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ABSTRACT

Canadian Native peoples are taking back control of community social and health programs through the Federal Health Transfer process. Questions of program efficacy need to be addressed to assist in the planning and implementation of effective alcohol and substance abuse recovery strategies. Culturally-relevant treatment is recommended for Native peoples to reclaim their cultural/spiritual identity and to heal from the spiritual bankruptcy of addiction. Using content analysis and qualitative evaluation of documentation and ethnographic interviews, this study examines the values embedded in the symbolic healing strategies of Native and non-Native outpatient and residential treatment centres across British Columbia. Considerable difference in the value placed on spirituality is found between Native and non-Native healing philosophies. Regionally distinct, syncretic healing models are utilized in Native urban and reserve programs which combine local traditions with practices adopted from Plains peoples. These syncretic models are creating controversy in coastal reserve communities.

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CHAPTER 1

INTRODUCTION

This thesis is about healing from the ravages of alcohol and substance abuse. In particular, it focuses attention on Native healing strategies while also taking a comparative look at the non-Native healing strategies available to the people of British Columbia (B.C.). It is important to recognize that any discussion concentrating on the devastating problems associated with alcohol and substance abuse can lead to a misrepresentation of the Aboriginal health picture by painting a negative stereotypical image of despairing people living in unhealthy and physically, spiritually and socially destructive environments. This is not my intention. It is essential to emphasize that even though alcohol and substance abuse is a very real and serious problem, it directly affects the minority of Aboriginal peoples, just as it does the minority of Canadians in general. Hopefully, the reader will discover that despite the need to describe the ways in which colonization practices have taken their toll on Aboriginal lives, they will also find a balancing message of healing and hope as it becomes clear that Aboriginal spiritual and cultural renewal is restoring holistic prosperity to Native individuals, families and communities at an increasing rate.

Furthermore, this thesis extensively examines issues of First Nations health, community, culture and spirituality. Being of Euro-Canadian ancestry and upbringing, I am not so presumptuous as to think that my own thoughts and interpretations, particularly about sacred philosophies, can begin to represent the full essence or reality of Aboriginal thinking. What I offer is my own elementary understanding of what I personally perceive it to be. My knowledge comes from the static -- documentation -- and, much more importantly, from the kinetic -- the living, vibrant and sacred teachings I have received from the generous individuals who have trusted me enough to share their beliefs and experiences with me.

A NOTE ON TERMINOLOGY

There are many names used when referring to Native people. Several of them are used in this document. Some clarification at this point will offset potential confusion arising from what may appear to be an indiscriminate use of the various terms. The governing aim has been to employ terms that are both accurate and respectful of those to whom they refer.

The term *Native* is used in a very inclusive way to incorporate all Aboriginal peoples of North America. It is frequently used by Native writers and speakers when referring to themselves and other Aboriginal groups. Juxtaposed to this is the term *non-Native*, which is also used throughout the document to describe North American populations primarily Caucasian or Europeon in origin. Again, this term is used most frequently by the individuals I spoke with when they were referring to members of this population.

The term *Aboriginal* is used in the widest possible sense to refer to any and all indigeneous first peoples, not only the Native peoples of B.C. and Canada but also of North and South America, New Zealand and Australia. The term is capitalized out of deference to the wishes of the Aboriginal peoples themselves, and as a way of showing respect to their identity as distinct peoples.

First Nations is a term deeply embedded with political connotations, even more than the term Aboriginal. However, my intent is not to focus on any political controversy relating to sovereignty issues but, again, to reflect the considerable and increasing usage of the term by B.C. Native peoples themselves.

NATIVE SUBSTANCE ABUSE AND RECOVERY: AN OVERVIEW

Across North America, alcoholism and substance abuse are major social and clinical concerns in many Native communities. British Columbia is no exception.

Alcohol-induced mortality and morbidity rates are higher in the Native population than in the general population, with an increased risk of death from alcoholism/cirrhosis, homicide, suicide, motor vehicle accidents, drowning, fires, exposure, pneumonia and poisoning (Foster *et al.* 1995; MacMillan *et al.* 1996; May 1994; Waldram *et al.* 1995; Young 1993). Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Effect (FAE) carry additional detrimental effects directly to the all-important next generation. Knowledge about contributing factors to the health status of Canadian Native people is limited since the literature generally does not assess confounding factors such as poverty (MacMillan *et al.* 1996). However, some information is available relating to the influences of demographics, geographic isolation and socio-political factors.

Demographically, Native North Americans are one of the fastest growing ethnic groups, and consequently one of the youngest, with a median age of 18 to 20 years (Foster *et al.* 1995; May 1994; Young 1991). The age of first involvement with alcohol is younger, the frequency and amount of drinking are greater, and negative consequences are more common for Native than non-Native youths (May and Moran 1995). For example, young populations frequently indulging in a recreational pattern of drinking which "emphasize high blood alcohol levels for a 'blitzed' experience" (Ferguson in May 1994), tend to have much higher rates of alcohol-related deaths (i.e., motor vehicle and other accidents, suicide, and homicide) than do populations that are elderly or middle aged.

Geography also plays a role in alcohol-related mortality statistics. Native populations continue to be localized in marginal geographic areas. Therefore, higher death rates occur due to factors such as higher-risk environments, greater distance from medical care resulting in death enroute to hospitals and/or clinics, and the reduced availability of services in general (Foster *et al.* 1995; MacMillan *et al.* 1996; May 1994).

Lastly, social, political, legal, and local policies may create conditions that exacerbate alcohol-related problems and rates. The low socioeconomic status of many

Natives shapes their behavioural patterns, including their drinking patterns. For example, 'anxiety drinkers' are more typical of the chronic alcoholic who tend to be "predominantly male, downwardly mobile, unemployed, and socially marginal to both Native and non-Native society; they tend to drink chronically, whether alone or with other drinking buddies" (Ferguson in May 1994:127-128). Changes in policy similar to those enacted in some Aboriginal groups and communities (Brady 1995; Leung *et al.* 1993; MacMillan *et al.* 1996; May 1994; Rowe 1997; Sachdev 1997; Waldram 1997a; Wiebe and Huebert 1996) could produce very different alcohol consumption characteristics and patterns of alcohol-related problems.

Alcohol and substance abuse affects many, if not all, areas of a person's life and can severely impede physical, social, behavioural, vocational, familial, spiritual and psychological functioning. In order to stop an escalating cycle of addiction, despair and violence, and to begin the healing and recovery process, health professionals, Alcoholics Anonymous (AA) and Native Elders agree that the individual must first recognize and accept that there is a problem, and must then take personal responsibility to affect positive changes in her/his life (Alcoholics Anonymous 1976, 1981; Watts and Gutierres 1997). Once that first step has been taken, the path to recovery can be chosen.

The AA 12-Step approach to recovery is considered to be an effective treatment strategy for many individuals to achieve and maintain sobriety. However, studies suggest that Native people have more success utilizing healing strategies which are culturally sensitive and incorporate Native cultural and spiritual beliefs (Brady 1995; Lamarine 1988; Leung *et al.* 1993; May and Moran 1995; Perley 1997; Sachdev 1997; Waldram 1993, 1997b; Walker *et al.* 1993; Watts and Gutierres 1997; Weibel-Orlando 1989; Wiebe and Huebert 1995). Researchers have addressed the relative merit of incorporating traditional medicine and community involvement with standard AA 12-Step programs in Native substance abuse treatment programs (Brady 1995; Waldram 1997a; Watts and Gutierres

1997; Weibel-Orlando 1989). Some ethnographic literature has focused on elucidating the specific cultural content involved in substance abuse and in traditional treatment methods (Aberle 1966; Jilek 1982; Waldram 1997b). Less studied factors include Aboriginal beliefs and values regarding alcohol or drugs as potent agencies and the means to counteract their abuse through the implementation of specific Aboriginal spiritual constructs.

Native peoples in Canada have been moving effectively to gain control of the treatment and recovery process in recent years. The 'healing movement' has gained strength and international recognition, through its alliance between the model of Western biomedicine and traditional healing approaches (Brady 1995; Sachdev 1997; Waldram 1997a). Aboriginally-controlled residential treatment facilities in Canada are generally based on the premise that 'Culture *is* Treatment' and that a culturally sensitive environment must be created so that holistic healing of the mind, body and spirit can ensue. Through this perspective, the loss of cultural identity is seen to be at the root of substance abuse problems, and hence much of the program content entails cultural reeducation combined with traditional healing and spirituality. The AA 12-Step program, and parallel programs such as Narcotics Anonymous (NA), are often also included with only minor modifications (Brady 1995; Waldram 1997a).

PROJECT SCOPE

As more B.C. First Nations take back the responsibilities of community social and health programs through the Federal Health Transfer Process, important questions of program efficacy need to be addressed in order to assist in the planning and implementation of effective alcohol and substance abuse prevention and recovery strategies within their communities. These questions constitute the research objectives of this thesis.

The primary objectives have been to: (1) determine the number and types of Native and non-Native alcohol and substance abuse recovery facilities located in B.C., (2) to

establish whether or not Native people access programs available at non-Native centres and (3) to describe, compare, analyze and evaluate the recovery and healing approaches implemented at the Native and non-Native treatment facilities. Utilizing a staged approach incorporating content and thematic analyses of intervention documents, and semi-structured, ethnographic interviews with program facilitators, themes of similarity and difference in the treatment strategies have been described. An attempt has been made to determine perceptions of and reasons for the treatment centres' levels of efficacy within the cultural context of their clientele. Particular emphasis has been focused on the cultural and spiritual components of the programs to examine and compare the symbolic healing beliefs and values of the recovery strategies. Within the constraints of the primary objectives, the following research questions have been addressed:

(a) What constitutes current Native spirituality and healing knowledge systems in B.C. as the people respond to social and cultural change in the larger context?

(b) Are traditional beliefs and practices being reinstituted or is a more syncretic healing model revealing itself?

(c) Are distinctive local or regional cultural traits, values or symbols being used or are they more universal in nature?

The thesis begins in Chapter 2 with an examination of the relevant literature which defines addiction theories in general and expounds on the view that cultural relevancy is an important element of Aboriginal healing. The concepts inherent in traditional medicine, also referred to as symbolic healing, are identified and discussed. Chapter 3 provides a detailed look at the research methods used to satisfy the objectives and to answer the questions posed. The value of incorporating both qualitative and quantitative methodologies to support an account that is both valid and reliable in scope, and deep in meaning is discussed. Chapter 4 reports on Phases One and Two of the project which involve selecting and analyzing documentation from the participating recovery centres. It is

shown that many similarities exist in the professional standards employed in the delivery of the programs and services at the Native and non-Native centres. It is also shown that some very important differences exist between the values and philosophies embedded in their programs. Chapter 5 provides an account of Phase Three, the interview process. Here, the emphasis is on meeting with counsellors, Elders and administrators in centres located in Coast Salish and Kwakwaka'wakw territories who share much valuable information allowing for a deeper understanding of attitudes, values and processes. Their own words are used as much as possible throughout this chapter. Perceptions of program efficacy are also discussed. Finally, Chapter 6 discusses the major findings from the different phases, explains how I interpret the interconnections of these findings, and attempts to describe how the research has led me to a deeper understanding and appreciation of the intricacies involved. The chapter concludes with recommendations for future research directions. These recommendations originate from the results of this research and from comments made by recovery centre personnel who identified research needs from their own on-the-ground perspective.

Due to the lack of available information regarding B.C. addiction recovery programs, this thesis has been designed to fill the role of an introductory starting-point. It is hoped that this project will be considered to be a pragmatic piece of comparative knowledge that will establish a baseline of information which can be used as a resource by other researchers for the design of further in-depth, longitudinal studies, and by program facilitators at the recovery centres themselves. It is also hoped that it will act as a spring-board for future understanding of program potency with positive health policy implications for First Nations community development planning.

CHAPTER 2

CONTEXT AND LITERATURE REVIEW

INTRODUCTION

The quantity of literature available on alcohol and substance abuse is staggering. The literature on Native North Americans' substance abuse issues, at one time rather small, has also grown to a substantial body of documents. For example, in a bibliography of relevant Native American alcohol-related literature published before 1977, Mail and McDonald list 969 works (May 1994:121). The number published since 1977 is anyone's guess, but it would be safe to assume that the literature may have more than doubled in the last 24 years. However, the vast majority of these studies and publications focus on Native Americans, leaving a sizable gap in the knowledge base regarding Native Canadians in general, and B.C. First Nations in particular. At the time this study was proposed only four publications could be found specifically addressing addictions recovery issues for B.C.'s First Nations (Anderson 1992; Harris 1995; Jilek 1982; Wiebe and Huebert 1996) and four studies which examined Coast Salish communities located in adjacent Washington State (Leung 1993; O'Nell 1993; Rowe 1997; Walker *et al.* 1993). This paucity of information regarding the addiction treatment strategies for B.C.'s First Nations people was an important justification of the need for this project.

THEORETICAL PERSPECTIVES

Addiction theories abound regarding causation, prevention and recovery. For example, a decade ago, Young (1991) surveyed the literature and counted 42 theories on Native drinking alone. An addiction theory is an abstract framework that organizes the concept of substance abuse into a set of fundamental intuitive principles. As such, it permits its adherents to priorize problems and to discover solutions to these problems

within the principles set out by the theory. Contemporary addiction theories that have gained the greatest acceptance by health professionals are those that are amenable to empirical scrutiny, have gratifying aesthetics and offer problem-solving potential. On the other hand, there remain some long-held orthodox theories of addiction that contain principles related to morality and personal conduct. These theories permit conservative members of society to take a moral and potentially racist high ground which, in turn, perpetuates a "blame the victim" stance with resulting punitive solutions.

This thesis concentrates primarily on recovery and healing approaches. It does not focus on prevention methods, although these are often merged with recovery programs to form a more comprehensive treatment. Neither does it focus on causation, empirical knowledge of which continues to remain elusive in the addictions field as a whole. Nevertheless, the recovery programs examined herein have evolved out of the Native and non-Native treatment centres' theoretical worldviews. In order to instil understanding of the goals, objectives and underlying values of these centres' healing strategies, several of the most contemporaneously entrenched types of addiction theories require brief description.

Biopsychosocial Theory

The Biopsychosocial Theory adopts a holistic approach and postulates that substance abuse is the net result of a complex interaction between a combination of biological, psychological, social and spiritual determinants. It is considered to be a unique conceptual framework combining the different theories described below. It is proposed that within that framework the practitioners of the various theories can work together towards solutions under the umbrella of common terminologies and concepts. This, in turn, enhances case management and allows for smoother, less traumatic movement of clients through the addictions system of care. However, even with its purported holistic

approach, the Biopsychosocial Theory still tends to place greater emphasis on the theoretical models that provide for clinical and empirical scrutiny such as learning theories and biological theories. For instance, it is specifically noted that

> the Biopsychosocial Theory incorporates both the concept of chemical dependency as well as certain principles of learning theory. ... Prior research related to chemical dependency syndrome is acknowledged; dependency syndrome is accepted as a real condition; [and] clinical application and future research pertaining to this syndrome is encouraged. As biotechnology improves (e.g., medical imaging, genetic screening) the role of biology in the development and maintenance of addiction should become clearer. ... By incorporating important principles of learning theory, the new theory preserves many valid concepts that have led to the development of effective behavioural therapies. (Ministry of Health 1996a:8-9)

Spiritual Theories

Spiritual theories in addiction recovery, such as the 12-Step Spiritual Theory pioneered by AA, which considers addiction to be a spiritual disease where a person becomes 'spiritually bankrupt', attribute substance abuse to the absence of a metaphysical or spiritual focus within the addicted person. These theories suggest that some individuals are powerless over substances and recovery requires the intervention of a spiritual force to guide them through the process of recovery (Alcoholics Anonymous 1976, 1981; Watts and Gutierres 1997). Health professionals with a biomedical focus tend to downplay the importance of spiritual theories due to the difficulty in conducting empirically grounded controlled clinical trials.

Psychological Theories

Psychological theories, or symptomatic theories, suggest that substance abuse and the development of an addiction is a symptom of another primary mental disorder as identified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) (American Psychiatric Association 1994) (i.e., personality disorders, anxiety disorders,

mood disorders). It implies that the underlying psychiatric disorder holds precedence and that treatment of the disorder will lead to a remission of substance abuse. More recently, a general agreement has been reached among addictions professionals that although substance abuse and psychiatric illnesses co-exist and interact, these conditions are distinct (Ministry of Health 1996a; O'Nell 1993). The term being used to describe individuals suffering from such comorbidity is 'dual diagnosis'. However, according to Walker *et al.* (1993) the bulk of the literature focuses on non-Native comorbid populations with little published empirical data available for Native populations.

Learning Theories

Learning theories contend that substance abuse is learned through the complex processes of behavioural acquisition and reinforcement (Levy and Kunitz 1974; Ministry of Health 1996a). Many learning theories have evolved from classical and operant conditioning theories to the more complex social learning theories that emphasize interaction between personal dispositions and environmental situations. For instance, in modern education learning theories, the importance of understanding individual capabilities and potential is accentuated. This principle is applied in addictions learning theories that focus on creating and maintaining behavioural change by matching individuals to specific treatments after a comprehensive assessment has determined the educational experience most suited to their specific needs and abilities (Chenail and Morris 1995; Ragan *et al.* 1995).

Biological Theories

Disease Theory

The Disease Theory suggests that substance abusers are different from non-abusers and that substance abuse is a progressive illness with an identifiable natural history as well

as a permanent condition or lifetime illness. Maltzman (1994) describes the disease state as a constellation of symptoms following a predictable and recognizable pattern, a syndrome which deviates away from a normal state of health and may be life-threatening. The Disease Theory further contends that a percentage of the total population inherits a genetic predisposition for the disease and therefore considers substance abuse to be a family disease.

Chemical Dependency Theory

The genetic factor is also contained within the Chemical Dependency Theory which describes substance abuse as a syndrome characterized by a clustering of both biological and psychological phenomena (Lindstrom 1992). These phenomena are symptoms of: (1) an altered behavioural state (i.e., an increasing and continuing rate of consumption in spite of others' opinions and/or serious health, work, family or legal problems); (2) an altered subjective state (i.e., development of cravings, lack of control and pre-occupation with consumption); and (3) an altered psychobiological state (i.e., withdrawal symptoms and increased level of tolerance).

The biological theories have been intensely debated mainly because they have clinical applications which can guide research into the biological determinants of addiction. An excellent example of this debate, as it relates to Native substance abusers, is the theory popularly known as the *Firewater Myth.*

Firewater Myth

The Firewater Myth states that Natives cannot hold their liquor because of their genetically inherited physical constitution (Garcia-Andrade *et al.* 1997; Leland 1976; May 1994; Vizenor 1983; Young 1989). This negative stereotype of the 'drunken Indian', which is deep-rooted in popular folklore, has its genesis in the 19th century and has continued to be a major arena where the genetic versus environment debate, with respect to population-level differences, has been waged with little, if any, evidence to support it. The

Firewater Myth gained some scientific support in the Fenna *et al.* (1971) study which compared cross-cultural rates of ethanol metabolism and reported that Natives metabolized ethanol more slowly than did Caucasians. They concluded that cross-racial differences in ethanol metabolism were possibly genetic. According to Lamarine (1988), no single study has contributed more substantially to the entrenchment of the Firewater Myth than the work of these researchers. To date, however, additional research findings on this issue, which have been substantial, can best be described as equivocal (Waldram 1997a) because even though some groups metabolize alcohol more slowly, this does not mean they are more prone to addiction or drunken-ness. Therefore, even if the researchers are correct in their findings that metabolic processing of alcohol is highly variable cross-racially, it does not explain the problems of substance abuse and addiction.

Furthermore, the term *myth* as used here holds the sense of meaning of a notion based on something other than fact (Bennett and Cook 1990; May 1994; Young 1991). Myths of this kind can mold attitudes and thus actions. They are powerful influences in human affairs. They condition situations and their preconceptions create potentially moral and racist consequences (Leland 1976:123). The truth or falsity of the Firewater Myth remains an important health issue that demands careful research, since premature conclusions have had significant impact on attitudes and policies for Aboriginal peoples.

Sociocultural Theories

Sociocultural theories hypothesize that substance abuse develops and endures as a result of disruptive social forces such as poverty, trauma, and family dysfunction, as well as demographic, geographic and/or political variables. These forces are believed to act as social stressors and substance abuse is considered to be an adaptation to the resultant misery. In other words, sociocultural theories suggest that addiction is a symptom used to mask those disruptive social forces (not to be confused with the symptomatic theories

described above). This is exemplified by the Executive Director of Round Lake Treatment Centre, a B.C. Native residential centre, who writes in the 1999 Annual Report,

> The research we have done indicates that 95% of the people who come to Round Lake for addiction treatment have a history of trauma. ... The loss of culture, language, abandonment, separation from family and community, and the trauma of the abuses ... were all experienced as children. ... We need to give voice to the children, parents and grandparents who are suffering from pain so intense that any addiction is used to deaden the emotional pain. (Round Lake Treatment Centre 1999:4-5)

Theory of Anomie

The most commonly cited theory for Native alcohol and substance abuse is the sociocultural Theory of Anomie (Dozier 1966; Young 1991) based on the theory developed by Emile Durkheim in the 1890s but with roots going back more than 25 centuries (Orrù 1987). Anomie literally means "the absence of laws or norms" (Orrù 1987:2). Theoretically, it contends that Aboriginal people are "mourning the loss of a historical tradition and reacting to the stresses of acculturation, including the demand to integrate and identify with mainstream society" (Lewis 1982 in Young 1993:42). The historical events contributing to this situation include the forced relocation of tribes, the breakup of families, residential schools, constant harassment from settlers and soldiers, and the failure of the reserve/reservation system to provide a well-defined set of social roles. These situations resulted in the disintegration of the Aboriginal cultures and fostered a state of anomie. While there is little empirical evidence to support a direct causal relationship between sociocultural problems alone and the development of substance abuse, the theoretical perspective of anomie can be recognized in the comments of many of the researchers and program facilitators cited in this thesis.

It is important to stress here that "all of this theorizing has contributed virtually nothing to our understanding of either the problem or the solutions" (Waldram 1997a:180) and that "we know as little about the outcomes of conventional substance abuse interventions as we do about indigenous intervention strategies" (Singer in Weibel-Orlando

1989:152-153). Nonetheless, and regardless of the theoretical stance chosen by researchers and practitioners, Weibel-Orlando cautions that,

> theory without empirical proof is simply unsubstantiated belief, a leap of faith. The field of cross-cultural studies of alcohol addiction is generally guilty, even with the best of intentions, of theoretical faith leaping. (1989:150)

Many researchers now urge a more critical stance in the study of cross-cultural addictions. They recommend conducting comprehensive and longitudinal testing on the basis that non-evaluative descriptions of healing interventions mar our ability to be of professional help to Aboriginal peoples (Bennett and Cook 1990; Brady 1995; May and Moran 1995; Sachdev 1997; Waldram 1997a; Weibel-Orlando 1989; Wiebe and Huebert 1996).

