Canadian Residential Schools and Urban Indigenous Knowledge Production about Diabetes

Heather A. Howard

Department of Anthropology, Michigan State University, East Lansing, Michigan, USA

Abstract

The construction of illness as an inscription on the body of colonization figures importantly among Indigenous community-based service and health care providers. While residential schools and diabetes have both been characterized as products of colonization, little work has been done to examine how they are connected to and informative for health provider practice. The research data presented in this article come from a collaborative urban Indigenous community-based study examining the legacy of negative relationships with food that was instilled in residential schools and used in diabetes intervention. I illustrate how residential school disciplined eating, providing a context for understanding the contemporary production of Indigenous health knowledge and practice in the urban setting, and the diet-related management of diabetes.

Keywords

decolonization; historical trauma; institutional discipline; Indigenous peoples; lived histories of food

I think emotionally, the impact of the residential school was quite traumatic. I do think physically it has affected us with diabetes, and heart disease and cancer, too. Our bodies take it in and we store it. ... The thing that really comes across is that everyone learned to survive in a way to make them move out of there and make them go forward. As a people we are a very strong people. We have done amazingly well despite what the government has tried to do to us as a people.

Joanne Dallaire, Cree research participant/collaborator

Joanne Dallaire's analysis of Indigenous peoples' poor health status as an embodiment of residential school experience highlights how community-based decolonizing theory offers a compelling lens through which to understand the particularities of Indigenous peoples' social suffering, and a potential path to improved health. Individual illness and disease are inseparable from collective experience. They are interpreted through shared, distinct, intersecting, historical and ongoing conditions of economic, political, and other oppressions. Restoration of health and well-being are achieved through actions grounded in collective resilience, which reestablish balance in the mind, body, heart, and soul of individuals, families, communities, and nations.

In Toronto, Canada, where the research I discuss in this article was conducted, the production of Indigenous health knowledge and practice is contextualized within the unique political–historical relationship Indigenous peoples have with colonizing nation–states. In her assessment of Indigenous health disparities, Naomi Adelson (2005:S46) emphasizes how historical colonial and paternalist actions, including the removal and institutionalization of children in past generations, manifest as “collective burden of discriminatory practices” in individual experience. Recognizing the distinctive Indigenous experiences of colonization and dispossession as these extend to “continuing domination, racism, exploitation, and economic disadvantage ... [is] critical to the success of individual and public health strategies” (Garvey et al. 2000:572). Decolonization challenges paradigms privileged in professional health care approaches to chronic illness such as unidirectional knowledge translation, overcoming so-called cultural barriers, and individual-focused behavior shift (Banister, Leadbeater, and Marshall 2011; McMullin 2005, 2010; Thompson and Gifford 2000).

Juliet McMullin (2005, 2010) expands analysis of the embodiment of inequality as a framework for understanding Indigenous peoples’ poor health status to consider the ways in which Indigenous identity, tradition, connections to land, and memory are mobilized to reinterpret and revitalize health. In relating a story about preparing a traditional Hawaiian meal, she describes the interdependence of physical, symbolic, spiritual, and family relationships around food which underscore how food socialization is a central theme in the production of Indigenous health knowledge and practice (McMullin 2010:12–13). In the multicultural Indigenous community of Toronto, the intersection of diverse yet shared oppressions and multiple identities and traditions add complexity to these processes.

The research presented here comes from a collaborative community-based study I conducted with the Native Canadian Centre of Toronto (NCCT) to examine how the legacy of negative relationships with food instilled in residential schools may be accounted for in contemporary diabetes prevention and management. My purpose here is not to evaluate the effectiveness of the program at the center of the study, nor to argue an etiological relationship between residential school and the disease of diabetes.¹ Rather, I illustrate how residential school was one institution among others that disciplined a habitus of eating (Bourdieu 1984; 1990:54), providing a context for understanding contemporary practice in relation to Indigenous peoples’ dietary habits and the management of diabetes. I follow Ferzacca’s approach (2004:43) in describing the “lived histories of food” embodied in the diet-related disease of diabetes as informative for health provider practice. Ferzacca describes how the denial of “other historical realities” is central to the medical nutritional therapy that prescribes a diabetes appropriate diet to patients in a veteran’s affairs medical center. I explore the production of health knowledge and practice through processes that expose the denial of historical realities as purposeful oppression complicit in the severity of diabetes among Indigenous people. Collective disclosure and acknowledgement of historical realities become central, perhaps ironically, to inducing Indigenous persons living with diabetes to change their eating habits. Ferzacca reveals the process by which the clinical parameters of

¹Reference to diabetes throughout this article generally refers to type 2 diabetes, although some participants experienced and/or discussed type 1, gestational, and prediabetes.

medical nutritional therapy squash patient identity and choice. In contrast, I show how Indigenous people reinterpret similar parameters of a diabetes-healthy diet as their own (see also McMullin 2010) by unmasking how the historical realities of residential school erased identity and choice, and by reframing their relationship with food through decolonization models. My analysis concurs with Thompson, Gifford, and Thorpe (2000:726) in their findings that, in an urban Australian Aboriginal community, health promotion needs to do more to “identify and understand the wider sets of social meanings attached to specific risk behaviors” in the focus on modifying diet among Indigenous populations. In particular, I illustrate how the past offers itself “to the living as a basis for creatively comprehending their present situation and making informed choices about how it is to be addressed and lived” (Jackson 2007:83).

I am also interested in the temporality of diabetes in life experience. James Scott (1990:xii–xiii) provides a useful framework for understanding the ways in which the buried collective experiences of Indigenous people push their way into the public to reveal “hidden transcripts” and disrupt the power dynamics which frame delivery of their health care. For more than a century, the residential school system generated “a hegemonic public conduct and a backstage discourse consisting of what cannot be spoken in the face of power” (Scott 1990:xii). Residential schooling was publicly presented as a pathway for Indigenous people to become productive and good Canadian citizens. However, this pathway actively entailed the brutal destruction of Indigenous sociocultural structures. It resulted also in the sexual and physically abusive victimization of Indigenous children. Since the 1990s, when this systematic physical and sexual abuse became public, the “public declaration of the hidden transcript” (Scott 1990:202) by school survivors transformed Indigenous/non-Indigenous relationships.

