TRADITIONAL MEDICINE IN SOCIAL WORK PRACTICE

by

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An MRP

presented to Ryerson University

in partial fulfillment of the

requirements for the degree of

Master of Social Work

in the Program of

Social Work

Toronto, Ontario, Canada, 2019

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ABSTRACT

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This partial grounded theory study explores the topic of Traditional medicine in social work practice in Toronto, Canada. Given the dearth of knowledge in this area, I wanted to explore the contrapuntal nature of two social workers' practice who refer to Traditional Medicine, and to conceptualize further on this approach. Social work literature and practice has paid little attention to this topic despite the field's purported commitment to equity and social justice. This is largely a reflection of how greatly we take for granted the bias towards Western medicine in our public health care system and in the social work referral system that is aligned with it. The World Health Organization defines Traditional medicine as: "Health practices, approaches, knowledge, and beliefs incorporating plant, animal, and mineral based medicines, spiritual therapies, manual techniques, and exercises, applied singularly or in combination to treat, diagnose, and prevent illnesses or maintain well-being" (Fokunang et al., 2011). Such approaches, which are based on Indigenous and non-Western ways of knowing are not covered by the Ontario Health Insurance Plan (OHIP), and thus remain largely inaccessible to the most financially marginalized. This is a problem for those who cannot afford to pay out of pocket for their health care. It is a grave disservice to those whose culture does not align with Western medicine; those whose health conditions have not been helped by Western medicine; and those who require a combination of Western and Traditional approaches to bring them to full health. This research explores the knowledge, experience, and processes of two social workers in Toronto who refer clients to Traditional medicine in spite of the structural bias towards Western medicine and its approaches.

Key Words: Traditional medicine, social work practice, contrapuntal approach, decolonization, the Medicine Wheel, Toront

ACKNOWLEDGEMENTS

I wish to thank the individuals who helped me see this MRP to completion: My family and friends who helped me through their guidance, encouragement, and regular check-ins; my supervisor, Purnima George for her detailed and constructive feedback, her warm and gentle manner, and the way she allowed this process to unfold at my own pace; and finally, the research participants who were so generous in sharing their time and experiences with me. I have grown a lot through this experience, and I feel that it has made me a more confident, steady, and focused person. I am also grateful for the fact that I listened to my hunch to do my MRP on the topic of Traditional Medicine in social work, and for the people and experiences that have helped shape my awareness of and interest in this topic over the years.

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CHAPTER 1. INTRODUCTION

Social workers in Canada see some of the most financially marginalized in society. Many of these people have complex physical and emotional health concerns on top of, and indeed tied to social issues such as poverty, homelessness, and domestic abuse, to name a few. Referrals by social workers for medical assistance have been constrained by two factors. First is a government supported health system based solely on allopathic medicine – an approach to health based on surgery and drugs that treats the symptoms of health conditions rather than underlying causes (Dean, 2005). And secondly, because of political manipulation and unscientific research (Dean, 2005), government health care funding only supports the allopathic paradigm. Dean (2005) writes, "as long as allopathic medicine remains the gatekeeper for access to health services and insurance reimbursement, health providers with other skills will not be allowed to play in their sandbox" (p.4). Traditional medicine, including herbalism, osteopathy, chiropractic, naturopathy, acupuncture, massage, and homeopathic medicine, is not covered by government funded plans (e.g. Ontario Health Insurance Plan), and thus, the effectiveness of Traditional medicine on chronic illnesses is lost to the social work referral system. If social workers theoretically offers the potential for change in the lives of service users, they have a professional as well as an ethical responsibility to make social work practice inclusive of individual clients' different cultural beliefs and practices related to health and the range of medical alternatives – particularly the traditional medicines that offer a long history of a return to health for those with chronic illness.

Canadians have, for a long time been subjected to publicity promoting the benefits of 'modern medicine' – the paradigm of drugs and surgery promoted by allopathic medicine. The idea of taking a pill that makes you instantly well has won over other approaches. However, this approach has ignored many underlying issues and left many more in its wake. Examples of such issues are the unforeseen reactions to drugs (including death) (Dean, 2005; Gaist et al., 2002; Healy, 2006; Moore, Cohen & Furberg, 2007); the delayed onset of cancer due to toxic chemicals (Colborn, Dumanoski, & Myers, 1996); and the pollution of waterways due to unused pills (Cheer & Moss, n.d; Kolpin et al., 2002). In addition, the capitalist system that places shareholder profits over patients' health (Angell, 2005; Brown, 2004; Dean,

2005) has endorsed a coordinated industry-wide response that includes: manipulation of research data and results (Armstrong & Winstein, 2008; Thompson, Baird, & Downie, 2001), widespread lobbying of political processes (Angell, 2005; Brown, 1981; Dean, 2005; Heyman 2003), false and misleading advertising (Russell, 2008), biased doctor education (D'Adamo, 2002; Dean, 2005) , and the creation of government regulatory bodies to hide drug ineffectiveness and prevent the use of Traditional medicines (Brown, 1981; Dean, 2005). A striking quote by Gandhi reads: "I have endeavored to show that there is no real service of humanity in the profession of medicine and that it is injurious to mankind" (as cited in Dean, 2005, p. 8). Baffling as this may seem, perhaps there is truth to it. It has taken considerable effort on the part of many dedicated individuals to show that governments, regulatory agencies, research organizations, medical journals and doctors have been "bought" (Dean, 2005). With this background in mind, the purpose of this research is to examine Traditional Medicine as an important, yet often overlooked tool in social work practice in Toronto, Canada.

A Note on Terminology

I use the term Traditional Medicine to refer to non-allopathic medical and healing approaches. The most prevalent term in the literature around this topic is 'Complementary and Alternative medicine', or 'CAM'. While I began this research intending to use the term CAM, I increasingly found it to be problematic. As Gale (2014) notes, the term 'CAM' re-asserts biomedical dominance, and takes for granted the history through which this dominance came to be. She writes, "the naming process is a glimpse into the complexities of power and history that characterize the field" (p. 805). Adding to this, Johnston (2002) notes that "for some Native Americans, and perhaps in some entire native societies (Csordas 2000), biomedicine appears to be the "alternative" medicine, that is, the one less likely to be preferred or sought first" (p. 197). Thus, for Gale, writing in the context of Native American healing systems, the term 'alternative' is "a relative and not particularly useful term in and of itself"(p.198), as it simply denotes choice. In addition, the term 'CAM' is ambiguous because it encompasses two very different attitudes towards biomedicine, and in grouping them together, is not clear about which one it

espouses. Complementary reflects an intention of working *with* biomedicine, while alternative reflects an intention of working outside of it.

My Personal Experience with Non-Allopathic Medicine

My interest in this topic stems from my personal experiences with both allopathic and Traditional medicines. Non-allopathic therapies have enabled me to recover from both a back injury (via chiropractic therapy) and from a concussion (via osteopathic medicine). In both cases, I originally sought the help of allopathic medicine, yet in the absence of positive results, I later turned to non-allopathic approaches, and found these to be much more gentle, holistic, and effective modes of recovery. I will share one of these occurrences in detail below.

At the age of eleven I retired from competitive gymnastics due to a back condition I had developed over time called spondylolysis. This is a common injury among gymnasts and figure skaters due to these being high impact sports that put intense strain on the back. After a Computerized Tomography (CT) scan diagnosed the injury, I sought the medical attention of an orthopedic doctor (the obvious and most sensible route my parents knew of at the time). The treatment I received involved wearing a back brace twenty-three hours a day for a full year and attending regular physiotherapy where I was given a series of strengthening exercises. However, after a full year of wearing the brace, the results of a second CT scan showed that my injury had not improved, nor even stayed the same – it had actually gotten worse. I was told that the condition had changed from *spondylolysis* to *spondylolisthesis*. The doctor I saw could not explain why it had gotten worse, and he did not offer any further solution except to continue physiotherapy and limit high impact sports.

I continued to reduce my physical activity after this, which gradually helped ease the pain, but I learned to live with a certain degree of malaise in that part of my back. About fifteen years later, upon the recommendation of a friend, I decided to see a chiropractor. After the first session I noticed a significant improvement, not just in my back, but in my legs and overall alignment of my body. Over several sessions I started to feel less strain in that area of my back and more steady on my feet. It made me realize

the trauma that I had been carrying around in my body for years. I saw that I had chosen to ignore my symptoms and had developed an attitude of being *tough* and *pushing through* which only added to the stress on my back. The chiropractic treatments allowed me to cultivate a different way of being in my body. I realized that rather than being *against* my body I could be more in tune with it.

In addition, the chiropractic treatments helped me to understand the fundamental connection between the physical body and emotional and mental bodies – not merely conceptually, but also experientially. As an example, one day I came to a chiropractic session, and after examining my back, the chiropractor asked me if I had been weighing a difficult decision. Indeed, I had. I asked him how he knew, and he said that the area in between my shoulder blades was especially tight. He said that this spot becomes stressed when we go back and forth in our minds about a decision. When he explained that, I could feel the truth of what he was saying. This recognition alone was therapeutic and enabled him to tailor the treatment to my needs *in that moment.*

Reflecting on how this same back condition was treated by the chiropractor compared to the orthopedic doctor years earlier, I realize how greatly the two systems of medicine differ. Allopathic medicine did not allow for this kind of individualized and sensitive treatment. Additionally, I recognize that even within non-allopathic care, depending on the practitioner, a high level of sensitivity, time, and individual attention is not necessarily a given.

Thus, my research on Traditional Medicine is driven by my experience that it can offer viable solutions to health issues and that, beyond this, it can open us up to a deeper understanding of, and relationship with our entire being – mind, body, emotion and spirit. At the same time, while I come to this topic with a degree of embodied knowledge and experience, this hinges on the privilege that my social location has afforded me. Family finances have allowed me to choose the non-allopathic route when allopathic medicine failed me. This is a financial privilege that many do not have. In addition, I recognize that practicing social work as a white, Jewish, cis-gender, heterosexual, able-bodied woman, in the context of ongoing colonization and racism against Indigenous people, their land, as well as all other

forms of hierarchical oppression, my voice is privileged over those who have to fight to have their voices heard.

Research Purpose

The purpose of this research is to learn about the process by which social workers in Toronto, Ontario refer their clients to Traditional Medicine. The three main objectives of the research are as follows: 1) to explore the value and knowledge base of social workers as it relates to Traditional Medicine; 2) to understand the obstacles to accessing Traditional Medicine and how to push for change; and 3) to understand how social workers decide whether to refer to allopathic/orthodox medicine or Traditional Medicine, or both.

The topic of Traditional versus allopathic medicine is rarely discussed in social work literature, education, and practice. This is troublesome seeing as social workers have an important presence in medical settings such as hospitals and community health centres. In addition, even when social workers are not placed in these settings, they are likely to encounter people who are dealing with health issues, or those who are under significant stress due to systemic racism and marginalization, thus making them more vulnerable to stress-induced illnesses and disease. In addition, these individuals may have experienced trauma and discrimination as a result of the medical system itself. Since social workers are often the first professional point of contact for these individuals, as well as their bridge to other services, they are potentially more influential in that person's wellness and healing journey than they may realize. It is important for social workers to challenge the status quo of Western medicine and explore the knowledges and perspectives that have been cast to the margins with regards to health and wellness. This includes the very philosophy and foundation on which our system of medicine is built. Many of us in the West take for granted the notion of Cartesian Dualism which treats the mind and body as separate. While Traditional Medicines vary widely and cannot easily be grouped together, they are commonly holistic in nature. Unlike Western medicine, they typically honour the connection between mind and body, as well as emotion and spirit. It may be wise for social workers to really consider that this separation between

mind and body is a cultural and indeed colonial formation, and thus to challenge and question the status quo of Western medicine. By bringing these issues and tensions into the purview of social work, we may find that it brings a new dimensionality to practice and deepens the possibilities for transformative and decolonial work. Decolonization involves being clear and honest about how colonization and the coloniality of power continues to dehumanize and take freedom away from Indigenous people. The work of decolonization must be achieved by re-evaluating the power dynamics in today's systems that are racist and designed to denigrate Indigenous communities and deny them their right to the land and to their unique cultures, languages, customs, and systems of knowledge. Hence, in order to be true, this work must stem from within Indigenous communities themselves, and it is us settlers that must follow their lead.

Here I provide a brief outline of the chapters that follow. In the next chapter, Chapter 2, I provide a literature review, looking at two broad sets of empirical studies: those that bring light to some of the harms of Western medicine, focusing specifically on iatrogenesis and Adverse Drug Reactions (ADR's) in hospital settings. I also look at studies that show the efficacy of Traditional Medicine and the reasons why people find it beneficial, drawing on key themes that emerged between these studies. I then conduct a critical analysis of these studies, addressing the strengths and limitations of the methodologies and theoretical frameworks employed, and the knowledge that was produced. In Chapter 3, I shift focus to the research that I have conducted for my MRP, outlining the three theoretical frameworks that I have chosen to guide my research: the Medicine Wheel, decolonization, and the contrapuntal approach. I will explain how each is relevant to the topic of Traditional Medicine in social work practice, concluding with a recent example from Canadian society that illustrates what is at stake in the issue of Traditional versus allopathic medicine, especially for Indigenous communities. In Chapter 4 I discuss the methodology I have chosen, which is Grounded Theory, and I explain the rationale for this choice. Then, in Chapter 5, I present the findings from my research, which I group by themes. Since few participants were recruited for this study, a substantive theory could not be developed (Corbin & Strauss, 1990). However, in the discussion

chapter, Chapter 6, I will provide working concepts and connections, as well as ideas for further study. I then present final thoughts about the issue of traditional medicine in social work practice in the concluding chapter, Chapter 7.

CHAPTER 2. LITERATURE REVIEW

A review of empirical studies on Traditional and allopathic medicine will help lay the groundwork for further discussion and inquiry into the topic of Traditional medicine in social work practice. The studies reviewed can be divided into two broad categories: 1) those showing the harms and failures of allopathic medicine; and 2) those showing the efficacy of and reasons for using Traditional Medicines. These themes are important to examine in tandem with one another, as the reasons for choosing Traditional medicine may become more compelling when the limitations, harms, and failures of western medicine are brought to light. Likewise, highlighting the efficacy of and rationale for the use of Traditional medicine is important in order to allow Traditional medicine to achieve greater respect in both social work and in Canadian health care at large, given that the medical model still dominates in these fields.

Harms & Limitations of Allopathic Medicines

There are numerous issues that could be undertaken in discussing the harms and limitations of western or allopathic medicine, as well as the social and bureaucratic infrastructure surrounding it. Such issues include the sustained inattention to nutrition in Western medicine as written about extensively by Dean (2005), and the lack of ethics training in some medical schools (Dean, 2005). In addition, political maneuvers have been undertaken in recent years in Canada to restrict non-Allopathic doctors from practicing. For instance, Dean (2005) cites numerous examples of naturopathic doctors (herself included) who have had their medical licenses revoked by provincial and state licensing boards such as the College of Physicians and Surgeons of Ontario (CPSO). The lawsuits that followed from these are evidence that such regulatory bodies may be "more interested in protecting the allopathic monopoly in the practice of medicine than in the health and well-being of patients" (Dean, 2005). Given the short time frame and limited space for this paper, however, I have chosen to focus on just one area of concern with respect to western medicine which comes from within the western medical establishment itself: that of iatrogenesis and adverse drug reactions (ADRs).

Iatrogenesis & Adverse Drug Reactions (ADRs)

Iatrogenesis refers to the inadvertent and preventable incitement of a disease or medical complication by a given treatment or medical procedure (Merriam Webster, n.d.). Adverse drug reactions (ADRs) are one type of iatrogenesis, and as the following literature shows, ADRs and other iatrogenic illnesses are a major issue in hospital settings where allopathic medicine has primacy. Kane writes about iatrogenesis in his (1980) editorial review entitled *Iatrogenesis: Just what the doctor ordered*. He reminds us that in a technologically advanced society, there involves a delicate balance between 'doing good' and 'causing harm'. For Kane, iatrogenesis is "ubiquitous", and thus (p.149), "the salient issue is not whether iatrogenesis occurs or how it can be avoided, but rather how it can be identified and minimized" (p.149). Kane leaves us with more questions than answers, a crucial one being: "When do the costs outweigh the benefits?" (p. 154). The empirical studies I reviewed on ADRs all come from the 1970's and 1980s, however as Dean (2005) writes in the introduction to her book *Death by Modern Medicine,* the number of ADRs reported by the Federal Drug Administration (FDA) has increased dramatically in recent years. She states, "even with so much attention on the dangers of modern medicine, the following inventory compiled by the FDA's Adverse Event Reporting System for the years 1998-2005 shows that it's just getting worse" (Dean, 2005, p.5). Additionally, she warns that this reporting system is "voluntary, not mandatory and research shows that only about one out of ten adverse events are even reported to the FDA" (p.5). The report states that between 1998 and 2005 serious adverse drug events increased by 260%, and fatal drug events increased by 270%. (Dean, 2005 p. 5). With this present-day reality in mind, I bring attention to several major studies on ADRs from the late 1970s and early 1980s.

Steel, Gertman, Crescenzi, & Anderson (1981), Schimmel (2003), and Mitchell, Goldman, Shapiro, & Slone (1979) each contributed to the empirical literature on iatrogenic illness and ADRs. Steel et al. (1981) found that 36 percent of 815 consecutive patients had an iatrogenic illness during their hospitalization (an ill effect not accounted for by their disease). They classified these events as 'major' and 'minor' and found that 76 patients, or nine percent of all 815 patients had a major iatrogenic illness

where ‘major’ was seen as something life threatening or something that “produced serious disability that was present on the patient’s discharge from the hospital” (p.639). In this study, an iatrogenic illnesses was believed to have contributed to death for 15, or two percent of all patients.