CULTURALLY RELEVANT HEALING

Culture has become an issue for Aboriginal peoples in healing from addiction due to their own interpretations of the etiology of substance abuse. As described above, alcohol and substance abuse are considered by many Natives to have arisen from, or been exacerbated by, the deprivation and erosion of their cultural integrity as a result of colonization practices. From this perspective, the reconnection of the Aboriginal person with her/his cultural/spiritual roots is essential to recovery and holistic prosperity. The idea that 'Culture *is* Treatment' is the underlying philosophy of Round Lake Treatment Centre:

> The philosophy of Culture *is* Treatment was developed into the utilization of sweat-lodge ceremonies, pipe ceremonies, and the Medicine Wheel concept, which teaches the balance of mind, body, spirit and emotions. With these teachings and spiritual beliefs it is that we have been able to empower individuals to move from their addiction to a journey to their centre; to their inner peace of mind. (Christian 1990 in Brady 1995:1489)

The beneficial association between Aboriginal healing practices and individuals suffering from substance abuse has been enthusiastically noted by anthropologists since at least the 1930s (Brady 1995). Furthermore, for the past three decades anthropologists, psychologists, psychiatrists, physicians and social workers, who have worked among

Aboriginal substance abusers, have shared a professional position and disciplinary bias known as 'revealer/advocate'. These professionals "defend the right of a people to heal themselves in any manner they see fit" (Weibel-Orlando 1989:149). The shared assumption has been that Aboriginally-developed addiction recovery strategies are inherently preferable to imposed mainstream intervention models which are not culturally sensitive. Nonetheless, in order to understand the concept of cultural relevancy, one must first consider aspects of identity in relation to individual identity and the broader concepts of cultural identity.

Establishing Identity

Defining who is a 'Native' is a difficult, if not impossible, task. Different definitions have been used by government departments, legislative bodies, social scientists, health researchers, educators and Aboriginals themselves (Hedican 1995). In the United States, the most commonly accepted parameter to determine tribal membership has been the degree of genetic or biological descent, referred to as "blood quantum" (May and Moran 1995; Sachdev 1997). However, in studies focusing on substantiating or falsifying the Firewater Myth, reviews of alcohol metabolism and levels of intoxication among all ethnic groups usually conclude that there is more variation *within* an ethnic group than there is *between* ethnic groups (Ehlers 1998; Reed 1985; Reed and Hanna 1986; Wolff 1973). This includes Native tribal groups where considerable heterogeneity exists (May 1994; Vizenor 1983).

Recently, there has been a shift in ideology within the social science and Native communities from the idea of common descent as defined biologically toward the idea of common descent as a transgenerational device for the transmission of an authentically rooted culture (Sachdev 1997; Wolf 1994). In essence, this is identification by self-categorization, so that anyone who claims to be a Native is categorized as one. For people

who believe they are Native, and who feel they have lost their cultural identity, cultural reconnection is an important element in the healing process and identifying which cultural group one belongs to can make all the the difference. As Keesing (1987) pointed out,

> A cultural model is one which represents a fairly uniform set of assumptions about the world shared commonly by a set of persons with similar cultural backgrounds and constituting what has been referred to as culturally constructed common sense. (in Watts and Gutierres 1997:13)

However, one needs to tread cautiously when considering any generalized definition of 'traditional Native culture'. This is particularly true in B.C. where the First Nations are richly diverse in their cultural beliefs and practices. The term 'culture' is used increasingly in an overly simplistic and static way which has the effect of "straightjacketing aboriginal people, just as in the colonial past, making some more 'real' than others, and burdening the rest with an essentialist position" (Brady 1995:1490). A theme that emerges from the bulk of the cited literature is that health promotion programs that address issues of alcohol abuse and recovery must consider the extensive heterogeneity which is reflected in Native tribal affiliations, culture groups, languages and degree of Aboriginal ancestry (May and Moran 1995).

Furthermore, when applying the notion of cultural relevancy to addiction recovery programs "the inherent artificiality of any general treatment of aboriginal mental health issues should be emphasized" (Waldram 1997a:171) because not only are there individuals who are still well integrated in their Native cultures as they currently exist, there are also those with varying degrees of orientation to non-Native cultures. Dozier (1966) argued that traditional controls were effective only in groups which still adhered to traditional social and cultural life. He believed that successful interventions are determined by the match between the level of acculturation of the addicted individual and the level of traditionalism of the intervention strategy. Therefore, close attention needs to be paid to the holistic complex of the personal, cultural and cross-cultural experiential truths of individuals before meaningful intervention programs can be matched to those needing

them. Urbanized and acculturated Native people encountering treatment programs which are grounded in traditional spiritual healing beliefs for the first time can encounter difficulties (Brady 1995; Waldram 1997a).

An extreme example of this was cited by Waldram (2000) regarding a member of the Coast Salish people who was suffering from problems associated with alcoholism that had resulted in him becoming estranged from his wife. He admitted he was not a follower of their traditional ways but his wife was and, following custom, she requested that a Spirit Dance healing take place. The Spirit Dance involved forced fasting, bathing in cold water and 'whipping' with cedar branches as well as being "lifted up horizontally by eight men, who then took turns digging their fingers into his stomach area and biting him on his sides" (2000:618). He did not experience a healing and eventually, in a civil action, he sued the Salish healers who had forcibly initiated him into the Spirit Dance.

While certain principles or themes can be transferred and applied effectively from one culture group to another, in some cases, practices have been considered too universal for program facilitators and clients who want only those cultural practices considered traditional to their area (Brady 1995). Anderson (1992), for example, describes the process and outcomes associated with Kakawis, a Native residential treatment centre located in Nuu-chah-nulth territory on Vancouver Island. He documents that a sweat lodge was introduced but rapidly fell into disuse because it was not a local tradition. The morning sweetgrass ceremony, also characteristic of Plains peoples but not Northwest Coast groups, attracted more staff members than clients. According to Watts and Gutierres,

> practioners attempting to understand and to incorporate Native American traditional ceremonial practices and beliefs into substance dependency prevention and rehabilitation programs would do well to begin with a study of the cultural context of family support networks and of interventive mediation practices present in the traditions of a particular local Native American community. (1997:15)

What has become clear is that to be effective, treatment must begin with an assessment of historical and current biological, psychological, spiritual, cultural, and social

health of the substance abuser in order to determine not only the effects of the substance abuse on each area of their functioning, but also to identify those areas that may either facilitate or hamper recovery (Harold *et al.* 1995; Weibel-Orlando 1989).

SYMBOLIC HEALING

Traditional Aboriginal cultures have recognized the importance of cultivating belief and expectancy in the healing encounter. They have created complex rituals and ceremonies, using culturally specific symbols and paraphernalia designed to foster an essential belief in the healer, patient and community (Jilek 1982; Neihardt 1988; Waldram 1997b, 2000; Wiebe and Huebert 1996; Wirth 1995). This type of holistic traditional medicine is what medical anthropologists refer to as symbolic healing. Key to a successful outcome is the individual's belief and expectancy of a positive healing experience (McGuire 1991; Watts and Gutierres 1997; Wirth 1995). It is the healer's responsibility to educate and convince the patient that they share enough elements of the same culture for the healing to occur. Where spiritual questions or confusion is part of a person's illness experience, a traditional healer may be the only person capable of assisting the person through their complex psychological states (Warry 1998).

The concept of symbolic healing is central to the effectiveness of contemporary Christian healing (McGuire 1991) as well as to nativistic religious practices. The most well-known of these include the Navaho's Native American Church; the Handsome Lake Movement of eastern Canada; the Sun Dance, Yuwipi and Sweat Lodge Ceremonies of the Plains; and Vision Quests, all of which claim to assist individuals in overcoming substance dependency (Brady 1995; Jilek 1982; Waldram 1997a; Walker *et al.* 1993; Watts and Gutierres 1997; Weibel-Orlando 1989). On the Northwest Coast, the positive therapeutic value of Salish involvement in the Shaker Church and Winter Ceremonies have been acknowledged since the early 1950s (Weibel-Orlando 1989). In the 1970s, after working

closely with Coast Salish Elders, who were reintroducing the previously outlawed Winter Ceremonies, psychiatrist Wolfgang Jilek was convinced that "Indian patients ... benefit much more from indigenous therapeutic procedures than from exclusive use of Western treatment resources" (in Weibel-Orlando 1989:150). He recommended institutionalizing a two-pronged therapeutic regimen that combined Western treatment with Native procedures in close cooperation with Native therapists.

There is a long-held and continuing debate surrounding the differences between 'illness' and 'sickness/disease', and between 'healing' and 'curing' (McGuire 1991; Waldram 2000; Young 1982). Perhaps one of the greatest challenges to the acceptance of symbolic healing as a bonafide 'medical treatment' is the fact that it is more concerned with the social aspects of illness, and of teaching people to cope with trauma and dysfunction, than it is with achieving a 'cure' as the biomedical system would define the term (Waldram 1997b, 2000). For example, in a recent study of Christian healing it is noted that "to be healed is not necessarily the same as to be cured. It is common to have a healing and still have symptoms or recurrences of illness" (McGuire 1991:42-43). In this regard, it has been suggested that,

> perhaps the European model that most closely approximates the approach of much traditional medicine would be the 12-step philosophy of addictions treatment, such as that promoted by Alcoholics Anonymous. An individual in these programs is never "cured" and is encouraged to admit to the need for a lifelong process of healing. (Waldram 2000:611)

Many of the studies examining Native recovery programs report the use of the AA 12-Step model of recovery in conjunction with varying forms of traditional cultural/spiritual activities (Brady 1995; Leung *et al.* 1993; Watts and Gutierres 1997; Weibel-Orlando 1989). These programs contain salient themes that are resonant of each other. For instance, spirituality, prayer, and belief in a culturally relevant Higher Power are all extremely important in both Native and non-Native AA 12-Step recovery strategies. This is exemplified by the prayers imprinted on the tokens associated with each of their

recovery programs. Individuals can carry these tokens with them as touchstones for reference, inspiration, and support (Figure 2-1). Nonetheless, there are two important conceptual differences which require illumination: (1) who is the patient; and (2) the powerful and agentive qualities of alcohol and drugs.

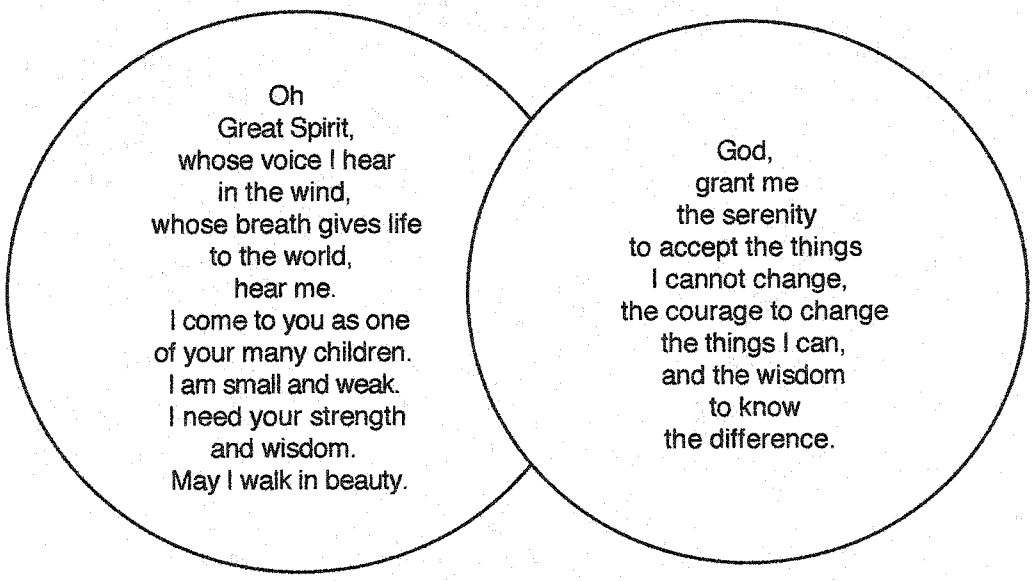

Figure 2-1. Prayers imprinted on Native and non-Native 12-step program tokens.

An important theme in symbolic healing relates to identifying who is actually the patient. The Anglo-conceptualized AA 12-Step model of recovery, while having an impressive spiritual foundation and reliance on belief in a Higher Power, maintains a relatively individual mode of intervention working with the alcoholic/addict alone. If family members want to be involved or need help themselves they attend separate groups such as Al-Anon or ACOA (Adult Children of Alcoholics). They can also specifically request family counselling. However, having said this, AA does provide a sense of community for the alcoholic/addict in the support network it creates through its own fellowship. But the individual must take an active role in seeking this fellowship out. In contrast, for many Native people, mediation tends to unconsciously interconnect family,

friends and community, past and present, as well as the use of shamanic intercession, positive sacramental agencies and ceremonies (Jilek 1982; Warry 1998; Watts and Gutierres 1997).

Second, a very common response to addiction is a sense of powerlessness by the individual, a sense of being unable to control the effects of alcohol or drugs as potent substances (Watts and Gutierres 1997). The AA 12-Step approach attributes this sense of powerlessness to character defects of the individual which must be confronted and corrected by appeal to the mediational intervention of a Higher Power. Responsibility for the behaviours involved in both the creation of the addiction and recovery from it is placed directly on the individual (Alcoholics Anonymous 1976, 1981; Watts and Gutierres 1997). In contrast, the Native approach places responsibility for loss of control and substance dependency less on the individual, although they are still held accountable, and more on spiritual, family or community disturbances (Watts and Gutierres 1997). Many Native traditions emphasize that persons who succumb to the negative aspect of powerful natural or supernatural forces do so at the risk of relinquishing inherent human capabilities to withstand such influences or to control such powers. In these cases, the mediating role of a medicine person and/or sacramental medicine such as tobacco, cedar or sweetgrass smoke may be sought to assist the individual in regaining autonomous human capabilities (Watts and Gutierres 1997).

SUMMARY

There is a sizable gap in the field of knowledge regarding the variety of substance abuse treatment approaches available to the various segments of B.C.'s population. To date, no one has published information explaining the similarities and differences of the recovery programs available, as they reflect their client base, nor attempted to evaluate the efficacy of these programs. Addiction theories of causation, prevention and treatment abound for Native and non-Native populations ranging from the sociocultural and spiritual

to the biological and behavioural, the latter being the preferred theoretical base for health practitioners who put their faith in the scientific method of the controlled clinical trial. Charges of unscientific romanticism tend to be tossed about when researchers examine healing methods such as symbolic healing that is used to restore health holistically and with a strong emphasis on the more nebulous and immeasurable spiritual and social components. However, the Biopsychosocial theory is now being adopted in B.C. and is offering a more holistic approach to addiction treatment.

The issue of Native identity is complex but essential to unravel when matching clients to effective treatment programs. The Aboriginal interpretations of the etiology of their own addictions explains why culture has become an issue in Native recovery programs and why mainstream approaches are insufficient for many Native people. The idea that Culture *is* Treatment is recommended to reconnect Native individuals to their cultural/spiritual origins as a route to recovery. Others can find success through the spirituality and fellowship found in the AA 12-Step program. However, to be effective, addiction recovery programs for Aboriginal people must match not only the level of acculturation of each person but also the extensive heterogeneity which is reflected in Native cultural groups -- that is it they need to be truly culturally relevant. Certain principles can be transferred and applied effectively from one culture group to another, but some may be considered inappropriate for clients who require cultural practices more reflective of their own local traditions.

Chapter 3 discusses the techniques used to examine and compare the healing strategies implemented in B.C.'s Native and non-Native alcohol and substance abuse treatment centres and clinics. It outlines the staged approach used in selecting, contacting and interacting with the program facilitators at these clinics. It reviews the rationales for the methods used to analyze, evaluate and interpret the information provided in order to satisfy the research objectives and to answer the questions posed.

CHAPTER 3

RESEARCH METHODS

INTRODUCTION

"Qualitative methods explore and quantitative methods legitimize" (Atkinson 1992 in Smith et al 1994:269). The research methods used for this thesis are manifest content analysis, ethnographic content analysis, and qualitative evaluation. Specifically, a manifest content analysis of treatment centre documents followed by a qualitative thematic analysis of ethnographic interviews with program facilitators, using the evaluative perspective of illumination, have been used to summarize and compare the Native and non-Native alcohol and substance abuse treatment programs currently available in B.C.. The results of these analyses have attempted to: (1) make the values that underlie the healing approaches more explicit; (2) identify which values are given priority in the implementation of the healing strategies and which are not; (3) identify and evaluate any incongruities between the stated values and goals of the programs and the actual applications, and hence make inferrences for program efficacy; and (4) identify potential research questions for future research.

The rationale for using these methods relates to the nature and characteristics of language as communication. There are several reasons for this emphasis. First, the potentials for discovering, understanding and evaluating the differences inherent in cross-cultural value systems is an important element in this project. Values are embedded in language and are fundamental to the understanding of a people's worldview. Therefore, the same theoretical machinery that is applicable to vocabularies in general is appropriate here (Werner and Schoepfle 1987). Second, discourse is key in therapeutic and educational encounters (Chenail and Fortugno 1995; Chenail and Morris 1995; Czarniawska 1998; Harold *et al.* 1995; Guttman 1996; Ragan *et al.* 1995; Smith *et al.* 1994), both of which play major roles in recovery centre treatment strategies. Third,

according to Spradley "language is more than a means of communication about reality, it is a tool for constructing reality" (1979:17). Different languages create and express different realities, they categorize experience in different ways, they provide alternative patterns for customary ways of thinking and perceiving (Waldram 2000). Lastly, there is empirical value in the structure, validity and reliability of content analysis as a quantitative method which balances the deeper interpretative results of the qualitative ethnographic methods.

METHODS: QUANTITATIVE AND QUALITATIVE

Researchers frequently suggest that combining quantitative and qualitative methods within a single research project is beneficial and can produce data that are empirical and useful for practical applications and scholarly research (Guttman 1996; Harold *et al.* 1995; Maxwell *et al.* 1986; Pomerantz *et al.* 1995; Smith *et al.* 1994). Werner and Schoepfle state that

> Validation ... provides checks on internal consistency -- that is, answers to questions about the fit of ethnographic findings with statistical conclusions and vice versa. The reversibility is important. Validations and checks of internal consistency can go both ways -- from ethnography to statistics and from statistics to ethnography. (1987:263)

Smith *et al.* (1994) point out that, when focused on the same issue, qualitative and quantitative modes of analysis may be used not only to examine the same phenomenon from multiple perspectives but also to enrich our understanding by allowing for new or deeper dimensions to emerge.

Smith *et al.* (1994) further suggest that the terms 'qualitative' and 'quantitative' do not adequately describe studies that bridge both types of methodology. A better distinction is found in comparing 'emic' and 'etic' perspectives. They submit that this distinction is important because it suggests that not all qualitative research designs are able to capture the emic worldview of informants. Some methodologies are traditionally etic in their use and are not suitable for understanding consultants from their own perspective but instead

represent the researcher's beliefs and values. Smith *et al.* affirm that "for studies to capture the complexity of clinical processes, they must be able to capture both emic and etic perspectives" (1994:268). This research has involved clinical processes, has combined qualitative/quantitative or emic/etic methods, and has benefitted as a result.

Content Analysis

Content analysis is a set of research techniques that uses a number of interconnected procedures to analyze and make valid inferences from texts. The techniques include: a theoretical frame of reference; assumptions and question posing; sampling; "unitizing" texts to achieve uniformity of recording and context units; defining categories; data collection, extraction and measurement; inferences; conclusions; test coding and revising; and backchecks of reliability and validity (Carney 1972; Weber 1990).

According to Weber, "there is no single right way to do content analysis. Instead, investigators must judge what methods are appropriate for their substantive problems" (1990:69). Nonetheless, the image of content analysis as a glorified frequency count is a dated one. Berelson's (1952) definition: "content analysis is a research technique for the objective, systematic, and quantitative description of the manifest content of communication" (Berelson in Ogilvie *et al.* 1982:220) is a minimal and unsatisfactory definition because it does not reflect what content analysts currently do. Consequently, this analytic format is now referred to as 'classical' content analysis (Carney 1972).

A more recent definition of content analysis was developed jointly by Stone (1966) and Holsti (1969) and has been adopted for the purposes of this thesis. It states, "content analysis is any technique for making inferences by objectively and systematically identifying specified characteristics of messages" (in Ogilvie *et al.* 1982:221). Unlike Berelson's focus on quantification, this definition does not make frequency counting an absolute necessity, nor does it specify that *only* the manifest content of a message is appropriate for content analysis. Instead, it also allows for the assessment of what is

"written between the lines", permitting the potential assessment of latent meaning and the use of qualitative data. As Holsti puts it:

> 'Reading between the lines' so to speak must be reserved to the interpretation stage, at which time the investigator is free to use all of his powers of imagination and intuition to draw meaningful conclusions from the data. (1969:13)

This definition suggests that the making of inferences is the major purpose of content analysis. This is critical because, according to Werner and Schoepfle (1987), inference of cause and effect is an important method for extending the reach and persuasiveness of ethnographic data.

Nonetheless, the objectivity and systematic nature of the method remain strong and important components (Carney 1972; Ogilvie et al. 1982). An objective coding framework reduces the possibility of researcher bias by preventing her/him from focusing on the most dramatic and/or interesting topics. More importantly, in this study it yields a structured description of Native and non-Native attitudes and values in quantitative terms, permitting the existence of similarities and differences in their healing strategies to surface and to be enumerated.

Content analysis is frequently used to analyze cultural differences because it can process vast amounts of writing of different kinds while looking for complex patterns. Its use is also indicated when source material is used to complement some other kind of data during an inquiry into attitudes. The goal is to see whether findings from the two separate analyses converge. This process, is termed "multiple operationism: the using of other techniques to produce findings to confirm those of a content analysis" (Carney 1972:64). As a check on inferences, some form of multiple operationism can be used in an attempt to establish converging findings by using different techniques on different types of source materials as has been undertaken through the staged approach in this thesis.

Three forms of content analysis were used as each phase of the project evolved. In Phase One a more "classic" word frequency count was used. In Phase Two a manifest

content analysis was used to study the statements written in the treatment centre brochures. These statements are taken at "face value" and no attempt is made to interpret the brochure writers' intentions at the coding stage. Also in Phase Two, the visual imagery on the brochures was analyzed requiring a more qualitative and interpretative analytic style. In Phase Three where ethnographic interviews were conducted, qualitative and thematic ethnographic content analysis was used. A more detailed description of the staged approach and research activities undertaken in the different phases will be discussed in Chapter 4: The Written and in Chapter 5: The Oral.

Ethnographic Content Analysis

Ethnographic content analysis (ECA) builds on the quantitative methods of content analysis and incorporates the qualitative methods of ethnography (Altheide 1987). It is used to document and understand the communication of meaning, as well as to verify theoretical relationships (Altheide 1987; Smith *et al.* 1994; Tesch 1990). Through ECA consultants (in this case treatment centre program facilitators) teach the researcher about the indigenous meaning of their worldview. Because ethnographic and content analysis procedures interface and complement one another, similarities and differences among text are revealed that would be difficult, if not impossible, to detect.

ECA uses many of the traditional content analysis procedures, in addition to the back-and-forth movement between concept development and data analysis, and the constant comparison that the ethnographic approach requires (Tesch 1990:64). For example, when establishing coding categories in traditional content analysis Holsti states, "the most important requirement of categories is that they must adequately reflect the investigator's research question" (1969:95). An excellent starting place. However, Altheide augments this statement when he describes ECA's process:

> ethnographic content analysis consists of a reflexive movement between concept development, sampling, data collection, data coding, data analysis, and interpretation. Although categories initially guide the study, others are allowed and expected to emerge throughout the study. (1987:68)

ECA draws on both numerical and narrative data, which allows for a narrative description to better interpret results. ECA constructs categories qualitatively in order to develop analytical constructs appropriate to individual research studies. In this way, theoretical relationships are verified and new concepts that emerge during the research process are discovered. Hence, data analysis is both statistical and textual (Smith *et al.* 1994).