For Indigenous children in Canada, residential schooling began in the latter half of the nineteenth century as part of a systematic, aggressive assimilation policy. By the 1930s, there were 80 schools across the country; the last closed in 1996 (Milloy 1998). Under this policy, children as young as toddlers could be forcibly removed from their homes and families to the schools, where they might remain until adults. Spending this extended time in residential schools robbed individuals of their capacity to return to their home communities (Milloy 1998; Knockwood 1992; Hodgeson 1990), and residential school experience is a significant factor in the movement of Indigenous peoples to cities. More than two-thirds of the Indigenous peoples of the nation–states of Canada and United States live in cities and other areas outside reserves (Howard and Lobo 2013). Approximately 70,000 culturally diverse Indigenous people live in Toronto, a large segment constituted of residential school survivors and their descendants (Howard 2011; Obonsawin and Howard-Bobiwash 1997).

Diabetes was virtually unknown among Indigenous peoples in Canada until the 1940s. It has now reached epidemic proportion (Public Health Agency of Canada 2003), with diagnosis occurring at younger ages for Indigenous peoples and in greater numbers compared to the overall Canadian population (Bobet 1997; Dyck et al. 2010; Oster et al. 2011; Simpson et al. 2003; Young et al. 2000). In Toronto, nearly 12% of Indigenous people counted on a 2001 census reported diabetes (Statistics Canada 2002). Caring for or living as a person with diabetes, and its complications including blindness, limb amputation, and organ failure, are

predominant features of urban Indigenous life, yet it is understudied (Ghosh 2012; Hagey 1984, 1989; Howard 2014; Iwasaki and Bartlett 2006; Lavallée and Howard 2011).

The framework of historical trauma (Brave Heart and DeBruyn 1998) that took hold in the past decade in some clinical practices, particularly in mental health and substance abuse interventions, highlights the connection between colonization and Indigenous health (Evans-Campbell 2008; Waldrum 2004; Whitbeck et al. 2004). The contemporary health problems of Indigenous peoples are (at least partly) explained as the result of historical trauma from massacres, genocidal policies, pandemics from the introduction of new diseases, forced relocation, forced removal of children through residential school policies, and the prohibition of spiritual and cultural practices (Brave Heart and DeBruyn 1998; Evans-Campbell 2008). These historically traumatic events are transmitted to the descendants of those with direct experience, with enduring psychological as well as social and economic effects, which impact health and identity, and translate into intergenerational collective explanatory narratives of disease (Evans-Campbell 2008:316).

The historical trauma framework has been elaborated in relation to the boarding school experience (Wesley-Esquimaux and Smolewski 2004) and termed “boarding school syndrome” (Robertson 2006), a concept James Waldrum (2004) describes as metaphorical rather than clinical as one might consider post-traumatic stress disorder. Both those who experienced the residential school directly and intergenerational descendants are referred to as ‘survivors.’ As Waldrum (2004:228) maintains, Indigenous people have embraced the syndrome, not as a pathological condition but as a metaphor for their historical relationship with European settler society.

In describing the harms of culture change to Indigenous peoples’ health, Joe and Young (1993) describe diabetes as a ‘disease of civilization.’ They consider the relevance of aggressive assimilation policy to changes in dietary and physical activity as generating the conditions for the high prevalence of type 2 diabetes among Indigenous people in North America. The system of removing children from their home to residential schools, and subjecting them to a pedagogy which ignored or demeaned their cultures while arguing the superiority of the colonizers’ worldview, was paired with nineteenth-century evolutionary views of Indigenous people as ‘by nature’ unclean and diseased. This idea persisted well into the twentieth century. My research is premised on the complimentary understanding of the structuring violence of residential school food socialization and diabetes as a disease of colonization.

METHODS

The experience of residential schooling and the severe upward spike in the prevalence of type 2 diabetes have become the subjects of particularly intense public and policy discussions. The research I report in this article in response to these factors derives from a project developed through collaboration between community members, social service agency staff, biomedical practitioners, and academics. My main collaborator was Ruth Cyr, a member of the Q’Appelle First Nation, a registered nurse, residential school survivor, and person living with diabetes. At the time of the research, Cyr was director of a program at the

Native Canadian Centre of Toronto (NCCT), which provides support services to Indigenous seniors living in the city; she currently works throughout the community as a diabetes educator. I worked with her in the Toronto Native Community History Project (TNCHP), a community-based research body located within the NCCT. The TNCHP was formed in the mid-1990s by a group of Indigenous community members and allies. It runs an archive, conducts community-led research, and provides a range of popular education activities. Many seniors served by the NCCT are residential school survivors and have diabetes, whose behaviors, such as hiding and hoarding food during a daily lunch program, were attributed to residential school experience. A community-based committee of residential school survivors was formed to design and conduct a project to explore how aspects of residential school socialization such as regimentation at meal times, the use of food in punishment, hunger, and stealing food to survive, left a legacy of negative relationships with food counterproductive to the contemporary work of preventing and managing diabetes. The project had two phases. In the first, residential school survivors provided their memories of diet and eating behaviors experienced in the schools. In the second phase, workshops based on these narratives were delivered as part of the NCCT's existing diabetes education and support group services.

The method of 'living history circles' was used to record survivor narratives. This method followed Barbara Myerhoff's model of group interviewing with Jewish holocaust survivors living in a seniors' residence in Venice, California (Myerhoff 1978), and a methodology I had developed in other TNCHP projects (Howard 2004; Sanderson and Howard-Bobiwash 1997). Living history circles were organized in response to interest within the community, and were based on the 'sharing circle' form of group communication commonly used in the community for social, cultural, service, therapeutic, and other activities. In the physical space of the circle, no particular position is privileged over others. Participants speak one after the other, say as little or as much as they want to, with the option to pass. The underlying principle is that each voice, experience, or contribution is significant and relevant.

Previous to this specific project focused on food, the TNCHP had held living history circles on residential school experience more broadly, and an earlier oral history project conducted in the 1980s had recorded community member memories of residential school relevant to this project (Howard 2004).