Similarly, In Schimmel’s (2003) study investigating 1,000 patients, they found that 30% of patients admitted to hospital experienced one or more “untoward” event stemming from one of the following: diagnostic procedures, therapeutic drugs, transfusions, ‘other therapeutic procedures’, acquired infections, and ‘miscellaneous hospital hazards’ (p. 59). An interesting finding in Schimmel’s (2003) study was that the risk of having such an episode seemed directly related to the length of stay in the hospital.

Mitchell et al. (1979) looked specifically at the clinical effects of drugs in hospitalized children, collecting information for 1669 children from the years 1974-1977. They found that children received an average of 7.6 drugs during an average hospital stay of 8.4 days. Adverse clinical events (whether attributed to drugs or not) occurred in 45.7% of the patients, while those deemed ADRs occurred in 16.8% of the patients, however among oncology patients, ADRs were reported in 52.5% of oncology patients . The most common ADRs were vomiting, rashes, injection site complications, nausea, leukopenia, and diarrhea. Drug use and ADRs increased with the age of the patient. Newborns, however, were given many drugs and ranked lowest on ADRs, but had the highest rate of adverse events not attributed to drugs. This suggests that some of the adverse events in infants may have been ADRs that were simply not recognized as such at the time of the study.

Efficacy & Reasons for Use of Traditional Medicine

This section will explore Traditional medicine: its efficacy, common themes, and reasons why people turn to Traditional medicines. First, it must be noted that it is well beyond the scope of this paper to account for the full range of Traditional medicines, especially given the wide diversity within Traditional medicine itself and my lack of emic knowledge (Padgett, 2008) on the topic. The World Health Organization defines Traditional medicine as: “Health practices, approaches, knowledge, and

beliefs incorporating plant, animal, and mineral based medicines, spiritual therapies, manual techniques, and exercises, applied singularly or in combination to treat, diagnose, and prevent illnesses or maintain well-being" (Fokunang et al., 2011). Thus, Traditional medicine includes a wide range of knowledge and practices. Writing from the "Native American" context, Johnston (2002) states that "the roles of healers are diverse across, and sometimes within societies" (p. 198). Additionally, it must be noted that published scholarly literature is in itself limiting when examining Traditional medicine as it excludes "folk medicine" (Payyappallimana, 2010), or the knowledge and wisdom about Traditional medicine that is transmitted orally within Indigenous societies.

Mindfulness

Various studies tested the efficacy of mindfulness as a tool in addressing physical, mental, emotional, and spiritual conditions. Samuelson et al (2007) introduced mindfulness in different correctional facilities in Massachusetts, United States. They found that mindfulness had a consistent positive impact on three self-report measures: hostility, self-esteem, and mood. Both Kabat-Zinn, Lipworth, Burney, & Sellers (1987) and Zhou, Peng, & Xie (2018) looked at the use of mindfulness as a therapeutic tool for patients with chronic pain. Kabat-Zinn et al. found that ambulatory chronic pain patients had significant reductions in pain over the four years following a mindfulness-based ten week program called the Stress-Reduction and Relaxation Program (SR & RP). Further, it was found that those with higher levels of compliance tended to have the greatest improvements in pain, and the highest compliers strongly ascribed their pain reduction to the mindfulness techniques (p.165). Participants in this study reported a high level of compliance with SR & RP, with over 93% of responders practicing at least one of the intervention techniques after completion of the program (Kabat-Zinn, (1987) p. 172). Zhou et al. (2018) also found mindfulness to be an effective approach to pain management in their population of community dwelling older adults in China. In comparison to Kabat-Zinn et al's study that employed the standard 10-week mindfulness program, the mindfulness program in Zhou et al.'s study was deliberately shortened, thus revealing that a less timely (and less costly) mindfulness program could also be effective

in helping people with chronic pain. Finally, Gray et al (n.d.) looked at the use of mindfulness among Indigenous youth in the United States who presented with issues such as poverty, homelessness, school truancy, and learning challenges. This study had a much different purpose than the other studies on mindfulness, and was unique in the literature in both its purpose and its scale. The study aimed to assess whether mindfulness could help "to heal minds and brains from the oppression of colonialism" (p.302). Qualitative interviews with the youth in Gray's study revealed several fascinating findings. Firstly, students reported that mindfulness practice aligned with their Traditional practices as both emphasized notions of gratitude. In addition, mindfulness helped students become more aware of the impact colonization and oppression was having on their lives. For instance, one student came to understand that "a colonized mind would not allow him to be aware of sacredness in what he was doing when he was fishing or listening to a Traditional story" (Gray in Gray et al., 2013, p. 305). Thus, mindfulness was a tool that, in turn, helped the students re-connect to the land and to their Traditional, spiritual practices. As Gray writes, "one student felt that mindfulness helped her become more peaceful and aware of what she was doing when she listened to her elders pray in her Indigenous language" (p. 305). All ten of the students that Gray interviewed said they would continue mindfulness after the project, and seven of the ten said they would continue mindfulness after they graduated, however there was no follow-up to determine if this was the case.

'Embodiment' vs 'The Body'

Mclean and Mitchell (2018) and Gale (2011) highlighted the notion of 'embodiment' in their studies on Traditional medicines. Mclean and Mitchell (2018) discuss embodiment in their narrative-based study on women who used Traditional medicine during pregnancy. The article defines embodiment as "awareness of and responsiveness to bodily sensations and experiences" (p.2). They add that embodiment also relates to the way in which society is inscribed on the body (p.2). For the women in this study, Traditional medicine was used to help alleviate some of the side effects that come with pregnancy. For example, one woman found massage to be effective in managing her twitchy leg syndrome (p. 6).

Women also expressed that the experience of embodiment helped them during their pregnancy. As one interviewee explained, “the more you engage with it [the body during pregnancy] and allow it a place to be, the more you let it go-and the more you are likely to be able to engage in being in labor” (p.8). The embodiment offered by Traditional medicine was an important practice that helped to counteract the iatrogenic effects that women ill-served by biomedicine experienced.

Gale (2011) also discusses embodiment in her case study on two schools of ‘CAM’ in England, one, a college of Osteopathy, and the other, a College of Homeopathy. The purpose of her research was to explore the body work used by osteopaths and homeopaths and understand how they differed both from one another and from biomedicine. A core concept taught to students was the notion of ‘body stories’, referring to the idea that people’s embodied experiences are literally stored in their tissue. Body stories in homeopathy and osteopathy is parallel to diagnosis in biomedicine, however a key difference is that the body-story is in itself part of the healing process, whereas in biomedicine, the diagnosis or label, (e.g. “bipolar disorder”) is a symptom to be treated (by Drugs) and has no intrinsic healing power. To illustrate this important difference, one example shared by a teacher/practitioner to their students is worth highlighting:

> “A woman came to me who had been having bad headaches ever since she was mugged. We tried all sorts of treatments, but then I noticed that here [indicates over the student model above her left shoulder] there was a palpable feeling that she was expecting to be hit again. It was about how she was holding herself. So I held my hand over the area [of the physical body] where she feared being hit again until I felt it dissolve. She never got headaches again.” (Gale, 2011, p.244)

This example from Gale’s (2011) study shows that this treatment approach and its emphasis on ‘embodiment’ can be especially useful in addressing trauma in patients. Rather than simply labelling the condition, the practitioner’s perception of the issue becomes one with the remedy, as it is carried out in a sensitive way, in which the physical ailment is understood as a direct cause of an underlying emotional issue and thus the condition is synergistically transformed.

As such, embodiment and thus homeopathy and osteopathy were observed in Gale's (2011) article to challenge the Cartesian dualism inherent in biomedicine (which treats the body and mind as separate), and in doing so, was seen to offer real solutions to chronic issues. In the above example, the 'dissolving' the practitioner felt when she held her hand over the patient's shoulder and the healing that followed demonstrates the use of 'energy work' – something that biomedicine does not acknowledge or seriously consider, and typically labels 'quackery' or 'fringe' techniques lacking a scientific basis.

In addition, Gale discovered that 'embodied work' meant that students of osteopathy and homeopathy were trained in how to listen to their own bodies as part of their work with patients. Students gained practice 'playing' the roles of osteopath/homeopath and patient. This was fundamental to their training as it allowed them to develop a sense of reflexivity and "intersubjectivity" (Crossley 2001, p. 144 as cited in Gale) with their patients. This underscores another key difference with biomedicine, for in biomedicine, the practitioner is seen as a mind acting on the body of the patient while the body of the practitioner is seen as irrelevant. However, in homeopathy for instance, the body of the practitioner is hardly irrelevant. "For the student homeopaths, the body emerges as a 'communicator' with agency not subsumed by or reduced to a mind-directed agency" (Gale, 2011, p.242).

Control

Another theme that emerged from the qualitative literature on Traditional medicine was that it offered a way for individuals to regain control over their medical treatment. Some women in Mclean and Mitchell's study (2018) expressed frustration over the allopathic approach, as they felt that in treating pregnancy as a medical condition, it positions the doctor as expert, and takes control away from women. For one woman this contrasted strongly with her experience with Traditional medicine, stating: "There's an actual diagnosis that's connected to you, how you are at that moment, and that's what Western medicine does not do." This parallels one of the seven distinctions between allopathic and Traditional medicine mentioned by Low (2004), where she says that allopathic medicine is generic while Traditional medicine, or as she terms it, 'alternative medicine' is individualized to the patient. Several participants in

Low's study shared instances of medical negligence on the part of allopathic doctors that made them decide to take control of their health as they had lost faith in the medical system. Thus, taking control meant seeking out different options and having autonomy to make decisions, which many people felt was taken away from them in biomedicine. Participants in Low's study shared that allopathic doctors were crippled by the bounds of that medical system, and dismissed individual patients' freedom offhand, as if the patient's experience was invalid. One participant stated, "some [doctors] just had a general distrust of chiropractors and again they were trying to take the control out of my hands and put into their hands" (p.73). Low (2004) is apt to remind us of the "World Health Organization's (2000) conclusion that a key measure of the success of health care systems is their responsiveness, where responsiveness is defined as the degree to which health care systems 'respond to people's expectations'" (p.113). Thus, while Mclean and Mitchell note that the idea of 'taking control' can be harmful by playing into neoliberal discourses around individualized responsibility, this is less a reflection of the Traditional medicines themselves, and more so a concern with respect to the barriers people face in accessing a wide range of health options. Furthermore, while Mclean and Mitchell voice the concern around neoliberal agendas, they also comment that the 'take control' mentality can be positive in ways that it aligns with public health and preventive medicine.

Critical Analysis

Contributing Disciplines

The studies on iatrogenic illness and ADRs come from esteemed medical journals, such as the New England Journal of Medicine (NJM). While searching for such articles, I noticed that the bulk of them were published in the 1970's and 80's. For example, Steel et al.'s study was conducted in 1981 and Mitchell's et al.'s study was conducted from 1974 to 1977. It is important to point out that rather than this being a limitation, it may be a confirmation that journals like the NJM have, in more recent years, developed stronger ties with pharmaceutical companies, thus making articles on topics such as ADRs more scarce over time as they do not contribute to a favorable image of drug companies and to the

medical establishment as a whole. As Whoriskey (2012) wrote in the Washington Post, “Since about the mid-1980s, research funding by pharmaceutical firms has exceeded what the National Institutes of Health spends. Last year, the industry spent $39 billion on research in the United States while NIH spent $31 billion”.

Paradigms and Theoretical Frameworks

While the articles on iatrogenic illness and ADRs present a more critical view of medicine by the very nature of these topics, they also have limitations on account of their relying solely on a medicalized view of the patient, as well as relying on the positivist paradigm and quantitative data. Granted, these studies are still valuable. They show that western medicine is far from perfect and that it often comes at a price for a significant number of people under its care, including children. One of the major limitations of the positivist paradigm is that the patients’ voices and full experience are not taken into account, and thus, the very definition of ‘iatrogenic illness’ or ‘untoward effects’ in these studies is inherently limiting. Ideas of illlness and ‘wellness’ are reduced to a medicalized view of the patient, lacking a holistic understanding of mind, body, emotion, and spirit that is found in Traditional medicines.

Methodologies

Identifying methodology/ies are important as this affects the types of research questions that are asked, as well as the methods implemented to collect data. All of the articles on iatrogenic illness and ADRs used methodologies in which there was no explicit interaction or dialogue between the researchers and the patients studied. For example, in Steel et al.’s (1981) study the data was obtained by abstracting from the patient’s medical record. In Mitchell et al.’s (1979) study, data was obtained by ‘specially trained pediatric nurses’ who monitored children to determine the occurrence of ADRs. In this case, the categorization of ADRs was subject to the discretion of the nurses, and thus, the very term ADR is a subjective measure. Mitchell clearly states, “a given adverse event may be attributed by some observers to drug therapy while others might not relate this event to drug therapy and consider it simply a manifestation of the patient’s illness” (p. 197). Further judgement on causality of the adverse reaction is

derived from the physician, whereby reactions may be categorized as 'unrecognized adverse drug reactions'. Thus, we see how the data which relies on the perceived 'expertise' of medical professionals is in fact not objective or necessarily reliable. These studies on iatrogenic illness and ADRs functioned within the medical institution, using the medical staff as the sources of data. Without alternate perspectives, such as that of the patient as well as other paradigms of medical treatment to inform the study, the findings are biased in favor of the medical model.

In contrast to Schimmel (2003) and Mitchell (1979), Steel et al. (1981) acknowledged that their methodology had limitations. They state, "we believe that these criteria [for iatrogenic illnesses] are conservative; if the study had judgemental bias, the effect was to *underestimate* the number of iatrogenic illnesses" (emphasis added) (p.639). Elaborating on this, they state, "if no documentation of any sort was available, no iatrogenic illness was recorded *despite suspicions of the project staff that one had occurred"* (emphasis added) (p.639). This problem", they write, was particularly common in cases of apparent psychiatric disturbances" (p. 638). This is a crucial issue that Steel et al (1981) identify in their own work, which, though acknowledged, is a direct result of the above issues: not including patients' voices and not looking outside of the medical model. These limitations show the pitfalls of top-down research. As we can see, the positivist paradigm influences who determines how concepts such as iatrogenic illness are defined (it is not the patient). Having a theoretical framework and methodology that centred participants' voices and uncovered issues such as sanism could have allowed participants to speak about their mental health experiences and expand the issue of iatrogenic illness much further. For instance, Kane reminds us that iatrogenesis encompasses a wide range of issues, some less obvious than others. He states, "we need to consider a range of iatrogenic disorders from the more obvious consequences of drug therapy and surgery to the more subtle problems of diagnosis, labelling, and general excess zeal" (p. 149-50).

The majority of the studies on mindfulness also used a positivist paradigm, while only one study, conducted by Gray (n.d.), assessed mindfulness through the interpretive paradigm. Zhou (2018), Kabat-Zinn (1987), and Samuelson (2007), effectively "bracketed" themselves out of their research (Strega &

Brown, 2015, p.8) – an approach that positivists do not see as problematic, but rather, see as essential to good, "scientific" research. For a positivist researcher, the aim is to be objective, while for interpretive researchers, objectivity is seen as an impossibility.

Many of the studies on mindfulness originated from the positivist fields of psychology, as well as nursing and criminology and used standardized tests and scales which could not be challenged by the research subjects. It can be seen in the studies by Zhou et al (2018)., Kabat-Zinn et al. (1987), and Samuelson et al. (2007) that their respective backgrounds of psychology, nursing, and criminology affected the cross-sectional methodologies they used which in turn determined their primary method of data collection which were various standardized scales and assessments.

For instance Samuelson et al.'s (2007) study on mindfulness in correctional facilities relied on two scales: the 'Cook and Medley Hostility Scale' and the 'Profile of Mood States'. The researchers do not question how such tools may cause harm to their participants and limit their voice. For instance, how might the Hostility Scale reinforce negative stereotypes and internalized messages for inmates? The use of standardized scales as the sole tool of measurement, conforms to a top-down research method where participants are not valued or seen as the individuals that they are. While the mindfulness groups at the prisons in Samuelson et al.'s (2007) study may well have been a valuable experience for the inmates, the nature of the research and standardized assessments used to assess the inmates' experiences does not enable this to come through; rather, all we see are numbers interpreted by the researchers. This is also true of the two research studies by Zhou et al. (2018) and Kabat-Zinn et al. (1987), where standardized scales are used to assess the efficacy of mindfulness practice on pain. Again, the participants voices are not represented. While Zhou et al.'s (2018) study with community-dwelling older adults takes into account some aspects of participants' social location and found that 'being female' and 'having lower educational levels' were 'risk factors' for higher levels of pain, their methods of data collection and analysis do not enable a deeper understanding of why this is so. An interpretive paradigm for instance would have allowed such questions to be explored by giving voice to participants and asking more in-depth questions.

In Gray's (n.d.) study her methodology of narrative analysis followed from the Interpretivist social science paradigm. Interpretivist social science (ISS) places a great value on the various ways that people create meaning from their interpretations of their experiences and social contexts (Rubin & Babbie, 2013) and this came through in Gray's study on mindfulness practice among Indigenous youth. Gray conducted her research through an interpretive paradigm and her sample size was far smaller than that of the other studies. She interviewed ten students, while the studies by Kabat-Zinn et al. (1987), Zhou (2018) et al., and Samuelson et al. (2007) had 225, 957 and 1,350 participants respectively. Hence, in the positivist paradigm, a large sample size is important as there is a need to 'prove' a hypothesis, while in the interpretive paradigm, the sample size is not as important as ensuring that the research reflects the authentic thoughts, feelings, and opinions of the research subjects. ISS, unlike its positivist antipode, denies that social scientific research can be free of value or 'bias', because it sees that values are inherent in every facet of everyone's lives (Neuman, 2006).