Qualitative Evaluation

The varied purposes for conducting evaluations differ with regard to the research questions they address and the kinds of methods needed to answer those questions (Chelimsky 1997; Maxwell *et al.* 1986; Tesch 1990). The evaluative perspective relevant to this thesis is known as "illumination" or "evaluation for knowledge" (Chelimsky 1997:10-11; Tesch 1990:65). For example, a sample question that has been addressed by knowledge-perspective evaluators is: "Which policies and programs might best address problems of alcoholic violence, based on which theory?" (Chelimsky 1997:14). According to Chelimsky (1997), the larger purpose of the knowledge perspective is to increase understanding about the factors underlying public problems, about the 'fit' between these factors and the policy or program solutions proposed, and about the theory and logic (or their lack) that lie behind an implemented intervention. Keeping in mind Weibel-Orlando's (1989) caution regarding theoretical faith-leaping, and in an attempt to take a more critical stance as urged by cross-cultural addictions researchers, the methods used for this thesis have endeavoured to take an illuminative rather than a descriptive stance in its comparison of the Native and non-Native recovery and treatment interventions.

A cultural domain, such as an alcohol and substance abuse treatment centre, has an associated universe of discourse (Chenail and Morris 1995; Guttman 1996; Ragan *et al.* 1995; Smith *et al.* 1994; Werner and Schoepfle 1987). Cultural values are inherently embedded in this discourse universe. Consequently, value statements surface with

regularity. The recurrent nature of these value statements identifies them taxonomically as themes. That is, all evaluative statements that consistently pervade the discourse within a cultural domain are themes of that domain. Identifying and analyzing these values and themes can help explain how intervention goals have been determined and what types of strategies program facilitators believe should be used. In addition, analysis of embedded values and themes can have important practical applications in pointing out evaluation criteria that might be skewed or limited (Gorman and Speer 1996; Guttman 1996).

THE STUDY POPULATION

Across British Columbia, treatment services for addiction recovery is available to residents from several sources delivered through a provincially managed "Addictions System of Care" (Kaiser Youth Foundation 1999:28) with funding available from Federal (i.e., Health Canada), Provincial (i.e., Addiction Services -- Ministry for Children and Families; Ministry of Health and Ministry Responsible for Seniors; and Ministry of Women's Equality) and private sources.

For First Nations residents, access to these services shifts depending on whether they reside on- or off-reserve. Band and tribal services, which preferentially but not exclusively, service Band members residing on-reserve, are funded Federally by the National Native Alcohol and Drug Abuse Programs (NNADAP) administered by the First

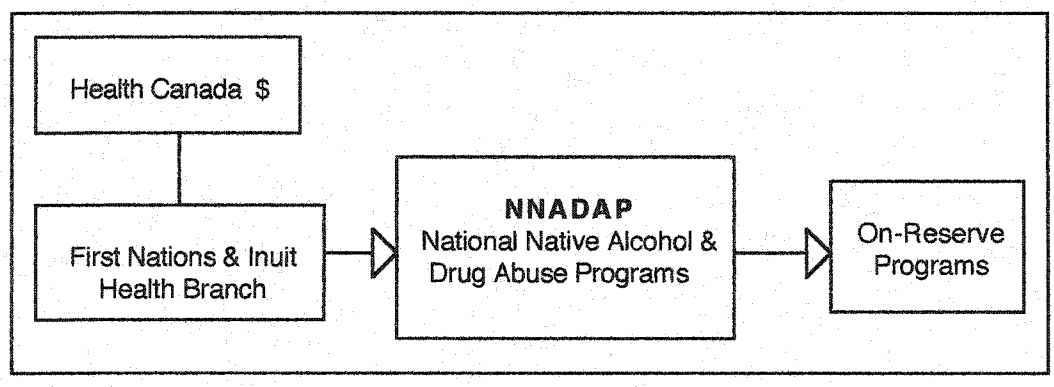

Figure 3-1. B.C. First Nations on-reserve addictions recovery services funding.

Nations and Inuit Health Branch (FNIHB), formerly Medical Services Branch (MSB), of Health Canada (Health Canada 2000; Kaiser Youth Foundation 1999) (Figure 3-1).

Approximately 15 years ago, Canada's Native reserve communities began negotiations to transfer community social and health programs, including the NNADAP programs, to local control through the Federal Health Transfer process. This process is part of the Government of Canada's policy of devolution of its First Nations and Inuit Health Programs. Up until now, the Federal Government has dictated the mainstream treatment programs reserve communities could use if they wanted to access funding. A recent report indicates that Health Canada has signed 170 transfer and integrated agreements covering 282 of the 631 First Nations and Inuit communities in the country (Health Canada 1998).

The Aboriginal Health Association of B.C. represents six community-based regional Aboriginal Health Councils (AHCs) which allocate and administer monies to approximately 200 off-reserve Aboriginal agencies for delivery of substance abuse, mental health, family violence, and sexual abuse intervention programs. Provincial funding for these agencies is provided by the Ministries for Children and Families, Health and Women's Equality (Kaiser Youth Foundation 1999:24) (Figure 3-2).

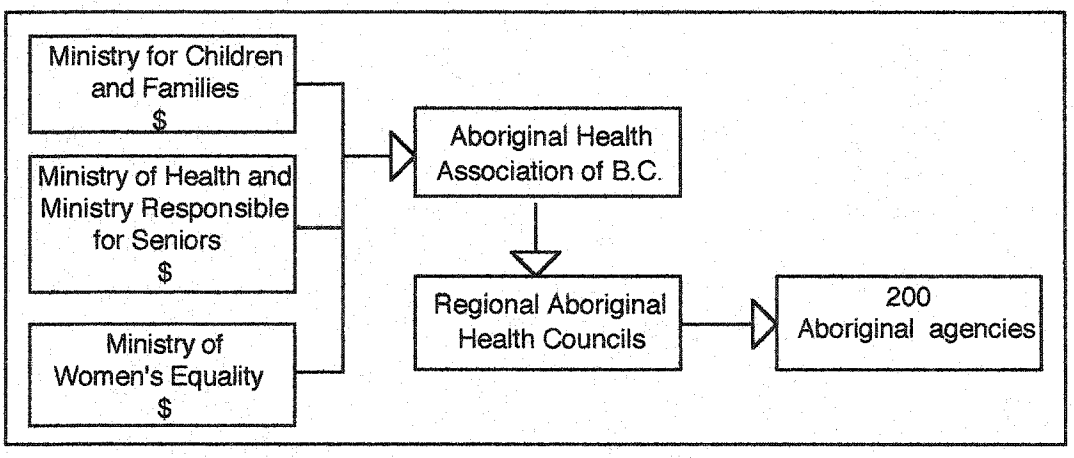

Figure 3-2. B.C. First Nations off-reserve addictions recovery services funding.

The sample universe for this project consists of all alcohol and substance abuse recovery centres listed in the *Directory of Addiction Services in British Columbia 1999* (Kaiser Youth Foundation 1999). The types of treatment centres and programs include: outpatient treatment, withdrawal management (detoxification), day treatment (intensive treatment in non-residential settings), residential treatment (intensive treatment in residential settings), and supportive recovery services. Other services related to addictions recovery and listed as adjunct and complementary programs include: transitional living, hospital-based substance misuse programs, needle exchange, methadone treatment, dual diagnosis programs, pregnancy support services and private counselling (Kaiser Youth Foundation 1999:28-33).

In order to ensure a comparative analysis, the sampling procedure involved selecting centres that: (1) are listed as outpatient and/or residential centres; (2) offer their services to Native and/or non-Native peoples; (3) are regionally comparable (i.e., have at least one of the same type of centre, for both groups of clientelle, located in the same region); (4) offer their services to anyone within those two groups (i.e., centres describing their services as exclusively available to a particular target group: men, women, youth, street youth, seniors, physicians, incarcerated individuals and/or other ethnocultural groups were excluded); and (5) focus their services on recovery from alcohol or substance abuse (i.e., centres describing their programs as focusing on problem gambling were excluded). The resulting sample population totalled 159 treatment centres: 70 Native and 79 non-Native outpatient clinics, and six Native and four non-Native residential centres (Table 3-1).

Outpatient Clinics

Outpatient programs generally incorporate three services: assessment, referral and case management. The assessment addresses an individual's substance misuse and related

problems, as well as their personal strengths which can aid in their recovery. Based on the assessment, a service plan is developed with the client, matching their needs to available resources. This assessment is followed by monitoring and interim adjustments to the plan. Counselling, support, and education are provided for persons attempting to terminate their own misuse of substances and those dealing with related problems in family relations, work, legal, and physical and emotional health areas. A variety of professional and peer counsellors operating in an outpatient program provide these services. All outpatient programs funded by Addictions Services provide prevention programming in partnership with other community organizations and individuals. Approximately 25 percent of an outpatient clinic's time is spent on prevention activities. The programs and target groups vary according to the needs and priorities of each community (Kaiser Youth Foundation 1999:28-29).

Table 3-1. Inventory of B.C. outpatient and residential substance abuse treatment centres invited to participate.

Ministry for Children and Families REGIONS	OUTPATIENT CLINICS		RESIDENTIAL CENTRES		TOTALS
	Native	Non-Native	Native	Non-Native	
2 - North + South Okanagan	5	9	1	1	**16**
3 - Thompson + Cariboo	12	6			**18**
4 - N. Interior, N.W. + Peace Liard	25	24	2	2	**53**
5 - Upper Fraser	3	5			**8**
8 - Richmond +Vancouver	3	12			**15**
9 - Coast Garibaldi + North Shore	6	7			**13**
10 - Central + Upper Vancouver Island + Central Coast	13	11	3	1	**28**
11 - Capital	3	5			**8**
Total Number of Regionally Comparable Centres	**70**	**79**	**6**	**4**	**159**

Residential Centres

Some people may require a safe living environment, free of alcohol and other drugs, while undertaking intensive short-term therapeutic work. Such clients usually have unstable living arrangements and lack support of family, friends, and employment; or they may be overwhelmed by pressures, problems, and inducements to resume substance misuse (Kaiser Youth Foundation 1999:30). The length of time an individual participates in a residential treatment centre program ranges from three to twelve weeks or more depending upon the centre itself and the needs of the individual. Costs to clients for residential treatment can range from no charge to $200/day. Subsidy funding may be available to offset some or all of the costs.

STAGED IMPLEMENTATION

The research design for this project uses a staged approach consisting of three phases. The processes involved in each of these phases are described below:

Phase One: Establishing Difference

The *Directory of Addiction Services in British Columbia 1999* includes brief statements describing the treatment approaches of each Native and non-Native outpatient and residential centre listed (Appendix 4-1). A word and phrase frequency content analysis of the "approach" descriptions was conducted to determine if sufficient difference existed between the Native and non-Native approaches to warrant further investigation. Differences were found to exist and Phase Two was implemented.

Phase Two: Extending the Invitation

To explore these differences further, letters were written to the treatment centres' directors, explaining the nature of the research, and inviting them to promote understanding by participating in the study (Appendix 4-2). Their contribution was to consist of

supplying documentation they felt described the philosophies and goals of their treatment programs. Every attempt was made to personalize the letters. Where it was not possible to learn the name of a centre's director, the letter was addressed to "Dear Director". The invitation package included: (1) the cover letter; (2) a response card offering two options (Figure 3-3); and (3) a self-addressed, stamped 9" x12" envelope.

To encourage participation, follow-up telephone calls were made to program directors who had not responded within one month of the invitation being mailed.

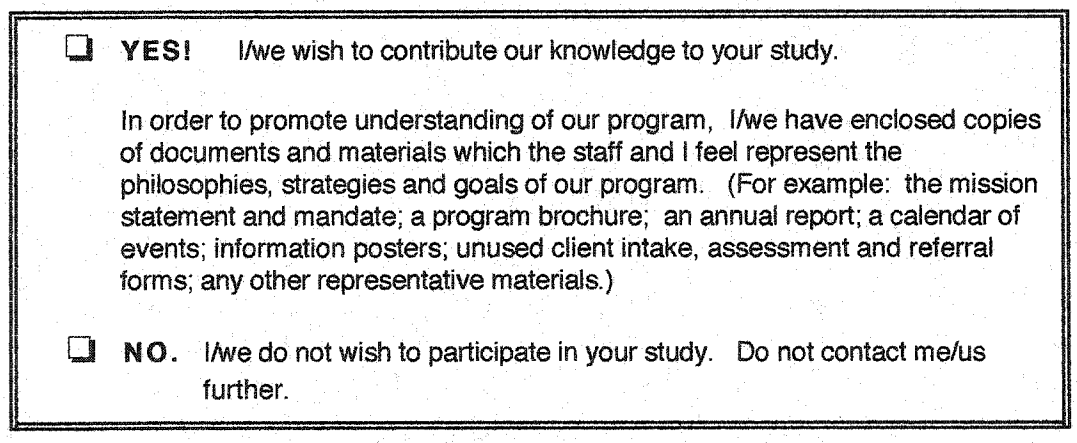

Figure 3-3. Response card for invitation to participate.

Phase Three: Meeting, Listening and Talking

Through the processes involved in Phase Two it became clear that many treatment centres did not have published materials suitable for the research project but were willing to participate through a face-to-face interview to address this lack of written materials. This was particularly true with the Native centres. For this reason, interviews were conducted at those Native treatment centres preferring to participate in this manner. The interviews were held primarily at Native centres located on or near Vancouver Island, the Lower Mainland, and Sunshine Coast to accomodate time and budgetary constraints.

In addition, through the follow-up telephone calls, several program facilitators spoke at length about their programs. Three of these were considered to be spontaneous

interviews, copious notes were taken, and transcripts were forwarded to the individuals for their approval. (See Chapter 5, for a detailed description of the interview process.)

Furthermore, to ensure comparability in the scope and depth of the data received from participating non-Native centres who had provided written materials, three additional interviews were conducted. Each non-Native centre selected was located in a different area (i.e., on or near Vancouver Island, the Lower Mainland, and Sunshine Coast) to enhance the regional comparability of the data with the Native centres also located in these areas.

The ethnographic interview was semi-structured, approximately one hour in duration, and audio-taped. The intention of the interviews was to: (1) fill out information from published materials that was scanty in scope; (2) provide validity checks; and (3) provide a deeper understanding of the centres' values and philosophies. Upon completion of each interview, a typed transcript was produced and forwarded to the participant for their review and approval prior to its inclusion in the analytic process.

SUMMARY

The different types of source materials gathered through the staged research design of this thesis along with the quantitative and qualitative techniques utilized in their analysis is a good example of multiple operationism. The following two chapters discuss in detail the stages of analytic process undertaken and the results obtained. Chapter 4 focuses on Phases One and Two by examining the documentation associated with the recovery centres. Both the textual and visual components of the brochures are analyzed to expand on the differences between the Native and non-Native centres' treatment approaches as established in Phase One. This set the groundwork for the Phase Three.

As Holsti points out, when one is attempting to infer aspects of culture and/or cultural change through a content analysis of written materials,

> A most important problem, one rarely resolved beyond doubt, is the selection of materials which do in fact represent the culture, or at least some significant aspect of it. Do ... [documents] ... represent merely a manifestation of the authors' personalities, or do they reflect the more general milieu? (1969:82)

To offset this problem to some degree, the interview analysis permits a deeper look into the workings of the treatment centres. Chapter 5, which focuses on Phase Three with its ethnographic content analysis and qualitative evaluation, goes a long way in determining if the centres' written representations of themselves match their activities, how the Native and non-Native centres differ or are the same, and how the ideas of cultural relevancy are regionally translated into alcohol and substance abuse healing practises.

CHAPTER 4

THE WRITTEN: DOCUMENT ANALYSIS

INTRODUCTION

As discussed in the previous chapter, the potentials for discovering, understanding and evaluating the differences inherent in cross-cultural value systems are key elements in this project. These values are embedded in language and are fundamental to a culture's worldview. In this case the cultures involved are twofold. First, is the culture of the alcohol and substance abuse recovery centre itself. The personnel who are associated with these centres, and the people who come to the centres for help, constitute the cultural domain and have an associated universe of discourse. Second, are the Native and non-Native cultures that sub-divide the recovery centre culture. These cultures communicate their worldviews through three forms of communication, namely the written, the visual, and the oral. This chapter deals with the written and the visual. The oral, as experienced through ethnographic interviews, is discussed in Chapter 5.

The document analysis was accomplished in two phases. In Phase One, a manifest content analysis of word and phrase frequencies was conducted on the descriptions of selected outpatient and residential centres' approaches, from the *Directory of Addiction Services in British Columbia 1999* (Kaiser Youth Foundation 1999). In Phase Two, brochures were selected for analysis from the wide array of documents submitted by participating recovery centres. A comprehensive thematic content analysis was conducted on the text and the visual imagery present in the brochures to discover which value statements (both textual and visual) surfaced with the most regularity.

MAJOR FINDINGS

The analysis of the directory listings establishes three main themes: the approaches used, the people benefitting, and the domains affected (Figure 4-2). A difference is found in the domain categories, especially the cultural and the physical which are present only in the Native listings. Spirituality is only minimally represented in the non-Native listings but is very present in the Native. The greatest difference exhibited in the non-Native listings is the emphasis on individual treatment. The other themes and their categories exhibit considerable and somewhat surprising similarity.

In the brochures selected for analysis, the concept of holism and its component parts (i.e., spiritual, cultural, social, psychological and biological), are established as the major comparable themes. Overall, the Native brochures offer a more substantial picture of the values and philosophies embedded in their recovery programs, both visually and textually, than do the non-Native brochures.

Outside of the cultural component, which exhibits the greatest contrast, a cursory glance would suggest little difference between thematic emphases in the Native and non-Native brochures and the programs they represent (Table 4-1). However, a closer examination of the intensity of theme occurrences (Figure 4-1) and of the sub-categories presents a different picture.

Holism appears to occur textually with corresponding frequency but sub-category analysis reveals a greater emphasis in the Native brochures. Spirituality also appears to occur equally in the text. However again, sub-category analysis indicates Native references to spirituality are evenly distributed, whereas the spiritual emphasis in the non-Native brochures is skewed towards references of AA and other 12-Step programs. Not surprisingly, all of the Native brochures explicitly and intensely refer to culture whereas culture is mentioned in only 32% of the non-Native brochures and half of those occurrences address Indo- and Asian-Canadian cultures specifically. Superficially, the

social theme also appears to be an aspect of recovery equally important to both Native and non-Native programs. Well over half of the brochures make textual reference to social themes. However, on closer examination this concept is more important in the Native brochures as each of the sub-categories are represented at approximately twice the frequency. Lastly, the psychological and biological themes are weakly and similarly represented in both sets of brochures.

Table 4-1. Percentage presence of major themes in brochures.

MAJOR THEMES	Native VISUALS + TEXT	Non-Native VISUALS + TEXT	Native VISUALS only	Non-Native VISUALS only	Native TEXT only	Non-Native TEXT only
Holism	**64%**	**36%**	36%	8%	45%	36%
Spiritual	**100%**	**76%**	100%	32%	73%	72%
Cultural	**100%**	**32%**	100%	0	100%	32%
Social	**100%**	**84%**	55%	24%	73%	68%
Psychological	**45%**	**44%**	0	0	45%	44%
Biological	**36%**	**36%**	0	12%	36%	28%
TOTAL # BROCHURES	**11**	**25**	**11**	(84%) **21**	**11**	**25**

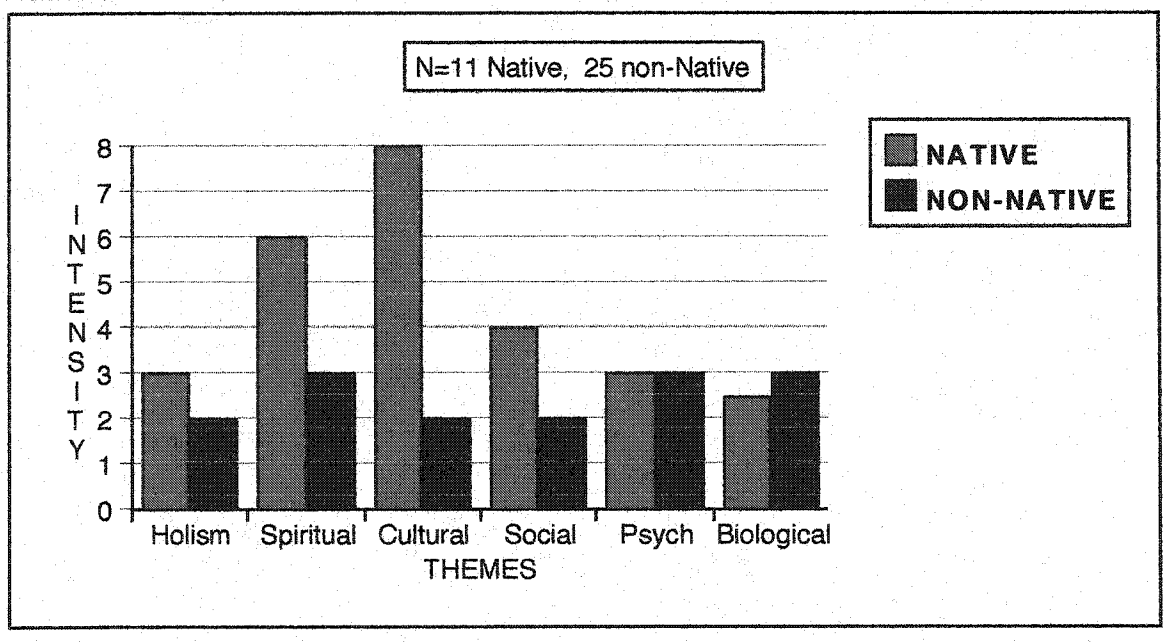

Figure 4-1. Average intensity per brochure where theme is present.

The visual imagery makes it readily apparent which brochures originate at Native recovery centres. Holism is represented to a much greater degree in the Native visual imagery. Furthermore, all of the brochures provided by these centres have strong visual imagery explicitly and intensely evoking regionally distinctive Native cultural and spiritual symbolism. On the other hand, of the 84% of the non-Native brochures which exhibit visual imagery, cultural symbolism is non-existent, and the concept of spirituality is vaguely depicted in approximately one-third of the brochures. Lastly, the social theme is visually represented in over half of the Native brochures, which is more than twice the frequency of the non-Native brochures.

PHASE ONE: DIRECTORY LISTINGS ANALYSIS

LISTING SELECTION

The *Directory of Addictions Services in British Columbia 1999* (Kaiser Youth Foundation 1999) contains listings of the alcohol and substance abuse recovery programs and services available to residents of B.C.. The sampling procedure (See Chapter 3, Study Population, Table 3-1) resulted in a total sample of 159 (76 Native, 83 non-Native) outpatient and residential recovery centre listings. These listings included four sections: (1) name, address, and other contact information; (2) funding information; (3) services provided; and (4) approaches used (See Appendix 4-1). The third section described similar administrative and treatment process services across the listings. For example, assessments, referrals, counselling, and programs for the substance abusers and their collateral associates (i.e., family and friends). The latter section, however, offered information that differentiated the programs from each other by succinctly describing their programs and philosophies. These sections were analyzed to determine if there were sufficient differences identified in the centres' philosophies to warrant further investigation.