Concerns have been raised recently about the harmful consequences that may be triggered for survivors asked to relive traumatic and horrific experiences they had in residential schools (Regan 2010). This was a consideration discussed by the survivor committee that oversaw the project, which sought to minimize negative impacts by using a community-based methodology, prioritizing the community-driven purpose of the project, and providing for the safety and protection of well-being of the participants through community resources. The research complied with the guidelines for ethical practice of the Aboriginal Healing Foundation, which funded the project, and the ethics policies and procedures previously developed by the TNCHP and other community-based research at the NCCT since the 1970s; under these guidelines, research is initiated with the understanding that it contributes to a community-oriented goal and allows for interviewee and community control over the data collected (Howard 2004, 2012).²

The living history circles were held at the NCCT in a supportive setting, with an Elder and social worker present to ensure the safety of participants. Ten living history circles lasting about two hours each were held, with an average of 12 persons in each circle. Forty-two participants came to the circles, several in more than one, with a total of 124 units of participation. Of these, 45 participants were men and 79 women, aged from 18 to 86 years; 67 were survivors and 51 identified as intergenerational participants. As a highly multicultural community with Indigenous people from across Canada, a broad range of residential school experience was represented. The circles were audio-recorded and indexed, and all materials associated with this project are held in the archives of the TNCHP. A grounded approach was used to analyze the data and shape the textual and structural description of findings (Creswell 2007:159–160). Content was reviewed holistically and comparatively by the author and members of the community-based committee and research team for recurrent ideas, perceptions, and experiences; these were categorized and coded for topical similarity, meaningful units and themes, diversity and nuanced contrasts, and significant statements, and were mindful of Indigenous methodological frameworks (Chilisa 2012; Denzin, Lincoln, and Smith 2008). The approach also respected Canadian federal ethics guidelines reflecting concerns that Western science-based evidence may marginalize Aboriginal ways of knowing and perpetuate health inequities (Canadian Institutes for Health Research 2009). The purpose of this study was to reveal deeper understandings of specific experience crucial to effective intervention (Creswell and Miller 2000; Golafshani 2003). It was not a requirement that the participants be diagnosed with diabetes, given that the high rates of diabetes in the community contributes to a degree of identification with the disease (see also Ferreira 2006; Smith-Morris 2010); hence both those with diabetes and others concerned they would eventually get it or who were caregivers for persons with diabetes participated in the research and the subsequent education workshops.

In the second phase of the project, survivor narratives highlighting several broad themes served as the foundation of a weekly series of 10 day-long diabetes education workshops advertised to the community as “Tribal Kitchens.” On average, 17 people attended each workshop. A total of 127 community members participated in the Tribal Kitchens, with the 100 women outnumbering men considerably. Similarly, 96 intergenerational survivors attended, outnumbering the 29 who had personally attended residential schools. Two did not indicate their relationship to the school experience. The workshops were organized around the ‘medicine wheel,’ a holistic metaphoric teaching tool used in numerous community-based health and social service settings (Bartlett 1998; Conti 2006; Dapice 2006; Lavallée 2007; Lavallée and Howard 2011). In the medicine wheel, content is encompassed within a circle, often subcategorized into quarters, and action is oriented toward balance and integration of the four parts. In our ‘wheel,’ content was distributed under the title, “Feeding Our Body, Mind, Spirit, and Heart,” with each session including (1) a theme of residential school experience as narrated by survivors, (2) allopathic perspectives including direct care

²These community-based protocols moved ethical research practice from a framework of paternalist protection to one focused on the agency of participants to own their stories and research methodologies, and were grounded in long-standing practice in the Toronto community and formalized by the TNCHP in 1990s (see Howard 2012). The TNCHP developed policy and critical analysis of intellectual property, which predates and contributed to national research ethics policy reform discussions that resulted in the Tri-Council Policy Statement 2, Chapter 9, Research with Aboriginal Peoples, released in 2010, and that are now integrated into institutional review board practices across Canada.

interventions such as glucose and blood pressure monitoring, (3) activities aimed at connecting people and food traditions, such as storytelling shared by community Elders, and (4) collective preparation and sharing of a meal. The workshops were designed to help participants practice healthy community-based intergenerational relationships around food and eating, and to foster a familial and positive environment integrating cultural stories about foods and their integration with traditional food gathering, preparation, and eating together.

OUR BODIES TAKE IT IN AND WE STORE IT

Information regarding food selection and eating patterns are critical to diabetes prevention and management (Ferzacca 2004:42) although little is understood about ‘healthy eating’ among Indigenous peoples (Willows 2005:S32). Dietary change—particularly the transition from a diversified range of foods gathered, hunted, fished, and gardened to a government commodity issued and store-bought diet heavy with processed foods, simple carbohydrates, and preservatives—has been associated with the etiology of diabetes among many Indigenous peoples (Benyshek, Martin, and Johnston 2001; Conti 2006; Ho et al. 2006; Kuhnlein and Receveur 1996; Lang 1989; Weidman 2010). Other analyses of Indigenous health focus on contemporary social determinants such as current economic conditions, security, and access to food including the impacts of urbanization. Historical factors are generally background for present circumstances (Power 2008; Willows 2005). Kuhnlein and Receveur (1996:442) also acknowledge the influences of education, including as provided by mission and boarding schools, on the contemporary food choices of Indigenous peoples. In this context, Benyshek and colleagues (2001:41) propose an etiology for diabetes as a “political disease,” with historical data of starvation, social, and economic disruptions all “consistent with experimental studies that show that chronic (protein) malnutrition is linked to type 2 diabetes.”

The social dynamics surrounding the meanings attributed to food, the relationships people have with food, and how these are contextualized in family and kinship relationships, are powerful considerations in diabetes prevention and management for Indigenous peoples. Erica Neegan (2005) writes that Indigenous learning traditionally took place through observation, example, and participation in daily living activities, embedded in the social relationships of family life and in relationships with animals and natural environment. Milburn (2004:421) further explains how reciprocal relationships in traditional foodways are “intimate and spiritual” and humans have a duty to maintain their shared roles in these relationships. Thompson and colleagues (2000:725) similarly describe for urban Aboriginal people in Australia that “(f)ood, in particular, represents powerful symbolic connections to belonging and sense of place and past. ... The meanings that food and other related social activities have are central in maintaining and reaffirming connections between individuals and the wider social context of everyday life.” In Toronto, another recent diabetes study recommended integrating family and intergenerational learning into Indigenous community approaches to diabetes research and intervention (Lavallée and Howard 2011). As I will show, family, social organization and community solidarity, experienced both as loss and potentially restorative power, were important factors in relation to food and its consumption.