Theoretical Frameworks

Gray's (n.d.) study (as cited in Gray et al., 2013) also differed from other studies in that it employed a well-defined theoretical framework – that of decolonization. It was through this theoretical framework that Gray re-framed mindfulness into the concept of 'neurodecolonization'. Indeed this influenced the questions she asked and the responses she was able to elicit from participants, and thus she was able to center the actual experiences of Indigenous youth. Her study brings to light how mindfulness can help Indigenous people reconnect to their Indigenous identity, a crucial ingredient for healing. Indeed, it is clear that mindfulness held deep value for the youth in Gray's (n.d.) study, while in the other studies on mindfulness, the participants' voices and contextual experience do not come through. While Gray (n.d.), a non-Indigenous researcher, did not explicitly situate herself in her research, her use of a decolonial approach allowed her research to address important social and historical issues.

In contrast to Gray's (n.d.) study, Samuelson et al. (2007) positioned their research through an individualized and de-contextualized theoretical framework. This is evident in the tools of assessment

which focused on the inmates' individual characteristics related to 'hostility' and 'mood'. Thus the research is more aligned with a psychological discourse which often serves to pathologize and de-contextualize the experiences of already marginalized individuals (Gable & Haidt, 2005). For instance, the study begins with the following description:

> "Individual criminal behavior has been attributed to an inadequate ability to effectively deal with severe stress, deprivation, and low self-esteem, and with peer pressure and the codes of behavior of groups such as gangs. These factors can be severely compounded by the injection or ingestion of drugs and alcohol, which offer the user relief from emotional discomfort by impairing or eliminating normal levels of awareness and impulse control" (Samuelson et al.,2007, p. 255).

While certain contextual factors are acknowledged in the above description, such as "severe stress" and "deprivation", they conveniently leave out words that get closer to the heart of the matter such as 'poverty', 'racism' and 'intergenerational trauma' – words that center the issues of social inequality. This language is not surprising given that Samuelson et al.'s (1987) study comes from The Prison Journal, a journal grounded in the discipline of criminology, which often reinforces systems of oppression instead of grappling with them. Thus, contextual factors are lightly and vaguely acknowledged by Samuelson et al., but are not reflected in the study's theoretical frameworks or methodology, and thus the study risks reinforcing oppressive systems.

Other articles using an interpretive paradigm were Gale et al.'s (2011) study on body work in homeopathy and osteopathic schools, as well as Mclean & Mitchell's (2018) study on thus use of Traditional medicine by pregnant women. Mclean and Mitchell's (2018) study uses a feminist theoretical framework to guide their research, which allowed issues to emerge that were not explicated in other studies, such as the fact that Traditional medicines offers a counterpoint to the patriarchal model of western medicine. This viewpoint was more apt to emerge in this study not just because the chosen population was pregnant women, but because narrative analysis was used. In narrative analysis participants are asked to "re-story" their lives (White & Epston, 1990 as cited in Padgett, 2008). Hence, this methodology complements a feminist approach as it allows space for women to reflect on their

experiences and “make sense of their world” in a process that is “retrospective in nature” (Riessman, 1993).

Low (2003)’s qualitative study used a symbolic interactionist framework, a model drawn from sociology, which allowed her to examine how Traditional medicine transformed individuals’ subjective understandings of their health status as they became involved in the process of healing. Like the other studies, Low’s work contained a relatively small sample size of 21 participants which allowed her to gain insight into each person’s story.

The studies thus reviewed introduce readers to one important concern regarding western medicine, and several key themes in support of Traditional medicines. It has been shown that there is significant concern coming from within western medicine about the harms of properly prescribed pharmaceutical drugs as well as other medical procedures within hospital settings. ADRs have been an ongoing issue over the last several decades, and this problem has gotten worse in recent years not better. In addition, a critical analysis of these studies reveals that the findings likely underestimate the true scope of ADRs, and most notably, do not take into account the emotional and psychological effects of drugs on patients. This highlights the fact that the classification ‘ADR’ is in itself subjective, and thus brings attention to one important limitation of positivist research, as it does not adequately represent the voices and experiences of those under study. The selected literature on CAM, which I have re-labelled Traditional medicines, highlights several themes and various critiques were noted. Firstly, mindfulness was found to occupy a significant portion of this literature. Various studies demonstrated the physical, mental, and emotional benefits of mindfulness practice across different demographics, from Chinese seniors with chronic pain to male and female inmates in correctional facilities. A notable critique however was that these studies, with the exception of Gray’s (n.d.), operated from a positivist paradigm, and thus, like the studies on ADRs, left ambiguities about the true meaning and value of mindfulness to participants. Gray’s (n.d.) study represents a departure from the positivist studies on mindfulness, as she used an ISS paradigm, specifically a narrative approach. This approach combined with a decolonial

framework showed that mindfulness was healing as it helped the youth detach from negative colonial messaging, and helped bring them into harmony with their pre-existing cultural practices, thus facilitating a greater sense of happiness and well-being. The other studies on mindfulness lacked this same kind of social awareness which was not surprising given their contributing disciplines of positivist psychology, nursing, and criminology. The literature on body work such as osteopathy and homeopathy revealed how these approaches have helped individuals heal from and manage conditions that were not helped by western approaches. It was discussed that these approaches center around the notion of embodiment which opposes the cartesian dualism inherent to western medicine. Embodiment sees the body and mind as interconnected, and in addition, regards the body of the practitioner as relevant, as it as a vessel of information that can help in treating the patient. Participants in these studies placed value on Traditional medicines as it offered them more individualized care and more control over their medical decisions. While the studies on embodiment brought forth valuable insights into the nature of these approaches, they did not bring attention to issues such as which segments of society it benefits, who it excludes, and these are related to broader social and historical issues.

What is Missing?

Related to the above concerns, the most glaring gap in the research is a lack of studies on Traditional medicines in social work practice. This MRP aims to bring attention to this gap and to begin to explore it. The financial inaccessibility of most Traditional medicines in Canada may account for this gap in the literature as most Traditional medicines remain inaccessible to low-income individuals. However, this should not be a reason to ignore the issue; on the contrary, it should be another reason to bring attention to it. While most Traditional Medicines are not financially accessible in Canada, it is not absolute, either. There are efforts to bring Traditional Medicines more into the public sphere, and in addition, greater awareness is being generated about its benefits. In Low's (2004) study on alternative therapies in Canada she notes that the public sphere operates as a "point of entrée" for some individuals, providing them with information about alternative medical treatments. For example, she cites a report that

was conducted for the Canadian AIDS Society conducted by Mason (1993) which found that "31 percent of those surveyed responded that the primary source of information about alternative therapies were AIDS service organizations" (p.33). A participant in Low's study also shared that "Within the AIDS committees, they have a list of all the natural therapies, whether it be *reiki*, therapeutic touch, laying on of hands, massage, reflexology, acupuncture" (p.33). This is to show that while there remain significant financial barriers to Traditional medicines for the most marginalized individuals, there is also a strong interest in and need for Traditional medicines among these groups. As such, there is good reason to generate research and discussion about Traditional medicine in social work practice.

In addition, as mentioned above, none of the empirical studies I reviewed except for Gray's (n.d) analyzed research findings through a social and historical lens. Gray's (n.d.) study was a notable exception to this as she centered the concept of neurodecolonization. This allowed Gray, as a non-Indigenous researcher, to generate research that had a positive effect on Indigenous people rather than misrepresenting and exploiting her research subjects. Her research revealed that that which settlers (Koleszar-Green, 2018) call mindfulness has long existed as a concept in Indigenous communities, and that its healing benefits in the study were largely due to its ability to help reconnect the youth to their pre-existing cultural and healing practices. For myself as a non-Indigenous researcher, Gray's research acts a guide post. I have chosen to frame my research through a decolonial lens, and also through the framework of the Medicine Wheel, recognizing that the holistic orientation that is threaded throughout 'CAM' is in truth informed by and rooted in Indigenous knowledges. This is especially important as I connect Traditional medicine to social work, since social workers, especially white social workers have historically and presently caused a great deal of harm to Indigenous families and communities (McCauley & Matheson, 2018) as evidenced by their involvement in the Sixties Scoop, the child welfare system, and all the ways that settlers, such as myself, take for granted the fact that we are on Indigenous land.

Further, by interviewing social workers who refer to both Traditional and western medicine, this research aims to explore ideas about how the two approaches may, or may not, balance one another, and

seek out social workers' opinions on this matter. This will be guided by the use of the contrapuntal approach, a framework that offers great potential for dialogue and progress, but has not previously seen in the literature on Traditional and western medicines.

CHAPTER 3. THEORETICAL FRAMEWORKS

I have chosen three theoretical frameworks to guide my research on Traditional medicine in social work practice: decolonization, the Medicine Wheel, and the contrapuntal approach. It is important to explicitly identify one's theoretical frameworks as this helps to evaluate research findings critically and to center key themes and concepts in the analysis (Ravitch & Riggan, 2017). This also gives the research more depth as it is guided by pre-existing ideas and theories (Ravitch & Riggan, 2017). In addition, as a non-Indigenous researcher, using decolonization and the Medicine Wheel as two of my theoretical frameworks can help keep me vigilant, reminding me to maintain a social and historical awareness around the topic of Traditional medicine in social work practice. This is so important, especially considering the tremendous harm that Indigenous communities have suffered through the endeavors of non-Indigenous researchers (Smith, 2012).

Thus, these three theoretical frameworks have been chosen both as a way to both challenge my beliefs as a researcher and guide me in a direction that I may, as an Indigenous professor of mine once articulated, "reduce the harms I will inevitably inflict on Indigenous people (by way of being a settler and a social worker) from one thousand harms to a hundred harms" (P. Lezard, personal communication, 2017). I describe these three theoretical frameworks below.

Decolonization

Decolonization starts with the recognition that modern nation states have colonized Indigenous lands, and that the exploitation of Indigenous people continues to this day. This recognition was made explicit in the UN Declaration on the Rights of Indigenous Peoples (UNDRIP), adopted by the UN general assembly in 2007. The declaration:

> "aims at empowering indigenous groups by according them control over the issues which are internal to their communities [and] it refers to procedures of participation and consultation in order to ensure that these Peoples are involved in the life of the larger society of a State" (Errico, 2007, p. 755)

Canada, the United States, Australia, and New Zealand were the only four UN member countries who voted against the declaration in 2007. Canada finally signed it in 2016, almost ten years later. This speaks to the anti-Indigenous racism entrenched in Canadian society that is just beginning to be acknowledged and redressed. As Gray et al note, part of the reason for the shameful unwillingness to remedy the human rights violations experienced by Indigenous peoples is the misconception that "Indigenous populations around the globe have been regarded as an 'impediment to progress and development'" (Burger, 1990, as cited in Gray et al., p. xx).

For Gray et al. (2013), when viewed through a strengths perspective, decolonization is not just about recognizing the harm done to Indigenous people and communities – it also involves allowing Indigenous knowledge and wisdom that has long been suppressed, to be expressed and shared. Likewise, for Mathebane & Sekudu (2018), decolonization is "a critical analysis of Western-informed ideological frameworks…" (p. 3).

However, to understand the true mission and challenge of decolonization, it is important to turn to the notion of coloniality. Coloniality "denotes 'the long standing power patterns that originate from colonization, but continues to be exercised in the absence of the colonial administration" (Maldonado-Torres, 2007, as cited in Mathebane & Sekudu, 2018, p. 3). Likewise, Tlostanova and Mignolo (2009) liken coloniality to the unconscious in Freud's theory of psychoanalysis, conveying that coloniality represents the "hidden weapon of both the civilizing and developmental mission of modernity" (as cited in Mathebane & Sekudu, 2018, p.3). Thus, the mission of decolonization must not only address the ideology of colonization, but also strive to uproot the systems of power that propagate it through strategies such as the "appropriation of other 'knowledges' and centering Europe as an epistemic hegemony of the modern world" (Quikano, 2000, as cited in Mathebane & Sekudu, 2018, p.3). Coloniality is an essential concept to bring to the issue of modern medicine in Canada. Without addressing coloniality we fail to see how our current medical system rests on and perpetuates the colonial ideal in which Indigenous and non-Western ways of knowing are squandered, devalued, and treated as

objects of appropriation. In seeing that this power dynamic still operates within the systems we encounter on a daily basis such as government-funded medicine, the task of decolonization is not yet complete.

The Medicine Wheel

The Medicine Wheel is "an ancient system of Traditional indigenous knowledge that many tribal peoples share under many different names" (Favorite, 2004). Illustrated as four equal sized parts of a circle, the Medicine Wheel speaks of the need for balance and harmony, and thus forms a basis for a holistic understanding of health and well-being. It sees human beings as comprised of four different interrelated parts: the physical, mental, emotional, and spiritual:

> "Just as in creation all things are connected but have different functions, so our mind, body, spirit, and emotions are part of the sacred circle of life and are interconnected. When one of them is out of balance, it affects the others. If you have a physical problem, it is connected to your spirit. If your mental state is out of balance, it will cause emotional turmoil" (Anishnawbe Health Toronto, 2000).

The Medicine Wheel is an integral part of Anishnaabe culture in Toronto, and is important for settler social workers to keep in mind when working with this population. The Urban Aboriginal Peoples Study (Environics Institute, 2010) found that 43% of aboriginal individuals they surveyed reported poor medical treatment as a result of racism and discrimination, and 18% reported negative experiences of discrimination or racism causing shame, lower self-esteem/self-confidence, or the masking of their aboriginal identity. The report also found that almost half (45%) of urban Aboriginal peoples surveyed say access to Traditional healing practices are equally important to them as access to non-Aboriginal or mainstream health care services, while one-quarter (27%) say Traditional practices are more important. In addition, Urban Aboriginal peoples in Toronto (43%) and Inuit in Ottawa (47%) are more likely than those living in other cities to say accessing Traditional healing practices is more important than accessing mainstream health care services (Environics Institute, 2010). Therefore, making space for the Medicine Wheel is crucial, as it provides the basis for Indigenous understandings of health and well-being, and places specific Traditional healing techniques into a comprehensive model.

Given this climate, some Indigenous folks have recommended bringing the Medicine Wheel as a teaching tool into health care settings in order to make healthcare more relevant and responsive to the needs of Indigenous people. For instance, Brad Lafortune, a Métis physiotherapist, wrote a piece for the Canadian Physiotherapy Association in favor of "expanding on this model [the medicine wheel] as a possible educational tool for healthcare providers" (Lafortune, B. n.d.). He notes the harm that Indigenous folks experience when this model is overlooked in Western health care settings. However, as a settler, it is important to be clear about how I am suggesting the Medicine Wheel be used, and to be awake in both my mind and body to the harm that has been perpetuated through surface level attention to notions of "cultural awareness". Gertie May Muise (1992) writes about the need to shift away from the idea of "cultural awareness" towards the idea of "cultural safety". She states, "ultimately cultural safety is defined by the clients' experience of safety, and this demands health care providers practice self-reflection and develop an awareness of culture and power differentials within health care settings" (p. 32-3). This notion of cultural safety is a crucial concept for settler social workers to remember in order to mitigate harm and move towards a more client centred approach to practice. As such, I do not recommend appropriating the Medicine Wheel; nor am I trying to impose it on other settler social workers. Rather, I am using the Medicine Wheel as an example of an Indigenous framework that informs healthcare and that must be recognized, especially when dealing with Indigenous clients. Coupled with decolonization, the intent is to have settler social workers reflect on their own cultural biases and see that Indigenous models of health and healing (such as the Medicine Wheel) differ considerably from Western understandings around health and healing. While there is much diversity between Indigenous cultures as well as different interpretations and uses of the Medicine Wheel, there is a common holistic orientation that is typically absent from Western medicine. While there are many Indigenous models that could be drawn on, the Medicine Wheel is particularly important in Toronto where it is an important aspect of Anishaabe culture. In addition to benefiting Indigenous service users, the Medicine Wheel's basic principle of holism and balance can also be extraordinarily useful for others marginalized by race, class, gender, sexual

orientation and ability, as it allows potential health issues to be seen in a more holistic and interconnected way, taking into account how social issues such as poverty, discrimination, or abuse can affect that person's well-being, opening the door to healing on a much deeper and more transformative level.

Contrapuntal Approach

Indigenous social work and Decolonization lead into the third theoretical framework that I will use to guide my research: the contrapuntal approach. The term 'contrapuntal' is originally derived from music. It refers to two lines that are different, but complement each other melodically. Mathabane and Sekudu (2017) extend this idea to social work epistemologies in the African context. The authors' use of the contrapuntal approach is motivated by the long suppression and overshadowing of local Indigenous knowledge in favor of imported, Western approaches to social work. The contrapuntal approach calls for greater balance between Western and local perspectives to make social work more relevant to local contexts in Africa. Similarly, the contrapuntal approach can address the need for greater balance between Traditional and Western Medicine in the social work referral system in Canada wherein Western medicine is prioritized over Traditional medicine and given far more power and legitimacy. The contrapuntal approach addresses this power imbalance, which is connected to colonization and the ongoing issue of coloniality. The value of the contrapuntal approach is that it can help encourage dialogue between these different points of view without a hierarchy. In this sense, the contrapuntal approach can facilitate the work of decolonization. Discussing this approach in the African context, Mathabane and Sekudu (2017) state, "through the contrapuntal approach, the perceived cultural hegemony of the West would most probably be neutralised and previously ignored perspectives of indigenous social workers amplified" (p. 8).