ANALYTIC PROCESS AND IDENTIFICATION OF MAJOR THEMES

A content analysis, using word and phrase frequency counts, was conducted on the directory listings. The sections describing the centres' approaches were small and approximately the same size allowing for data manageability and equivalency. For example, the average word count per listing between the two groups was almost identical (i.e., Native = 35 words; non-Native = 34 words). The resulting word and phrase lists were subsequently coded and combined into categories. The categories with the highest percentage of frequency occurrences in the listings were identified and compared. The final step subdivided the categories into three themes: (1) the treatment approaches used; (2) the personal domains addressed and/or affected by the treatment approaches; and (3) the people/social groups who benefit and/or are associated with the treatment approaches (Figure 4-2).

RESULTS

There is surprising similarity between the different people or social groups identified as being affected by the recovery centres' programs. I anticipated that Native centres would focus their programs on community, family, children and youth to a greater extent than the non-Native, but they do not. However, where there is a large difference, which may speak to this anticipated result, is in the non-Native centre emphasis on providing treatment to the individual.

There is also quite a lot of similarity between the treatment approaches identified. Educational techniques are used most often to deliver the treatment and prevention programs. A holistic philosophy also appears to be equally important to the Native and non-Native centres. It is identified in the non-Native listings most often as the Biopsychosocial approach. Of all the other approaches detailed in the listings, the AA 12-Step and harm reduction approaches are identified as being used most frequently.

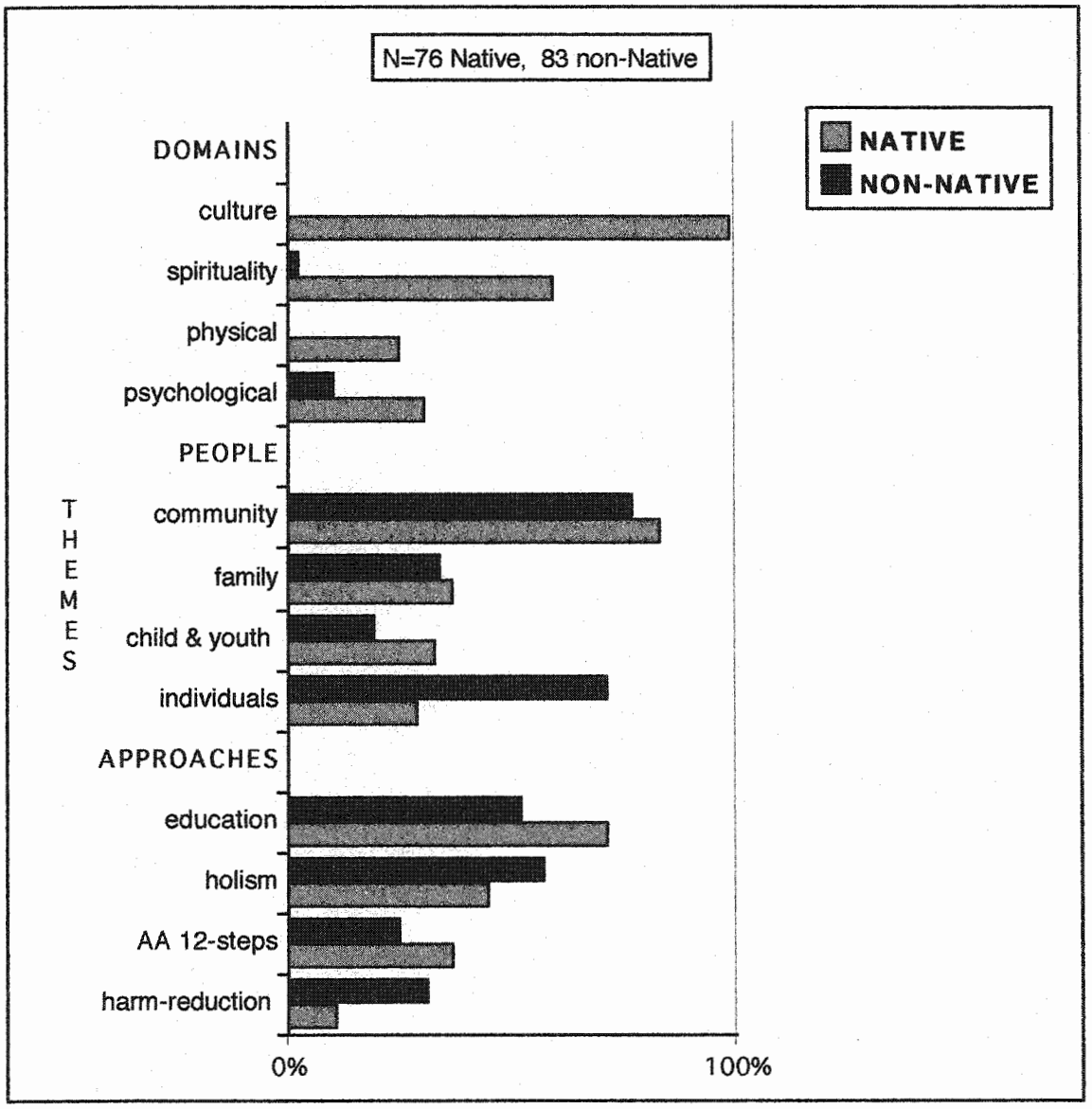

Figure 4-2. Frequency of directory listing themes.

The greatest difference in the data relates to the personal domain categories. Here, the cultural and physical domains are mentioned exclusively in the Native centre listings and the spiritual is strongly represented in the Native listings but is almost non-existent in the non-Native. The cultural domain which includes references to traditional activities, beliefs and values is fairly obvious and to be expected, although not to the extent that it would be completely absent in the non-Native listings. Regarding the spiritual domain,

there is a very strong spiritual component to the AA 12-Step approach which could be taken into consideration as providing a greater spiritual presence in the non-Native healing approaches. However, the reference to AA 12-Step is also greater in the Native listings which tends to boost the spiritual component in their listings even more. The Native centres also include physical activity in their approach descriptions, particularly sports and outdoor recreation activities, which the non-Native centres do not.

The extreme differences found in the personal domain categories between the Native and non-Native treatment approaches, along with the non-Native emphasis on the individual, established that sufficient difference existed between the healing strategies in these two groups of recovery centres to warrant further investigation.

PHASE TWO: BROCHURE ANALYSIS

BROCHURE SELECTION

The same 159 recovery centres selected for analysis in Phase One were invited to participate in Phase Two of the study (See Chapter 3, Staged Implementation). Of the total number of centres invited, 80 centres responded and agreed to participate in the study. Seventy-one (89%) of the 80 participating centres provided written materials (note that every non-Native centre provided documentation), and 36 (51%) of these centres supplied brochures (Table 4-2). I attempted to encourage participation through follow-up telephone

Table 4-2. Centres providing documents for analysis.

	Native	Non-Native	Totals
Participating centres that provided brochures	11	25	36
Participating centres that provided documents	21	50	71
Total Number of Centres Participating	30	50	80
Total Number Centres Invited to Participate	76	83	159

conversations with the recovery centre personnel. Quite a few of the Native centres, particularly in the more remote areas, expressed willingness to participate in the study but regretfully could not because their recovery programs operated on the basis of oral tradition and hence they had no appropriate written documentation.

The range of documentation provided by the centres varied widely from hand-written notes to questionnaires and workbooks to complete program policy and procedure manuals. Thirty separate types of documentation were inventoried (Appendix 4-3). From this wide array of information sources, brochures were selected as the most reasonable units for analysis for several reasons: (1) they are relatively small in size providing manageability of data; (2) they are consistent in size providing equivalent data sources; and (3) they can be assumed to be the first, and potentially only, information piece that a recovery centre would offer an individual to introduce their services suggesting that the brochure will advertise what the centre's personnel regard as its most important features. Therefore, the brochures were assumed to be highly representational of a recovery centre's values and beliefs as well as the general services it provides.

Types Of Brochures

In order to ensure analysis of independent cases of comparable units only one brochure per recovery center was selected. Most centres sent only one brochure but several sent more than one. For example, 11 Native centres provided a total of 26 brochures and 25 non-Native centres provided a total of 39 brochures. For the centres providing more than one brochure, the one selected for inclusion was the introductory brochure, that is the one most vividly outlining the salient features and philosophies of the alcohol and drug programs being offered by that centre.

There were three categories of brochures. The first two were included in the analysis, the latter was excluded.

Alcohol and Drug Service Brochures

These brochures focus exclusively on the centres' addiction recovery programs. In most cases, particularly at the non-Native centres, these brochures represent the full extent of programming available at the centre and constitute the entire purpose of the centre's existence. These brochures were included in their entirety for analysis.

Multiple and Integrated Service Brochures

These brochures tend to originate from centres such as Community Health Centres and/or Native Friendship Centres where a variety of services are offered to the clientelle. For analytic purposes, any programs described in the brochure explicitly mentioning the influence of alcohol and drug abuse were included. Other programs being offered by the centre but making no mention of alcohol and drug abuse were excluded from analysis. Services and activities available for everyone to access (i.e., drop-in centres, recreational facilities, communal activities) were included. It is assumed that these services and activities are also available to individuals involved in the centre's addiction recovery programs. Lastly, any reference to the centre's overall philosophy, mission, mandate, values, beliefs were also included as these aspects were assumed to be the essential components that underlie the justifications for all of the programs offered by the centre.

Excluded Brochures

It is important to note the topics covered by the brochures that were provided but excluded from analysis because the centres that provided them obviously felt they were important issues requiring attention by people affected by addictions. Several of these brochures are specifically inclusive of alcohol and drug abuse issues (Appendix 4-4, Part I). These brochures were excluded from analysis because the originating centres provided more than one brochure. The other excluded brochures focus on programs that make no mention of alcohol and drug abuse (Appendix 4-4, Part II).

ANALYTIC PROCESS AND IDENTIFICATION OF MAJOR THEMES

An inductive approach was used to establish the major themes and component sub-categories. To begin, a set of six brochures, three Native and three non-Native, were randomly selected and were laid out together on a table top to see if there were any obvious physical differences. The Native brochures could be immediately distinguished from the Non-Native brochures by the visual imagery depicted. Therefore, two major areas were determined to be relevant for analysis: 1) visual imagery and 2) textual content.

This stage in the analytic process led to a separation and compartmentalization of components in order to 'loosen' the discourse and allowed the embedded values to surface, to become more explicit. Dey refers to this process as "splitting and splicing" to "strip away unnecessary detail and delineate more clearly the more central characteristics of the data" (Dey 1993:39). This process magnified which values were given priority in the various Native and non-Native healing approaches. In Chapter 6, I will attempt to overcome this separation by reintegrating the relationships between the stated values and goals as delineated through the analysis of the written, visual and oral data sources.

The six brochures were closely examined and the initial major themes were identified. These themes included program similarities (i.e. treatment and administrative services), and other contrasting themes, more relevant to this study, were found in the descriptions of specific programs and philosophies. It is from these differential aspects that the major themes and sub-categories were ultimately established.

Each brochure was assigned a separate code-sheet (i.e., spreadsheet) which was rearranged into different comparative perspectives and combinations during the analytic process. The remaining brochures were coded to the themes and sub-categories with adjustments and fine-tuning occurring along the way. The first six brochures were re-coded after all the other brochures had been coded once to check for coder reliability.

As an additional element of the analysis, in order to examine the weight given to each of the themes it was decided to calculate the intensity of use for each of the themes and sub-categories, both textually and visually, and not simply its presence (Figure 4-1). Therefore, all of the brochures were re-coded a second time. The numerical results were very similar to the original coding process with very minor fine tunings required for the final analysis. This process benefitted the analysis by focusing the final results more acutely. Consequently, I feel confident that the reliability of the coding is high.

RESULTS: PROGRAM SIMILARITIES

There is a great deal of similarity in the services provided in alcohol and drug abuse recovery centres in British Columbia. These similarities are due in part to the constraints and mandates established by the funding agencies (i.e., Provincial Ministry for Children and Families and Health Canada) to ensure the accessible, accountable and professional delivery of both treatment and prevention programs. Other similarities are due to the nature and standards of ethical practice of the various professions involved in providing support and guidance for people struggling to overcome their own addictions or in learning to cope with the addictive behaviours of a loved one or co-worker. These professions include but are not limited to Counselling, Social Work, Psychology, Psychiatry, Nursing, and Medicine. It is safe to say that the services offered in Native and non-Native recovery centres in B.C. are congruent with addictions professional practice throughout the world.

Treatment Services

Outpatient services are provided free of charge to anyone directly or indirectly suffering from the effects of substance abuse. Residential centres usually have costs attached to treatment, however, financial assistance may be available to clients requiring subsidization. Probably the most important standard requirement in the field of addiction

recovery is the ethic of confidentiality. Confidentiality is essential in order for a client to build a strong foundation of trust. Therefore, all information shared is considered to be confidential within the "limits of the law" and will be released only with client consent. The limits of the law include situations where there may be a risk of an individual harming either themself or another person, and/or when the release of information is demanded by subpeona.

It is generally accepted that no one treatment or intervention approach is helpful to all persons experiencing alcohol and substance abuse. Consequently, the services offered by Native and non-Native centres utilize professionally trained staff with knowledge and skills of various therapies to individualize treatment plans best suited to benefit their clients. However, even though a wide range of treatment therapies is available, the brochures describe very similar treatment *processes* through which a client will move when accessing the services of recovery centres. These treatment processes begin with assessments. The assessment process determines the extent and seriousness of the problem. Based on the assessment, a treatment plan is designed to meet the individual's needs and to establish personal goals. These needs and goals may include one or more of the following services: referrals, counselling, group work and after care.

Referrals to other agencies could include detoxification programs, residential treatment centres, supportive recovery homes, day intensive programs and/or other community resources. Counselling is available both for individuals who have substance abuse problems themselves and for members of their families. However, if the centres find themselves in an overload situation where wait-lists are necessary, the priority for counselling tends to focus on the addict seeking help. Counselling is usually available for individuals, couples, and families. Group work is a frequently mentioned service which includes general support groups and more in-depth therapy groups aimed at working through specific issues. Frequently, programs are designed for specific groups to

supplement other recovery work such as youth programs and parenting programs. Continued support after the core program or residential treatment has been completed is almost always provided. However, the centres vary on the length of time this support may be available.

Prevention Services

All centres are available to provide information, education and prevention services. These are generally aimed at addressing the needs of people in the community who are not currently experiencing substance abuse problems but may be at risk of developing them. Staff are encouraged to work with parent groups, schools, and interested community organizations in developing and presenting effective prevention programs, particularly for youth.

Without a doubt, a great deal of professional similarity exists in the Native and non-Native alcohol and drug abuse recovery programs in B.C. Furthermore, an accreditation process is currently taking place throughout the province which will standardize the programs and evaluation processes to an even greater extent. In essence, the greatest similarities include the standards of ethical therapeutic practice, the availability of service, the process of treatment, and efforts to build community-based prevention programs.

With these *similarities* in mind, the content analysis of the brochures discussed below focuses on discovering any meaningful *differences* between the programs, therapies and knowledges included in the various approaches offered by the Native and non-Native recovery centres in an attempt to make more explicit the values and beliefs that are embedded in their healing programs.

RESULTS: COMPARATIVE THEMES

The primary objective of the brochure analysis is to gain a comparative province-wide examination of Native/non-Native treatment strategies and the values and beliefs

embedded therein. In addition, the brochure analysis is intended to delve deeper into the questions posed by this thesis regarding the spiritual nature of recovery and symbolic healing. The analysis reveals that both spirituality and symbolic healing are present, that neither stands alone, and that they are part of a more inclusive concept, namely holism.

The major themes of recovery in the brochures emerge from the concept of holism and of creating a healthy balance. Holism is an all-encompassing theme identified to varying degrees in both Native and non-Native brochures. In its full nature holism integrates and attempts to balance the spiritual, physical (biological), psychological (mental/emotional), social, and cultural aspects of life. These components work very well as the major themes for both visual imagery, or the symbolic, and textual content for the brochure analysis with specific sub-categories patterning themselves within these major themes.

Holism

The theme of holism, sometimes referred to as balance, is a useful indicator of the presence or absence of spirituality in a recovery centre's programs. Explicit visuals and textual phrases listing all of the components of holism inherently include spirituality as a component of healing equally important to individual well-being and absent from the medical model of healing.

The brochure analysis results suggest that Native recovery centres consider holism, and by inference the inclusion of spirituality, to be a more important aspect of recovery and healing programs than do the non-Native centres (Table 4-3). Holism is present at twice the frequency in the Native brochures. It is identified, both via explicit and implicit visual representations as well as with a greater number of textual references across the sub-categories in almost two-thirds (64%) of the Native brochures. Furthermore, for those occurrences of 'undefined' holism, the analysis shows that the spiritual component is

present in other forms (visually and textually) in those same Native brochures. Therefore, it can be assumed that spirituality is present where the elements of holism are unspecified.

Table 4-3. Brochure analysis results: Holism.
(See Appendix 4-5 for descriptive examples of visual and textual sub-categories.)

HOLISM Sub-Categories	Explanation of Sub-Categories	Percent Presence: Native Brochures	Percent Presence: Non-Native Brochures
VISUALS			
Explicitly holistic	images explicitly represent holism	36%	0
Implicitly holistic	set with other elements, holism is inferred	9%	8%
	Total presence of holism in visuals	**36%**	**8%**
TEXTUAL			
Holism-full	balance, spiritual, mental, physical, social	27%	32%
Holism-partial	spiritual component not explicitly mentioned	9%	8%
Holism-undefined	unspecified which aspects are included	27%	0
	Total presence of holism in text	**45%**	**36%**
	Total presence of holism in visuals + text combined	**64%**	**36%**
	TOTAL NUMBER OF BROCHURES	11	25

Comparatively, in the non-Native brochures, visual representations of holism are minimal and inferred. The bulk of the holistic emphasis is found textually in one sub-category where holistic components are explicitly identified. Overall, slightly more than one third (36%) of the non-Native centres refer to holism.

Spirituality

Overall, spirituality has a much greater presence in the Native brochures. If one were to look only at the combined totals of the visual imagery and textual references to this theme there would be difficulty supporting this statement. However, a closer examination of the distribution of spiritual references present throughout the sub-categories clearly indicates a much stronger presence than is evident in the non-Native brochures (Table 4-4).

The greatest difference in spiritual representation rests in the visual imagery where it is present, in one form or another, in every one of the Native brochures. Spiritual symbolism is explicitly *or* implicitly present in all of the brochures and in the vast majority both forms are present. The symbolism depicted in the Native brochures is considered so

Table 4-4. Brochure analysis results: Spirituality.
(See Appendix 4-5 for descriptive examples of visual and textual sub-categories.)

SPIRITUALITY Sub-Categories	Explanation of Sub-Categories	Percent Presence: Native Brochures	Percent Presence: Non-Native Brochures
VISUALS			
Explicitly spiritual	symbols of spiritual beliefs clearly depicted	82%	0
Implicitly spiritual	allowing full benefit of the doubt, images may infer spirituality	82%	32%
	Total presence of spirituality in visuals	**100%**	**32%**
TEXTUAL			
AA, NA, 12-Step, 16-step program	recommends AA/NA/12-step programs; "many roads, one journey"-16-step program	36%	52%
Spiritual beliefs respected	explicit mention of person's spirit, cultural / spiritual beliefs; development of traditional values/beliefs	36%	16%
Aboriginal teachings and beliefs	mentions Aboriginal traditional teachings and practices (i.e., Medicine Wheel, Red Road, healing circles, spiritual symbolism)	36%	0
Christianity	refers to Christian celebrations, pastors	9%	8%
Prayer and meditation	explicit use of prayer and/or meditation; reference to inner wisdom	9%	4%
	Total presence of spirituality in text	**73%**	**72%**
	Total presence of spirituality in visuals + text combined	**100%**	**76%**
	TOTAL NUMBER OF BROCHURES	11	25

strong because it contains images that represent complete doctrines and belief systems in iconic representation. For example, the Medicine Wheel is represented as well as mythical beings from oral teachings such as *Sisiutl* from the Kwakwaka'wakw people, and the

Thunderbird and Whale from the Coast Salish people. Also included are images of paraphernalia associated with spiritual rituals such as pipes and drums used to communicate with the spirits.

Contrasting this are the non-Native brochures where spiritual symbolism can be only vaguely inferred in the images depicted in only one third of the brochures. There are no explicit symbols that might relate to any particular spiritual belief or doctrine. Instead, all of the images are more abstract. Each image was contemplated carefully, allowing for full benefit of the doubt, when coding for spiritual content. The most common aspect of the symbolism that infers a sense of the spiritual in these images is that they tend to be sky-related. For example, abstract images of the rising sun, a soaring eagle, and suggestions of rainbows. It is important to note that this generous approach towards coding spirituality in these brochures' images probably over-estimates the spiritual content of the non-Native visuals considerably. This suggests that an even greater difference exists between the spiritual emphasis of Native and non-Native programs than the tabulated numbers reflect.

Surprisingly, textual references to spirituality appear to hold a much more equitable position (73% Native, 72% non-Native). However, upon closer examination of the sub-categories, there is again a stronger and more consistent presence of spiritual references in the Native brochures. Native emphasis is spread equally between reference to AA 12-Step programs, traditional Aboriginal spiritual teachings, and a respect for individual spiritual beliefs. Prayer in general and Christianity in particular are also mentioned, albeit to a lesser degree, but equal to each other. For example, one of the Native brochures has the following prayer written on its cover:

> O, Great Spirit, whose voice I hear in the winds that breathes life into all the world, hear me. I am small and I am weak. I need your strength and your wisdom that you have hidden under every leaf and stone. Let me always walk with beauty in my eyes to ever behold the red and purple sunsets. Make my hands always respect the things that you have made and my ears

> sharp to your voice so that I will know what you have taught my people:
> not to be better than my brothers and sisters but to fight my greatest enemy,
> myself. (174a)[1]

It is important to note that this prayer is coded as a single presence under the sub-category of 'prayer and meditation' but clearly represents a much stronger spiritual presence. This is indicative of the strength of presence of the spiritual theme throughout the Native brochures.

On the other hand, spirituality in the non-Native brochures, while apparently present at an almost identical level, is mentioned with less frequency and is more skewed with the bulk of the occurrences present in the sub-category of 'AA, NA, 12-Step, 16-step programs'. In two-thirds of these occurrences, the use of AA 12-step programs is stated to be strongly encouraged in conjunction with the centre's treatment program. In the other third, the occurrences are simply listings of the support groups' contact phone numbers and/or meeting times and locations. In these situations the centre's endorsement of these programs as a spiritual and social support for the individual can only be inferred. A small percentage of the centres explicitly refer to the spirit or a respect for the spiritual beliefs of their clients while Christianity and prayer are mentioned to an even lesser degree than in the Native brochures.

Cultural

Not surprisingly, the most obvious difference between the Native and non-Native recovery centres' brochures is illustrated by the cultural theme (Table 4-5). Every one of the Native brochures convey strong cultural imagery. Several brochures include cross-cultural and anti-racism images. There is a regional distinctiveness separating the brochures of centres located on the coast, depicting imagery drawn in the traditional

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[1]References cited from recovery centre brochures or interviews are coded alphanumerically to assure confidentiality. They are included in the thesis to inform the reader who may find contextual relevance important and therefore can identify and/or compare statements made in the same brochure or by individuals from the same recovery centre.

Northwest Coast style, from the brochures of centres located in the central and northeastern regions which depict images of the Medicine Wheel and paraphernalia evocative of a Plains cultural influence.

A large percentage (82%) of the Native centres make specific reference to their incorporation of culturally appropriate components in their recovery programs, workshops and activities. One could assume that a spiritual component is also included. However, if the inclusion of spirituality is not explicitly stated or even inferred, as in the spiritual sub-category of 'Aboriginal teachings and beliefs,' this assumption is not made and the description is given a cultural emphasis rather than a spiritual one. Nonetheless, the potential for embedded spirituality in the cultural component should not be ignored.