Some historians have described the intersection of food and abuse within residential schools. Mary-Ellen Kelm (1998:80) describes how, in British Columbia, Indigenous children's bodies were transformed by the residential school experience and "those who survived the experience did so embodying competing and contradictory notions of their physical selves." Curriculum focused on the hygienization of the children and the denigration of Indigenous food practices, paired with the exaltation of dominant society's idealized dietary habits (such as consuming all the food groups), ingrained conflicting notions for Indigenous people because "the dietary standards of the schools were not very high ... schools with successful farms sold their produce while their students went hungry ... children were given very little to eat and that was often spoiled" (Kelm 1998:63, 71).

After World War II, John Milloy (1998:112) writes that food services are better documented and provide evidence of the preoccupation of school management to sufficiently feed the children, and the difficulties children experienced moving to the school diet from their traditional foods. Milloy (1998:122–123) describes how children scrounged the school grounds to eat "what they could find: cats and wheat. And often children ate what they could steal ... hunger and the resultant disorder and dishonesty were at times the nexus around which further mistreatment and abuse clustered." In the model of intergenerational suffering, these experiences were internalized and transmitted to descendants in "explicit models and ideologies of parenting based on experiences in punitive institutional settings" (Kirmayer, Simpson, and Cargo 2003:S18).

In the living history circles, residential school survivors were asked about the types of food available, what a typical day's meals might include, where food was sourced (which could range from school run farms to scavenging), meal times and the dining environment, how food was prepared, if they participated in food preparation, and if the children's food differed from that consumed by staff. Other questions solicited memories about food being withheld or associated with punishment, stealing food or going without, or eating things they would not usually consider as food. They were also asked to discuss differences between food at the schools and in their homes, their ideas about the break with traditional foods and forms of food gathering, if they felt their experiences with food constituted abuse, and if they saw patterns in their current eating habits that may have originated in their school experiences. Here, I focus on the regimented and disciplinary relationships with food, including the association between power, punishment, morality, and food; the legacy of deprivation; the possibilities for reclaiming food traditions in the urban context; and the use of social memory to shift survivors' identification with victimhood to resilience.

My collaborator, Ruth Cyr, spent 11 years at a residential school in Saskatchewan. To her, this institution perpetuated generations prone to unhealthy physical, mental, spiritual, and emotional conditions, including low self-esteem, depression, unhealthy relationships, and compulsiveness, all of which may negatively impact diabetes prevention and management. Prior to the development of this project and as others elsewhere were evolving ideas about the intergenerational impacts of historical trauma (Brave Heart and DeBruyn 1998), community-based theory at the NCCT posited that the mental, spiritual, and emotional trauma endured by residential school survivors could not be divorced from trauma inflicted on their bodies, and would have residual long-term impacts of the development of disease.

Existing testimony recorded by Toronto Indigenous community members bolstered emphasis on the significance of recollections of diet, lack of food, starvation, and punishment associated with food experienced in residential schools as traumatic enough to impact later and intergenerational relationships around food. For example, an oral history recorded in Toronto in 1983 related a community member's memories of Mount Elgin residential school near London, Ontario. This survivor's story described "appalling conditions" of sickness and death. Children resorted to eating frozen apples found on the school grounds because meals were withheld as a form of punishment; the meals themselves consisted of "oatmeal with worms." When children fell sick they were confined to a cold attic to die, and others were compelled to prepare the bodies of the dead so that "the undertaker won't have such an awful job washing a dirty Indian like that," this survivor was told, and further recalled feeling, "I really felt that I was helping ... he's lucky to be away from all this. He doesn't have to worry about eating wormy oatmeal anymore and getting strapped for nothing."

Similar stories related by participants consistently illustrated how the dining atmosphere was connected to abuse, punishment, and therefore shame, sin, power, and control. Numerous survivors spoke of the punishment of children who wet their beds: "For kids who wet the bed, they would be humiliated at meal time. When they would dish out the tea, they would turn their cups upside down so they would not get any, weeks at a time for some of them." One survivor added that if the child soiled his or her pants, he or she would not get a meal at all. Another added that in many instances, these children may have been too young to be toilet trained. The cruelty and humiliation for bed-wetters at meal time was an extension of a series of actions in a larger process of constant humiliation. As another survivor added, "They would make bed-wetters stand in the hall with the wet sheets over them, and stand there for a while, so everyone would see. The nuns were cruel."

Shame and control were associated with food in other ways. Mealtimes were regimented, silent, and controlled. As one survivor noted, "We would line up like the army in cafeteria, wait to do the seating. He took his time, every word for word. They would try to find ways to humiliate you." Other survivors related how they were force-fed cod liver oil: "They would barf, and they would get beaten up and put their face into the bowl, and that only made things worse. The meal was a real ritual. Meal time wasn't really a pleasant experience. All those years it was pure terror, horror, shame and guilt, sadness." As Isabelle Knockwood (1992:44), a survivor of the Shubenacadie residential school in Nova Scotia described, "This was the atmosphere we ate our meals in—an atmosphere of fear of the unknown, the unexpected and the reality that you could be next."

Another survivor explained that he internalized an association between being forced to perform oral sex in the residential school, and being given the host at church on the tongue. For this participant, the trauma of sexual abuse was associated with the mouth, and food and eating were negative experiences. Abuse, punishment, shame, and sin worked together to create in people a very negative relationship with food as part of the overarching goals of the schools to maintain power over the children.

Today as adults, some survivors experience a sense of guilt for feeling grateful to the residential schools, without which they thought they would have died. In the 1930s, traditional ways of life were increasingly curtailed by prohibitive federal policy and surveillance, as well as resource extraction which disrupted hunting, fishing, and gathering. Many Indigenous families were starving and relied on rations, and parents were under the threat of fines or having their rations cut off if they did not send their children to school. Many children were orphaned, or their parents so poor or ill with tuberculosis that the children were removed to residential school. Two orphaned sisters, who attended the Shingwauk School in Sault Ste. Marie, Ontario in the 1940s, recounted how they coped with their internment at the school. One adopted the strategy of learning quickly to follow and obey rules; she was taken into the fold of the staff. She worked in the kitchen that served the staff, a coveted job because the food was described as consistently superior to that served to students. The other sister, more “hard-headed,” attributed her survival to resistance. When asked to talk about the food they ate, the first sister responded, “We had carrots and string beans, and good vegetables. We got beef and raised the cows for milk, and we got buttermilk. And we had honey for our spread.” Her sister broke in, “No we didn’t!” Although she admitted that her sister had tried to have her moved to dining room service so she could eat better food, she found herself too often at odds with the staff. In one instance, a matron mistook her chewing food for talking, “We were supposed to be quiet in the dining room. ... I guess she saw my mouth moving and she thought I was talking, and I got a slap right across the face. And I slapped her back! It was just a reflex actually, but I mustn’t be too negative, you know, I try to be positive.” Her sister concurred, and concluded that “it was the best thing that ever happened to us because we were orphaned. It was our only option.” In response to the Shingwauk stories described, a survivor who attended a different school remarked that students were not allowed anywhere near the kitchens. He said, “I probably would have poisoned the missionaries if I did!”