Relevance of the Theoretical Frameworks to Traditional Medicine in Social Work Practice

The aforementioned theoretical frameworks have been chosen based on the understanding that the medical model generally employed in mainstream social work practice is a system developed in the Anglo-saxon context which has systematically squandered and sought to erase Indigenous and non-

western forms of medicine, or otherwise sell them for profit. A key example of this is the way in which plant-based medicines are chemically altered so that they can be patented and sold for profit (Dean, 2005). This money making endeavor has effectively trampled on the rights of Indigenous communities whose sacred knowledge and relationship with plants and the natural environment is integral to both their physical and cultural survival. Meanwhile, the patenting of drugs has also had deleterious consequences for the rest of us, as the profit driven nature of Big Pharma has led to a culture where doctors overprescribe drugs, many of which are not sufficiently tested and have harmful side effects (Dean, 2005).

Thus, it would be in all of our best health interests to regard western medicine with a critical eye, and to be more open minded about so-called 'alternative' medicine. For instance, it may come as a shock to those of us who grew up with western medicine, or who currently work in mainstream social work practice and public health settings, that properly researched prescribed and used drugs have accounted for 5.18% of deaths in the United States in the last three decades (the fourth most common cause of death) compared to 0.0001% for natural supplements (Dean, 2015). Indeed, in Canada just like the United States there is a broad misconception about the safety of drugs versus natural supplements.

In looking at social work referrals to health care, both 'decolonization' and 'Indigenous social work' reminds us to center Indigenous perspectives and practices in regards to health and healing. Making room for these wisdoms and techniques is part of the work of decolonization as well as the duty put forth by ISW. The contrapuntal approach can remind us to strike a greater balance between allopathic and Traditional medical approaches. This combination of theoretical frameworks yields favorably to the issue of social work referrals to medical care, as it demands that Traditional medicine be positioned on an equal playing field with allopathic medicine to ensure that individuals in need of medical attention and preventative care are helped in the most appropriate and effective manner.

'Seeing Makayla' and the example of Oklahoma

A potent illustration of the imbalance of medical care in Canada and its relevance to Indigenous communities is the story of Makayla Sault. Makayla was an eleven-year-old girl from Ontario's New Credit Nation who had cancer and died in 2015 (Hanrahan & Wills, 2015, p. 208). After eleven weeks of chemotherapy, Makayla and her parents decided to end her treatment. Speaking to this decision, her mother recalled: "It's a mother's worst nightmare… I remember I would just watch her and listening to her pray, 'Oh God. Come and get me, come and take me from here.' She said, 'Mom, [it's] not the leukemia but it is the chemo that is going to kill me'" (Walker, 2014, as cited in Hanrahan & Wills). After eleven chemotherapy treatments, the side effects of which drove Makayla into intensive care, the family decided to pursue an alternate route: Indigenous medicine combined with care at the Hippocrates Health Centre in Florida, a centre that offers nutritional and other programs to help people become disease-free (Hanrahan & Wills, 2015). This private decision made by Makayla and her family quickly became a public issue. Children's Aid threatened to take Makayla away from her parents. The family's decision to seek gentler, more holistic medical solutions was seen as a criminal offense, a sign of irresponsible parenting and child neglect. Leah McLaren, a columnist for the Globe and Mail criticised the family's use of alternative therapies as "superstition" and "magical thinking" (as cited Hanrahan & Wills, 2015). Thanks to Indigenous community members however who spoke out on behalf of Makayla and her family, the case ended in favor of keeping Makayla with her family.

In the eyes of western medicine and the Canadian government, when Makayla left the hospital, she was signing her death warrant, whereas, in the Indigenous perspective, she was signing her life warrant. Proponents of Western medicine will highlight the fact that the Indigenous and other 'alternative' treatments did not 'cure' her of cancer. The heavy 'outcome-based' focus of Western medicine gives little if any consideration to the physical/mental/emotional/ and spiritual harm and suffering patients can incur from treatments such as chemotherapy. In addition, firm adherents of the 'cut-burn-poison' approach inherent to allopathic cancer treatment likely do not pause to consider that people may be more likely to become well if they feel good about how they are being treated.

While, ultimately, Makayla was permitted to seek non-Western medical and healing approaches, the criticism and stress she and her family faced in doing so reveals that Canada has a long way to go in recognizing the health freedom of its citizens. In particular it highlights the barriers and racist stereotypying faced by Indigenous people when they choose to make decisions that align with their culture. Evidently, Indigenous knowledges and healing approaches still bear the stain of racist, colonial attitudes and assumptions about Indigenous cultures as "backwards" and "irrational".

The medical freedom that exists in the state of Oklahoma in the U.S. provides an interesting counterexample to the constraints experienced by Makayla and so many other Indigenous as well as non-Indigenous people across Canada. A populist movement emerged in Oklahoma in 1907 which guaranteed its people freedom from government and corporate control over their affairs, including that of medicine. As Dean (2005) writes, "there was no room for a medical monopoly in a state of self-reliant people, Indian shaman, and healers who knew more about treating snakebite than allopaths or even naturopaths" (p. 33). Johnston (2002) raises a similar point stating, "it is well documented that, in any society, people's first resort when ill is often to home- and family-based remedies and only secondarily to engage a healing practitioner of some type [...] in this scenario, when the home remedies do not suffice, people next seek a Traditional healer and/or, in the case of the Navajo and others, the native American Church or a Christian healer; the care of last resort is the biomedical system" (p. 197).

Thus, the purpose of these stipulations in Oklahoma was not to favor Traditional over allopathic medicine, but rather, to "put allopathic medicine in its own allopathic box" (Dean, 2005, p. 33) in order for citizens to have full control over their medical decisions. The example of 'health freedom' in Oklahoma is a useful reminder that our current healthcare system and the social work referral process that is aligned with government sponsored health care is biased in favor of Western medicine and that medical freedom is in fact limited in this country – most especially for those who are socially and financially disenfranchised.

In sum, decolonization and the Medicine Wheel help connect traditional medicine in social work practice to a broader social and historical analysis of the racism and discrimination against Indigenous people and their ancient knowledge and healing practices . Meanwhile, the contrapuntal approach envisions the possibility of transforming health care by bringing Traditional and western approaches into greater balance and dialogue with one another. The example of Makayla Sault is a potent reminder of how the issue of health freedom disproportionately affects Indigenous people and is a reminder for both readers and myself that medicine and the question of the health freedom of citizens is, indeed, entangled with issues of race and politics.

CHAPTER 4. METHODOLOGY

Approach of Inquiry

In seeking out the knowledge base, points of view, and strategies of social workers who refer clients to Traditional medicine, this research followed a Grounded Theory design. Grounded theory is a qualitative, inductive method of inquiry that, in its full form, aims to generate a theory about a particular process through the methodological gathering and analysis of data. Developing such a theory is a lengthy and iterative process that requires going back and forth between data collection and analysis until research categories have been fully 'saturated' and a theory arrived at (Padgett, 2008). While I employed the beginning techniques of grounded theory, it was not my intention to develop a theory. That would have required a far larger sample size than the one I have, as well as multiple interviews with each individual research subject.

Nevertheless, the use of qualitative research, and specifically grounded theory, was useful as it reveals the nuances, complexities, contradictions, and dilemmas which can in turn help generate further discussion and inquiry into a topic that is seldom taken up in social work literature and mainstream social work practice, that of Traditional medicine. Broadly, this research aimed to learn about the process of social workers who refer their clients to Traditional medicine. Within this, three research objectives were established: 1) to explore the value and knowledge-base of social workers as it relates to Traditional medicine; 2) to understand the obstacles to accessing Traditional medicine and how to push for change; and 3) to understand how social workers decide whether to refer to orthodox medicine, or to Traditional medicine, or both.

As the name suggests, grounded theory is meant to emerge from the "ground up" rather than imposing a theory or theories onto the data. In spite of this, I chose to apply several theoretical framework, as this ensured that important historical and social issues, namely colonization and coloniality could inform the analysis, and thus better meet the demands of social justice. This was especially important given both my position as a non-Indigenous researcher as well as my interviewing two non-

Indigenous social workers. Indeed, the topic of Traditional and Western medicine cannot be talked about without discussing colonization and coloniality, as these have shaped and formed the very categories of Traditional and Western medicine. Applying these theories was a way to address and highlight these critical issues. In addition, the application of the contrapuntal approach which may be seen as "deductive" enabled a conceptualization of what the participants were, in some cases already describing, a process that is "inductive". Thus, despite these contradictions, grounded theory offered a way to understand the contrapuntal nature of these two social workers' approach to practice, and as such can be used to develop a full theory on the process of social workers who use this approach in practice.

Recruitment and Sampling Techniques

To find participants for this study I used convenience sampling by reaching out to social workers who I knew previously. I asked them if they knew of any social workers who referred service users to Traditional medicine (at the time I was using the term 'CAM'). I welcomed social workers of any age, race, gender, sexual orientation and gender identity, and clearly stated this in the recruitment email. I sent the recruitment email (See appendix A) to these social workers which they then forwarded to the potential participants. This yielded two participants, and a third was acquired through snowball sampling. The interview with the first participant however, could not be used in the final data analysis because I learned in the interview with her that she was not a social worker. Thus, this research is based on data from interviews with two participants. Both of the participants work in health care settings in Toronto, Ontario: one in a hospital, and the other in a community health centre.

Data Collection

I used a one-on-one semi-structured interview style, and interviewed each participant only once. Since it was not my intention for the data to be "saturated", I only engaged in open and axial coding, and thus, again, did not attempt to develop a theory. A semi-structured interview style was chosen so that questions could be tailored to each of the four research objectives (Galletta & Cross, 2013). A

predetermined set of interview questions helped stimulate and challenge participants' thinking in a way that more open-ended interview styles such as narrative inquiry may not have. Having this structure also gave participants a sense of security and direction as they were guided by the interviewer. At the same time, the semi-structured interviews also had an aspect of flexibility and fluidity. This allowed for a natural flow of conversation and allowed for spontaneous insights and sharings on the part of the participants. This combination of structure and fluidity was ideal for exploring the topic of Traditional medicine in social work practice, because it allowed for a ground-up approach while also ensuring that the major research objectives were met.

Data was audio recorded and in addition some hand-written notes were taken during the interviews to highlight important points. Participants were also given a paper copy of the interview guide so they could follow along throughout the interview. The audio recordings and transcriptions were stored in a locked file on my personal computer.

Data Analysis

After the interviews were recorded and transcribed, the transcripts were reviewed, and key concepts were highlighted as part of the open coding phase. Where appropriate, 'sensitizing concepts' from the literature were brought in. However, as Padgett (2008) notes, the primary goal of grounded theory is inductive (p.33), and thus the data analysis will focus on the participants' responses. Thus, after open coding was completed, I then looked for relationships among the open codes, grouping information further into the next level of coding, axial coding. This phase coincided with the process of horizontalization – i.e. identifying related meanings or essences amidst the data. In addition, 'Comparative analysis' was used to "examine contrasts across respondents, situations, and settings" (Padgett, 2008, p.33). Again, due to the small sample size and time constraints of this study, the data analysis ended here. In choosing a theoretical lens that combined decolonization, the Medicine Wheel, and the contrapuntal approach, the theoretical perspective,

methodology, and topic of study are linked, and thus mutually shape how the findings are presented (Holstein & Gubrium, 1995).

Ethical Considerations

Qualitative research (QR) has important benefits such as being highly responsive to environmental stimuli, having the ability to interact with the situation and pieces of information at multiple levels simultaneously, and to perceive situations holistically (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). However, in spite of these advantages, there are also important ethical issues that must be taken into consideration with QR, such as respect for privacy, establishment of honest and open interactions, and avoiding misrepresentations (Warusznski in Van den Hoonaard, 2002). In grounded theory the researcher is involved in every stage of research, from defining a concept to designing the interview questions, as well as transcription, analysis, and reporting on the concepts and themes. Thus, it was crucial to remember that as a researcher I am not detached from the research process, and to be conscious of my own prejudices in order to mitigate the risks of influencing the study (Corbin & Strauss, 2008). I employed certain techniques in order to help mitigate and address these risks. One such technique I used was reflecting back to participants about what I heard during the interviews in order to avoid misrepresentations. Moreover, in order to ensure confidentiality of the research participants I chose to leave out the participants' names. This may be especially important in the case that participants share information and opinions about social workers' positions on health care that is unpopular to their workplaces.

Using grounded theory as my research methodology, I have intended to examine the knowledge, perspectives and approaches of social workers in Toronto who refer service users to Traditional medicine. While a complete theory could not be generated as the sample size was too small and the time frame too short, grounded theory's inductive approach to research and goal of identifying essential themes and basic

connections between these themes, allowed this preliminary research on Traditional medicine in social work to be developed.

CHAPTER 5. MAJOR FINDINGS AND ANALYSIS

This chapter discusses the research findings from interviews with two social workers who identified as women who refer their clients to Traditional medicine. The participants' names have been replaced by pseudonyms in order to maintain anonymity. I will first present a brief profile of the research participants including how Traditional medicines fit into their respective workplaces. I will then elucidate themes that emerged from the interviews. These themes were largely shaped by the original research objectives, though some new themes were also added according to participants' responses. For instance, one of the social workers discussed her incorporation of nature as a healing tool into her practice, so I have given specific attention to this in the analysis. In addition, the other social worker I interviewed spoke of the moral and ethical concerns that she faces in her work as a medical social worker which I felt were also important to highlight. Other themes that were discussed include: social workers' prior knowledge and experience with Traditional medicine; service users' obstacles to in accessing Traditional medicine; how social workers decide whether to refer to Traditional medicine or allopathic medicine; and how to make the referral process more balanced between Traditional and western medicine.

Profile of Participants

Two Toronto-based social workers were interviewed for this study. Mave is a medical social worker at a tertiary care children's hospital, and Camilla is a social worker at a community health centre (CHC). Mave was interviewed in-person and Camilla was interviewed by phone. Both participants completed their Master of Social work degrees in Toronto: Mave, at the University of Toronto and Camilla, at Ryerson University. Camilla has been working in the field for thirty years. Mave did not say how long she has been in the field, however, she appeared to be in her mid-thirties. Mave and Camilla are both white women. Other demographic information such as sexual orientation, gender identity, religious background and ability were not determined. The two women were selected as they met the recruitment criteria of social workers who refer their clients to Traditional medicine, however it was found that Mave

had significantly less freedom than Camilla to do so given the restrictions at the hospital, revealing important issues around access and "cognitive justice" (Santos, 2016) across different institutions.

The frequency of referrals to Traditional medicine differed considerably between the two participants, with Camilla using Traditional medicine or referring service users to it "everyday", while Mave stated she refers "regularly - so probably at least monthly". As we will see, their sharings highlighted important differences in how their places of work differ in their attitudes towards Traditional medicine, and thus presented both similar and contrasting reflections.

Major Findings

Understanding and Experience of Traditional Medicine

Definitions of Traditional Medicine

Towards the beginning of the interviews I asked the participants how they define Traditional medicine. At the time of my interview with Mave I was still using the term Complementary and Alternative Medicine (CAM), and in the interview with Camilla I had switched to the term Traditional medicine, though admittedly made the mistake several times of calling it CAM (a sign of my becoming accustomed to this term throughout my research and also due to my Western-informed view).

When I asked Camilla, "How would you define what's called CAM?" She was reflective and cautious ,and instantly perceived the colonial implications of such a term. She stated the following:

> Hmm... I don't ...I don't… I would use the word...holistic… umm...I would use the word...it depends. I would be careful around appropriation or colonizing anything, so you know people might use the word like 'new age', and it's like, well it's not new. A lot of holistic things are very old and they're from Indigenous cultures, so I would just be very mindful of my language around that.

When I asked Mave this same question, this was her response:

> I think I like the idea...I like the term complementary, versus alternative [which] makes it sound fringe or it's an either/or. So, um, I tend to like the idea of like, a holistic health perspective. That resonates with me.

She continues,

> I know there's like integrative medicine. That's something, you know that comes up in terms of like, some of the doctors I might follow on Instagram or watch YouTube videos of, so I definitely have a personal interest in alternative health. I've seen a naturopath in the past I've, I've done, even recently, acupuncture.

Mave's and Camilla's responses are similar in that they both pick up on the risk of 'othering' of Traditional approaches, and in addition, both discuss being drawn to the idea of 'holistic' health. Granted, Mave does not make the connection to colonialism explicit in her response, which can serve as a reminder for many of us to think more carefully, deeply, and critically about how colonial structures have shaped settlers' worldviews, and challenge ourselves to consciously make connections between modern institutions such as medicine and the coloniality of power (Mathebane & Sekudu, 2017). Mave's response also shows inconsistency in her use of terminology, as she uses different terms at different points, sometimes calling it alternative, sometimes using complementary, and other times integrative medicine. I point this out not to be petty or place blame but to show that there is a common lack of specificity and clarity in language in this area.

Social Workers' Personal Experiences with Traditional Medicine

Both participants described having personal experience with Traditional medicine. Camilla shared:

> In my youth I was introduced to expressive arts therapy...through my own therapy and using the arts as a way to heal and access painful or difficult emotions. So yeah, expressive arts was very interesting to me, and helpful in my own journey. So I also... once again, I wanted to share that with others so that's why I took training and I bring that into my work in counselling practice. And also I access alternative or holistic health as well. And um... and I'm also connected to nature, I feel it's also like it's like things that I experienced in life that I find helpful I always share... I think information is power… so I always share that knowledge with my with my clients just as an offering around things that might be useful in their healing.

