding. Based on 3 dominant themes identified within the literature—connection with self, community, and political context—we discuss each from the differing worldviews and provide an illustrative story based on the front-line experiences of workers at the Nimkee NupiGawagan Healing Centre. The stories were collected, verbally, from the Executive Director of the centre, who has had direct contact with the staff and youth since it opened in 1997. Stories were later verified with staff. The stories are provided to help the reader better understand the key components of the 2 world views, as well as relay the limitations of imposing strictly Western psychiatric–based diagnosis and treatment responses onto First Nations and Inuit youth. The transformative power of storytelling is well-documented among Aboriginal scholars and Elders alike (see King[1] and Mehl-Madrona[47]).

Connection to Community

Western orientations toward health concentrate on the absence of disease.[48] By extension, mental health, including substance abuse, is defined as the absence of mental disorder. As discussed, psychiatry concentrates on diagnoses based on a system of classification. This system, whether categorical or dimensional, emphasizes an individual's healthy mind.[38,39]

Conversely, an Aboriginal world view of mental health asserts a holistic approach that accounts for cultural context and considers the person and the community (relations among the person and community) and their past, present, and future intersections.[7,47,49,50] Community is comprised of "the land, people, and the nonphysical world and their

inter-connections. For example, the Whapmagoostui Cree of Northern Quebec."[2, p 149] For example, Wieman, referenced on the Anishnawbe Health Toronto website,[51] explains that an Aboriginal culture–based understanding of mental wellness includes "having good social relationships . . . [and] having a sense of connected-ness to the community." To further illustrate, the Whapmagoostui Cree of Northern Quebec do not have a Cree translation for the Western word health, but rather refer to being alive well—wiyupimaatisiiun—which emphasizes community, history, identity, and resistance. It follows that to not be alive well may not mean a pathological condition of the individual, but instead, something pathological in society.[48]

> *Story from the treatment centre.* Many of the communities from which the youth who attend the Nimkee NupiGawagan Healing Centre are characterized by pain and trauma from the impacts of colonization. Most of these communities have little knowledge of their traditional cultural practices and beliefs. From one community in particular, a young boy by the name of Joseph attended Nimkee and learned of his cultural heritage. He learned and adopted spiritual beliefs. This spiritual connection facilitated a connection to his true identity. A part of Nimkee's programming is involvement of the immediate family (that is, parents or guardians) in one week of the youth's residential treatment process. This is done in a sensitive manner such that the parents are not insulted, or reject outright, the traditional teachings their children are learning. Joseph's family attended the centre and also learned about their cultural heritage, which made it possible for them to practice their beliefs as a family when they returned to their home community. It followed in this case, and frequently in other cases, that once Joseph returned home, other children from the family, and extended family, requested to attend the centre. The youth are very connected through their place in the community, and this transfers to the healing of not only the youth who attended treatment but also their families and communities.

Connection to Self

Aboriginal conceptions of mental health do not assume the mind–body dichotomy or dualism that frames Western psychiatric beliefs about mental health.[30,52,53] Waldram[54] explains that an Aboriginal world view focuses

> more on developing an understanding of the body and mind as a whole, and on how illness is symptomatic of an imbalance between the individual, the society, and the spiritual realm.[p 71]

As such, the term mental wellness is more appropriate, as it incorporates physical, mental, cultural, and spiritual elements of health.[55] This is evident in the work of Health Canada's First Nations and Inuit Health Branch *Mental Wellness Strategic Action Plan for First Nations and Inuit*.[56] The Framework conceptualizes mental health as

> a lifelong journey to achieve wellness and balance of body, mind and spirit. Mental wellness includes self-esteem, personal dignity, cultural identity and connectedness in the presence of a harmonious physical, emotional, mental and spiritual wellness.[56, p 1]

Aboriginal health practices attempt to restore a sense of balance, harmony, and coherence for a person and nurtures their inner spirit.[57,58]

> *Story from the treatment centre.* A traditional teaching offered to the youth at Nimkee is that their identity, values, and language are innate within their inner spirit but may be dormant. They are taught that they have a genetic memory. The cultural environment at Nimkee helps to nurture the youth's inner spirit. For example, the youth are able to quickly participate in a sweat lodge once at Nimkee because their spirit is awakened and this is what motivates the youth to do what they do. This is what happened for Jamie. He was afraid of the dark, of taking off his shirt in front of others, and of sitting close to others. Because the sweat lodge is a cultural activity, the youth are motivated by their inner spirit to participate. Jamie did. This is different from a decision to play floor hockey, for example, because it is something to do. The spiritual part of the youth's being needs to be in balance with the emotional, mental, and physical aspects of their self, and so they are internally motivated to take part in cultural activities to achieve this. A person's spirit causes their heart to beat, their blood to flow, and the movement of energy. Youth like Jamie become quickly attuned to this once in the Healing Centre environment.