The schools’ aggressive devaluation of Indigenous languages and cultural principles included the denigration of traditional food and its gathering and preparation, which were integral to traditional Indigenous family life. Children were taught to hate the food their mother cooked (Milloy 1998). Survivors reflected on the legacy of cultural deprivation in residential school and these narratives were in turn recontextualized in the Tribal Kitchen workshops in terms of the possibilities for reclaiming food traditions in the urban environment. Loss of ties to the land and the internalized break from values around the relationship of food with social life, parenting, family, and community were seen as potentially important factors impeding community health. One survivor explained that she was taught in residential school “that moose meat and elk, and buffalo were bad, and ... food that would have been good for us, wasn’t good. Only in the summer time when I was at home we would have nice fresh fish.” This survivor related this experience to a confrontation she had more recently with her medical doctor, who advised her to cut red meat out of her diet: “Red meat, my doctor told me not to eat red meat, and I just couldn’t do that. I told my doctor, ‘you’re telling a buffalo-eater not to eat red meat?!’” In reclaiming dietary choice, this survivor drew together her historical experiences in residential school and traditional life, while mediating the power dynamics of her relationship with her health care provider.

Survivors often adopted a negative relationship to food from poor diets, including being hungry and malnourished. The Mohawk Institute, a residential school in Brantford, Ontario attended by a number of participants, was more widely known as the “Mush-Hole” in reference to the gruel, which constituted most of the inmates’ diet. Survivors’ negative relationships with food were shaped by past patterns of eating quickly and in silence, and feeling guilt associated with stealing food. In the living history circles, the preoccupation with food was directly linked to survivors’ own current unhealthy habits, such as overeating, eating too quickly, or hoarding, and a number described how their negative relationship with foods developed in residential school were passed onto younger generations.

The spirit of resilience and resistance also emerged in survivors’ accounts of solidarity in the face of punishment, particularly around those who had their meals withheld as punishment. As a survivor said, “We would stick together. It didn’t matter if it were the boys or girls, if one of us got punished, each of us would save a little bit of our meal and put it away for that kid that got punished and went without his meal.” Another survivor related that “sometimes we had food inspectors and they came and watched and made a report. We would really act out when that happened. We would take our potatoes and squish them through our fingers, and just be naughty. I knew we’d get in trouble later, but it was worth it.”

Humor was a key survival strategy that seemed universally deployed in the residential school setting and in the survivors’ remembering their experiences. Humor and resistance were usually paired to highlight their ‘unkillable’ spirit: “Humor was one of the things that people learned and we learned as a survival skill. That is how we survived is that we could laugh.” Others saw stealing food was an act of resistance, as satisfying for getting away with it as for satisfying hunger. Some women, for example, recalled with glee successfully stealing carrots, turnips, and butter from the staff kitchen and stuffing them in their large bloomers that were part of the school uniform. Those who recalled this with humor also saw the value in the solidarity they developed with others; they formed life-long friendships grounded in their shared experience of getting away with things at school.

The Tribal Kitchen workshop sought to reflect on people’s survival strategies to move beyond their trauma and highlight their strengths, bravery, resilience, and creativity. Many conveyed stories about how they had been creative about coping with tragic circumstances. Some survivors were able to recall living a relatively traditional lifestyle at home before being taken to the schools. They were adept at traditional subsistence activities such as hunting, fishing, gathering, and the ceremonial life that went along with these activities. These survivors could draw on the value of these cultural lessons to cope with hunger, abuse, and other deprivation in the schools. For example, many talked about gathering what they could around the school grounds, and snaring small game to temporarily squash hunger pain that endured throughout the day. One recalled “eating rosebuds because we were so hungry, or anything we could eat—dandelions, and there was a root that was like horseradish, but we were so hungry.” Another survivor framed this experience in terms of what he learned as a child at home with his parents and grandparents: “It seemed when you’re brought up in your own home, where you live, if you’re lacking in something, you just went in the bush and picked berries. If you needed something to make you healthy, you just went in the bush and

it was there for you to make yourself well.” In a few cases, the survivors were allowed to set up snares for rabbits on or near the school grounds.

The survivors were very reflective on how their past experiences at home were adapted to the residential school life, but also how lessons from home still guided their lives. For example, one person who attended Fort Albany residential school in northeastern Ontario recalled how he went home in the summer and hunted ducks or geese with his brothers and father: “We would watch him clean them, and he would always be telling us stories, and perhaps I still have this tradition, as I am a writer and a poet now, and that’s telling stories, right? So, remembering all that, I can imagine, the whole tremendous amount of stuff that my people could have told me if I had access to them all the way through life.” To remember only the traumatic events of residential school throws the community out of balance, and denies the creativity and resilience that pulled people through the experience. Rather than seeing residential school survivors as people who may not fit into the community or fulfill traditional roles because they were denied cultural upbringing, the purpose was to value their ingenuity in surviving the schools in the past, as well as for contemporary day-to-day living.

Ruth Cyr and other community-based health care providers often describe the “five White foods”—sugars, salt, milk, lard, and flour—as foreign to the bodies of Indigenous people and central to combatting diabetes. The intended double-entendre of “White” foods is utilized by numerous other Indigenous community diabetes programs, which increasingly are proposing a counter-dietary model, sometimes referred to as the “decolonization diet,” which revolves around restoring the relational and nutritional qualities of traditional Indigenous food practices while acknowledging that it may not be practical or possible to precisely reproduce them in the city (see, for example, <http://decolonizingdietproject.blogspot.com/>). That is, some hunting, fishing, and gathering activities may not be possible in the city; however, the nutritional and relational qualities of Indigenous food traditions can be reproduced. Foods traditionally consumed by Indigenous peoples of the region which are rich in nutrients, low in fat, and appropriate for diabetes management such as corn, beans and squash, berries, turkey, venison, and fish are obtainable, and were prepared in Tribal Kitchen workshops. The holistic and decolonizing approach of the Tribal Kitchen focused on how food can contribute to healing through the socializing and sharing involved in its preparation and consumption. Elders and traditional teachers shared traditional food knowledge which ranged from ceremonial and traditional stories about foods to the intimate relationship with the natural world which informs Indigenous relationships to food (Bodirsky and Johnson 2008; Milburn 2004:426–427). Moreover, in the city, Elders may serve as surrogates of knowledge sharing to the wider Indigenous community for the extended family from whom many were disconnected by the residential school experience (Howard 2004).