Camilla described how her interest in nature as a source of healing was inspired by her work with an Indigenous Elder:

> I had the luxury of and honor of working with an Indigenous Elder when I was struggling, and he just said every time I'm suffering to go down to the water… go by water, go by water. And that's

what… and that's what I did as part of my healing.

Further, she added, “And so, all of it was *very* nature based, and the spirit of, you know, connecting with the Earth and gifts from the Earth for strength, and asking for help”.

Thus, for Camilla, bringing nature into her therapeutic work with clients is informed by her personal struggles and subsequent experiences of being helped by different types of Traditional medicine. The idea of nature as medicine may seem silly to other settler social workers and settler health practioners, however Camilla’s experience has shown her its healing benefits. Speaking further about what she learned from the Indigenous elder, she adds, “I don't appropriate that, and I don't use Indigenous teachings *at all* in my practice, but my *own* experience of nature, and how it's grounding.”

Camilla also cautions us about making judgements about such healing approaches, and urges us to instead question where those judgements come from, stating: “I think it's also that judgment around it being, I don't know, airy fairy or stuff like that. I think it's also around colonization and valuing of Western medicine.”

Mave shared that she, too, has turned to Traditional medicine in her personal life, stating:

> I definitely have a personal interest in alternative health. I've seen a naturopath in the past; I've done, even recently, acupuncture. [...] My mother also had an interest and explored that. So it was normalized to me as a child.

Thus, the women’s personal interest and experience with Traditional medicine has helped to normalize it in their eyes, and has motivated them to help connect service users to the same, to the extent that they can. When their professional ability to do so is restricted, this has caused them to question the status-quo of the social work referral process that prioritizes western medicine, as will be shown in a later section.

Perspectives on Traditional & Western Medicine

Benefits of Traditional Medicine

I asked the women about the feedback they have received from their clients who have used Traditional medicine. Camilla shared the type of feedback she has received from service users who seek healing through nature:

> ...Oh you know, you know, [they say things like] 'I went by the lake and I sat down by the lake and then I felt calmer, you know, I started sobbing and then I felt calmer', or 'I went down to the lake and pretended like I was having a conversation with somebody I was really struggling with'. Or people will talk about going down and talking to a loved one or somebody who's passed over and they talked to them and asked them for help or support… and so, it's always very powerful feedback; or for some people are just like, you know, 'no it didn't do anything' [laughs].

I also asked Camilla about the feedback she receives from her clients about other Traditional approaches offered at the CHC such as acupuncture, naturopathy, and yoga. She immediately replied: "Oh, clients love the naturopath... love, love, love." Asking her if the naturopath helps service users with chronic illnesses, she replied yes. I asked her if she could share some examples, and she replied:

> Yeah, so I have many... so I'm not sure which ones... but somebody who I was working with, um, was trying to quit smoking. So she was going to the naturopath, and they were prescribing… you know… different remedies for her, and she found it very helpful. Someone else was dealing with insomnia – and these are all… these are folks who have experienced trauma in their life. They were getting assisted with remedies to help them sleep. Oh my god, so many different things…

Given that Mave, on the other hand, has limited opportunities to refer clients to Traditional medicine she did not have as much to draw on in terms of client feedback related to these approaches; however she did share the following:

> I would say with spiritual care it can be really meaningful and really valuable. Sometimes, the kinds of things that trip people up with mindfulness... sometimes people don't have an interest in it. But I do try to normalize that if you've noticed your thoughts you were doing it right. So sometimes it's also supporting them to understand that you didn't *fail* at mindfulness, for example, that's come up a few times. And also normalizing that there's many different options for many different people. So just because that maybe was doesn't feel like a fit to you right now doesn't mean there might not be other things to explore to benefit your holistic health.

Thus, from the participants' perspectives, Traditional medicine can benefit service users with various health conditions, especially those related to trauma, as trauma manifests in many different ways on the levels of mind, body, emotions, and spirit. That Mave had fewer examples to draw on again speaks to her narrow freedom to refer to Traditional medicine at the hospital. Yet, nevertheless, her practice experience speaks the importance of spiritual care and mind-body approaches in health care.

Social Workers' Concerns Around Western Medicine

The participants shared various concerns around western medicine, from its lack of cultural relevance to its aggressive approach to treatment. Their concerns are derived from observations in their workplace, as well as feedback from clients, and from their own life experiences and personal beliefs. Asking Camilla what she sees as some of the limitations to western medicine, she replied:

> Well it's a very narrow... narrow approach. It's… some clients don't find it helpful... um... they're searching for other ways to heal after trying, you know, the medical model or mainstream things, and they're frustrated and they want to access other things but they might not know about them, or they might not be able to afford them. So, you know, there's frustration. There's also a whole equity issue that comes into it, like who has access? You know, marginalized folks who are living in poverty, you know, they get frustrated that they can't access Traditional medicine.

Camilla's response is interesting as for her, the notion of Western medicine being harmful is not just about the nature of its medical instruments, but the way in which it is a social institution that marginalizes other approaches to medicine and makes these financially inaccessible to many people. She continues:

> ...So it's just a very limited way of practicing. And it's also… based in, you know, it also ignores, you know, clients who come from other cultures that are here in Canada and they... back home would access certain, you know, herbs, or teachings. It's also, you know, it's very... It can be oppressive for them. Like they can't access those things here in the same way. And it doesn't fit for everyone. You know... I met with a client for the second time yesterday, who's… I won't get into what country she's from, but you know, she's referred to counselling, and she just talking to me about, like, she doesn't even know what to do. It's so foreign to her. It's not something she can relate to. Back home they would talk to, you know, like an Elder in their village or, you know... so it's like this whole counseling... like I don't know how... I'm not sure. We'll have to see how useful... I'm not sure yet. I'm not sure how useful it will be for her. We'll have to figure out how to… we'll have to figure that out. And I'll be looking for other ways to support her too, right? So…

Thus, in spite of there being an effort to include Traditional approaches at the CHC, western approaches still dominate and can push service users unwillingly into care that is foreign to them, and ultimately not helpful, and maybe even harmful. It necessitates having a social worker who is cognisant of these cultural differences and open-minded enough to recognize when another avenue is needed, and to be willing to seek this out.

Mave, too, voiced concerns about working in a system dominated by western medicine. It was

evident in the interview with her that these concerns constitute deep moral and ethical dilemmas that she encounters on a daily basis at the hospital in her role as a medical social worker. For instance, when I asked her how she balances western medicine along with Traditional medicine, she replied:

> It's not balanced. Like, let's be honest. It is still… I'm working in a Western medicine system, which looks at that as a necessity, right? And this, as an alternative, that can be *dangerous*. Right? Like, really, the system's view is probably that that's an alternative that can, um, yeah… be dangerous. So now, for me, I don't just go 'ahhh', I'm not afraid of it personally, and I don't view it as a… you know, just a monolithic threat, right? But yeah, it's not balanced.

Sensing that this imbalance does not sit well with her, I asked her if that is something she struggles with. She replied, quite sincerely, "Yeah, it doesn't feel good". Elaborating further, she states:

> Sometimes I do think about... Cause when I was working more in the general medicine inpatient population, sometimes I would think about, um... you know, the medications being used on children, and um, you know, kind of treating *symptoms*... and think of like, you know, I wonder in terms of a holistic health perspective if there are… like trying to really understand the root cause of these things... looking at multiple factors… like could there be something not through pharmacology, not through western medicine that would help these kids?

She shared particular reservations about cancer treatment and the environmental causes of disease:

> Generally, I've been working with such rare conditions, that, you know it's not like something that is treatable. But if you're talking about chemotherapy or something like that, I don't know, I have mixed feelings about it. Like is there research… like… part of me is like, have they suppressed some research about other things that can help treat cancer that are not chemotherapy and so harsh on the body? So like, that's a personal thing I have. And I also have this view around, um, also our environment, right? How the medical… like how… where the money flows with funding [to] Big Pharma. So meanwhile, are we looking at the environmental factors that may be contributing to the increase in disease, and addressing those factors?

Reflecting further, Mave shared feeling that there is both value to western medicine, as well as areas where she feels it could take into account a more balanced and holistic approach:

> That being said, because I work where I work, we see the sickest of the sick in the province. So, you know, if a kid needs oxygen, chronically, to develop, or they have some of these rare conditions, yeah, there isn't… there's not likely to be something that the complementary health system could do to take it *away.* You're not going to take away Down syndrome, for example, to use like a lay… like a common genetic syndrome. But you know, eczema, or like, reflux. Like, we see *a lot* of that… eating challenges using tubes to feed children formula. And like some… there's a new formula that's more based on actual food and... or like the blenderized diet. So for

> me, personally, I know as a parent, I would be more receptive to real food blended than a 'food product'. Right? That being said, there are times when like, um, the professionals don't see that as the best option for the child.

For Mave, contending with these issues can be unnerving, and source of deep concern, both personally and professionally:

> So, you know, I think, you know, am I a… am I a cog in a system that sometimes does harm by like overmedicating or even like medical trauma or like a lot of things. Like am I cog in a system that does harm as opposed to like working outside of that system, or alongside of that system in an environment probably more aligned with my values and interests? So there's like a personal level, and then sometimes there's also like, you know, we're supposed to help be... *adhere*.. Have you heard of this word 'adherence'? Adhere to treatment, right? [...] That can be tricky, especially where that line falls, right? Because if you're in another country, tube feeding wouldn't be an option. So because you're in Canada, because tube feeding is an option, does that like… does that mean, it's a requirement? Do you know what I mean? Like there's lots of different ways to look at it.

Thus, while social workers exist alongside medicine more so than directly in it, the medical experiences of patients have a direct impact on social workers, raising serious questions and concerns related to practice values and ethical decision making.

Social Workers' Concerns and Skepticism Around Traditional Medicines

The women also shared concerns around Traditional medicine. In particular Mave voiced concerns about Traditional medicine and health as it is branded to the western consumer. She discusses how it is often co-opted by capitalism and can cater mainly to rich white women, an important critical reflection on her own social location as a white woman as well as a critique that implicated myself as a white female:

> Sometimes some of it is very expensive… sometimes it's very, like, rich white woman-oriented, you know? Let's not… *lie*, right? And sometimes, also, it's… it's taken up with like, like the 'wellness diet', or it's, um... yeah, taken over by capitalism and the diet industry, and like Lululemon [laughs]. You know what I mean? Yeah, not that, like... So I think that being sensitive to… class, being sensitive to some of the potential risks – emotional risk, financial risk...

I asked Mave to elaborate on what she meant by emotional risks; she shared:

> I mean, well, I would say that like, for example, there… so, um I know, like, sometimes people are *really* vulnerable. So I meet, in my work, families who are *so* vulnerable, and so *desperate* for

> their child to be healthy, to have more physical capacity, mental capacity than what they currently have, and what's expected of them. So for example, you know, there's... there... one time a colleague and I um... researched something that a family was putting a lot of money into, and the advertisement for this alternative physical therapy was, like, this image of a child in a wheelchair to walking, right? Like it was a cartoon or whatever. Um, and potentially, like, you have families who are very low income throw a lot of money into something that... it doesn't always create that result. So the ethics of kind of the emotional roller coaster, or like, for example, there's oxygen…. some cameras here use oxygen tanks, and inside oxygen tanks. So sometimes it can be a lot of financial.. like they can pour a lot of finances into it, and a lot of emotional energy in terms of hope. And hope is important, like, I want families to have hope. But you don't want them to have false hope or for that to be taken advantage of.

Mave's ethical concerns about Traditional medicine when being branded as a "cure all" are not to be taken lightly, especially in a hospital where patients have severe and life-threatening conditions:

> I think that, you know, people seeking it outside of hospitals is great, but for some people where, you know, they... there's only one specialist for their condition within a hospital, and I worked... I've worked in genetics here. And there are some really rare genetic diseases where there's only specialization in a tertiary level hospital like this. And children will die or have developed serious developmental delay if they don't follow strict diets moderating proteins or different things that I think sometimes in the alternative health or complementary health, those kind of conditions are not acknowledged, like sometimes it's like a lot of marketing, like, 'we… everything can be cured through alternative', like you know, clean eating and supplements and things like that. And there's some things that people are born with that, from what I see here that I… I have a hard time believing that.

Speaking further about the damage that too great a focus on alternative health can cause, Mave states: "And then I also think in terms of what I was referencing around diet, and weight, there is like, a risk of orthorexia". Unfamiliar with the term orthorexia, I asked her to explain. She replied:

> Oh, so it's a form of disordered eating where the person is very concerned with the purity of food. And it becomes an obsession. It can get in the way of eating socially, going out to dinner with friends, things like that, and becomes restrictive. So some... like part of the worry is if someone's vulnerable, could they become orthorexic by an immersion in some of the things that could come up from [an] alternative health perspective? And I've seen some patients here who went from orthorexia to anorexia. You know what I mean? And to their intestines and things in their body not working in and needing a medical interventions to save their life. So, um yeah…

Camilla did not share specific concerns related to Traditional medicine. Her main concern was around the importance of offering service users the freedom to choose and support them in their decision to choose

Traditional or Western medicine or a mixture of both. She highlights the importance of mitigating judgement and shame.

> We get into trouble when we start prioritizing or valuing or judging. You know some… some clients who are really identified with Traditional medicine can feel a lot of shame or judgment if they need if they need pharma... pharmaceutical support, and that's horrible, like that's a horrible burden to carry, right? If they're finding ...whatever helps, they're finding it helpful then, you know, there should be no judgment, right?

She added:

> I think there can be so much, there could just be so much judgment. I think, ultimately it's the client who really suffers in that, and so people will judge if it [Traditional medicine] is too airy or too, you know, it's not grounded in science, or it's not not useful or that's too hippie-ish, or flaky or you know, that's too whatever... And there will be judgment around 'well, pharmaceuticals, you know it's horrible…' and I understand, I absolutely understand, you know I have a strong political analysis around the psychiatric system and over-medicating people, and the racism, sexism... and like I have a solid analysis on it. I *also* know that I see clients that have found it *helpful* to access medication. So I'm not going to, I'm not going to judge that like, there's no way I'm going to judge that.

Incorporating Traditional Medicines into Social Work Practice

Types of Referrals - Traditional and Western

A brief summary of the different kinds of Traditional medicine offered at the two medical settings will illustrate how the two medical settings differ, and will further provide a context for the findings that are to follow. At the hospital, Mave's ability to refer clients to Traditional medicine is quite limited: she can refer any of her clients to mindfulness groups, and to certain spiritual care. She stated:

> We have a spiritual care department, and we have a Buddhist monk who practices mindfulness and leads families in mindfulness meditations if they're open to it. Or other, if there's other spiritual care providers who engage people in prayer or different things like that. So I can refer to them. I can refer to them and I do. So if there's an openness to that from a family, I see whether they're open to it in general, or whether they're only open to it from their specific faith, and then try to match them. But yeah, definitely, I make that referral. We've had mindfulness programs here, and then I've made referrals to them.

Other treatments are available to patients with certain conditions, for instance Mave shared that Cannabidiol (CBD) oil can be used to treat patients with seizures. While it is not permissible for Mave to prescribe this herself as a social worker, she can refer clients to someone who can. She states: "If I knew a family was interested in that, I know a way to get them a referral. And I've supported that before". In addition, both massage therapy and reiki are provided at the hospital, however, unfortunately, these are only available to patients in palliative care, and therefore, as a non-palliative care social worker, Mave cannot refer clients to these. She states, quite dryly, "unfortunately, your child has to be dying to qualify for a massage therapist... but we do have massage therapists."

I asked Mave if she is able to refer patients and families to CAM outside of the hospital. She replied:

> [No], I'm not referring outside of the hospital. Like unless there's like a mindfulness group… or you could even consider DBT [Dialectical Behavior Therapy] uses mindfulness (how much you want to stretch it, right?). Outside the hospital I could refer to that [...] so if it was something with the yoga and mindfulness and it's in the community, I would refer. If it's actual like naturopath, acupuncturist, massage therapist, that I don't have any experience referring.

However, in a later part of my interview with Mave, she relayed that her scope of referrals is not so clear-cut; for example she can strategically refer clients to community health centres (such as the one Camilla works at) where a broader range of Traditional medicines are funded, and available. Mave explains:

> Some community health centres have alternative health care providers. So that's great. That's an opportunity for those families if they're interested in it to access it. And they have social workers and lots of good things, and that's part of how I sell it, right? That it's a team approach, and there's different providers.

Thus, Mave can, if she chooses, strategically connect clients to a broader range of Traditional medicines than are offered within the hospital. Comparatively, it is easier for Camilla to connect her service users to Traditional medicines because the CHC where she works offers them on site and the staff are more accepting of non-western approaches. An example of this is their on-site naturopaths, an important service for those seeking free, non-western medical attention. The naturopaths, she explains, are unpaid, as they are students from a naturopathic school who provide their services in exchange for co-op hours. Thus, this

service is available all the time, whereas other Traditional medicine and therapies at the CHC such as yoga and acupuncture are available much less frequently. Yoga classes are provided by CHC staff who are trained in this area, however due to limited programming and room availability, Camilla states, "they're not always ongoing, it's like maybe twice a year". Camilla also describes bringing nature into her therapeutic practice, which she considers its own form of medicine. This will be further elaborated upon in future sections.