Connection to Political Context

Health, in particular for First Nations and Inuit in Canada, is imbued with social, political, and economic influences and must be viewed within historical and continually shifting parameters.[2,48,52] The impacts of intergenerational trauma, owing to assimilation policies and practices in Canada, must be considered when addressing the current mental health and coping strategies (for example, substance abuse) of First Nations and Inuit. Kirmayer et a1[49] concur and argue that a historical perspective is necessary to avoid "psychologising"[p S20] political issues. To illustrate, issues such as "secure attachment and trust, belief in a just world, a sense of connectedness to others, and a stable personal and collective identity,"[49, p S20] all particularly relevant to the history of colonization of Aboriginal Peoples in Canada, are not accounted for in psychiatry's diagnosis of posttraumatic stress disorder.[49] McCormick[59] elaborates:

> [C]ounseling grounded in Aboriginal values and perspectives . . . start[s] with the recognition that substance use and related mental health problems are not only symptoms of individuals' distress but also efforts to cope with untenable social situations brought on by a history of collective oppression.[p xix]

> *Story from the treatment centre.* The impacts of residential schooling are evident in the generation

> of today's Aboriginal youth who are having strained relationship issues with their parents and extended caregivers. When Janice completed the Nimkee program, she, like many of the other youth in the program, said one of the greatest things to come from it was her ability to communicate better with her parents, and to trust that she will be heard. While in the program Janice spoke on a regular basis with her parents by telephone, and her family was brought to the treatment centre for a week to participate alongside her in her treatment journey. Her family learned how important it was that they communicate effectively with Janice and that they encourage and speak positively with her and their other kids. Her parents also learned about the stages of youth development and cultural understandings of parenting. Janice also relayed, again as most other youth do, that the most meaningful part of her time at Nimkee was participating in cultural programming. This includes, traditionally, learning about parenting. Healthy parenting skills have been critically impacted, owing to the history of colonization of Aboriginal Peoples in Canada (for example, residential schooling).

Discussion

The Nimkee NupiGawagan Healing Centre's adoption of a culture-based model of resiliency is loosely akin with a Western approach to health promotion; that is, it neither focuses solely on the eradication of an illness or a disease. From a health promotion perspective, health is understood to be a state of unity or balance across the physical, mental, social, and spiritual components of a person's well-being, rather than merely the presence or absence of disease. This corroborates with the World Health Organization's holistic definition of health. Connection to self, community, and political context, including the determinants of health, can be accounted for within a health promotion framework. The historical drawback of the disease-based approach has been the majority placement of substance abuse outside the context of this understanding; there has been a lack of recognition of the impacts of the determinants of health. The underlying assumption of a determinants of health perspective is that "reductions in health inequities require reductions in material and social inequities."[60] Quite simply, "[t]he conditions in which people grow, live, work and age have a powerful influence on health. Inequalities in these conditions lead to inequalities in health."[61, p 2] There is increasing acceptance of this approach within Canadian health care generally, and within the fields of substance abuse and mental health specifically.

The Assembly of First Nations[62] and others[63] have added to this understanding of the determinants of health, and propose indigenous-specific indicators of well-being. In addition to the determinants of health commonly applied within the mainstream (for example, income and social status; education and literacy), Aboriginal-specific indicators include, for example, health care, lands, and resources, and language, heritage, and culture.[62] Health Canada's current Mental Wellness Framework for Culturally Appropriate Mental Health Services in First Nations and Inuit Communities[56] likewise places mental health and addictions issues in the context of the broad determinants of health. Simply stated, "[t]he social origins or prevailing mental health problems require social solutions."[49, p S21]

Nowhere is the need for this holistic understanding more evident than within the realm of solvent abuse among First Nations and Inuit youth. Research has shown that chronic solvent abusers are disproportionately located in impoverished social environments and are more likely to use solvents as a coping mechanism (for example, to suppress emotional pain).[64–68] Solvent abuse cannot be understood in isolation from the relationship between large social issues and individual people. The whole person, alongside social and political processes and structures, needs to be accounted for in understanding and responding to any health issue, including solvent abuse. A health promotion approach, with its focus on the determinants of health, offers an opportunity for synthesis between Western diagnosis–based and Aboriginal (for example, a culture-based model of resiliency) world views.

In the attempt to apply a more inclusive understanding within psychiatry, conventional models of service and health promotion must be fundamentally rethought so that they are consistent with Aboriginal realities, values, and aspirations. The magnitude and complexity of this task is demonstrated by Waldram,[54] who found that behaviour that may be viewed as pathological by psychiatrists in the Canadian prison system may in fact be viewed by Elders as culturally appropriate. He explains a case in which "[b]iomedicine identified an abnormality, a psychopathology, [and] which was de-problematized by the Elder when placed within its proper cultural context."[54, p 184] The work of Wieman[69] at Six Nations Mental Health Services, similarly relays the importance of, and challenge for psychiatry and other mental health practitioners to respect local values and traditions and connect with community networks when providing care.