CONCLUSION

Diabetes prevention and management education needs to include all members of the community in ways that focus on the restoration of self-determination for both the individual and the community. The overall result of this project was to work towards positive health results by turning around the negative collective experience of residential school. Living

history circles served as a powerful tool to shift the direction of social memory from one in which only the traumatic, awful things about residential school were recalled, to one in which the creativity and resilience of survivors were highlighted. Survivor and intergenerational participants could think critically about the perception of failure of diabetes management and prevention in terms of structures of racism and colonialism as opposed to victimization and inevitability.

“Our bodies take it in and we store it” references both the negative impacts of residential school and culture-based concepts of health and well-being, which can be restored. This project was a model for collaborative research specifically emergent from the Canadian context of research with Indigenous peoples, which promote the value of Indigenous knowledge frameworks to scholarship and research that is meaningful to the communities with whom it is conducted. However, the research also speaks to the wider global explanations for the loss of well-being for Indigenous peoples, where disease, especially those classified as “White” diseases, are read as ongoing colonialism (Ferreira and Lang 2006; Garro 1993; Lang 1989; Thompson and Gifford 2000). The community-based theory that framed the project viewed the residential school as an institution that internalized in survivors the loss of land and forced a break from values around food and social life within families, replaced with foreign “White” foods. In their lived histories of food, negative associations with food were normalized and passed on to later generations, in ways seen as counterproductive to the dietary aspects of diabetes prevention and management. The acknowledgment and integration of residential school experiences opened a pathway toward reclaiming healthy, community-based, social, and intergenerational relationships around food, its preparation, and eating. These were integrated with the presentation of social aspects of traditional food gathering, ceremonies, preparation, and eating together as strategies for modifying lifestyle and diet, which may be conducive to diabetes prevention and management in that they focus on food in the context of human relationships and social life. Community resources and the strengths and resiliency learned from the survivors provide context for traditional concepts and strategies to be combined with new technology and conventional medicine to prevent future illness. The restoration of balance is fundamental to understanding the experience and mitigation of diabetes in Indigenous peoples (see also Garro 1993; McMullin 2010; Thompson and Gifford 2000). This moves beyond terms of cultural difference and socioeconomic disparities, and broadens analyses to include understandings of the historical power relationships that shape the culture of medical practice and the persons it serves (Adelson 2005:S54).

Drawing together critical medical anthropological and Indigenous community-driven perspectives, I have contributed to discussions of historical trauma, community-based participatory research, and health improvement. A structural analysis to public health ensures attention to categories of race and ethnicity in relation to dietary behavioral change, the significance of early childhood social environments to life-long dietary patterns, relationships to food, and disease risk (Nwasuruba, Khan, and Egede 2007; Patrick and Nicklas 2005). I have illustrated how the living history circle ethnographic method pioneered by Myerhoff (1978) with participants who have experienced trauma, can provide a sensitive and supportive environment that not only encourages rich, affirming, and even healing narratives to emerge but also powerfully names “a large domain of the sources,

forms and consequences of social life” (Kleinman, Das, and Lock 1997:xxv). My purpose has not been to argue a causative relationship between residential school experience and diabetes but to emphasize the importance of the structural violence of residential schools to understanding challenges faced by this population in dietary-related aspects of their management of diabetes. However, as action aimed at dismantling the socio-historical structures that have disciplined relationships to food in ways that hinder diabetes prevention and management, the framework may be of utility in studies of other populations disproportionately impacted by chronic illness.

Residential school has been a major factor contributing to the urbanization of Indigenous people in Canada and to their health problems, in this case illustrated as an institution that disciplined a habitus of eating affecting diabetes. This is explained within the context of contemporary decolonizing discourse of leadership and community organizers today. The construction of illness as an inscription on the body of colonial experiences figures importantly in an emerging Indigenous epidemiology. Waldram (2004) described ‘residential school syndrome’ as a metaphorical diagnosis for colonial experience, and diabetes might also be viewed as such a metaphor (Ferreira 2006:326) not just of the past but also in terms of ongoing colonization. Community-based efforts to address the disease are implicitly decolonizing in their approach, and attention to Indigenous health from this perspective raises new, unique, and engaging questions for the study and practice of the social dimensions of health and medicine more broadly.

Acknowledgments

I am grateful and honored for the responsibility I have been granted within the Indigenous community in Toronto to document and share its important history, and particularly to the survivors who shared their experiences—Ruth Ann Cyr, Joanne Dallaire, and the committee of survivors who originally oversaw this research: Susan Morrison, Helen Parker, Eric Carlson, as well as Ryan McMahon who served as coordinator of the Youth Program at the Native Canadian Centre of Toronto at the time the project was carried out. The support of the Native Canadian Centre of Toronto, Toronto Native Community History Project, and the Aboriginal Healing Foundation is appreciated immensely.

References

- Adelson N. The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*. 2005; 96(S2):S45–S61.
- Banister, EM, Leadbeater, BJ., Marshall, EA., editors. *Knowledge Translation in Context: Indigenous Policy and Community Settings*. Toronto: University of Toronto Press; 2011.
- Bartlett, J. The medicine wheel for comprehensive development in health. Winnipeg, Canada: University of Manitoba; 1998. Unpublished manuscript
- Benyshek DC, Martin JF, Johnston CS. A reconsideration of the origins of the type 2 diabetes epidemic among Native Americans and the implications for intervention policy. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*. 2001; 20(1):25–64.
- Bobet, E. *Diabetes among First Nations People*. Ottawa, ON: Health Canada; 1997.
- Bodirsky M, Johnson J. Decolonizing diet: Healing by reclaiming traditional indigenous foodways. *Cuizine: The Journal of Canadian Food Cultures/Cuizine: revue des cultures culinaires au Canada* Online. 2008; 1(1) <http://www.erudit.org/revue/cuizine/2008/v1/n1/019373ar.html>.
- Bourdieu, P. *Distinction: A social critique of the judgement of taste*. Nice, Richard, translator. Cambridge, MA: Harvard University Press; 1984.
- Bourdieu, P. *The Logic of Practice*. Stanford, CA: Stanford University Press; 1990.