In addition to the services just mentioned, both social workers, not surprisingly also refer to Western medicine as this dominates in both medical settings. Camilla can (and does) refer to: general practitioners (GPs), nurse practitioners, psychiatrists, dieticians, nutritionists, and physiotherapists. Speaking of the distinction between naturopaths on the one hand and dieticians and nutritionists on the other, she states:

> We do have dietitians and nutritionists [but] they're still Western medical model based, unless they've done, you know, extra, I don't know... holistic kind of training but they still very much go by medical model and, you know, Canada's Food Guide and so they're just totally different from a naturopath.

On the other hand, she stated, naturopaths, "work with natural remedies, non pharmaceutical, all natural and herbal". Mave is generally less involved in making referrals, however she says she "does unofficially refer to psychiatrists".

Ways of Incorporating Traditional Medicine Into Social Work Practice: Nature as Healing

Camilla speaks about bringing nature into her practice as a tool to help some clients with severe trauma. Thus, when you consider connection with nature as Traditional medicine, Camilla not only refers clients to such practitioners but also incorporates it directly into her work. She states, "I'm always bringing in connection to nature as [something] calming and soothing." I was curious to learn more about this, especially because nature was not brought up in the interview with Mave, nor is it given much attention in social work literature or in the literature on Traditional medicine or CAM. She explained this part of her practice quite extensively:

> Well, in my office, I have a variety of stones. And so when people are highly activated and triggered like having an anxiety attack or dissociating, or flashbacks, I will use several grounding techniques. So, one of them, I work with stones, and you know we do a practice around drawing their attention to how heavy the stone is, what is the texture of the stone, the temperature of the stone and that's, you know, the grounding practice, just using stones. I will also… I have a big window in my office, so I get people to look outside and you know, look at the trees and describe the trees to me, and what color they are. So I just, you know, that's another grounding exercise as well. I also, you know, people talk about going down, and um… walk... I suggest walking, being outside. We're very close to the lake so, um... you know, I just, I ask them if they're interested in [being] outside and if they would want to walk somewhere, where would they want to walk? And people quite often say the lake, so I just suggest things when they sit down by the water, I talk about the water being able to you know, hold their pain and suffering, and that they can you know release, and you know... find a place by themselves and kind of share and shed some of their worries and difficulties, and kind of unload it and offer it to the water and it can be soothing. Or throwing stones in the water, or picking up a stone and giving a message or giving a worry to the stone and then releasing it and throwing it into the water. So I have a lot... I have a lot of like practices that I do. I could go on for hours with that.

Camilla adds that she does not engage clients in these practices haphazardly, stating, "It's also knowing your clients, right? Like some people I wouldn't suggest that to, because I have a sense of them. I inquire with clients: *what do you find soothing? What do you do to calm yourself?*" This notion of inquiring with clients was an important message throughout the interview with Camilla and will be shared in greater depth in a later section on how the social workers decide whether to refer to Traditional medicine or Western medicine. Camilla elaborated on her rationale behind encouraging clients to connect with nature, describing its use specifically with trauma survivors:

> I'm talking about clients, trauma survivors, who have very highly activated nervous systems and need a lot of safety and stabilization for the nervous system, so the number one thing for that is grounding. Calming, grounding, calming, grounding. So there's... a huge portion of my work is around that, stabilizing the nervous system, and getting it toned down, right?

Thus, while not applicable to all of her clients, Camilla finds she can extend what she has learned from an Indigenous Elder about the healing power of nature to offer similar advice to service users, helping them in ways that are quite simple, safe, and in addition, do not carry any financial burden. Below I present what the women shared specifically about how Traditional medicines have, from their perspective, helped service users.

Decision to Refer to Traditional or Western Medicine or Both

Seeing as Camilla has the ability to a diverse approaches (though it is still biased towards Western medicine) I inquired about how she decides to refer her clients to one or the other or both. She described her approach as such:

> I inquire a lot with clients, like what are they in terms of how they... any cultural or religious or spiritual practices, or you know, any way that they're connected with nature, or what do they find calming and soothing and healing? And you know, I draw on that as well, so I don't do, like, I don't project my… what I think. I think there are so many... so, so, so many things out in the world that you know to one person they would mean nothing, to another person, you know, going and sitting by the lake might be worth the same as what someone is getting by sitting and doing meditation for sixty minutes, or a yoga class. In saying that… So I do believe in holistic healing and I do believe there's not one way for everyone, it depends on what they relate to, what they respond to, what brings meaning to them. Whether it's religion, whether it's, you know, homeopath or naturopath or yoga or going to church, or as I said, nature, or if they're Indigenous, connecting to their Indigenous practices.

Speaking specifically about her decision to direct clients to practices around nature, Camilla states,

> I always inquire what people *already* do. And then I just kind of pull on it. So if people talk about they like being outside in nature, it calms them. They like going on walks, it calms them. Then, *then* I just kind of will tweak it a little bit, so it's like okay why don't we add in this to it, or try... right? So it's never just like randomly go to the water, you know what I mean? There's a context to it.

Further, as stated earlier, at the heart of Camilla's referral process is her belief in the right for clients to choose. While she has personal misgivings about western medicine, she also feels it is important to put these to the side, seeing client choice as the number one priority. She states:

> It's about choice, right? Choice... choice and access to information. What are the different things that are available to support you, what are your comforts and needs, what can you afford…

Moral and Professional Dilemmas of Social Workers

This section highlights uncertainties and concerns shared by Mave about referring services users to Traditional versus western medicine. This highlights that despite the above views about Traditional and Western medicines, her work as a medical social worker is also layered with a lot uncertainty as to what constitutes best practice and how to weigh different medical options for service users. She shared:

> I remember one time when I was a student, my colleague was talking to family and they were not comfortable with antidepressants. And this was in a psychiatry setting. And she asked them, have you heard of St. John's Ward [St. John's Wort]? or whatever it's called? And I kind of thought about that afterwards, would I have, you know, put that on the table as something they could research or look into? Um... Yeah, and I don't know where I st– like that's not something I have personally done. [...] I've noticed psychiatrists actually tend to... not all psychiatrists are going to… going to a psychiatrist doesn't mean you're going to get a prescription. And it's your choice. And getting information doesn't mean you have to do it. You know what I mean? So some of those... breaking it down, so it's not as scary. Now, would I do that with St. John's wort? And if not, like, would I say you can talk to your family doctor about... you can talk to the pharmacist about it? It's a good question.

Thus, Mave is curious about the possibilities offered by non-western medicine, and yet, she is also uncertain about what to promote and what not to promote. In addition, as the following quote shows, she is conscious of what she calls social work's "credibility issue", and described her experience with feelings of self-consciousness and fear about how she would be viewed by both professionals and service users if they associated with things that are "alternative" to the norm. She began by stating, "I think social work has a *credibility issue*." Asking her what she means, she replied:

> Social work… [laughs] I can speak from my perspective, I can share, I don't know how many other medical social workers you're going to interview, but... social work has an issue with image, for sure. 'Child snatchers' is the one image I had. But also in terms of… there's such a range with how people practice, and people know what a psychologist is but a lot of people don't know what a social worker is. 'Is that the one that works in OW [Ontario Works]?' Um...so... and then sometimes, also, there's this, you know the stigma of the 'hippie-woo-woo social worker' who believes in spiritual things and alternative things, and, um… so in a very kind of conservative, often like… what's the word… with a hierarchy of power that's very old. If you look "alternative" to the norm, to the status-quo, that's a bad thing. So I... like, I know that it could be twisted. You know, it could be twisted, right? It could be viewed as a very bad thing if, for some people if I was *promoting* certain things, right? or inappropriate. So I think that's… I was even worried about, you know, my hairstyle and my fashion, or whether I wore eye makeup, I remember coming into this setting and like, 'should I look… should I make myself a little conservative' to fit in?' And I decided against that, but I think that there... in a way there needs to be permission, and education, and normalizing. Cause otherwise, the image of us being 'fringe' and then pushing things that are 'fringe', and dangerous and are in this land of the unknown can be harmful to our profession, too.

She described the role of "credentialism" in this as well, stating:

> I feel like because we don't have a doctorate, in a doctor-dominated environment, as well as in a culture where status, where there's credentialism and status is assigned based on

> credentials, a lot of people don't even know there is a thing called a 'master of social work'; they know that psychologists or doc– well they're confused, 'what's a psychiatrist, what's a psychologist') – but they know they're doctors, often. Right? So I think that makes us… we're more precarious. We're more vulnerable to commit to problems, because our name is confusing. There's a lot of unknown. And then there *are* a lot of social workers, because we're social justice oriented, who are more open minded to complementary, like you know sometimes we're called 'granola social workers', versus 'the coach bag social workers'. ...There's those too! So, I just think that, like, sometimes that harms how credible we are seen by our professional peers, or even by *clients*... 'No I need a psychologist' or 'No, I want to know what the doctor says. Does that make sense?

Based on Mave's sharings, the hospital is not a simple place in which to be a social worker, especially one who is interested in shifting the status quo. She shares that there are obstacles and challenges that arise due to the ugly and troubling history of social work itself, and due to the fact that social workers' knowledge is often devalued by other professionals and by service users themselves. Thus these complexities complicate practice and may also forestall change.

Barriers to Traditional Medicines in Social Work

I asked the women to describe the obstacles service users face in accessing Traditional medicine. Camilla stated, point blank, "folks can't afford it". From her perspective at the CHC, the lack of public funding for Traditional medicine is the primary barrier to clients being able to access such services. She explained:

> ...Like who were funded by doesn't fund for naturopath positions. So our management was creative and did a partnership. So there's a hierarchy in terms of what the government funds, so it's not necessarily internally within our management structure. But it's once again it's like what positions are we funded for. Well we're totally funded for physicians, nurses, dieticians, National Health promoters, social workers. But we're, you know, we're not funded for an alternative medicine practitioner, right? A Traditional practitioner.

Thus, at the CHC, the barriers to Traditional medicine are not created by the institution itself but rather are the result of the government's valuing and prioritizing western medicine over Traditional medicine. To clarify this point, I asked Camilla if Traditional medicine is accepted in her place of work, and she replied, "Yeah, very accepted".

My interview with Mave revealed other obstacles in addition to the financial ones – obstacles which originate from within the hospital itself, further limiting the ability for patients to receive care that is more holistic and balanced between western and Traditional medicines. Indeed, these findings indicate that Traditional medicine occupies a far more controversial and tenuous place in the hospital compared to the CHC. Mave shares how her ability to refer to, or even discuss Traditional medicine with her clients is restricted:

> What I would say is, I think I would be acting inappropriately according to the authorities in the hospital if I were to um, you know, say [to a patient and/or their family] *have you talked to a naturopath?* Or *have you explored that?* So I'm not putting it on the table unless its mindfulness, unless it's um… maybe yoga. I wouldn't… yeah unless mindfulness, you know, Jon Kabat Zinn, kind of took something from Buddhism, and made it like, you know, twisted and made this Mindfulness Based Stress Reduction that's been integrated into healthcare, um, and research and whatnot. So because it's been integrated into this, the system I'm working within, that's something I feel comfortable recommending, or discussing teaching to my clients. That I don't mind me putting it on the table.

This emphasizes that there is a system of power and control operating within the hospital that determines which knowledges and practices are seen as "legitimate" (and hence colonized), and restricts the entry of many non-western practices. Consequently, this system of power and control impacts the freedom that social workers such as Mave have to connect her clients to non-western healing approaches.

Recommendations on Balancing Traditional and Western Medicines

I asked the women how in their view Traditional and Western medicine could become more balanced with one another so that Traditional medicine could be more given more power and legitimacy within the social work referral system. They shared numerous ideas and reflections about how to make changes which corresponded to their particular places of work, from more dialogue, to partnerships with schools of Traditional medicine, to shifting and diversifying medical research.

Dialogue

On the micro level, both women shared ideas about the importance of dialogue – talking more

openly about different healing and therapeutic approaches so that there becomes less stigma, fear, and ignorance about referrals to non-western medicine. Mave states:

> I think that complementary has a lot to offer that's not being fully… that's not well accessed. And yeah. I would love, for example, the association to help almost give permission around… or give examples, or have talks about this. Cause I think if we don't talk about it, then we're left with this feeling of 'I don't know what's right in terms of making referrals and integrating practices, *is that 'fringe*'?

In Camilla's experience, dialogue is also important. However, this differed from Mave's reflection on dialogue as, evidently the work climate is very different in the CHC compared to the hospital and there are staff with diverse views and backgrounds. Camilla reminds herself of the importance of engaging in dialogue with social workers and other professionals in the CHC in order to broaden her knowledge and make practice more inclusive. For Camilla, engaging in this dialogue is an act of social justice:

> The staff team that I work with, like, there's different people from different cultures, and so they offer, you know, they share their... their thoughts and their wisdom and knowledge with me, and so like, I find it really interesting and important. So you're at Ryerson and everything is about decolonization and anti-oppression work, and so it's really important to be inclusive and to recognize other knowledge and not just be caught up into the dominant Western culture, so it's my whole… it's kind of my whole approach to my life, and to my work.

In addition, while Camilla continually engages in dialogue with colleagues to broaden her perspective and keep herself open, she also is not afraid to share the wisdom she has gathered in her life around health and well-being in order to help her clients. She says:

> I feel it's also, like, it's like things that I experienced in life that I find helpful I always share. I think information is power... so I always share that knowledge with my... with my clients just as an offering around things that might be useful in their healing.

Partnerships and Networking

Camilla's primary recommendation to make Traditional medicine more balanced with Western medicine was "more partnerships". By partnerships she is referring to those the one that already exists in the CHC with a naturopathic school – a strategic way for services not funded by the government to be

made available to individuals free of charge.

She did not know specifically of any advocacy work to help bring Traditional medicines more into the public domain, replying, “I guess the advocacy part comes from our individual networking with alternative or Traditional practitioners that we know, and seeing, you know, if a partner would offer or donate time. But in terms of on the policy level, none of us are involved in that.”

Research

Mave’s answer to the question of how to make the medical referral process in social work more balanced differed from Camilla’s answer about partnerships, as again, Traditional medicines are viewed differently between their two places of work. In addition to creating “permission” and opportunities for dialogue Mave’s also shared was of the opinion that medical research needs to shift as this is what determines which approaches are seen as credible. The dialogue between Mave and me shown here highlighted her views on this:

> M: I think mindfulness is a good example, right? Like, we have research. People connected it to health outcome… positive health outcomes, physically and from a mental health perspective, and so there’s more acceptance of integration. Well, from my perspective, I may be wrong, but I believe that acupuncture is actually, has good research behind it as well. So, you know, *can there be an openness to have more of a real integration*? And then, I do like the idea of integrative medicine and like, having doctors who are medical doctors who also have similar education as a naturopath be involved, you know, I'm going to be kind of...I'm going to go out there, if the schools of naturopath… probably if they took off homeo...
>
> R: ...homeopathy?
>
> M: ...homeopathy from their course... course listings, you know, that might help.
>
> R: Help with what?
> M: Getting it more integrated, seeing it more legitimately. Because homeopathy is something that’s very easily dismissed. Right? Versus other forms, or, you know, it's, I think there's a lot of other things where it's easier to probably *find* research, get research and get acceptance.
>
> R: Do you feel like because of that element, homeopathy sort of discredits other professions [in Traditional medicine], even…
>
> M: Yeah, yeah I do. I do, because I feel like that’s...when... when I talk about it with people, that’s the easiest thing to dismiss. Right? Like point-nothing in...in alcohol, right? …of a

> substance [sighs]. Anyways, so my uncle also wrote a book on chiropractors, and an investigative journalist book on neck manipulations gone wrong, leading to death or significant… and um, paralysis or things like that, so I kind of… why I'm bringing that up is I think, *if* some of the risk was mitigated, if some of the things that are more fringe were… 'okay, *you* are either a homeopathic doctor *only*, or you're a naturopath and it *doesn't* include homeopathy, I think *that* would help, personally, but that's... I'm thinking very big picture [laughs] ...to help it be integrated.

Thus, for Mave, in order to have more integration or balance between Traditional and Western medicines, there needs to be movement on both sides. On the one hand she feels that medical institutions need to be more open-minded and responsive to research that shows the efficacy of certain Traditional healing techniques such as acupuncture and to allow these practices to make their way into the mainstream. On the other hand, she feels that unless certain branches of Traditional medicine such as homeopathy, which she gathers are easily discredited, are isolated from other Traditional medicines, this integration will be unlikely to occur, as it compromises the credibility of Traditional medicines as whole.

Adding to this, Mave made it clear that she also sees a need in some cases to have spaces outside of mainstream hospitals where people can access Traditional medicines:

> I do think that having a space *outside* of Orthodox medicine, clinic spaces, *that's* therapeutic for people who've had negative experiences with Western medicine. So I wouldn't want it *all* to be... like I wouldn't want the only way to access it to be… I wouldn't want western medicine to just *consume it all* and take it all over. [Like] 'Oh, now… now it's… you can get it by coming to us…' and it's probably diluted, and I would still… I would want it to be integrated *within* western medicine as an option for all patients and that doctors and social workers referring, but I would also want there to be spaces outside of orthodox of western medicine institutions for people to engage in alternative health practices or complementary medicine.