Table 4-5. Brochure analysis results: Cultural.
(See Appendix 4-5 for descriptive examples of visual and textual sub-categories.)

CULTURAL Sub-Categories	Explanation of Sub-Categories	Percent Presence: Native Brochures	Percent Presence: Non-Native Brochures
VISUALS			
Explicitly cultural	images explicitly represent cultural components, cross-cultural issues	100%	0
Implicitly cultural	set with other elements, culture is inferred	18%	0
	Total presence of culture in visuals	**100%**	**0**
TEXTUAL			
Native client base	services focus on Native clients, identity	64%	16%
Visible minorities	services available for Indo/Asian-Canadians	0	8%
Culturally-relevant Native programs	programs use culturally-relevant activities, traditional practices, aboriginal language, Elders and Native staff where available	82%	0
Cross-cultural issues	influences of culture-of-origin, multi-cultural issues, anti-racism	18%	12%
	Total presence of culture in text	**100%**	**32%**
	Total presence of culture in visuals + text combined	**100%**	**32%**
	TOTAL NUMBER OF BROCHURES	11	25

Brochures from Native recovery centres tend to state that their services are mainly intended for a First Nations clientele and make no specific mention of other visible minority ethnic groups, such as Indo- or Asian-Canadians. However, some suggest an inclusive policy and stipulate that while the focus is on First Nations people, non-Native people who are in need of healing and who respect the First Nations way are welcome to access their services.

In contrast to these strong cultural aspects, none of the non-Native brochures present visual imagery that involves cultural symbolism in any way. In total, cultural components are mentioned in only 32% of the non-Native brochures and the majority of those occurrences specifically address Indo- and Asian-Canadian cultures. Mentions of services for First Nations clients occur only as listings of other community services such as AA 12-Step support groups meeting at the local Friendship Centre. None of the non-Native centres specify that their services are available for or focus on First Nations clients. They tend to state, as mandated, that their services are available to anyone suffering from problems related to their own or someone else's substance abuse.

Social

The relative distribution and comparative weight between the Native and non-Native social sub-categories is fairly similar to that previously discussed in themes of holism and spirituality (Table 4-6). That is, while the figures totalling the themes' occurrences appear to indicate a fairly equal emphasis, especially in the textual components, closer examination of the sub-categories once again expose a stronger social content in the Native brochures. Visually, aspects of the social occur over twice as often in the Native brochures as they do in the non-Native. The concept of interconnectedness plays a role in this emphasis as do representations of family.

The analysis of the sub-category of interconnectedness reveals slightly more than twice the occurrence in the Native brochures than in the non-Native. However, it may

be important to keep in mind the number of references to the spiritual sub-category of AA 12-Step programs in Native and non-Native brochures where the concept of inter-connectedness can also be found in the AA fellowship. Considering the sub-categories of interconnectedness and AA 12-Step together may produce a more even distribution.

Table 4-6. Brochure analysis results: Social.
(See Appendix 4-5 for descriptive examples of visual and textual sub-categories.)

SOCIAL Sub-Categories	Explanation of Sub-Categories	Percent Presence: Native Brochures	Percent Presence: Non-Native Brochures
VISUALS			
Social	images of family, community, justice, inter-connectedness	55%	24%
	Total presence of social in visuals	**55%**	**24%**
TEXTUAL			
Inter-connectedness	unity, connecting with humanity, enhancing relationships	45%	20%
Outreach	services for people in home, hospital, prison	36%	20%
Community enhancement	events & activities (i.e., bingos, meals) to promote community well-being & self-reliance	18%	4%
Community involvement	community has right & responsibility to be involved in solutions; memberships available	36%	20%
Justice	addresses legal/court issues, advocacy and liaison workers	45%	28%
	Total presence of social in text	**73%**	**68%**
	Total presence of social in visuals + text combined	**100%**	**84%**
	TOTAL NUMBER OF BROCHURES	11	25

The sub-categories of outreach, community enhancement and community involvement obviously contain communal aspects. Again, while they are addressed in both sets of brochures, the emphasis is greater in those from Native centres. This suggests that programs and activities that include community as a whole, rather than focussing on individual recovery, are more frequently incorporated in the Native healing programs.

Justice, the last of the social sub-categories is directly related to the psychological sub-category of violence. They will be discussed together below.

Psychological

There is no visual depiction of the psychological theme or its component parts on any of the brochures of either group. References to this theme are entirely textual (Table 4-7). Surprisingly, there is a low occurrence of the psychological theme in both the Native and non-Native brochures. It is present in less than half of each. The relatively low presence of psychological themes may be explained by the fact that this analysis is focusing

Table 4-7. Brochure analysis results: Psychological.
(See Appendix 4-5 for descriptive examples of textual sub-categories)

PSYCHOLOGICAL Sub-Categories	Explanation of Sub-Categories	Percent Presence: Native Brochures	Percent Presence: Non-Native Brochures
VISUALS			
Psychological	images suggest grief, loneliness, violence, mental illness	0	0
	Total presence of psychological in visuals	**0**	**0**
TEXTUAL			
Grief & loss	addresses grief & loss issues	18%	16%
Suicide	addresses suicide issues	9%	16%
Violence	includes any form of violence or abuse	27%	28%
Dual diagnosis	mention of mental disorders & illness in addition to addiction	0	20%
Addiction is a symptom	belief that addiction is a symptom of inner pain or historical trauma	9%	0
	Total presence of psychological in text	**45%**	**44%**
	Total presence of psychological in visuals + text combined	**45%**	**44%**
	TOTAL NUMBER OF BROCHURES	11	25

on program differences, whereas psychological themes can be assumed to exist more predominantly in the program similarities discussed above that deal with assessments, counselling and other psychologically-focused therapies and/or referrals to psychiatric professionals. The highest occurrence is found in the sub-category of violence. Here it is present in just over one quarter of each group's brochures.

Violence is classified as a psychological or mental health issue because personal psychological problems can manifest themselves through an individual acting out overwhelming feelings (i.e., grief, anger) or reinacting the intergenerational cycle of abuse as perpetrated on or witnessed by them (i.e., sexual abuse, spousal assault). Suicide, of course, is the ultimate violent act against oneself, also manifested from psychological or spiritual problems. These acts are very often exacerbated by the influence of alcohol or drugs, leading to the requirement of justice in one form or another. As Warry states,

> mental-health problems are clearly connected to conflict with the law -- the vast majority of Aboriginal crimes, for example, are petty offences associated with alcohol abuse, or involve various forms of minor assault that are connected to interpersonal problems. (1998:129-130)

For the purposes of this analysis, violence is defined as issues relating to assault or abusive behaviour of any sort. This includes, but is not limited to, physical abuse or assault, emotional abuse, sexual abuse, sexual assault, spousal abuse and child neglect. Justice, as a consequence, is defined as any reference to police involvement or judicial issues including, but not limited to, arrests, charges, court appearances, incarceration, release, probation, and advocacy or liaison officers such as the Native Courtworkers.

Violence and justice appear to be of greater concern overall in the Native recovery centres with justice holding the higher position (Table 4-8). When considered together, over one half of the Native brochures address one or the other issues of violence or justice in their text compared to just over one third of the non-Native brochures. Furthermore, if one considers the content of the additional brochures that have been contributed to the study but excluded from this analysis for reasons discussed above (Appendix 4-4), it is

evident that issues of violence, and one can assume a corresponding justice, are highly relevant to the Native centres. Two-thirds (67%) of these brochures explicitly address issues of violence. In contrast, only 7% of the non-Native brochures, received but excluded from the study, address the issue of violence.

Table 4-8. Brochure analysis results: Violence and Justice.

Sub-category	Percent Presence: Native Brochures	Percent Presence: Non-Native Brochures
Violence	27%	28%
Justice	45%	28%
Violence ***or*** justice	55%	36%
Violence ***and*** justice	18%	20%
Total Number of Brochures	11	25

The sub-category which is strongly psychological, and medical in nature as it deals with psychiatric diagnoses using the DSM IV, is the issue of 'dual diagnosis.' Dual diagnosis (Chapter 2) is the co-occurrence of mental health and substance abuse disorders. There is no mention of dual diagnosis in any of the Native brochures. However, it is the second highest component of the psychological theme found in the non-Native brochures. Furthermore, one of the non-Native brochures contributed but excluded from analysis exclusively addresses the issue of dual diagnosis. This leads to the final component of the holistic framework which speaks more directly to the biomedical nature of addiction.

Biological

The biological theme has occurrences in exactly the same number of brochures, just over one third, in both the Native and the non-Native brochures (Table 4-9). As usual, the distribution of the occurrences is slightly different. This theme is the least represented of all the major themes discussed in the Native brochures. In addition, this is the one instance

where the pattern shifts visually as the biological theme is not represented at all in the Native brochure imagery while the non-Native brochures do depict images of biomedical symbolism and recreational activities.

Table 4-9. Brochure analysis results: Biological.
(See Appendix 4-5 for descriptive examples of visual and textual sub-categories.)

BIOLOGICAL Sub-Categories	Explanation of Sub-Categories	Percent Presence: Native Brochures	Percent Presence: Non-Native Brochures
VISUALS			
Biological	laboratory tools, medical association symbols, recreation, physical activity	0	12%
	Total presence of biological in visuals	**0**	**12%**
TEXTUAL			
Biomedicine	mentions of medical staff, biological elements of addiction	18%	16%
Addiction is a disease	belief that addiction is a progressive illness, family has heritable genetic predisposition	9%	12%
FAS/FAE	mention of foetal alcohol syndrome/effect	0	8%
Physical activity	use of physical and recreational activities	18%	4%
	Total presence of biological in text	**36%**	**28%**
	Total presence of biological in visuals + text combined	**36%**	**36%**
	TOTAL NUMBER OF BROCHURES	11	25

The textual occurrences of this theme in the Native brochures are emphasized to a slightly greater degree and are more evenly distributed between discussions of 'biomedicine' and 'physical activities.' This suggests a relatively balanced completion of the holistic circle of components. Contrasting this are the non-Native brochures where the heavier emphasis is on the biomedical and disease concepts. This becomes more apparent if the visuals are also taken into account.

However, neither set of brochures contain much in the way of a biological/physical emphasis. It is the least represented component in the healing process as discussed by both the Native and non-Native recovery centres' brochures.

SUMMARY

The goals of the document analysis have been to comparatively examine the treatment approaches provided by Native and non-Native recovery centres as presented in their directory listings and brochures, to make more explicit the values and beliefs embedded therein, and to delve deeper into the questions posed by this thesis regarding the spiritual nature of addictions recovery and symbolic healing.

All 159 centres were included in the analysis of directory listings. Of that total, 71 centres (45%) provided written materials, 36 (23%) of these included brochures. Twice as many non-Native recovery centres were able to contribute brochures than were Native. This is not indicative of the level of interest for research participation but in the difference between a traditionally oral culture and a culture that communicates more readily through writing and documentation.

The brochures can be considered a form of advertising used to 'sell' the values and benefits being offered through the recovery centres' programs. Dey points out that,

> advertising is another medium in which the symbolic character of communication may be more significant than the explicit content of the message. In this case the 'hidden' message may be intentional: the advertiser deliberately plays upon our identification with certain characters, or the positive associations invoked by particular images. Here, contexts are consciously designed to evoke multiple meanings. (1993:34)

Clearly, the traditionally oral Native culture that uses documentation (i.e., brochures) to communicate today relies much more heavily on visual imagery to convey unspoken messages of regionally distinct cultural and spiritual beliefs and identity as well as the social values of community and interconnectedness. For example, explicit images of mythical spirit beings associated with Coast Salish and Kwakwaka'wakw oral teachings

are represented on brochures from those regions along with other elements depicted in the classic Northwest Coast artistic style. Images of the Medicine Wheel, sacred pipes and shields are depicted on brochures from central and Northern B.C. Comparatively, the imagery present on the non-Native brochures was much less explicit. However, using the greatest benefit of the doubt in interpreting the symbolic imagery present, such as the rising sun, rainbows and soaring birds, positive associations of hope and spirituality are implied. Furthermore, the actual physical space used on the brochures to depict the imagery was much greater on the Native brochures than the non-Native indicating the importance of the unspoken message to the former groups.

A great deal of professional similarity exists in the services offered and processes involved in B.C.'s addiction recovery programs. These similarities include the availability of service, the processes of treatment, and efforts to build community-based prevention programs. The similarities are due both to the mandates established by the funding agencies and to the standards of ethical therapeutic practice.

The differences between the centres' programs have been displayed in the major themes, specifically: spiritual, cultural, social, psychological and biological themes, and the sub-categories of each theme. These separated and compartmentalized themes and sub-categories emerge from the all-encompassing theme of holism. This separation of components undermines the centres' attempts to present their programs as holistic. But the data splitting and coding is required at this stage of the analytic process in order to make the embedded values more explicit. By its very nature, a holistic approach does not compartmentalize its components and each would also be found in, or have an effect on, the other components. For example, spirituality probably plays a meaningful latent role in the cultural sub-category of 'culturally-relevant programs' heavily represented in the Native brochures. In Chapter 6, I will attempt to overcome this analytic separation by bringing the

component parts back together to tell a more complete and integrated story regarding the Native and non-Native treatment approaches.

Overall, the Native documentation suggests that Native recovery centres place a much greater emphasis on the spiritual, cultural, and social aspects of healing than do the non-Native centres, all aspects of symbolic healing and traditional medicine. Furthermore, the visual imagery expresses some regional differentiation which opens the door wider to the research question, "Are distinctive local or regional cultural traits, values or symbols being used or are they more universal in nature?"

The next chapter involves the analysis of ethnographic interviews conducted with individuals working in recovery centres on Vancouver Island, the Sunshine Coast and the lower Mainland of B.C. This geographic region incorporates the territories of two First Nations: Coast Salish and Kwakwaka'wakw. The majority of the interviews conducted are with First Nations individuals at Native recovery centres to offset and balance the lesser amount of documentation provided by this group. Program facilitators from three non-Native centres, who had provided limited documentation, were also invited to participate in the interview process in order to ensure a modicum of qualitative comparability.

CHAPTER 5

THE ORAL: INTERVIEW ANALYSIS

INTRODUCTION

In Phase Three, addiction counsellors, Elders and administrators at the Native and non-Native recovery centres were gracious enough to take the time to meet with me and to participate in the interview process. During the semi-structured interviews these individuals shared their insights into their centres' healing approaches and philosophies. The techniques of ethnographic content analysis (ECA) and qualitative evaluation have been used to analyze the interviews and to find connections between the resulting categories. Using the themes and sub-categories established in the document analysis from Chapter 4 as an initial guide, the inductive and reflexive approach of ECA's process allowed space for other categories to emerge which addressed the research questions more specifically. A different structural framework was established to discuss the connections between the categories established in this process for the Native centres (Figure 5-2). Furthermore, the categories established in the brochure analysis (i.e., holism and all of its subcomponents, particularly the enmeshed spiritual, cultural and social components), rather than being separate from each other, permeate and influence the various elements of the model. A more explicit treatment of the relationship between the separate themes established in the brochure and interview analyses will be discussed in Chapter 6.

MAJOR FINDINGS

The issue of Native identity is complex and sits at the core of any healing program addressing Native alcohol and substance abuse recovery. Separation from their cultural/spiritual roots through the traumatic effects of residential schools, adoption or

fostering out to non-Native homes, or mixed blood resulting in a straddling of two cultures but acceptance in neither can create a loss of connection to self. Self-medication to ease the resulting pain of this separation frequently leads to addiction and spiritual bankruptcy.

Non-Native recovery centres tend to have a very small Native client base. Consequently, they offer no programs to support the cultural/spiritual element of recovery. Rather, there seems to be an assumption that Native clients are being serviced in their own communities or in Native recovery centres. They refer the Native clients they work with to these centres to address the cultural/spiritual reconnection process.

Recovery centres located in Coast Salish and Kwakwaka'wakw reserve communities are stressing a renewal of traditional cultural/spiritual practices in a holistic and collaborative manner to benefit all Band members. AA 12-Step programs cannot be sustained on reserve but the traditional practise known as the 'Way of the Table' is a powerful tool bringing people together for support, and the rebuilding of family and community structure, while providing opportunities for education and program delivery.

Recovery centres located off-reserve in urban areas are working with a multi-tribal client base. Due to their personal histories, many clients reach adulthood with little or no idea where their cultural roots lie. Counsellors are emphasizing reconnection of clients to cultural and spiritual practices which resonate most powerfully for them, be that the AA 12-Step programs, Native cultural/spiritual beliefs, Christianity or other religions. These centres often find the need to experiment with and reinvent traditional practices seeking common ground for their clients' cultural reconnection.

People belonging to Plains tribal groups, particularly the Lakota and Cree, are proactively introducing their traditional practices of the Medicine Wheel philosophy and Sweat Lodge ceremonies into B.C. Native treatment programs and communities. The Medicine Wheel philosophy is being taught to Native addictions counsellors across the country as a healing tool. It holds a position of primacy in Native treatment programs for

clients in the urban centres but not on the reserves of coastal B.C.. Sweat Lodge ceremonies are being introduced with varying degrees of acceptance and controversy in reserve communities. They are the best example of a syncretic healing model with local languages, songs, and ritual paraphernalia being integrated into the traditional Plains ceremonial structure.

MAKING CONTACT

My marketing background has taught me that in order to gain the greatest percentage of responses to a mailout it is important to follow-up, preferably by telephone. With this in mind I built a telephone follow-up into my research design.

Communication Styles

As I spoke with program facilitators at the Native centres, it became patently clear that I had made an error in judgement in my original design: I was asking people from an *oral* tradition to provide me with *written* materials. I had made the erroneous assumption that in today's high-tech, sound-bite, brochure-oriented world that everyone communicated in this fashion. Many do. But as I quickly learned, many do not. This is particularly true in reserve communities where the nature of community dictates a different approach. Drop-in and face-to-face encounters make brochures or orientation packages unnecessary (Figure 5-1).

It became clear to me, through the interview process itself, that for First Nations people it is much more important to first establish a relationship by personally interacting (hence the value of my telephone follow-ups that I fortuitously stumbled upon). Once the relationship has been established in this manner perhaps then paper will change hands in the form of brochures or information packets. A non-Native counsellor at an urban Native centre explains this process:

> Insofar as sending any printed or published information about the Native Healing Centre to support your research project, there is very little published information which describes the programs or even the centre itself. This is due in part to the fact that there is a literacy problem in the area and so it is meaningless to put information on paper. Also, coming from an oral tradition, the people have a strong preference for face-to-face or telephone encounters. (76BBp3)

The non-Native centres work in quite a different manner. Every centre that agreed to participate sent documentation of some sort, as requested. In many cases, reams of paper were sent, the bulk of it consisting of standardized and mandated materials. Covering letters or notes stated that if I required more information, once I had studied the materials provided, a meeting could then be arranged to talk about their programs.

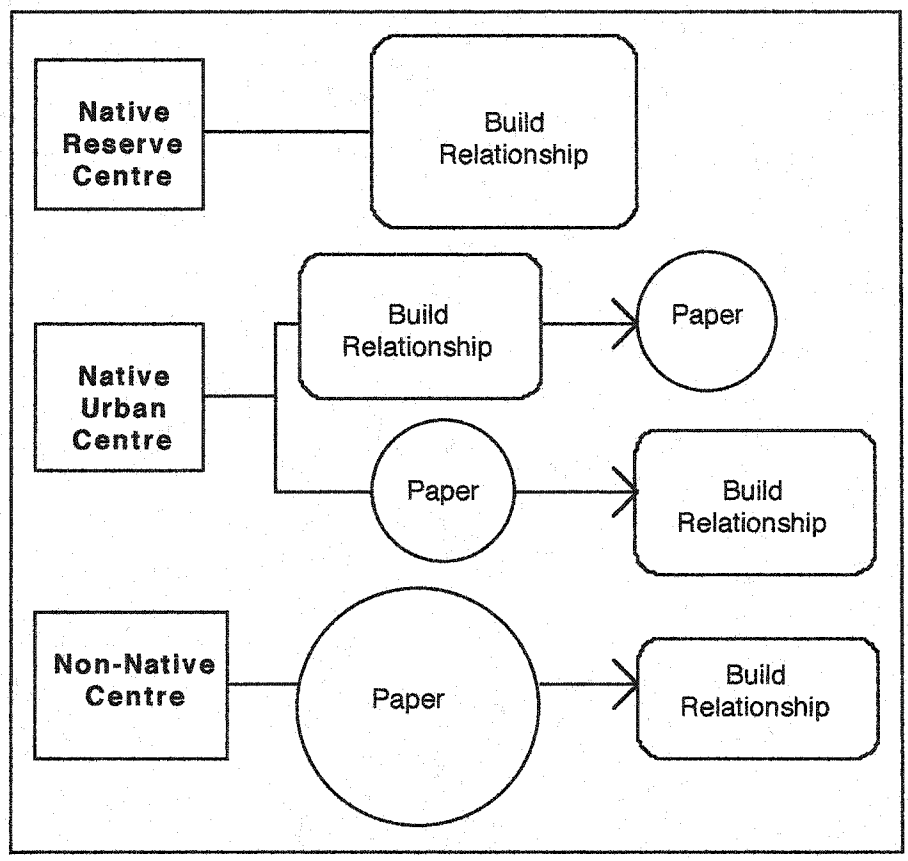

Figure 5-1. Communication and interaction styles.

This difference in attitude also permeates the way that the centres initially deal with their clients. For instance, a non-Native counsellor at another Native urban center told me,

> Here, working in a very Native way, we make connection right away. I'll take them over and introduce them to one of the teachers. ... You stick a piece of paper in front of the relationship right away and its not really valued that much. People who have been involved in different systems [such as] the welfare system, they've already had enough paper shoved at them. So it's really important for us that we establish the relationship, and that they can identify themselves as *in* a community. (169MBp2)

A Native Elder at the same centre describes the effect of the paper-first approach,

> Sometimes they get mad and say, 'I didn't want to go to that white man's place. ... When I went downtown I spent 45 minutes filling out papers and I got 15 minutes to talk, and I went there to talk'. (169MCp3-4)

There was one notable exception to this standard administrative practise in the non-Native centres. The counsellor there pointed out that most agencies give a person a stack of forms to fill out when they walk into the clinic. This can be a real problem for the less educated or illiterate people. Their agency has taken this into account and structure their admission process differently. She explains,

> The first thing that they do is sit and wait for a counsellor. Then they talk to a counsellor. They don't fill out forms when they first walk in. We do that quite differently than a lot of agencies .... Sometimes it would work fine, to fill out forms. Sometimes it would not. We go to the extreme of, 'It might be a problem for people, so let's not do it that way'. (164BBp10-11)

The difference between the Native emphasis on an oral communication style and the non-Native emphasis on a written communication style permeates all levels of addictions services and needs to be recognized as an important element of program planning, delivery, evaluation and accountability. This is more than a matter of deciding whether a centre needs brochures to advertise their programs and services for their potential clients. There is a fundamental difference in the way the Native and non-Native counsellors and administrators 'do business'.

For example, currently in B.C. there is an accreditation process occurring in the addictions field for the purpose of further standardizing the administrative processes (i.e.

forms) involved in addictions program delivery and accountability. This process was discussed at length by the program facilitators at the non-Native centres. They expressed an expectation that the provincial funding agencies will be more willing to fund standardized programs offered by those centres with accreditation. While this may streamline the paper trail, it tends to favour the non-Native centres due to the inherent difference in communication styles. The non-Native centres are much more comfortable with the mandated documentation process.