- Brave Heart MYB, DeBruyn LM. The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*. 1998; 8(2):56–78. [PubMed: 9842066]
- Canadian Institutes for Health Research. *Aboriginal Knowledge Translation: Understanding and Respecting the Distinct Needs of Aboriginal Communities in Research*. Ottawa, ON: Author; 2009.
- Chilisa, B. *Indigenous Research Methodologies*. Thousand Oaks, CA: Sage; 2012.
- Conti K. Diabetes prevention in Indian Country: Developing nutrition models to tell the story of food-system change. *Journal of Transcultural Nursing*. 2006; 17(3):234–245. [PubMed: 16757662]
- Creswell, JW. *Qualitative Inquiry and Research Design*. 2. Walnut Creek, CA: Sage; 2007.
- Creswell JW, Miller DL. Determining validity in qualitative inquiry. *Theory into Practice*. 2000; 39(3): 124–131.
- Dapice A. The medicine wheel. *Journal of Transcultural Nursing*. 2006; 17(3):251–260. [PubMed: 16757664]
- Denzin, N.Lincoln, KS., Tuhiwai Smith, L., editors. *Handbook of Critical and Indigenous Methodologies*. Thousand Oaks, CA: Sage; 2008.
- Dyck R, Osgood N, Hsiang Lin T, Gao A, Stang MR, et al. Epidemiology of diabetes mellitus among First Nations and non-First Nations adults. *Canadian Medical Association Journal*. 2010; 182:249–256. [PubMed: 20083562]
- Evans-Campbell T. Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*. 2008; 23(3):316–338. [PubMed: 18245571]
- Ferreira, ML., Lang, GC., editors. *Indigenous Peoples and Diabetes: Community Empowerment and Wellness*. Durham, NC: Carolina Academic Press; 2006.
- Ferreira, ML. Slipping through sky holes: Yurok body imagery in northern California. In: Ferreira, ML., Lang, GC., editors. *Indigenous Peoples and Diabetes: Community Empowerment and Wellness*. Durham, NC: Carolina Academic Press; 2006. p. 73–104.
- Ferzacca S. Lived food and judgments of taste at a time of disease. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*. 2004; 23(1):41–67.
- Garro, L. Explanations of diabetes: Anishinaabeg and Dakota deliberate upon a new illness. In: Joe, JR., Young, R., editors. *Diabetes as a Disease of Civilization: The Impact of Culture Change on Indigenous Peoples*. Berlin/New York: Mouton de Gruyter; 1993. p. 293–328.
- Garvey G, Towney P, McPhee JR, Little M, Kerridge IH. Is there an Aboriginal bioethic? *Journal of Medical Ethics*. 2004; 30(6):570–575. [PubMed: 15574447]
- Ghosh H. Urban reality of type 2 diabetes among First Nations of eastern Ontario: Western science and Indigenous perceptions. *Journal of Global Citizenship & Equity Education*. 2012; 2(2):158–181.
- Golafshani N. Understanding reliability and validity in qualitative research. *The Qualitative Report*. 2003; 8(4):597–607.
- Hagey R. The phenomenon, the explanations, and the responses: Metaphors surrounding diabetes in urban Canadian Indians. *Social Science & Medicine*. 1984; 9(3):265–272.
- Hagey R. The native diabetes program: Rhetorical process and praxis. *Medical Anthropology*. 1989; 12(1):7–33. [PubMed: 2486129]
- Ho LS, Gittelsohn J, Harris SB, Ford E. Development of an integrated diabetes prevention program with First Nations in Canada. *Health Promotion International*. 2006; 21(2):88–97. [PubMed: 16407394]
- Hodgeson, M. *Keep the Circle Strong*. Toronto: Nechi Institute on Alcohol and Drug Education, York University; 1990.
- Howard, HA. Unpublished PhD Dissertation. Department of Anthropology, University of Toronto; 2004. *Dreamcatchers in the city: an ethnohistory of social action, gender and class in Native community production in Toronto*.
- Howard, HA. The Friendship Centre: Native people and the organization of community in cities. In: Howard, H., Proulx, C., editors. *Aboriginal Peoples in Canadian Cities: Transformations and Continuities*. Waterloo, ON: Wilfrid Laurier University Press; 2011. p. 87–108.