Of course, the biggest roadblock limiting service users' access to Traditional medicines is the cost. Mave raised a valid point in tandem with this – that it is not just the lack of funding for Traditional medicine that is problematic; there are other services as well as that should be covered under government-sponsored health care but are not. She stated:

> Personally, I think that... this is my value system: mental health care, dental, health care, *good quality* alternative/ complementary health care… so like social work practices included *should* be covered, right? Ideally. Like if, if, I know it can become… I just I just think that where we draw the line is very strange. Like, people have to pay for oxygen, but we're saying it's essential for

> them to live. You know? Dental… like gingivitis can cause like heart disease, but no, that's a private thing for you to pay for. Like, I just… I think that... and mental health you know, if you... you're not severely ill then you know, then you have to pay for it. Like I don't have to be *severely* ill to see my family doctor, why do I have to be severely mentally ill to get free mental health care services?

This highlights that in addition to the debate around Traditional and Western medicines, there are other important gaps in the medical system that lack rational explanation and infringe on peoples' medical freedom. These are relevant concerns within social work as it is concerned with the most socially and financially marginalized in society. Thus, investing time, attention, and energy into these issues is important.

For clarity, I will summarize the suggestions that Mave and Camilla shared about how to create more balance in the social work referral system between Traditional and Western medicines. In Camilla's view, the most logical and plausible solution to creating more balance in CHC would be to develop more partnerships, such as those with various schools of Traditional medicine. This would allow service users to access more Traditional medicines for free and more often. This would constitute a meso-level approach, requiring coordinated action between different organizations; yet at a level below that of engaging in large-scale political action. In addition, both Camilla and Mave spoke about the need for more dialogue to help reduce stigma, fear, and ignorance around Traditional medicines. For Camilla, this suggestion constituted a micro-level approach, as it was suggested as a way for social workers to keep themselves informed and open to different worldviews and perspectives on healing. Therefore, this would be the most workable solution, but of course with limited returns for service users. Mave also recommended more dialogue, however in her case this entails a far more complicated process at the hospital, requiring "permission" from the medical association, alluding to the issue of firmly entrenched power structures governing choice and access to information. Lastly, Mave felt that another critical step towards more balance surrounded the issue of research in order for the association to be inclusive of some, though not all Traditional approaches. While Mave did not explicitly state this, this last suggestion would seem to be related to her first suggestion of dialogue, as dialogue would be needed between the

two different spheres of medicine in order to determine which approaches to include and which not to include – otherwise it must be asked who (i.e. which sphere) would decide this?

The research findings thus presented offer a beginning look into the experiences of social workers in Toronto who refer service users to Traditional medicines in spite of the heavy bias towards Western medicine in the social work referral system and Canadian health care at large. The findings offer insight into two social works' experiences in this endeavor, exploring their personal knowledge and experiences related to Traditional medicines; their practice-informed views on the costs and benefits of Traditional and Western medicines; the challenges and moral dilemmas they face in referring service users to one or the other; and finally, ideas about how to create more balance in the social work referral system to offer health freedom to everyone, not just those who can afford to pay for it.

CHAPTER 6. DISCUSSION

Before discussing the research findings, I will bring attention back to the theoretical frameworks that were outlined in chapter three: decolonization, the Medicine Wheel, and the contrapuntal approach. Decolonization recognizes the tremendous violence, harm, and suffering that colonization has brought to Indigenous communities, as it has attempted to remove Indigenous people from their land and has systematically sought to undermine every facet of their culture. This includes but is not limited to their ancient knowledge and healing systems such as the Medicine Wheel. Further, the coloniality of power (Mathebane & Sekudu, 2018) speaks to the ways in which colonialism still operates in contemporary society through the power dynamics undergirding everyday systems, such as that of modern medicine. With this in mind, decolonization seeks to bring attention back to the knowledge and wisdom that exists in Indigenous communities in spite of generations of trauma, suffering, and loss. It asserts that in order to bring health, harmony, and balance back into Indigenous communities, a return to Traditional knowledges and practices must take place (Gray et al., 2013). Indeed, institutions must undergo a thorough transformation if this decolonization process is to occur.

Second, the Medicine Wheel is a core part of Indigenous teachings. It holds that human beings are composed of four interconnected parts: body, mind, emotion, and spirit; and it sees these four parts as being in continual relationship with one another. Thus, through the Medicine Wheel, healing is a question of holism and balance. The Medicine Wheel is a core philosophy that separates Traditional Medicine from allopathic medicine.

Third, the contrapuntal approach is a theoretical model that addresses the need for balance between two seemingly opposite points of view. In this case I apply the contrapuntal approach to Traditional medicine on the one hand, and Western medicine on the other. I use this model to bring attention to the fact that the referral system in social work favors Western medicine over Traditional medicine – an enduring example of the coloniality of power. Applying the contrapuntal approach to this topic can encourage us to bring Western and Traditional medicine into greater balance with one another

and enable dialogue. Where applicable, these frameworks will be used to discuss and analyze the research findings, and to dig deeper into an analysis.

Discussion of Findings

While this study was not intended as a comparative analysis, important differences were discovered between the acceptance of Traditional medicine at the CHC compared to the hospital. Though both Mave and Camilla had an interest in holistic approaches, it was clear that they also had very different work environments and different levels of freedom to refer to, and operate from a holistic framework. This impacted the range of medical options that the social workers could refer service users to, and it denoted very different power dynamics within the two work settings. As such, the womens' responses and sharings were quite different. For instance, Mave expressed much more uncertainty, skepticism, and fear around some Traditional approaches compared to Camilla. Given these differences, I have chosen to discuss the findings separately for each of the two social workers.

Mave: A Social Worker at a Tertiary Care Hospital

The interview with Mave revealed a complex array of thoughts and reflections on the topic of Traditional and Western medicines, and above all suggested a process of personally working through the reality of working in an environment that in her opinion is "imbalanced" in favor of western medicine. She expressed a desire for more balanced care between Traditional and western approaches, and shared concerns about particular aspects of both allopathic medicine and Traditional or "alternative" medicines. Her concerns about allopathic medicine included: the aggressive nature of allopathic cancer treatment; a suspicion about the suppression of research; the heavy emphasis on drugs in treating children; risks of medical trauma; and the lack of "real food" in cases of tube feeding. These concerns are not unfounded. For instance, her concern around cancer treatment and the heavy reliance on drugs coincides with Mitchell et al.'s (1979) study on the clinical effects of drugs among hospitalized children. In addition, her concerns about allopathic cancer treatment also harkens back to the story of 11-year old Makayla Sault

whose experience and strong opposition to chemotherapy is a sobering example of how Western medicine may not always be the best option for a child. Below I discuss key themes from my interview with Mave.

Lack of Balance and Ethical Dilemmas

When I asked Mave if she struggles with the lack of balance between Traditional and allopathic medicine, I was struck by her response. She said, sincerely, and as if with remorse, "yeah, it doesn't feel good". This sentiment could easily be overlooked, especially through the gaze of Western medicine where such feelings and gut responses on the part of practitioners do not have a clear place. However, if we are permitted to bring attention to the Medicine Wheel, this statement suddenly becomes quite meaningful and important. The fact that some medical approaches do not sit well with her, a social worker, or anyone for that matter, is important information and can serve as a clue that a holistic approach is lacking. Mave gave another clue to this imbalance when she shared, "I don't like going to hospitals, I work in a hospital, but I don't like hospitals, right? It's uncomfortable." While this statement may seem innocuous, as *we all know nobody likes hospitals*, it is the normalization of this reality and the dismissal of the potential for other options that is problematic. Framed through the Medicine Wheel, such sentiments are important and are not to be disregarded. Indeed, there is much logic to this. If Mave feels uneasy about some of the medical approaches used in the hospital such as cancer treatments, how are the patients who are undergoing these treatments and their families expected to feel? How might this negatively impact their health? In addition, how might the therapeutic relationship between Mave and her clients be impacted if she cannot be open about her deep misgivings? And, further, how might this situation impact Mave's health and well-being if the unease she experiences in her work continues unresolved? These are important questions to unearth in order to explore possibilities for more transformative and holistics practice.

Following from her reflection on the lack of balance in the hospital, Mave shared that she sometimes wonders if she is just a "cog in a system that does harm". The notion of coloniality (Mathebane & Sekudu, 2018) is relevant here as it suggests an underlying power structure that dictates

how this system operates, leaving Mave, as a social worker quite powerless to influence or change it. Thus, while Mave has discomforts and uncertainties about the goodness and efficacy of some Western approaches, it is difficult for her to find a professional outlet for these concerns. It was clear that there is tight control over which approaches are permitted in the hospital and which are not, again emphasizing this notion of coloniality. On this, Mave stated, "I think I would be acting inappropriately according to the authorities in the hospital if I were to um, you know say 'have you talked to a naturopath'"? As Mave explained, mindfulness is one of the few Traditional medicines that is commonly accepted in the hospital. She stated, "Jon Kabat Zinn kind of took something from Buddhism, and made it like, you know, twisted and made this Mindfulness Based Stress Reduction [MBSR]". This highlights the unfortunate process by which other knowledges are subjugated and appropriated in order to gain entry into our modern institutions. For Mathebane and Sekudu (2018) , "coloniality and modernity are like two sides of the same coin" (p.3), which "sustains itself through an underlying logic of power, which includes, among other strategies, appropriation of other 'knowledges' and centering Europe as an epistemic hegemony of the modern world (Quijano, 2000 as cited in Mathebane & Sekudu, 2018). Thus, from Mave's sharings we can see that Traditional and non-Western knowledges are not balanced in the hospital, and that beyond this, there is a system of power and control that blocks the exchange of different ideas, opinions, and knowledges around health and healing.

Adherence

Further linked to coloniality, Mave spoke about the expectation of "adherence". As a social worker, she is expected to help patients "adhere" to certain medications and treatments. This too signals a system of power and control within the hospital that subjugates other knowledges. The notion of adherence implies a hierarchy of power where some treatment options are deemed superior to others, to such an extent that following them is almost a requirement. It suggests that there is little opportunity for patients and their families to challenge, question, or inquire about other possible treatment options, which presents another barrier on top of the already limited availability of Traditional medicines in the public

sector. In addition, Mave raised an important issue, commenting that "it can be tricky where the line falls" between something being a medical option versus a medical requirement. This echoes a concern raised by Kane (1980) that was shared earlier in the literature on iatrogenic illnesses. He stated that in medicine there is a delicate balance between 'doing good' and 'causing harm'. Mave used the example of tube feeding, stating "if you're in another country, tube feeding wouldn't be an option. So because you're in Canada, because tube feeding is an option, does that like, does that mean it's a requirement?" As the literature on iatrogenic illnesses suggested, with technological and medical advancement also comes the risk of becoming less cognisant about the relative risks and drawbacks of these approaches. It suggests the need to continually question and challenge that which is deemed "advanced" and thus "required" over other options, and to trouble which knowledges are permitted entry into modern systems and which are not.

Concerns and Skepticism about Traditional / "Alternative" Medicine

While Mave shared concerns about allopathic medicine, she also expressed reservations, concerns, and skepticism around Traditional medicines or those perhaps more appropriately called "alternative". Her instinct to view some of these approaches conservatively so as not to give patients and their families "false hope" is important and apt judgement, and serves as an important reminder of the profound moral responsibilities of social workers. Further, her noting that alternative approaches are often co-opted by capitalism and primarily serve "rich white women" is so important to keep in mind. This is additionally important given how the majority of literature on "CAM" sidesteps issues of social location, particularly class, and thus renders findings applicable to a privileged minority. These skepticisms that Mave holds are important to highlight and bring to the table when discussing the different approaches to health and wellness. However, it is also important that these concerns not be used to negate Traditional medicine as a whole as there is a difference between Traditional approaches, and the appropriation of these approaches used to serve capitalist interests.

The skepticism Mave expressed around homeopathy is important to examine here. She expressed skepticism about this approach as well as the belief that homeopathic medicine undermines the credibility of other Traditional approaches. She shared believing that if it weren't for homeopathy, other Traditional approaches would more likely be accepted in the hospital. However, it is important to critically examine the history of modern medicine here. Dean (2005) writes about the "medical fight" that occurred between homeopaths and osteopaths in Canada and the United States at the beginning of the 20th century. She describes how homeopaths along with other non-allopathic medicines were deliberately cast out of the mainstream, contrary to the popular belief that homeopaths died out due to lack of public support. She explains how medical licensing boards were created in the United States for the purpose of giving allopathic medicine a monopoly over the medical system. Dean writes:

> "In order to get around the fact that there was no provision in the U.S. Constitution to establish a medical monopoly under federal law, Flexner suggested that a licensing organization, not controlled by government, be developed so that allopaths could establish uniform medical licensing laws in all states. The idea was to create only one licensing board in each state under the control of the allopaths for all medical care. No one, who had not graduated from an approved allopathic medical school, would be permitted to take a licensing exam. Homeopaths, eclectics, osteopaths, and others were to give up their 'dogma' and 'surrender' to 'science' as these medical philosophies were, according to Flexner, nothing more than 'unscientific' 'cults'" (Dean, 2005, p.26).

While greater research into homeopathy would be important to understand its usefulness and efficacy, this snapshot of history should serve as a red flag, as it shows how mainstream medicine and the social work referral system that is aligned with it came to be biased in favor of allopathic medicine. Once cognisant of this history, it is easier to be clear about the fact that other knowledge and practices have been systematically undermined. In addition, Dean (2005) reminds us that "to this day, homeopathy remains a major treatment modality in Europe and India" (p. 30). Thus, it is also useful to look outside of Canada and the United States to see how medicine differs in other parts of the world. This is valuable information that can be used to direct and inspire change in the social work referral system. In this vein, Gray et al. (2008) remind us that the notion of 'cultural competence' which is so widely talked about in social work, is in truth more about understanding than it is about knowledge. Similarly, Pon (2009) warns that cultural

competence as it is widely used in social work is a form of "new racism" (p.60). He states, "Cultural competency resembles new racism by otherizing non-whites by deploying modernist and absolutist views of culture, while not using racialist language" (p.60). When we look more honestly and critically, developing 'cultural competence', if there is such a thing, requires openness and constant dialogue and communication as well as the willingness to leave one's 'cultural comfort zones' (Gray et al., 2008). Through such openness and humility we may indeed see that it is less about understanding the 'other's' culture and more so about understanding our own.

Camilla: A Social Worker at a Community Health Centre

Incorporating Nature into Practice

Camilla's incorporation of nature into her practice with those who have experienced trauma illustrates how the Medicine Wheel and decolonization can help people in their healing journeys in ways that Western medicine alone may not be able to. Camilla made it clear that she does not "appropriate Indigenous teachings", yet her practice still speaks to Indigenous worldviews around holism and the importance of nature as a gateway to healing. By incorporating nature into her practice she helps people (who are receptive) connect to nature's healing properties, and thus to their own spiritual essence. This is a possibility not just for Indigenous folks, but also, as Mave discussed, those who have experienced severe trauma in their lives and are in need of "calming" and "grounding". Though Mave did not frame it as such, this therapeutic approaches is simultaneously an act of decolonization, as everything in our secular, modern society discourages us from this kind of deliberate connection to nature (Kimerrer, 2013). Disconnected as we are, we do not seriously consider that our physical well-being could be connected to our spiritual well-being, and we have become removed from the language of the natural world which can foster healing. In her spellbinding book Braiding Sweetgrass, Indigenous botanist Robin Wall Kimmerer (2013) writes that "the animacy of the world is something we already know, but the language of animacy teeters on extinction–not just for Native peoples, but for everyone" (p.57). The Medicine wheel's

emphasis on holism, balance, and harmony offers a constant reminder to come back to this place of connection, to discover who we are at our core.

Practice Values & The Contrapuntal Approach

Camilla's sharings about her practice values demonstrate a viewpoint that is aligned with the contrapuntal approach. She stated, "We get into trouble when we start prioritizing or valuing or judging". This directly corresponds to the notion of a contrapuntal approach which, as applied by Mathebane & Sekudu (2017) to social work in the African context: "recommends having two or more independent but related and co-existing perspectives in social work interacting and dialoguing with one another without a hierarchy" (p.4). The key phrase here is "without a hierarchy", signalling that neither perspective, Traditional nor western medicine should be prioritized above the other. This is the very approach that Camilla described taking at the CHC. Despite having her own feelings about western medicine for instance the overmedicating of clients in Western psychiatry, she stated, "I *also* know that I see clients that have found it *helpful* to access medication. There's clients who find pharmaceuticals stabilizing for them, otherwise they would, you know, be in and out of hospital. So I'm not going to, I'm not going to judge that like, there's no way I'm going to judge that." She stated, "we get into trouble when we start prioritizing or valuing or judging". Thus we can see that this approach at its core is about being client-centred.

Implications for Social Work Practice

What do the above findings signify in regards to social work practice in Toronto, Canada? Firstly, they underscore that it is important for social workers to become aware that there is in fact a bias towards Western medicine within the social work referral system, and in Canadian society at large. Camilla's example of the woman who had been referred to counselling despite this being foreign to her culture, is a reminder of this bias and its associated epistemic injustice (Mathebane & Sekudu, 2017). It serves as a

reminder for other social workers to be cognisant that there are important differences within and between cultures regarding health care, and that one approach cannot be assumed to work for everyone.

Although social workers are not health care providers per se, it is important that they have knowledge about health care and different healing approaches in order to make their practice more client-centred. Becoming informed in this regard would assist in the decolonizing of social work practice itself, and is something that can be taken on by all social workers, not just those in health-related settings. For instance, it would be important for a social worker working in a transitional housing program to be knowledgeable about different health care paradigms and approaches even though the most obvious issue they are dealing with is housing. This is because health is a principal aspect of peoples' lives; and wherever there is social and economic marginalization, health issues are likely to follow. In becoming more aware of the coloniality of power in mainstream medicine and the suppression of Traditional approaches, social workers can open to a more well-rounded understanding of the range of medical approaches. In doing so they can inquire with patients about what works best for them, working collaboratively with clients in a manner of curiosity to seek out gateways to physical, emotional, mental, and spiritual well-being.