This statement is supported by the reams of standardized forms, documentation and text-heavy brochures received from the non-Native centres compared to the fewer number and wider range of visually-enhanced documents and brochures received from the First Nations centres. For instance, 53% of the participating non-Native centres included standardized forms (i.e., Michigan Alcohol Screening Test (MAST); Drug Abuse Screening Test (DAST); and Medical Triggers Screening Test (MTST)) as part of their contribution to this study. In comparison, only 10% of First Nations centres included forms in their contributions and these consisted of non-standardized forms uniquely designed for their centres. As one counsellor at an urban Native centre remarked,

> We can use the screening tools that the Ministry provides -- the MAST and DAST. We don't tend to use them that much because it's usually pretty obvious what's going on for people. I call them the "Cosmo Quizzes" because you can fudge them any way you want. (169MBp15)

The Interview Process

To accomodate this difference in communication styles, and to encourage greater participation by the Native centres, I began to offer program facilitators the option of meeting for an interview. This option was readily accepted (Table 5-1). In addition, spontaneous telephone interviews were conducted with individuals out of reach geographically who were eager to discuss their programs with me. To gain a deeper perspective of the non-Native programs, and to obtain some comparative data, interviews

were also arranged at three non-Native urban centres which had provided minimal written materials and had expressed interest in participating in the interview process.

Table 5-1. Number and location of recovery centres participating in interview process.

Ministry for Children and Families Region	First Nation Territory	Native Urban	Native Reserve	Non-Native	Total # Centres
5 - Upper Fraser	Coast Salish		1 ☎		1
8 - Richmond & Vancouver	Coast Salish	2		1	3
9 - Coast & North Shore	Coast Salish		1	1	2
10 - Van. Is. & Central Coast	Coast Salish		1		1
11 - Capital	Coast Salish	1	1	1	3
10 - Van. Is. & Central Coast	Kwakwaka'wakw		4 ②		4
4 - N. Interior, NW & Peace	Carrier	1 ☎	1 ☎		2
Total # Centres		**4**	**9**	**3**	**16**

☎ Interviews conducted by telephone. All others face-to-face.

② Joint interviews with two individuals, each representing separate but affiliated centres.

Nineteen people participated in the interviews (Table 5-2) which were conducted between June 13 to September 8, 2000. All face-to-face interviews were held on site at the centres. A copy of the interview questions (Appendix 5-1) was sent well in advance of the meeting to reassure the participant of the nature of the research questions and to allow for their advance consideration and preparation.

Table 5-2. Number and culture group of individuals interviewed.

Interviews at → Interviews with ↓	Native Urban Centres	Native Reserve Centres	Non-Native Centres	Total # Individuals
Native individuals	4	9	1	14
Non-Native individuals	2		3	5
Total # Individuals	**6**	**9**	**4**	**19**

Upon arriving at a centre, and prior to the official commencement of the interview, some time was spent in establishing mutual trust and rapport. Some rapport had already been formed through the follow-up telephone conversations when we discussed the research project and arranged the meeting. Nonetheless, face-to-face interviews can be stressful for both parties. To ease this stress, and to build a more personal relationship, some time was spent in getting-to-know-each-other conversation while all recording equipment and paperwork remained in its travelling case. Some people required more time than others in this process. These individuals needed some indication of my ability to *listen*, and to *hear and accept* how difficult the subject matter we would be touching on could be for them. This was particularly true for those individuals recovering from their own traumatic and addictive backgrounds. They needed time to share some of their own personal stories before any thought of an interview could begin. The time required for this process ranged from 10 minutes to an hour and a half. It could not be rushed.

Once we both felt comfortable to continue to the next stage, any questions or concerns on the part of the participant(s) regarding the interview process or the research project itself were addressed. The Letter of Consent (Appendix 5-2) was discussed and signed. Permission was secured for the interview to be recorded on a Sony mini-disc recorder. Each participant was guaranteed the right to read over the typed transcript prior to its inclusion in the research project and to edit it in any manner they wished. This would also provide an opportunity to ensure their written words were in fact what they had intended to say and that they would not be misrepresented in any way.

The interviews followed a standard semi-structured ethnographic interview format averaging one to one and a half hours in length. Once the interview began in earnest (i.e., the recorder was turned on) the participant was assured that the interview questions provided were designed only as a guide; that the goal of the research was to understand their healing program from *their* perspective; and that if there was something they felt was

important for me to know that was not included in the questions that they should feel free to move the conversation in that direction. "What I'm most interested in learning about," I assured them, "is what *you* feel is most important for me to know about your program."

All of the interviews began in a similar way in order to ease apprehensions and nervousness. We began with "grand tour questions" (Spradley 1979) such as, "Why don't you begin by describing the centre itself, the people who come to the centre for help and the people who work here." As the interview progressed and the research questions were addressed naturally in the flow of the conversation, I spoke as little as possible. However, if the conversation started to move too far off topic or if the individual appeared to feel uncomfortable with the unstructured nature of the process, needing more direction, I would steer the interview in a slightly more structured fashion by referring back to the questions. Still, as much as possible, I tried to keep my own preconceptions out of the formula. That is, I wouldn't say, "What I want to know is..." Instead, I might say, for example, "You mentioned how spirituality has a role in healing. Could you talk a bit more about that?" The interviews ended either due to time constraints on the part of the participant or at a natural closing point when it seemed the interview had run its course.

As promised, each participant was sent a copy of the interview transcript to review and to make changes if they wished. They were given six weeks to review the transcript. At that time, if I had not heard back from them (and I heard from no one in that time frame) I wrote another letter stating that I was assuming everything met with their approval and the interview would be included in the analysis unless they informed me otherwise. Only one Native individual responded with concerns at this point. She felt that her comments seemed disorganized. When I assured her that I was looking past the conversational structure to the underlying themes she agreed to let the transcript stand.

ANALYTIC PROCESS AND IDENTIFICATION OF MAJOR THEMES

According to Seidman,

> the reason an interviewer spends so much time talking to participants is to find out what *their* experience is and the meaning *they* make of it, and then to make connections among the experiences of people who share the same structure. (1998:110)

Following Seidman's guide in searching for deeper understanding of the issues, structures, and processes that imbue participants' stories, a qualitative approach was used in working with the interviews. Each interview was analyzed in the same order as conducted. When all of the interviews had been analyzed once, the first two interviews were re-analyzed to assure coding reliability.

The analytic process consisted of four steps. First, I read through the interview transcript quickly and eliminated any obviously superfluous comments which had little or no relevance to the research objectives. These eliminations included: introductory and closing remarks; passages that would violate confidentiality by identifying either individuals or clinics; redundancies, false starts, or descriptive passages expressed more succinctly elsewhere; common sense details of treatment and/or administrative processes which are standard practise; personal digressions unrelated to the research topic; or extended questions, clarifications or personal comments by myself.

Next, I immersed myself in the transcript, marking it up to identify categories, themes, quotes and descriptive examples using a combination of colour coding and margin notations. Marked for inclusion were excerpts that supported or expanded on the categories and themes identified in the brochure analysis; any new categories; and distinctive treatment and administrative processes. Particularly striking excerpts which offered succinct examples, passionate statements, supportive and/or clarifying passages were highlighted. Also highlighted were comments which contradicted the majority and/or were simply surprising. Frequently, as in the brochure analysis, there was overlap in the placement of excerpts relating to cultural, spiritual and social concepts. It remains difficult,

if not impossible, to tease apart these three interwoven categories primarily because it is in their very nature to be intercconnected. Therefore, at this stage I retained the overlap and placed the excerpts (or portions thereof) into more than one category. This step was completed by refiling all of the excerpts into their assigned separate category files.

The third step had two parts. By this time, potentially important differences between Native reserve and off-reserve urban centres had been revealed. Consequently, the first part of this step was to split the interview data into these two categories. Part two consisted of rereading all of the separate categories file by file, further winnowing and refining the categories. At this point, less compelling passages, digressions and redundancies were set aside. Patterns and themes began to be exhibited through the emphasis and passion of the speakers, and through the repeated discussion of a topic from more than one source. These passages were retained and subtle categories previously undetected also began to be identified.

It is difficult to understand and explain holistic concepts using a linear text. Therefore, the final step consisted of 'mapping' the data in an attempt to visualize the links, connections and patterns between the categories. One map each was roughed out for each grouping of Native reserve centres, Native off-reserve urban centres and Non-Native centres. This final step was very helpful. It provided a visual aid of the patterns and concentrations among and between the categories.

RESULTS: NON-NATIVE CENTRE DE-EMPHASIS

The thesis research objectives and questions focus on contemporary First Nations spirituality and addiction healing strategies in B.C.. They examine what these strategies look like as the people respond to social and cultural change in the larger context. They enquire whether traditional beliefs and practices are being utilized or if a more blended, syncretic healing model is revealing itself. They ask what constitutes a "culturally-

relevant" program? To address these questions both Native and non-Native centres were invited to participate.

Non-Native centres were included in the study in order to determine whether or not they supported culturally-specific recovery strategies to any great degree through their own programs, and whether or not they were accessed by First Nations individuals requiring help. There is very little support for either of these situations. This is not to say that non-Native centres do not welcome First Nations people as clients. However, there do not appear to be any proactive efforts on the part of non-Native centres to encourage First Nations to access their services. Consequently, their First Nations client base is minimal. For example, counsellors at two separate non-Native centres offered the following client information:

> Primarily, a good 75% to 80% of our clients are just basically 'Joe Public' white Caucasian. ... We do have an East Indian population, as well. ... The population of the Native people in [the community] is about 300 people. ... We have had some Native clients, but ... the percentage would be minimal -- maybe 1% or 2% of the population is seeing us. (123JKp9,10)
>
> We get mostly Caucasians. ... Other ethnic groups that we get: we sometimes have ... East Indian. I've had Vietnamese. I've had Pakistan. ... We have the odd First Nation but not many. I'd say in the time I've been here, which is six years, I've had six or eight First Nations people. (164BBp7)

There appears to be a distinct separation of services. This is most likely due to the assumption that culturally-relevant treatment is available for First Nations clients through their own recovery programs. Hence program facilitators at non-Native centres do not feel the need to offer these services. The few Native clients who access their programs tend to be referred to Native centres. For instance, as one counsellor voiced:

> Hopefully, they're being serviced somewhere else. The Native Friendship Centre certainly does a good service and we refer people there if it doesn't seem like it's working here for them for whatever reason. They also have their own treatment centres which are just for First Nations people. So, there's a focus there. I think that they do their work in their own culture, in their own communities, they have a big support system in their own communities. But it would be interesting to do a survey to see. (164BBp7)

Due to the reality of this situation, the bulk of the interview analysis will focus on the perspective of the program facilitators working at Native centres. There is one notable exception. One of the non-Native centres is situated in very close proximity to a reserve community. They have proactively worked in collaboration with the Band to offer programs to the reserve population and they have a First Nations counsellor on staff. Consequently, their client base is comprised of approximately one-third First Nations. Most of these clients come from the reserve. However,

> There's also probably an equal number of non-status people that live around and about the Coast that are First Nations ancestry but may not be [Band members], so they can't get service from the ... Band but they can get service here. (1CMp12)

The First Nations counsellor at this centre also participated in the interview process and her interview will be included in the analysis as representative of an off-reserve urban Native centre, even though this centre has been categorized as a non-Native centre.

RESULTS: CULTURAL RELEVANCY

Figure 5-2 graphically illustrates the categories and the connections between them as revealed through the interview analysis. The categories established in the brochure analysis, that is holism and all of its subcomponents, particularly the enmeshed spiritual, cultural and social components, rather than being separated from each other, permeate and influence the various elements of the model.

The explanatory discussion will begin centrally with the concept of Native identity. The complex issues surrounding culturally-relevant treatment have their genesis here. Moving upward on the graphic model, the impact of cultural/spiritual loss will be briefly discussed. This sense of loss and separation devastates an individual's sense of self, a crucial foundation to building holistic prosperity. Next, the text will flow down both sides of the circle and into two tribal areas: Coast Salish and Kwakwaka'wakw. First, to the right, to discuss the sense of cultural renewal emerging in reserve communities that

individuals and families are tapping into for reintegration and healing. Second, to the left, to discuss the reconnection of the lost souls finding themselves in multi-tribal urban communities, some knowing where they're from, many having no idea whatsoever. This discussion will also describe the influence of Plains traditions in treatment programs and the controversy surrounding it's overlapping adoption into local traditions, particularly on the B.C. coast. Lastly, a brief description of the effectiveness of AA 12-Step programs

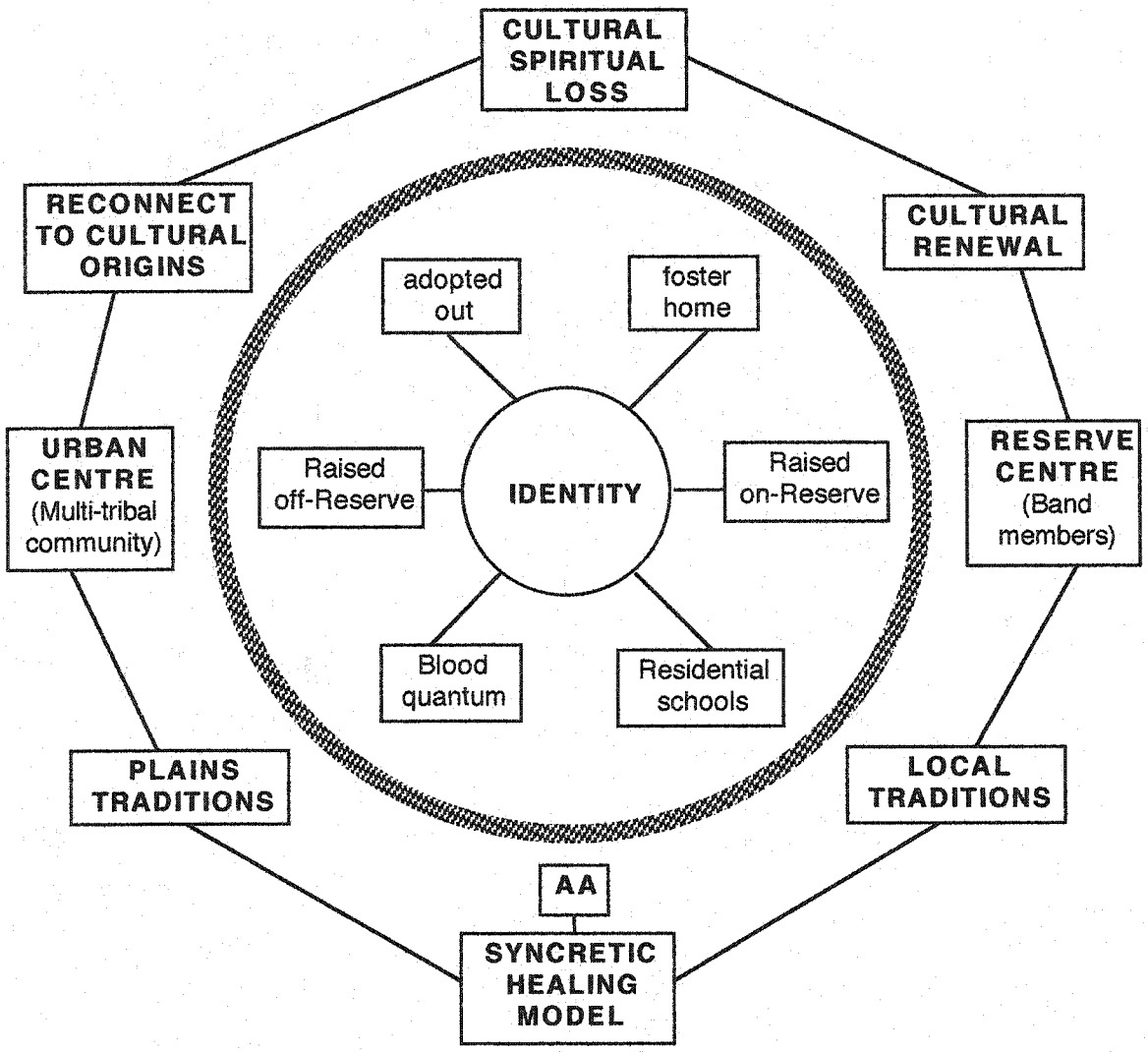

Figure 5-2. Culturally relevant addictions treatment in British Columbia.

will precede the final discussion of the creation of syncretic healing models that incorporate B.C. coastal and Plains traditions and the controversy surrounding their adoption in B.C. First Nations communities and recovery programs.

Native Identity

> The First Nations individual has been put through so many different actual abuses throughout contact. Consequently, very many of our people are separated from everything positive about being First Nations. We try to go back to that connection and, in that connection, we feel their spirit is rekindled or revived. Up until then, First Nations people may feel that they are not worthy to be who they are because of assimilation practises and residential school. All those things really did negate the First Nations identity. Really destroyed that. We have found ... that reconnection to cultural identity is very healing in itself. The whole idea of claiming back who you are. (118MAp5)

One of the standard practises of addictions treatment in B.C. is the use of a client-centred approach. With this approach each person who seeks help is looked upon as an individual with a unique combination of needs, experiences, strengths and weaknesses. Counsellors can be guaranteed of one thing -- that each client is unique and will require an individually designed treatment plan. Therefore, it is inappropriate to essentialize any individual's cultural or racial characteristics. For instance, a Native counsellor caught herself by saying, "I shouldn't say 'them' because that locks them into a place. It isn't right for anyone to assume that's just how Natives are, because *they* differ as well" (1MLp25). She went on to point out that, "One of the mistakes that is made is to assume that all Natives are spiritual and that they all believe in smudging and that kind of thing. Some of them would run out the door if I ever did that" (1MLp25).

There are many factors that can influence how an individual's cultural identity may have been affected. Figure 5-2 identifies six of the major factors. Each of these factors was referred to repeatedly in many contexts throughout the interviewing process suggesting that identity issues are a significant underlying factor in addictions causation and treatment. Each factor can have tremendous impact on its own. Furthermore, an

individual may have experienced not only one but several of these independent factors in varying combinations of intensity. This presents a continuum of situations where at one end, for example, an individual could have deep traditional roots having been raised on reserve, having well-known family bloodlines going back generations with a high percentage of registered "blood quantum" (See Chapter 2, Establishing Identity). For instance, a Kwakwaka'wakw counsellor working on reserve spoke of elders and family members who taught him,

> As long as you know who you are and where you come from that's all that matters. Knowing what village you come from, your father's side, your mother's side. Knowing what Big House you come out of. Knowing who the hereditary Chiefs are. Knowing who the *Wiwoma* [Women of High Rank] are. Knowing what family Coppers you have. That bloodline's strong. My Grandmother illustrated to me, 'People will say things, push at you, punch you, say ugly things, think ugly things. They could do all the damage on the outside but if you know who you are, your roots are deep, they can never pull your roots, you'll continue to grow'. (140RGp43)

At the far end of the continuum might be individuals who have a much lower percentage of blood quantum, may have been adopted out or fostered to non-Native families and lived away from their tribal home with little or no knowledge of their traditional roots. This situation is frequently encountered in the Native urban centres:

> For example, there was one person we had here who was adopted out, was 24 years old, with no clue where she's from, who her parents were, what reserve she's from or idea where she was born. [She was raised] in a white family. She became a heavy user and *that* was one of the other reasons. 'I don't have a background. I don't have a base where I can build something on'. (120APp13)

Scattered along the continuum between these two extremes are individuals with varied combinations of identity issues who have been raised off-reserve. A Native counsellor, herself raised on-reserve, stated, "There are hundreds, literally thousands, of First Nations who do not have an *idea* what a reserve is. They'll hear about them, they see it, but they haven't got an idea what a reserve is actually like. They think it all looks like this where you can go to the mall" (1MLp31). Those with 'mixed blood' also face the dilemma of straddling two cultures and feeling as though they belong in neither -- "you

have some Native people looking down at you because they consider you to be more white than anything. Then you have non-Native people who consider you to be more Native" (135TCp25). A particularly vivid personal experience was shared by a Native counsellor working in a reserve centre. It offers a striking example of the reality of being raised cross-culturally:

> My identity issues were part of why I was medicating because I grew up off reserve. My Dad's non-Native and he spent my whole life convincing me, 'In Canada your nationality goes by your father, so therefore, you're not Indian, you're white and if anybody tries to tell you any different, don't listen to them because *you are white.*' Well, run around looking like me all your life trying to tell everybody you're white! This was *my* issue growing up -- trying to convince everybody, 'I'm not Native. What's your problem? What Band? I'm not from a Band.'... It was very confusing and it was very painful. ... I didn't know until I was an adult that I was connected to this Band. I certainly didn't know that all these people that came from this Band were distant relatives or relatives. I had no idea. (135TCp27)

And, of course, weaving its way through each of the potential identity combinations is the insidious and devastating experience of residential school. This institution was established with the explicit purpose of eradicating Native culture and identity through the assimilation of children into the Euro-Canadian culture with the expectation that the domino effect would topple its way back through the families, communities and nations (Furniss 1995; Milloy 1999). The residental school experience cannot be done full justice in this thesis. However, it must not be ignored. The multiple traumatic abuses experienced by the generations who attended the schools, as well as those still feeling its impact in what is being referred to by First Nations people as the 'seven-generation process', constitute major contributing factors to the level of alcoholism and substance abuse being experienced in First Nations communities (Feehan 1996).

> It all started related from residential school when we were taken away from our homes. ... We were robbed from childhood. We were robbed from our language, our culture, our traditions. ... And forced upon religion ... "Hey, you've got no choice. You're going to learn to be a Catholic". (139NHp2)

> I do a lot of work with my people because I know the residential school. I know what happened in that area. A lot of people call it a Holocaust and I

> think it was. ... My youngest client is 14 years old -- you talk to him, he's *very* much residential school. His grandmother was residential school, his mother was residential school, he's very much residential school. It's still there. It's gone down seven generations. (169MCp3,6)

Cultural / Spiritual Loss

> You can tell, they might have had a traumatic childhood but they will talk about the gathering of berries and you will see in them the sickness. You will see the sickness, the spirit... the spirit is gone, those days are gone, they suffer the loss. ... The breakdown of their values, their belief system. Some of them carry around a grief that they don't even know they carry. (1MLp24)

Addiction is often referred to as a spiritual disease where one is considered to be spiritually bankrupt. In essence this means the person feels completely alone, isolated from humanity, separated from her/himself. There is no connection to their soul, their innermost being whose very birthright dictates that they have every right to *be* who they are in this world, to *accept* who they are, and to *know* they are a sacred part of the world. In their desolation, they have no sense of connection to a sacred Higher Power, by whatever name it may be known, and no knowledge of the spiritual means by which to find it.

The holistic nature of traditional Native lifeways weaves spirituality through every component. For example, a Kwakwaka'wakw Longhouse event or potlatch would include the social (i.e., community social roles), the physical (i.e., dances, feasting), the mental (i.e., knowledge) and the spiritual (i.e., prayers). However, the spiritual is not simply expressed through prayer but is also inextricably linked to each component. The gatherings involve ceremony and associated spiritual rituals. The dances and songs include the spiritual powers associated with the original source of the dance and/or song as well as the accompanying paraphernalia such as the masks and the powerful family crests.