- Howard, HA. Community-based and community-engaged knowledge production: An evolution of Relationships. Paper presented at the annual meeting of the Central States Anthropological Society; Toledo, OH. March 22–24; 2012.
- Howard HA. Politics of culture in urban indigenous community-based diabetes programs. *American Indian Culture and Research Journal*. 38(1):49–72.
- Howard, H., Lobo, S. Indigenous peoples' rural to urban migration within the United States and Canada. In: Ness, I., editor. *Encyclopedia of Global Human Migration*. New York: Wiley-Blackwell; 2013. p. 297–301.
- Iwasaki Y, Bartlett J. Stress-coping among Aboriginal individuals with diabetes in an urban Canadian city: From woundedness to resilience. *Journal of Aboriginal Health*. 2006; 3(1):15–25.
- Jackson, M. *Excursions*. Durham, NC: Duke University Press; 2007.
- Joe, JR., Young, R., editors. *Diabetes as a Disease of Civilization: The Impact of Culture Change on Indigenous Peoples*. Berlin/New York: Mouton de Gruyter; 1993.
- Kelm, ME. *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900–50*. Vancouver: University of British Columbia Press; 1998.
- Kirmayer L, Simpson C, Cargo M. Healing traditions: Culture, community and mental health promotion within Canadian Aboriginal peoples. *Australasian Psychiatry*. 2003; 11(S1):S15–S23.
- Kleinman, A., Das, V., Lock, M. Introduction. In: Kleinman, A., Das, V., Lock, M., editors. *Social Suffering*. Berkeley: University of California Press; 1997. p. ix–xxvii.
- Knockwood, I. *Out of the Depths: The Experiences of Mi'kmaq Children at the Indian Residential School at Shubenacadie, Nova Scotia*. Blackpoint, NS: Fernwood; 1992.
- Kuhnlein HV, Receveur O. Dietary change and traditional food systems of Indigenous peoples. *Annual Reviews in Nutrition*. 1996; 16:417–442.
- Lang GC. 'Making sense' about diabetes: Dakota narratives of illness. *Medical Anthropology*. 1989; 11(3):305–327. [PubMed: 2770468]
- Lavallée L. Physical activity and healing through the medicine wheel. *Pimatisiwin Journal of Aboriginal and Indigenous Community Health*. 2007; 5(1):127–153.
- Lavallée, L., Howard, H. *Urban Aboriginal Diabetes Research Project Report*. Toronto: Anishnawbe Health Toronto; 2011.
- McMullin J. The call to life: revitalizing a healthy Hawaiian identity. *Social Science & Medicine*. 2005; 61:809–820. [PubMed: 15950093]
- McMullin, J. *The Healthy Ancestor*. Walnut Creek, CA: Left Coast Press; 2010.
- Milburn M. Indigenous nutrition: Using traditional food knowledge to solve contemporary health problems. *American Indian Quarterly*. 2004; 28(3):411–434.
- Milloy, J. *A National Crime: The Canadian Government and the Residential School System, 1879–1986*. Winnipeg, MB: University of Manitoba Press; 1998.
- Myerhoff, B. *Number Our Days*. New York: E. P. Dutton; 1978.
- Neegan E. Excuse me: Who are the first peoples of Canada? A historical analysis of Aboriginal education in Canada then and now. *International Journal of Inclusive Education*. 2005; 9(1):3–15.
- Nwasuruba C, Khan M, Egede LE. Racial/ethnic differences in multiple self-care behaviors in adults with diabetes. *Journal of General Internal Medicine*. 2007; 22(1):115–120. [PubMed: 17351850]
- Obonsawin, R., Howard-Bobiwash, H. The Native Canadian Centre of Toronto: The meeting place for Aboriginal people for 35 years. In: Sanderson, F., Howard-Bobiwash, H., editors. *The Meeting Place: Aboriginal Life in Toronto*. Toronto: Native Canadian Centre of Toronto; 1997. p. 25–59.
- Oster RT, Johnson JA, Hemmelgarn BR, King M, Balko SU, Svenson LW, Crowshoe L, Toth EL. Recent epidemiologic trends of diabetes mellitus among status Aboriginal adults. *Canadian Medical Association Journal*. 2011; 10(1503):1–6.
- Patrick H, Nicklas TA. A review of family and social determinants of children's eating patterns and diet quality. *Journal of the American College of Nutrition*. 2005; 24(2):83–92. [PubMed: 15798074]
- Power EM. Conceptualizing food security for Aboriginal people in Canada. *Canadian Journal of Public Health*. 2008; 99(2):95–96. [PubMed: 18457280]

- Public Health Agency of Canada. Diabetes in Canada, Chapter 6: Diabetes in Aboriginal Communities. 2003. <http://www.phac-aspc.gc.ca/publicat/dic-dac2/english/49chap6-eng.php>
- Regan, P. Unsettling the Settler Within: Indian Residential Schools, Truth Telling, and Reconciliation in Canada. Vancouver, BC: University of British Columbia Press; 2010.
- Robertson LH. The residential school experience: Syndrome or historic trauma. *Pimatisiwin Journal of Aboriginal and Indigenous Community Health*. 2006; 4(1):1–28.
- Sanderson, F., Howard-Bobiwash, H., editors. *The Meeting Place: Aboriginal life in Toronto*. Toronto: Native Canadian Centre of Toronto; 1997.
- Scott, J. *Domination and the Arts of Resistance: Hidden Transcripts*. New Haven, CT: Yale University Press; 1990.
- Simpson, Corabian SP, Jacobs P, Johnson JA. The cost of major comorbidity in people with diabetes mellitus. *Canadian Medical Association Journal*. 2003; 168(13):1661–1667. [PubMed: 12821619]
- Smith-Morris, C. *Diabetes among the Pima: Stories of Survival*. Tucson: University of Arizona Press; 2008.
- Smith-Morris, C. The chronicity of life, the acuteness of diagnosis. In: Smith-Morris, C., Manderson, L., editors. *Chronic Conditions, Fluid States: Chronicity and the Anthropology of Illness*. New Brunswick, NJ: Rutgers University Press; 2010. p. 21–37.
- Statistics Canada. Aboriginal Peoples' Survey Adult health statistics for Toronto. 2002. http://www12.statcan.ca/english/profil01aps/statistics.cfm?component=1&community=CMA_002&theme=4&lang
- Thompson SJ, Gifford SM. Trying to keep a balance: The meaning of health and diabetes in an urban Aboriginal community. *Social Science & Medicine*. 2000; 51(10):1457–1472. [PubMed: 11077950]
- Thompson SJ, Gifford SM, Thorpe L. The social and cultural context of risk and prevention: Food and physical activity in an urban Aboriginal community. *Health Education and Behavior*. 2000; 27(6): 725–743. [PubMed: 11104372]
- Waldram, JB. *Revenge of the Windigo: The Construction of the Mind and Mental Health of North American Aboriginal Peoples*. Toronto: University of Toronto Press; 2004.
- Weidman, D. Globalizing the chronicities of modernity: Diabetes and the metabolic syndrome. In: Smith-Morris, C., Manderson, L., editors. *Chronic Conditions, Fluid States: Chronicity and the Anthropology of Illness*. New Brunswick, NJ: Rutgers University Press; 2010. p. 38–53.
- Wesley-Esquiaux, C., Smolewski, M. *Historic Trauma and Aboriginal Healing*. Ottawa, ON: Aboriginal Healing Foundation; 2004.
- Willows ND. Determinants of healthy eating in Aboriginal peoples in Canada: The current state of knowledge and research gaps. *Canadian Journal of Public Health*. 2005; 96(S3):S32–S36. [PubMed: 16042162]
- Whitbeck LB, Adams GW, Hoyt DR, Chen X. Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*. 2004; 33(3/4):119–130. [PubMed: 15212173]
- Young TK, Reading J, Elias B, O'Neil JD. Type 2 diabetes mellitus in Canada's First Nations: Status of an epidemic in progress. *Canadian Medical Association Journal*. 2000; 163(5):561–566. [PubMed: 11006768]

Biography

Heather A. Howard is assistant professor with the Department of Anthropology at Michigan State University and the Centre for Aboriginal Initiatives at the University of Toronto. Her interests are in knowledge production in social service and health care delivery, participatory community-based research, and critical analysis of health care transformation.