Despite the imbalance between Traditional and western medicines and the limited power that social workers such as Mave have to change this imbalance, even in her case, there were ways that she found to push the envelope to provide more diverse options to patients and their families. She discussed how she could maneuver around the restrictions at the hospital by connecting her patients to CHCs where more Traditional approaches are provided – "selling it" as she put it, as a place that has a "team approach" with "different providers". This is one small example of how social workers can apply "stealth social work" (Baines, 2007) in the area of health care, maneuvering within the system to help meet service users' needs. For social workers like Camilla who work at a CHC where Traditional medicines are provided but still limited, she recommended advocating for more partnerships with different schools such a naturopathic school to be able to offer free health care (and preventative health care) to those who are

financially disenfranchised. In both cases, these actions require being invested in the health outcomes of service users and the decolonization of health care at large. Thus, despite the challenges involved in this, social workers should not fall asleep to these issues or become resigned to it, thinking it is not important. Imbalance in the medical referral system is equally as important as any other issue in social work. Social workers should be talking about this, because change cannot occur without dialogue. Furthermore, at the end of the day, social workers, especially those such as myself who are privileged by race, class, gender, ethnicity, and sexual orientation, have an ethical duty to continually trouble the status quo and carve pathways of change. As decolonization reminds us, this includes becoming allies with Indigenous folks who are already involved in this work on the ground.

On further reflection, it may be that these findings are most useful to social workers who are not already positioned in health care settings, as they may not automatically see or be encouraged to examine the relevance of Traditional medicine for their practice. While this research is by no means "groundbreaking", it can help garner attention and discussion around Traditional versus western medicine where it has previously been lacking. Additionally, in order to develop a fuller understanding of Traditional medicine in social work practice it would be important to interview many more social workers in the Toronto area, especially Indigenous social workers and those from other backgrounds that are connected to other Traditional health approaches, such as Traditional Chinese Medicine (TCM). This would help develop a fuller picture of the issues at hand, i.e.: which Traditional medicines are currently being accessed by service users, how social workers go about connecting clients to these services, what obstacles they face in doing so, and their ideas about how to extend "health freedom" (Dean, 2005) to those who need it most. In addition, it would be useful to conduct qualitative interviews with service users to learn about their experiences being referred to Traditional Medicines by social workers, and how this impacted them in their healing journeys. Though the women in this study gave some examples of their clients being helped by Traditional medicines, these were limited, and cannot replace hearing from the clients themselves.

Another take away from the findings, one that is less overt, is the notion that part of helping service users in their healing journeys is connected to the steps practitioners themselves take towards deeper healing in their own lives. This was alluded to in my interview with Camilla, as she talked about her personal experience using expressive arts therapy "as a way to heal and access painful emotions", and, later in her life, discovering the healing potential of nature under the guidance of an Indigenous Elder. Just as a psychoanalyst who has themselves undergone psychoanalysis may offer a more grounded and informed approach to patients, so too may a social worker who has been helped by Traditional Medicine be better able to direct service users in this area. Indeed, experience teaches us far more than words can. This is especially the case with Traditional Medicine, as the interrelation of mind, body, emotion, and spirit as put forth by the Medicine Wheel is one thing to know intellectually, and a whole other to understand experientially. In stressing the importance of experience over an intellectualized understanding of learned concepts such as the Medicine Wheel, non-Indigenous social workers are less likely to appropriate these teachings, appreciating instead where their understanding begins and ends, and thus can know what to speak to and what not to speak to. This is, I believe, what Camilla describes when she stated the following:

> ...And so, all of it was *very* nature based, and the spirit of, you know, connecting with the earth and gifts from the earth for strength and asking for help from, you know, so, so I - I directly experienced that, so I don't appropriate that and I don't use Indigenous teachings *at all* in my practice, but my *own* experience of nature, and how it's grounding.

Implications on Self

This research journey has pushed me to shift my focus away from my personal experiences with Traditional Medicine and to think more critically about the historical and social processes that renders much of Traditional Medicine inaccessible to the socially and financially disenfranchised. It has reminded me to be humble, especially as my experiences are rooted in considerable financial and social privilege. At the same time, this journey has also enhanced my interest in Traditional Medicine. It has been fruitful on a personal level, as I have become more informed about the topic and thus more able to speak about it.

Having said this, I am aware that there is much more to understand and explore. I do not believe that Traditional Medicine is only relevant to Indigenous folks, for we have all to an extent been colonized, and our health care system is just one manifestation of this. I certainly do not pretend that we are all treated equally here in Canada; Indigenous folks have been treated terribly. They know and experience this in ways that I could never speak to. This does not, however, mean that the decolonization of our healthcare system, i.e. restoring balance between Traditional and Western medicine would not benefit everyone.

Bringing Traditional Medicine into the realm of social work has also enriched my learning and helped me to acquire a more balanced perspective. Camilla's emphasis on the importance of inquiring with clients, and the need for a contrapuntal-like approach wherein Traditional and Western medicine are positioned equally was a key learning for me. I was quite humbled when Camilla said, "Ultimately, it is the client who suffers". For me, this emphasized the "social" aspect of "social work". It emphasized the importance of having a client-centred approach in whatever one does as a social worker, and to occupy a space of not knowing as much as I might think I know.

CHAPTER 7. CONCLUSION

The purpose of this MRP was to explore the knowledge, values, and processes of social workers in Toronto who refer clients to Traditional Medicine. I have endeavored to bring attention to this issue, as it is grossly underexplored in social work literature, practice, and education. As mentioned earlier, while this study was not intended to be a comparative analysis, it did largely become one. It was seen that there is more openness and direct access to Traditional Medicine in the CHC as compared to the hospital even though it is still quite limited in the CHC. Both social workers relayed that there is a clear bias towards Western medicine in their places of work, and thus greater need for information, dialogue, and creative solutions. Further, the privileging of Western ways of knowing and the social and political apparatuses underlying this was especially troubling for the social worker in the hospital, causing confusion, dis-ease, and ethical and moral dilemmas. In addition, the participants' experiences with service users has shown them the limits of an approach based solely on Western medicine, including its lack of cultural relevance, its often aggressive approaches to treatment, and the lack of a holistic approach that addresses mind, body, emotions, and spirit.

Given the small sample size, this research cannot be generalized to social workers in Toronto. Further interviews with social workers are needed, including Indigenous social workers and those with different ethnicities and cultural backgrounds. Knowing that many forms of TM are financially inaccessible to individuals in Canada, it will be important to build on this research. This is needed to encourage more dialogue, awareness, and inquiry into the issues of Traditional Medicine and health freedom, and to help spur action so that individuals receive the most appropriate and fruitful medical care. Based on the above discussions, I do feel that the field of social work, though implicated in the perpetuation of a colonial/imperial agenda, must help push for greater balance between Traditional and Western medicine, whether this be through micro, meso, or macro-level engagement. In addition, dialogue and contact with Indigenous and non-Western healers, community members, social workers, and other health professionals is encouraged to ensure integrity and movement in the direction of greater

balance between these two paradigms. The three theoretical frameworks I have used to guide this research, decolonization, the Medicine Wheel, and the contrapuntal approach are ways that can help steer us in the right direction.

In addition, it may be useful to approach the issue from a perspective of what *already* exists rather than what is missing. In Low's (2004) study she talks about "reconceptualizing the health care system", and envisions a model which she adapts from Chrisman and Kleinman's (1983) analysis. In this she describes a process of porous movement between three interrelated spheres which she labels "lay sector", "regulated sector", and "unregulated sector". As she states, "the usefulness of Chrisman and Kleinman's (1983) analysis lies in its recognition that lay forms of self-care, as well as the activities of alternative practitioners and other folk healers, are indeed part of the larger health care system" (p. 40). Thinking of health care in this way may help empower social workers to have sustained engagement in the issue of health freedom. It would be wise for social workers to not dismiss health care as a field that is separate and removed from social work, but to instead take interest in the issue of health freedom. Doing so is necessary in order for social workers to remain true to their role as key social supports and advocates.

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APPENDIX A

Recruitment Email

Hello,

My name is Rachel Holoff. I am a Social Work Master's student at Ryerson University. I am contacting you to see if you are interested in participating in a research study.

This research is being done as part of my Masters project and my supervisor's name is Purnima George. The focus of the research is Complementary and Alternative Medicine (CAM) in social work practice. Examples of CAM include acupuncture, naturopathic medicine, Traditional Chinese Medicine, osteopathy, massage, meditation, and energy work. The objectives of the study are 1) to explore the approach social workers take in referring clients to CAM 2) to understand the obstacles to accessing CAM services, and 3) to understand how social workers can resist the mainstream referral process and bring CAM referrals more into mainstream social work practice.

To participate you must be a **social worker** who has referred service users to CAM.

If you agree to participate you will be asked to participate in a 60-90 minute one-on-one interview. You will have the option of being audio-recorded, however this is not mandatory for participation. If you do consent to being audio-recorded you may review the interview transcript. All participants will also be provided with a copy of the final research paper upon completion.

In appreciation of your time, you will receive a $30 gift certificate to Amazon and reimbursement of additional costs such as travel, parking, and child care up to $20 total.

Your participation is completely voluntary and if you choose not to participate it will not impact your relationship with Ryerson University. If you are interested in participating, a consent form will be sent to you by email for you to review, and written and signed consent will be obtained at the time of the interview. I am also happy to answer any questions you have about the consent form prior to setting up an interview.

The research has been reviewed and approved by the Ryerson University Research Ethics Board (protocol number REB 2019-034). If you are interested in more information about the study or would like to volunteer, please reply to this email.

Sincerely,

Rachel Holoff

APPENDIX B

Consent Agreement

Ryerson University Consent Agreement

You are being invited to participate in a research study. Please read this consent form so that you understand what your participation will involve. Before you consent to participate, please ask any questions to be sure you understand what your participation will involve.

Complementary & Alternative Medicine in Social Work Practice

INVESTIGATORS This research study is being conducted by Rachel Holoff, MSW Student at Ryerson University.

If you have any questions or concerns about the research, please feel free to contact Rachel Holoff at rholoff@ryerson.ca.

PURPOSE OF THE STUDY To investigate the strategies and approaches that social workers in Toronto use in referring their clients to Complementary and Alternative Medicine (CAM), as well as any obstacles they face in doing so. Discussion may also include why CAM is an important tool for social work practice. The study will include 2-5 participants. Participants of any age, race, ethnicity, ability, sexual and gender identities are welcome as long as they are a social worker who has referred patients to CAM or have been previously. The results of the study will contribute to a Major Research Paper.

WHAT YOU WILL BE ASKED TO DO Participate in a one-time 60-90 minute interview. The location of the interview is flexible, and can be negotiated depending on participants' preferences and needs. Possible

locations include: the participant's workplace so long as there is aural and visual privacy or in a private room at Ryerson's Student Learning Centre or library.

Examples of questions:

- How do you balance CAM along with your usual mainstream process of referral?
- In your view, how can CAM services be made a part of mainstream social work practice?

Once the interview has been transcribed, the transcript will be emailed to the participant if they want. The final research paper will also be sent to participants by email.

Demographic information is not required.

POTENTIAL BENEFITS Participants may not directly benefit from participation. However, one potential benefit to participants is the satisfaction of sharing their knowledge about a topic (CAM) that is an important and often undervalued tool in social work practice. The sharing of this knowledge and experience will help equip at least one emerging social worker and potentially others with a greater understanding of the strategies, challenges, benefits, and potential downfalls of referring service users to CAM. The sharing of this information could help generate discussion among social workers about the value of CAM in social work practice instead of taking for granted the dominance of the medical model in mainstream referrals. In turn, it is hoped that the knowledge shared will, in the long run, benefit the health and well-being of service users who seek more holistic and culturally appropriate services.

WHAT ARE THE POTENTIAL RISKS TO YOU AS A PARTICIPANT Depending on your work environment there is a low risk that involvement in this study would lead to your being ostracized in the workplace, if the perspectives and practices that you share around

CAM are contrary to the dominant views of your workplace. Further, there is also a low risk of your personal identity getting revealed if you have been referred to me by another individual and if this individual mentions your participation in the study to someone else. In addition, there is a low risk of your personal identity getting revealed as there may not be many social workers who refer to CAM. While the research questions are of a professional nature, if any of the questions make you uncomfortable, you may skip answering a question or stop participation at any point, either temporarily or permanently.

CONFIDENTIALITY Your name will not be shared in the published research paper or interview transcript. Instead, you will be referred to by a pseudonym.

The data will be kept until the second reader has approved the research paper which is expected to be August 2019. The data will be kept until then in order to allow for corrections and changes to be made to the final paper.

Please indicate on the signatory page below whether you agree to be audio recorded in the interview. Audio recording is *not* mandatory. If you consent to the interview being audio-recorded, you have the right to review and edit the transcript. The recording and transcript will be secured in the researcher's Google Drive.

INCENTIVES FOR PARTICIPATION You will be offered a $30 gift certificate to Amazon as an incentive for participating in the interview. If you choose to stop participation (described below under Voluntary Participation and Withdrawal), the full lump sum must be given to you whether or not you complete the research.

COSTS OF PARTICIPATION You will be reimbursed for expenses such as travel costs, parking, and child care up to $20 total. By agreeing to participate in this research, you are not giving up or waiving any legal right in the event that you are harmed during the research.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
Participation in this study is completely voluntary. You can choose whether to be in this study or not. If any question makes you uncomfortable, you can skip that question. You may stop participating at any time and you will still be given the incentives and reimbursements described above. If you choose to stop participating, you may also choose to not have your data included in the study. Your choice of whether or not to participate will not influence your future relations with Ryerson University, or Elaine King, or the investigator, Rachel Holoff, involved in the research.

QUESTIONS ABOUT THE STUDY If you have any questions about the research now, please ask. If you have questions later about the research, you may contact:

Purnima George
Interim Associate Director, Graduate Program and Associate Professor
416-979-5000, ext. 7146
p3george@ryerson.ca

This study has been reviewed by the Ryerson University Research Ethics Board. If you have questions regarding your rights as a participant in this study, please contact:

Research Ethics Board
c/o Office of the Vice President, Research and Innovation Ryerson University
350 Victoria Street
Toronto, ON
M5B 2K3
416-979-5042
rebchair@ryerson.ca

COMPLEMENTARY & ALTERNATIVE MEDICINE IN SOCIAL

WORK PRACTICE

CONFIRMATION OF AGREEMENT

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to participate in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement. You have been told that by signing this consent agreement you are not giving up any of your legal rights.

_____

Name of Participant (please print)

_____

Signature of Participant

_____

Date

I agree to be audio-recorded for the purposes of this study (not mandatory).

Yes □ No □

If yes, I understand how these recordings will be stored and destroyed (please sign below).

_____

Signature of Participant

_____

Date

If you agreed to be audio-recorded, would you like to read the transcript of your interview?

Yes □ No □

APPENDIX C

Interview Guide

Introductions:

- How did you become interested in social work?
- How long have you been doing this?
- Where did you go to school?
- How do you characterize your practice?

Objective 1: To explore the value and knowledge base of social workers as it relates to CAM
Major Research Q: What does CAM mean to social workers and how does it factor into their practice?

- How do you define CAM? Do you use this term? Why/Why not?
- How did you become interested in CAM?
- What types of alternative practitioners do you refer clients to? (massage therapists, chiropractors, osteopaths, acupuncturists, Traditional Chinese Medicine doctors, nutritionists, reiki/energy workers, yoga, mindfulness/meditation)
- What types of orthodox practitioners do you refer clients to? (psychiatrists, medical doctors for diagnosis, dietitians)
- How did you come to develop your practice knowledge around connecting clients to CAM?
- How do you decide whether to refer clients to orthodox or alternative medicine?
- Are there time you use both orthodox and alternative medicine, and if so, why?
- When do you do CAM referrals? Is it upon the request of clients or on your own initiative?
- How do you balance CAM along with orthodox referrals?
- How often do you tend to refer clients to CAM services?
- Is your approach of practice accepted in your department?
- If it is not accepted, or critiqued, how do you navigate those challenges?
- What feedback do you get from your colleagues about your approach?
- What feedback have you received from your clients about CAM services?

Objective 2: To understand the obstacles to accessing CAM services and how to push for change
Major Research Question: What are the obstacles to accessing CAM services?

- Are there obstacles for you as a social worker in referring to CAM? If so, what are they?
- Are there obstacles for service users in accessing CAM? If so, what are they?
- Is your practice going to be affected by the new provincial budgetary changes? And If so, what are the principle implications of this? First to you, and then to your clients?
- Do you see it becoming easier or harder to connect service users to CAM or orthodox medicine, or both?
- In your view, how can CAM be made more a part of mainstream social work practice?
- What if any movements, coalitions, or groups do you know of that are working to help make CAM and orthodox medicine more accessible to low income people?

(continued…)

Objective 3: To understand how social workers decide whether to refer to orthodox medicine or to alternative medicine or both.

Major Research Question: How do social workers evaluate the referral process so as to make decisions of how to make references, ie. whether to refer to orthodox medicine or to alternative medicine, or both (ie. complementary medicine)?

- What are the *benefits* of using *only the mainstream approach* to referrals?
- What are the *limitations* of using *only the mainstream approach* to referrals?
- What are the *benefits* of using *only the alternative approach* to referrals?
- What are the *limitations* of using *only the alternative approach* to referrals?
- Do you have any examples?
- Do you have any literature references for each of benefits/limitations?