In 1885, after colonial and Canadian authority was established, potlatch and its associated traditional practices were outlawed by legislation known as the "potlatch law" which remained in place until it was rescinded through a revision of the Indian Act in 1951 (Cole and Chaikin 1990). The potlatch was a central institution of many Northwest Coast

groups, including the Coast Salish and Kwakwaka'wakw. The potlatch law resulted in the decimation of many of the traditional social roles and the dismantlement of the family structure. Longhouses were burned, masks, costumes and ritual paraphernalia were confiscated, and people were jailed up to six months for dancing (U'mista 1975). First Nations groups had different reactions to the law ranging from abandoning the potlatch altogether to defiantly attempting to thwart enforcement attempts through stealth and disguise as they continued to hold potlatches through an underground resistance (Cole and Chaikin 1990, U'mista 1975). Naturally, through laws such as the potlatch law, cultural/spiritual traditions declined and in some areas disappeared, but they were never completely extinguished.

A Kwakwaka'wakw elder remarked, "That's what most of us are missing is our culture. A lot of us don't know how to sing our songs. A lot of us don't know our powers from our designs. We're one of the wealthiest people going with our designs" (169MCp7). A counsellor from the same culture describes the impact of the decimation of women's social roles:

> In our culture, we're to treat the women with the greatest of respect because the women are the givers of life, they're the historians, and the women bring the wealth over to the groom. So, if there's a Chief who's going to be married to a woman, it's *her* wealth that brings his standing higher. Therefore, she's to be treated with respect. ... But today, our women are really badly scarred. They have so many scars because of being put down verbally, physically, mentally, emotionally. They're so scarred from their role being stripped from them -- they're nobody. ... The women's role being stripped from her, that left it open for the kids, the younger generation, to be attacked. So, it's just like all these different roles were taken away and now everyone has their different appetites and their different ways of living. (140RGp27-28)

These examples from the Kwakwaka'wakw are fairly typical expressions of the effects of the loss of traditional lifeways experienced in B.C., particularly among the Coastal groups. Similar examples were described by the Coast Salish counsellors who spoke with me, as well as those whose homes lie further north but who were currently working in reserve or urban centres included in this project. These losses were keenly

controlled by the incoming power structures of Church and State, through the institutionalization and segregation of individuals and groups, and through legislation which outlawed traditional practices allowing for the imprisonment of those who ignored the new rules.

Cultural Renewal on Reserve

> We do our best to reclaim our past now by learning our language and cultural activities and drumming and singing. You know, all those things that we had to ask permission for before but now we don't have to ask permission, we just do it. ... You start looking at individual renewal and family renewal as a result of a national renewal. (162JUp1,2)

As B.C. Bands and tribes work towards reestablishing self-government and sovereignty through treaty negotiations, land claim settlements and Federal Health Transfer negotiations, First Nations people are experiencing an increase in self-esteem and a renewed sense of pride in their cultural traditions and identity. Since the potlatch law was rescinded in 1951, a resurgence in traditional activities associated with the potlatch are now occurring openly and frequently. Counsellors and Elders in addictions recovery programs are able to guide their clients to these activities in order to expose them to their cultural origins. A frequent theme repeatedly stated throughout the interviews was the idea that, "Often, that's the part that was missing in their life -- the cultural/spiritual part -- and to reconnect with that is really helpful for the healing process" (100DFp8).

To address the research question which asks, "are traditional beliefs and practices being reinstituted or is a more syncretic healing model revealing itself", one must first be aware of the local, regional and/or tribal context. As Dey says, "meaning can be conveyed 'correctly' only if context is also understood" (1993:32). Therefore, a number of the traditions practiced by Coast Salish and Kwakwaka'wakw identified during the interviews as relevant to treatment deserve introduction.

Coast Salish Traditions

> At our ceremonies there's always drumming, the event that needs to be discussed, and a meal. I try to make sure that the clients come to any events or ceremonies that are happening so that they're exposed to the culture again. We have traditional Winter Dances. We have the bone game, *Sle'hal.* (100DFp8)

Winter Spirit Dancing

During the winter months, generally from November to April, the Coast Salish people participate in Longhouse ceremonies. People participating in Longhouse ceremonies must be alcohol and drug-free. It is believed that during the winter season the spirits move closer to the earth, sweeping their way on a traditional path throughout the entire tribal territory. The spirits descend to the earth in November beginning at the eastern-most edge of the territory, in the Upper Fraser River Valley. As the season progresses, they travel south-west to Northern Washington, Puget Sound and lower mainland areas, sweeping to the northernmost edge of their territory on central Vancouver Island and adjacent Sunshine Coast.

One of the very powerful Longhouse healing ceremonies is known as the Winter Spirit Dance. Spirit powers are manifested in personal songs, dances, face paintings, headdresses and other items of costume. A spirit power may come to an individual unsought or unannounced and may lie dormant. The presence of an unacknowledged spirit power is often made apparent in an individual by illness, uneasiness or restlessness. When spirit power or sickness is diagnosed as the cause, the individual is initiated at the onset of winter as a spirit dancer. It has been suggested that these initiations are rites of passage where an individual experiences symbolic death, rebirth, and reincorporation into society (Jilek 1982; Kew 1990).

Games: *Sle'hal*

Sle'hal is a traditional hand game or bone game that has persisted up to the present where it is played outside, generally in the summer. *Sle'hal* includes inter-village

competition, power demonstrations involving special singing, supernatural help, and betting. Throughout the game, singing and drumming take place by teams of up to 100 individuals. These activities are limited to the side holding the bones, while the opposing side concentrates, in silence, on guessing where the bones are hidden. Singing strengthens the gambling powers of one's own team, enlivens the bones enabling them to take on an action almost their own, and confuses the opposing guesser (Maranda 1984; Wake 1997).

A 50-year-old *Sle'hal* player, who has participated as a pointer in competitions all over western North America, relates his *Sle'hal* experience:

> I could feel this strength taking over, the power and the spirit -- and I stood up and started to sing this [power] song. It can really take over. ... [Playing the game] takes a lot of skill, understanding and memory. The pointer has to be very prepared physically, mentally, emotionally and spiritually ... you can feel the bones, or know where they're at without seeing them. There's a power and a strength in the bones. (Sam in Wake 1997:23)

Cleansing and Purification

> Our people have always believed in purifications. You could do that a number of ways, with running in the woods or on the beach, or steambath, or going in the streams. (162JUp13)

Steambaths: Haq't°at'

> I remember my old aunties and my mother-in-law, they were doing it on an individual basis. They sat on a chair like this and they had a bucket of water there. They put the hot rock in there and they wrap themselves -- around the bucket and themselves -- that created a steambath. That was the way it was done *here*. It's called *Haq't°at'* in our own language. It means steambath. (162JUp13)

Going to the Water

> Every morning, I'll get up at 4:00 or 5:00 in the morning -- whether snow or shine, ... It's something my *gla'x^{h}gla'x^{h}*, my Mum and Dad, taught me, my Grandparents taught me. 'Always go back to the water,' they said. 'It will always bring you back strong. And your cedar branches are there. Brush yourself. Regain your strength'. (139NHp21)

Ceremonies

The most important heritable ritual property a kin group could own was a cleansing ceremony involving ritual paraphernalia and a song. Such a ceremony was used to wipe

away a disgrace and, more commonly, to enhance occasions such as the bestowing of an inherited name. The two most important cleansing ceremonies involved the ritualist's rattle and the *sxwayxwey*, a performance by two or more young men wearing distinctive costumes and masks, who danced around the subject (Suttles 1990:468).

Potlatch

Families with social position to maintain held potlatches to celebrate major life changes resulting in family members' change in status. This change was marked with a cleansing ceremony and the distribution of wealth items. In contrast with a feast, which might be held any time of the year and was usually indoors, the potlatch was traditionally held outdoors in good weather. However, since the early 20th century such events have been held more frequently combined with Winter Spirit Dancing (Kew 1990:478; Suttles 1990:469). This change is no doubt due to the ramifications of the potlatch law as discussed above.

Kwakwaka'wakw Traditions

> I think that [cultural renewal] started happening even bigger when they built this Big House here. They ... have a dance group with dancing every Sunday.... They have also started a language group. They're trying to get the language going and preserve the language and teach it to the kids. ... They've held button blanket classes where we all came and learned what our crests were and made our button blankets. ... So, I think they're really trying to bring the culture and the traditions back into play. (135TCp19-20)

Winter Dancing Ceremonies

Winter Dance Ceremonies, in a different form and with different spirits from the Coast Salish, were also a traditional activity of the Kwakwaka'wakw that took place in the community Big House. These ceremonies were also associated with feasting, potlatching, entertainment and theatrical activities. They were also based on a spiritual theme where supernaturals capture and spirit away the men and women who were to be the actual dancers and performers, initiated them, and imbued them with their awesome qualities

(Codere 1990; Holm 1990). The powerful family crests and designs, referred to earlier, and the privileges associated with them were a major ingredient of the Winter Dance ceremonies.

Potlatch

The Kwakwaka'wakw potlatches share the general characteristics of the Coast Salish potlatch. They, too, are used to ceremonially mark major changes in family members' status such as memorials and weddings, and to transfer titles (Codere 1990; Cranmer 1990).

***Digita* ceremony**

Another potlatch ceremony, referred to as *Digita* ceremonies, are intended to wash away shame. Traditionally, once a *Digita* ceremony has been completed in front of witnesses, the situation is considered resolved and should never be spoken of again.

> I feel, now, it's coming closer and closer to a time when everyone's going to sit down and do a lot of *Digita* ceremonies. To '*digita*' in our language is to 'wipe away the shame, to wash away the tears, to make a correction.' I feel that a lot of ceremonies will take place -- feasting, potlatching -- where everyone says, 'OK, this is it'. (140RGp28)

The individual needing to *digita* buys gifts, sends out invitations to the Chief and Council, family members, any people associated with the issue to be resolved and for witness. Family bloodlines, the House name, and any Coppers' names are announced in the opening speeches to establish the individual's right to speak and to conduct the ceremony. Everyone sits in a big circle, in candle light and participates in a feast. The individual then speaks in front of everyone about the conflict that has created the need for the *Digita* ceremony. Everyone listens. Once the people directly involved in the conflict have spoken and everything is clean in the air, anyone else in attendance is permitted to share, to *digita*, to make things right. At the end of the night the gifts are given to everyone who attended the ceremony (140RGp37-38).

Games: *Haqoas* Bingo

Haqoas Bingo is a dice game where you need to roll doubles to win. Any time you roll doubles it's a free-for-all for a pile of gifts that are in the middle of the table. A person continues to roll the dice for ten minutes. During that period they could take somebody else's gift. At the end of the ten minutes anything in front of them is theirs to take home with them. This game is often played in the winter, when food supplies can be low for some families. Wealthier community members provide everyday items such as sugar, flour, potatoes and laundry soap and these are given away in the game.

> I've taken an object where I've just thrown in ... a stick. They say, 'What's that?' I say, 'That's a mystery gift.' So, then they're all fighting for that mystery gift. ... The mystery gift ended up being, one time, a full meal ... and then we had dessert and then we had snacks afterwards. ... The one person who got it was a little boy who said, 'What's the mystery gift?' and *everybody* just clapped and clapped they were so excited because this little boy went home with a full meal for his family. (140RGp15)

The purpose of the game is to bring laughter and everyone playing together. To this end, it is also used to restore balance when people are mourning and grieving together -- "the tears are cleansing and the laughter's healing" (140RGp14).

The Way of the Table

A major theme found throughout many of the traditional Northwest Coast practices described above and one that is being continued in one form or another in a very big way in addictions recovery programs on Coast Salish and Kwakwaka'wakw reserves is what is referred to as the "Way of the Table." "The Way of the Table has been there forever but because of residential school we kind of lost it" (162JUp2). "Years ago, culturally, everybody used to be able to go to one house and just eat and eat and eat, and tell all kinds of stories and reminisce. They really like it" (140RGp3). The Way of the Table involves a community gathering where food is shared. It is a tool being used in a very holistic way to bring people together both with each other and with their cultural roots.

For instance, the Way of the Table can be used to bring families back together where healing is needed to build connections broken by residential school separations:

> It sounds simple but some families have a great deal of difficulty coming together. ... The families where you grew up -- you might be in the same [residential school] building but you don't really know your own family. ... It's coming now. The people are ... realizing it. Now we can do something about bringing our families back together, little by little. So here, we have potluck dinners, galore. That's one of the biggest tools that we use is our potluck meals. ... It could be any occasion, like somebody coming home from treatment centre. We'll call their immediate family and their extended family and their extended family's friends... it sort of grows. We put out invitations. ... [We do them] in the Longhouse or in the hall, either one. ... After the meal then the speeches start. People will say all kinds of encouraging words about, 'Looking after yourself now,' and, 'It's good to see you coming back looking so good.' Lots of speeches like that are made. Then, the individual, or the family, can talk about what it was like and how good they feel now. ... Then we have a drum/song. Everybody wishes each other peace. (162JUp2-4)

Monthly luncheons organized specifically for the elderly are frequently used as a way to benefit both the elders themselves and the community as a whole. The elders benefit through the provision of a healthy meal in the company of their peers while health care providers can provide education to them on topics such as addiction, AIDS, nutrition and diabetes. The community benefits because often, when the elders get together, they tend to reminisce and talk about the history and cultural traditions of the community. The elders are valued and honoured for the knowledge they hold, even though they often don't realize themselves the depth of knowledge they possess because for so long they have been forced to suppress it. This is the essential knowledge-base required for cultural renewal. One of the Kwakwaka'wakw counsellors describes a recent elders' luncheon:

> The elders sitting there were talking about *so* many things. We fed them and they sat there and they talked and talked. They reminisced about old days and then, all of a sudden, they started talking Kwakwala, the language, Kwakwala. They were coming up with all these old words that haven't been used for years. They started describing where it came from, what tribe it came from, talking about the different dialects. I told my co-worker, 'At the next luncheon record them and hold this because this is real history.' Our oldest member in the elders' group is 93. (140RGp3-4)

Support groups are a very common tool in addiction recovery, as attested to by the success of Alcoholic Anonymous -- a classic support group model. Unfortunately, AA does not have a good track record in reserve communities (discussed below). However, what has worked extremely well in one of the Kwakwaka'wakw reserve communities is a support group which began with a luncheon "just to be together and to provide education or any lines of support, methods of support to whoever's at the lunch" (140RGp3). It began with only six members and has grown to host 104 people. The original idea for the group was presented to a couple of Elders who considered it for some time and then suggested it be called *Gila*, after the grizzly bear "because it's the bear who struggles to survive in the animal kingdom" (140RGp3). The *Gila* Group is now considered to be "the heartbeat of the community and the healing journey" (182JBp10).

Of course, because meals are involved, sometimes on a large scale, funding can be a serious problem. The Federal Government provides funding for NNADAP programs. With this funding comes restrictions regarding how the funds can be spent. Cultural activities have not been a priority. However, Federal Health Transfers have occurred in some of the communities involved in this project. The Tribal Councils now in charge of the monies are allowing more leniency as they become aware of the value and importance of cultural reconnection as a healing tool in addiction programs. In one situation, a counsellor described his ability, over the past five years or so, to gradually provide cultural activities in connection with dollars tagged for substance abuse programs. These 'community gatherings' have been a really strong tool and the counsellor describes them as follows:

> We went towards holding gatherings, feasting gatherings, where we brought in services, subjects -- whether it be suicide, grieving -- we brought that into the group. We call them 'gatherings' but we don't tag a name to it. We bring the luncheon and we generally invite the Elders in. The Elders sometimes are the ones that we touch base with first to start something and then, from the Elders, we carry on with the rest of the community. (182JBp8)

> We bring the teaching to the table. We bring it to the table and share it with the community and the community comes in for the activity. The activity is

> actually having a feast. The *feast* is the draw and that opens the door where we have a chance to share with them during the feast what we learned. (182JBp40)

Cultural Reconnection Through off-Reserve Recovery Centres

Off-reserve centres offering alcohol and drug recovery programs that participated in the interview process of this project were located in urban Friendship Centres and Native Healing Centres. In one sense, the Friendship Centres in particular tend to operate as self-contained communities. Individuals living in small reserve communities know everybody in the community and know where they fit into the social structure. When these individuals move off reserve to the city they often flounder because the small community structure is gone. "Sometimes they need to make structure again, to identify community. This place is sort of a community" (169MBp3), said one of the urban counsellors.

One of the major areas of similarity in the Friendship Centres' structure to the reserve recovery centres is the self-contained and holistic nature of their programs. For instance, a reserve administrator asserted that "addictions plays a main role in the wellness of a person -- it's all connected -- the economics, the social effects, education, everything" (11LBp2). Consequently, in this community all of the programs have a single vision -- to be interconnected and to work together as a team. Similarly, in the Friendship Centres, the addiction recovery programs are closely interconnected with all of the other programs that address areas of an individual's wellness requirements. These programs include: economic development such as employment and housing support, educational needs, cultural/spiritual activities, justice, social, and other health requirements. As one counsellor described it,

> We're kind of nestled in the centre of that, which is a real advantage because often recovery will be about getting back on track -- getting some strength in your ability to do things in the world -- and that may be getting a job, or it may be finishing off your grade 12, or any of those things. ... Often, in the best of situations, a person will integrate that into their recovery program. (169MBp1-2)

The Native Healing Centres also believe strongly in the holistic approach, but tend not to have in-house access to this wide range of programs and are more likely to need to refer a client out to community resources for support in these areas.

A major difference between the reserve and the urban centres is the composition of their client base due to funding mandates. On-reserve services are available to Band members only (Figure 3-1), while urban centres offer their services to all off-reserve First Nations people in addition to any Band members residing on-reserve locally who may prefer to get help away from their home community (Figure 3-2). Non-Native people are also welcome to receive service, especially from the Friendship Centres which actively promote the enhancement of cross-cultural relationships. Consequently, urban centres tend to cater to a multi-cultural Native community with a large percentage of transients as well as those who have settled in the area from the Eastern, Northern, and Southern tribal groups. "The Métis and everybody's here. The Cree is here. ... If you're Salish, ... if you're Kwagiutl, if you're Tsimshian. ... Even Haida Gwaii are here" (169MCp13).

Rather than speaking about the concept of cultural/spiritual 'renewal', as was done a great deal with the counsellors working on reserve, the emphasis in the off-reserve urban centres leans towards a cultural/spiritual 'reconnection'. This reconnection can be a very complex and difficult process due, to a large extent, to the previously discussed factors relating to personal Native identity (Figure 5-2). The clients accessing urban programs are much more likely to have been raised off-reserve, to be much less connected with their cultural origins, to have experienced a much greater likelihood of being adopted out or fostered in non-Native homes, and of course, they will probably also have residential schools issues. Therefore, counsellors and Elders in urban centres need to be well-trained and eclectic in their knowledge of Native cultural/spiritual variability.

For the person with knowledge of their cultural/spiritual roots, the counsellor first needs to approach the client and ask them as much as they possibly can about their culture.

"The more he can speak about his traditional culture, the more pride he can get. You're really trying to get them to teach you" (120APp13). Then the counsellor can take on the role of guide, directing the client and introducing them to authentic practitioners in the greater community who are active in the traditions of that individual's cultural group, and who can support the individual in the re-entry process. For these people,

> Looking at it in a spiritual way is to keep your thoughts on your own traditions and the culture of your grandfathers and grandmothers, your medicine people from where you come from. If you're a Cree from Saskatchewan, then you focus on that. Or if you're Stö Lo Nation from Capilano, then you focus on the Elders there. (120DRp22)

Of course, this is after first ensuring from the client that this is what s/he desires. As has been previously mentioned, just because someone is Native does not necessarily mean they wish to become involved in Native cultural or spiritual traditions. It is a greater challenge for counsellors in urban centres to be sensitive to the spiritual beliefs of the client, whatever they may be. The non-Native counsellor at the urban centre in Carrier territory explains,

> While some hold beliefs about the value of praying over bundles, some consider this practise (and other Native traditions) to be bad medicine. Many of the Native people are practising Catholics. One individual recently became very interested in Buddhism and was learning everything he could about becoming a practising Buddhist. Many aboriginal people come in and say, 'I don't want to know about any of that cultural stuff, I just want to get sober'. (76BBp2)

But what of the individual who has little or no knowledge of their cultural origins? A more investigative approach is required on the part of the counsellor. Questions can be asked about where the individual last lived, where they lived the longest, how many friends they had in the area. If, for example, the individual lived in one area for 12 out of 24 years, there's a pretty good chance that their cultural roots are located there. Then some education about the traditions and culture from that area can begin. Often, the counsellors say, if there is a true connection with the person to the culture, they can see it resonate with the individual as they begin to enquire more for deeper cultural/spiritual connections.

Plains Traditions

A very interesting phenomena occuring in B.C. is the dramatic influence and adoption of cultural and spiritual traditions of the Plains cultural groups, in particular the Cree and the Lakota. There appears to be a concerted and proactive movement on their part to introduce their traditions across Canada, particularly into the addictions recovery programs.

For example, smudging with sweetgrass or sage is a Plains purification activity stylistically different from the Coast Salish purifications mentioned above. The Plains smudge involves small pieces of the dried herbs being lit to smoulder in the shelter of a shell, or the lit end of a sweetgrass braid, carried from person to person, with the smoke being swept with an eagle feather over the individual. Another method is for the individual to scoop the smoke in their cupped hands and sweep the smoke over their face and head.

Two other major Plains traditions are being adopted into the B.C. coastal area, with varying degrees of acceptance -- the Medicine Wheel and the Sweat Lodge.

Medicine Wheel

The most influential and far-reaching doctrine is the philosophy known as the Medicine Wheel (Figure 5-3) which teaches a holistic concept of healthy balance. The Medicine Wheel approach is being taught to all Native addictions counsellors as a treatment tool for their clients. When discussing the rise of Medicine Wheel use in health programs, a health-care practitioner on the Aboriginal Television Network program, *Sacred Circle*, stated "we've built contemporary methodologies from traditional philosophies, and the basics of philosophies never change."

The counsellors at all of the urban centres referred to the Medicine Wheel frequently throughout their interviews. It is clearly entrenched in their healing programs. However, during the interviews conducted at reserve centres it was mentioned only once by a Coast Salish counsellor where she emphatically stated that while she also practised a balanced and

holistic approach, she would *not* name the Medicine Wheel in her programs as it was not a Coast Salish tradition and would instill a distinct and unacceptable Plains flavour with her clients. With this in mind, it is important to have some understanding of the Medicine Wheel philosophy because it is much more than a simple diagrammatic model.