Consider John's experience at the Nimkee NupiGawagan Healing Centre. This story relays an Elder's simultaneous reliance both on Aboriginal (traditional medicine) and on Western (behaviour modification) approaches to treatment and healing.

> *Story from the treatment centre.* When John started at Nimkee he learned that he had to take part in a spiritual assessment (for lack of a better word) with an Elder. The Elder does a type of reading through which he is able to see negative energy blocks in a person. The Elder can tell from this whether the youth needs certain medicines, for example, or a feast. A lot of youth like to participate in the assessment because it is a time when they can have their name, clan, and colours identified to them. When John arrived at Nimkee it was quickly evident that he used his size to intimidate, control, and bully others, including Elders. In John's assessment, the Elder said he saw a trauma near John's neck, and John responded that he had never tried to commit suicide. The Elder continued

> to see this energy at John's neck, and John eventually relayed that his father tried to stab him in the neck when he was a young boy. The Elder told John that this block needed to be moved because John could not express himself with his voice, and as a consequence, he was compensating by being physical.
>
> The Elder held a spiritual intervention; he sang traditional healing songs, used his hands to move the energy block, prayed, and used traditional medicines. They included blueberries and unshelled peanuts. The Elder told John that when he felt himself getting angry, he needed to ask the staff for his medicine. Blueberries are a sacred traditional medicine as they are the first food to be offered by the earth. They will assist John in reconnecting with his internal energy and strength. Shelling peanuts gave John an activity to occupy himself with and time to reflect on his emotions and return to a calmer state of being. The Elder also encouraged John to speak with his counsellors each time he finished his medicine.

A fundamental shift in thinking will require both the discipline of Western psychiatry and those who work within it to question their own sense and placement of self, community, and political context. Vicary and Bishop[52] and Haggarty and O'Reilly[45] suggest that mental health professionals need to educate themselves in traditional Aboriginal approaches to treating mental illness and the role of culture in mental well-being to be able to consider their relevance to mainstream psychiatry practices. Reflecting on how to accomplish this type of education, Pazaratz[70] draws on his experiences with training staff at a residential treatment centre for Northern youth, and suggests that "staff need to be versant with their own experiences or socialization acculturation. They must understand the basis of their own beliefs, mindsets, and assumptions."[p 24] They must also be willing to take up the challenge of doing this. The consequence, according to Chaimowitz,[55] can be recognition that "Aboriginal concepts of problem-solving, reparative justice, and healing can contribute to [psychiatry's] . . . own set of experiences and knowledge base."[p 606]

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Résumé : Des benzos aux petits fruits : le traitement offert à un centre de traitement pour abus de solvants chez les jeunes Autochtones souligne l'importance de la culture

Les jeunes des Premières nations et Inuits qui abusent des solvants constituent l'un des groupes de toxicomanes les plus stigmatisés du Canada. S'inspirant de la réponse au traitement en résidence qui est fondé sur un modèle culturel de résilience, cet article discute des implications culturelles de l'approche individualisée de la psychiatrie pour traiter les troubles mentaux. Une revue systématique des articles publiés dans La Revue canadienne de psychiatrie au cours des 10 dernières années, doublée d'une revue de la littérature canadienne et internationale, a révélé un écart de compréhension et de pratique du traitement et de la guérison de la toxicomanie et des troubles mentaux entre l'approche psychiatrique occidentale basée sur les troubles et l'approche autochtone basée sur la culture. Les conceptualisations divergentes de la santé mentale et de la toxicomanie sont discutées du point de vue de la psychiatrie occidentale et autochtone, l'accent étant mis sur le lien à soi-même, à la collectivité et au contexte politique. Appliquant une méthode autochtone de transfert des connaissances — raconter des histoires —, les expériences des travailleurs de première ligne d'un centre de traitement d'abus de solvants pour les jeunes font état des difficultés d'appliquer des réponses occidentales à la guérison autochtone. Ceci prête à une discussion sur la façon dont la psychiatrie peut profiter du débat grandissant à propos du rôle de la culture dans le traitement des jeunes Autochtones qui abusent des solvants. Il y a un besoin significatif de recherche psychiatrique compétente en matière culturelle portant spécifiquement sur le diagnostic et le traitement des jeunes Inuits et des Premières nations qui abusent des substances, dont des solvants. Cette compréhension pour les psychiatres de première ligne est nécessaire afin d'améliorer la pratique. Une perspective de promotion de la santé peut être un point de départ valable pour parvenir à cette compréhension, car elle situe l'approche de la psychiatrie du traitement des troubles mentaux dans le cadre de l'étiologie des peuples autochtones.