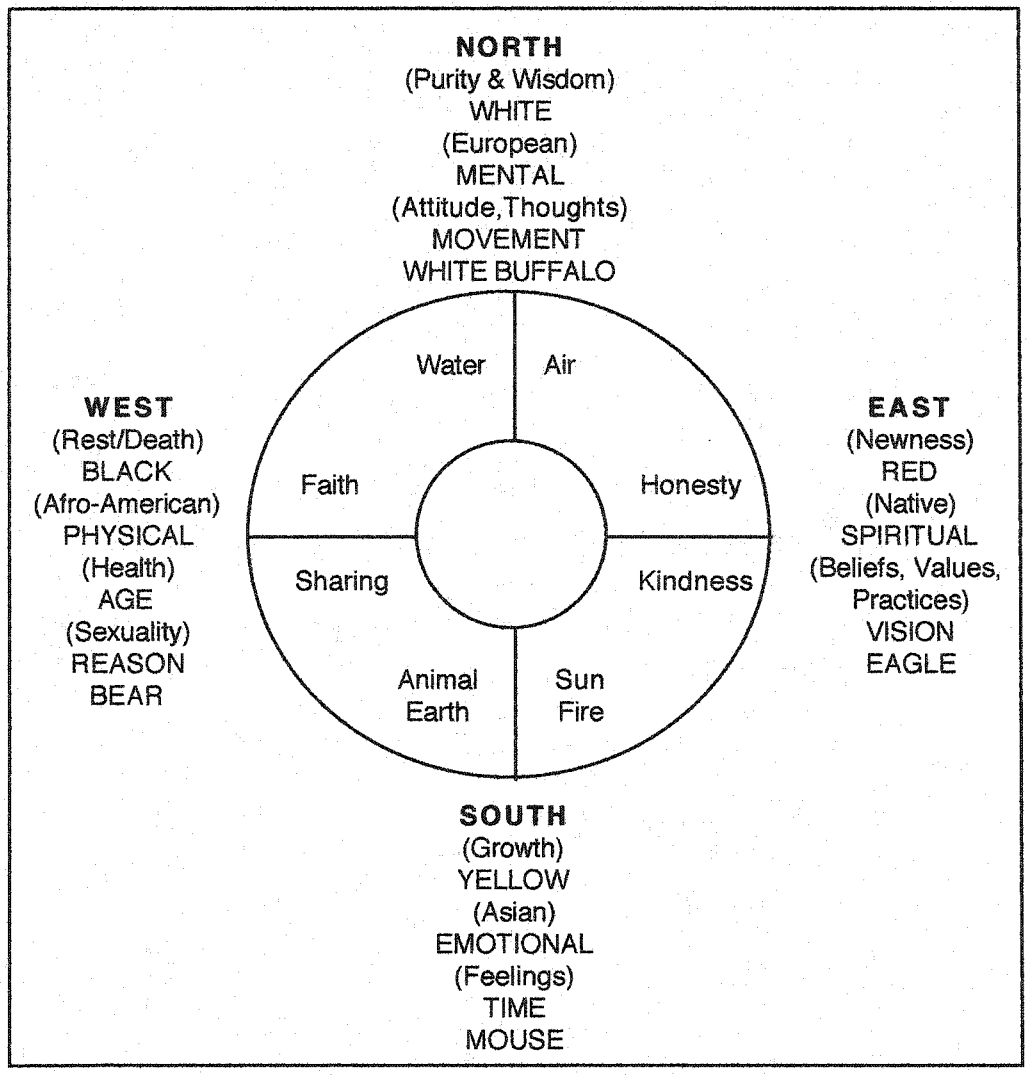

Figure 5-3. Graphic representation of the Medicine Wheel.

The use of the Medicine Wheel as a philosophical model is traditional among many Native people, particularly tribes of the Northern Plains (Friesen 1995; Harrod 1987; Storm 1972). It is a foundation for lifelong learning that has developed over thousands of

years. It has been stated that, "The Medicine Wheel is the very Way of Life of the People. It is an Understanding of the Universe" (Storm 1972:1).

While there are some variations to tribal identification and interpretation of the directional elements (Figure 5-3), the basic parameters of balance, interconnectedness and dynamism remain consistent (Cowan 1995; Friesen 1995; Harrod 1987). The essence of the Medicine Wheel is movement and change. A person must not remain where it is most comfortable but must stretch themselves and grow by seeking understanding in each of the other directions. As a person journeys around the Medicine Wheel they discover themselves by learning about the different elements symbolized in the directional phases of the Medicine Wheel through which they pass (Storm 1972). This learning process maintains a state of constant growth, balance and renewal.

The symbol of the circle is fundamental to the Medicine Wheel. The circularity emphasizes motion. It underscores the interrelationships of all things in a unity of perfect form, and it suggests the cyclical nature of all relationships and interactions (Cowan 1995; Friesen 1995; Harrod 1987; Storm 1972). Physically and temporally the pattern of the circle repeats itself in endless ways, providing repeated experiential learning opportunities.

Wherever a person stands offers a different perspective. No one perspective is the right one, and only from a multitude of perspectives can a person begin to approach understanding. At any point in time, the whole story is contained only in the integration of many perspectives (Cowan 1995). This is the first and most important lesson (Storm 1972). The experience of each direction brings with it certain lessons that, over time, through experience, reflection, and integration, reveal broader and deeper meaning, both individually and collectively.

It is important to note that any physical manifestation of a medicine wheel such as a drawing on paper, is *not* the Medicine Wheel. Rather, the Medicine Wheel is "the living, interdependent web of recurring cycles and developmental sequences that comprise our

world" (Cowan 1995:226). The Medicine Wheel includes the understanding that derives from experiencing the world in this manner. Thus, to confuse any physical manifestation *as* the Medicine Wheel is a critical mistake. It is only a referent, a heuristic tool that may be used to help point directions, facilitate conversation, enable shared meaning, and motivate exploration of the real, yet intangible, lifeway (Bastien 1993; Cowan 1995; Storm 1972; Wilson 1981).

An illustration of how the Medicine Wheel is used in addiction treatment was offered by the director of one of the Native Healing Centres:

> The treatment plan is circular in that it's the Medicine Wheel. When the person first comes and begins counselling, they, along with their counsellor, determine which area in the Wheel they want to develop in. That could be mental, physical, emotional and spiritual. ... We call that the recovery process. We help them regain the balance in life because our belief is that if you're off-balance then that's where these things are going wrong for you, perhaps, and you're turning to alcohol and drugs to cover up something. So, we strive to put the whole individual in balance. (118MAp3)

What remains interesting, particularly for urban centres located in Coast Salish territory, is that the Medicine Wheel is offered first as a reconnection to a cultural/spiritual tradition. Whether or not it is pursued it always appears to hold the prime position. For example,

> If an individual is interested in pursuing Native culture, but don't know what sorts of things this might involve, I will direct them to people who can teach about the Medicine Wheel and/or Sacred Talking Circles or other practices. (76BBp2)

> My favourite is, 'Have you heard of the Medicine Wheel?' Go from there. If they say, 'No,' I'll say, 'Are you curious?' 'No.' 'OK, let's just go on then'. (1MLp34)

> As a non-Native I can't sit and talk to somebody about the Medicine Wheel, out of respect. But I'll certainly encourage them, or find that information or resource for somebody to do that, if they want to explore their relationship to the Medicine Wheel or the West Coast ideas. (169MBp15)

While it appears to be justified by the belief that it is being used as a holistic tool to re-establish balance in the individual, there must be more to it or those more firmly

entrenched in their Coast Salish or Kwakwaka'wakw traditions (such as those still living on-reserve) would also embrace the Medicine Wheel as a treatment tool. But they are not.

Sweat Lodge

The Sweat Lodge, sometimes referred to as the Purification Lodge, with its specific architecture and ceremonial content, also has its origins with the Plains groups.

> In the darkness of the Purification Lodge, in the womb of the Mother, there is no race, only spirit, just as it was in the beginning. When we leave and when we enter the lodge we say ... "All my relations". We are saying that we are related to all things; all beings are the children of one Creator, and we are but one of many children. None is above the other; no one is holier than another. (Irwin 1997:25)

The Sweat Lodge involves prayer, sharing of cultural information and therapy, including confession and peer support. It has physiotherapeutic and psychosocial benefits in the treatment of alcoholism and substance abuse. It has been described as having both placebo effects and altered states of consciousness (Waldram 1993). Elder Campbell Papequash clarified the Sweat Lodge's central importance to the development and maintenance of a positive self-identity when he explained that,

> many Aboriginal people of today were reared without their cultural beliefs. The Sweat Lodge is used to re-identify ourselves with our traditional lifestyles and customs. The Sweat Lodge is used wholistically [sic] to assist in healing the imbalances of life which occur in the mind, body, spirit and emotions. (Papequash in Waldram 1997b:86)

The lodge is typically made of a willow frame covered in canvas tarps with four doors representing the four cardinal directions. The lodge is closed and made utterly dark. Water (sometimes laced with herbs) is sprinkled on heated rocks creating intense steam and heat. Participants sing, drum and pray. At the end of the first 'round' the cover of the door to the East is opened for relief then closed again and the next 'round' begins. Four rounds are completed moving around the cardinal points. Almost every item, action, gesture, utterance and element associated with the Sweat Lodge ceremony has a culturally symbolic interpretation that can be imparted by the Sweat leader as s/he teaches the values and behaviours representing Native ideals (Waldram 1993; 1997a).

Sweat Lodge ceremonies are not being embraced as a treatment tool by the counsellors in urban recovery centres to the same degree as the Medicine Wheel. There appears to be more discernment occuring prior to introducing clients to this particular practise of the Plains culture. Perhaps this is because it is a more specialized cultural/spiritual practise or perhaps they are simply not in a position to conduct Sweat Lodge ceremonies (Sweats) because their facilities tend to be physically located in the downtown central core.

Nonetheless, through the networking that occurs in the Native communities and between the centres' program and/or cultural coordinators, the counsellors are usually aware when a Sweat is scheduled to take place in the community and whether their clients may attend. Some of the interview participants I spoke with counselled caution prior to making referrals to ensure the Sweat leaders were known to be reputable and authentic spiritual practitioners. One stated that her centre required criminal checks and signed agreements with any outside facilitators working with her clients, including Sweat leaders, because "there are lots of people wanting to do certain things these days and I think it's very easy to get side-tracked into something that's maybe not too good. Especially with youth and children" (118MAp6).

Sweat Lodge ceremonies are being introduced into Coast Salish and Kwakwaka'wakw communities with varying levels of acceptance and controversy. There is some disagreement between the Coast Salish counsellors interviewed as to whether or not Sweat Lodge ceremonies were a traditional practise of the Coast Salish people. Most assured me that they were not. However, one counsellor from a relatively remote reserve was confident in his response when he assured me,

> Yes. It came from the known time, from [an Elder] who used to be from here. They called it *teetil'aiye*, meaning 'secret place to pray.' The Sweat Lodge is in the bay. I put it there because that's where he used to go to bathe and he used to pray there. ... We call it in our language *wheetba'sla*, meaning 'cleansing yourself'. (139NHp18)

When asked if it was similar in format to that being introduced from the Plains, he responded, "It's pretty near the same but I've put mine into our *h^{w}oyten*, into our language, trying to find our own songs. Plus, everything we use is cedar because we call ourselves 'Cedar People,' too" (139NHp19-20).

There was no doubt on the part of the Kwakwaka'wakw counsellors that Sweat Lodge ceremonies were definitely not part of their cultural heritage. However, I was informed that

> a lot of people in this area have adopted Sweat Lodge and smudge and that sort of thing as part of their ceremonial practices. ... [It's being accepted more] ... by off-reserve First Nations rather than those that are living on-reserve who tend to be more traditional. (135TCp3)

Referring to his own personal experience, one counsellor explained,

> I, myself, have taken a lot of different cultures' methods of personal growth and healing into my own life. Smudging with sage, sweetgrass and cedar. My people don't smudge. I turned religion off for awhile and I needed something to fill that spirituality and I borrowed it from a Medicine Man -- he allowed me to take part in a smudging, allowed me to take part in Sweats -- we don't have Sweats. So, this is how I made my connection in spirituality. (140RGp29)

A Carrier administrator describes her community's gradual re-introduction of cultural practices by explaining that Sweats are now being performed on a regular basis -- every full moon and on Sundays. She openly acknowledges that the traditions are Plains in origin, not Carrier. But, she says they listen to Elders who have maintained some memory of their traditions, such as the type of wood to use for a particular type of Sweat, the type of smoke to use, and what to do after the Sweat. She described a situation that occured, after a recent murder/suicide experience, when two young people aged 17 and 20 years died, and the community was grieving greatly.

> A young man was told by an elder to put pine wood on the fire and rocks after the Sweat so that a thick smoke would go through the whole community. In this way the healing prayers would travel with the smoke through the whole community and heal and cleanse the whole community. So they did and it was wonderful to see. There was so much smoke! It was very unique. It was like a thick fog flowing right through the entire community. (75JMp3)

Alcoholics Anonymous

The term "spiritually bankrupt" was coined by the founders of Alcoholic Anonymous. Consequently, it should come as no surprise that spirituality, prayer, and belief in a culturally relevant Higher Power are extremely important in both the Native and non-Native substance abuse recovery programs. AA, Narcotics Anonymous (NA) and other 12-step programs are strongly endorsed by counsellors in the urban centres as a treatment option or as a conjunct with their traditional cultural/spiritual life-way.

> We... make sure that they're involved in Alcoholics Anonymous or Narcotics Anonymous or the Longhouse -- what the West Coast people use -- or the Sweat Lodge -- what the prairie people use -- just to keep them balanced. If they are strong into Christianity, usually it's the evangelical type, and you get them involved in that, and that balances the spiritual part of it. (120DRp20)

However, as previously discussed, the AA 12-Step model maintains a relatively individual mode of intervention. For many First Nations people, mediation tends to unconsciously connect family and community, past and present. A counsellor elucidates:

> They bring with them the sadness and the trauma of past generations. It repeats itself in the present generation, in their own environment and the environment of the community. ... So, when I work with them I must always take into context the community. It starts with the individual, then with the family, then with the community, and all that it involves. It can be the church, it can be the politics, it can be the land claims, it can be nepotism, it can be all of those things that they bring with them. It's extremely hard to work with them alone. ... It's different than the non-Native. They can isolate. They can almost go through two or three sessions without ever mentioning *anyone*. Really! It's quite a phenomenal thing. Whereas with First Nations you will hear about Grandma, Grandpa, Uncle, cousins, the honourary Grandfather, the honourary Uncle, who isn't even an uncle, and their brothers and sisters who aren't brothers and sisters but are probably first cousins or second or third but they're 'brothers' or 'sisters.' So, when they come in the door they bring with them all of them. (1MLp23-24)

Most of the counsellors informed me that the AA 12-Step program has been unsuccessful in reserve communities. It seems to go in waves where the groups will last for a little while but they cannot be sustained -- they will collapse. The inherent family and

community connections described above could be one important element to explain this phenomena. One counsellor informed me,

> Sometimes, I'm labelled as an AA Counsellor and when you've got that kind of a label people that are practising are going to stay 10 feet away from you. And if *they* won't come near me, neither can their families -- like their wives, their children. So, it's distanced the people from me sometimes, with that kind of a label ... To do or not to do... That's a good question because it's so controversial. (162JUp6-8)

The greatest stumbling block in the success of an AA program, or any program that is explicitly identifiable as an alcohol and drug abuse recovery program in any community, Native or non-Native, is the fear of being shamed. Without exception, every program facilitator I spoke with talked about the idea of confidentiality -- not the professional ethic of counsellor/client confidentiality -- but the idea that, "Oh, I don't want to go up there. People will see that I'm trying to quit drinking or that I'm trying to make a change in my life" (139NHp11). As one counsellor said,

> It's really hard, here, to have a 12-step program because of the trust level. Everybody knows everything about everybody in a small community and the trust level is really hard to work on. So, when the trust level isn't there, the people don't come out as much or if they do come, they don't share -- they're afraid to share because so-and-so is sitting in the same room. (162JUp6-8)

"That is the double-edge of the idea of community," a counsellor at an urban centre informed me. He continued to say,

> If someone is struggling with their addictions they don't want it brought into their own community so they'll come out and access services. They may have a drug and alcohol counsellor [on reserve]. ... [But] someone from there may come down to see us rather than go to see the person that's there. (169MBp3)

Counsellors in two Coast Salish reserve communities commented that some improvement in AA attendance was occuring and suggested this was due, in part, to the location of the meeting site. In both communities, new healing centres had been built in more isolated locations away from the centrally located Band Administration offices, where the meetings had previously been held. Also, in one community, the counsellor held

annual AA Inter-tribal rallies and as part of the celebrations incorporated a give-away of decorated paddles, merging aspects of the potlatch tradition, as acknowledgement of the participants' successful sobriety,

> I give paddles away every year. They're beautiful paddles. I really enjoy doing that. I've got a friend who makes them and I've got a friend who puts art on them. I give them to the people who come to the program here. We call it, in our language, our *han'at'um*, meaning 'our giveaway'. (139NHp13)

Syncretic Healing Models

The sixth edition of the *Pocket Oxford Dictionary* defines syncretic as, "attempting, especially inconsistently, to unify or reconcile differing schools of thought" (Sykes 1978:924). In addictions recovery for First Nations people, these differing schools of thought consist of the multi-tribal traditions, AA and other 12-step programs, and mandated government programs.

> We use all the tools that we're trained in. ... We balance them out to keep them motivated, and then using the transtheoretical model, which is required by the Ministry of Health, in regards to precontemplation, contemplation, action stage, etc. and we utilize that. What I do with that is I add in the ... holistic approach to alcoholism. ... We intermarry all the different modules that are used. (120DRp19,20)

There is a greater use and acceptance in the urban centres of syncretic healing models than in reserve communities. This may be due in part to the multi-tribal nature of the client base in urban centres. It may also be due in part to the powerful influence of traditional family structures in B.C. coastal reserve communities. For instance, as mentioned above, if an influential member of the family is against accessing a particular service, program, or traditional ceremony from another culture, that person is most likely to ensure that all members of their family, and possibly their extended family, boycott the service as well. However, this can also work to advantage when that influential family member supports the service or event.

> It's always one side of the family. It's funny how it's one side. In each community you go to you can always tell, it's one side of the families. ... I hold an alcohol and drug workshop every now and then. These are people that come, that are members.... These are all my family. ... It always goes only one way. One family works on healing but if everybody would just come together as one, we wouldn't have that problem. (139NHp6-7, 10)

The adapted introduction and use of the traditional Plains Sweat Lodge ceremony in Northwest Coast reserve communities is a prime example of the creation of a syncretic healing model in addictions recovery. On one of the Coast Salish reserves I visited, the addictions counsellor had introduced a Sweat Lodge to the community 11 years ago and has been working with it since that time. It is an excellent example of the syncretic process, the controversy surrounding it and the potential healing benefits resulting from it. Here is her story:

> We have the Longhouse here every winter. People that participate in the Longhouse are not allowed to drink -- they have to be alcohol and drug-free -- and that's fine. But once that season is over, the drinking picks up around here, big time. So, I don't know if I did the right thing, but I went into my head and I started thinking, 'We need something that starts after Longhouse finishes so that the people can have a continuum of that Longhouse feeling.' That's why I was very willing to take a risk and try this Sweat Lodge ceremony.
>
> After thinking about it for some time ... a friend of mine said, 'Do you still want a sweat lodge? ... There's two men here. That's their mission. They're from South Dakota. That's all they do is travel around and help people put up sweats. All you have to do is offer them a pouch of tobacco.' I went out and bought a pouch of tobacco and I went to them and I gave it to them and I said, 'We'll go talk to our Elder.' ... She came with us and we selected a place in the backyard. ... We gathered up blankets and stuff and the men went out and got willows and we had our four-day sweat. Four days! That was the beginning. ... they said, 'You can use our Sioux songs, Lakota songs, until you get your own in our own language. You'll know how to set this place up after we leave.'
>
> You create a support group right in there. ... It's done in a really respectful way. ... They talk about all the things that have been done to us through colonization: our language, our songs, our prayers, our ceremonies, our rituals, everything that's been taken away. We're counteracting that when we do this. We sing our songs. We drum. We say our prayers in our own language. We *have* our own language in there. We create ceremony.
>
> What I've been stressing this year is *the linking*. We're using this formation but we're using our own medicines -- our cedar, our juniper --

> everything around here. We use everything local... and we're bringing in our own language and our own style of prayers and our own drumming. All that comes in even though the formation is Plains. It's a real good marriage. ... [But] I never mention the word 'Medicine Wheel' because that really makes it more Plains-like and I don't dare say those words in here.
>
> It's been very controversial ... using that tool ... *here*.... Because they say it's not *our* way. ... We've had a lot of people who have come to me and have said they want to go in but their Dad won't let them or their Mum won't let them. They urge their kids to stay away. I get kind of scared sometimes of what people think about me. ... but then I say, 'On the other hand, look at this person, he feels so good now and it's so wonderful to see him bouncing back and feeling clear and clean.' Families -- whole families that go in -- and they come and they feel so good and they're grateful that the tool is there. (162JUp13-18)

DOES IT WORK? PERCEPTIONS OF EFFICACY

The concept of symbolic healing is central to the effectiveness of contemporary Christian healing, such as that found in Alcoholics Anonymous, as well as to nativistic religious and traditional healing practices, such as Northwest Coast Longhouse ceremonies and Plains Sweat Lodge ceremonies. Obviously, spirituality plays a major role in these healing processes as do social and cultural elements. However, a re-examination of the theoretical perspectives identified in Chapter 2 as relevant to addiction recovery indicates that the spiritual and sociocultural theories are the two forms *least* able to provide clinical and empirical results of efficacy. Consequently, health professionals with a biomedical focus tend to downplay their importance.

Waldram (2000) points out that the field of medical anthropology continues to be vexed by this issue of efficacy in traditional medicine and symbolic healing. Charges of unscientific romanticism are tossed about when researchers examine traditional medical processes that are used to restore health holistically. Holism includes spirit and thus requires one to travel deeply on the healing journey so as to reconnect to soul. As Moore so aptly puts it, "the soul is not nearly as rational as the ego" (2000:59). Rational, modern life, which holds 'W'estern 'S'cience and 'B'iomedicine in the highest esteem, teaches us

to "think that our social problems and our personal struggles will be resolved once we understand the situation and gain control of it" (Moore 2000:59). We attempt to understand our health-related problems through the authority of the Controlled Clinical Trial. While this may be an essential, and welcome necessity for purely biological and physical ailments (if, indeed, such a thing *really* exists), healing scourges of the soul, like addiction, requires different ideologies and methodologies.

A consequence of biomedicine's hegemony, that betrays its secular core, is the dismissal of what may be the most significant aspect of traditional medicine, the placebo effect (Waldram 2000:617), that profound, yet unexplainable, healing phenomena. Communities who live by traditional values *know* their religion is not simply belief but is a way of life in which one appreciates the holiness of every façet of experience and honours that holiness with specific rites. Moore suggests that, "when *we* [in this modern, rational world] live from a deeper place, we become palpably aware that life is *fundamentally* mysterious and is ultimately incomprehensible to our rational ways of thinking. We realize that we need other kinds of intelligence and skills" (Moore 2000:60) [emphasis mine].

Clearly, then if the Native and non-Native addictions recovery field is planning to continue on its present course of a holistic approach, new understandings of efficacy must be built to "counteract the biases inherent in the utilization of biomedical understandings and methods characteristic of much previous work" (Waldram 2000:603). In the meantime, funding for the recovery centres is dependent on outcome measures to some degree. Therefore, the non-Native and off-reserve Native centres have a mandated Outcome Measures form to fill out for each client to measure the efficacy of their programs. This process is described as follows:

> Alcohol and Drug measures five domains. We get the baseline at intake and then at discharge we find out where they're at in those exact same areas and then in a follow-up three to six months later, *if* we can find them, we find out how they made out there, too. The five domains are basically: use and consequences -- has the use decreased and/or have the consequences decreased, either one would be considered a success; how has it affected

> your family, social life; your physical health; your mental health; your leisure; and is there a decreased involvement with the law. (1CMp18-20)

This follow-up process only works for those people who remain accessible and none of the urban recovery centres examined efficacy rates on a longitudinal basis -- 12 months is the longest period, and this is optional. The percentage of people most centres are able to contact for follow-up is quite low because people tend to get lost in the larger populations. Furthermore, as another counsellor puts it,

> It's preaching to the converted because those clients who are stable, who have found a job, have got a phone, so we can get in touch with them. So it's rather dubious. It's bad science, let's face it. ... We don't have the manpower or the time to do a good Outcomes Measure when it really comes down to it. It doesn't work. (169MBp7-8)

The situation is somewhat different for the centres located in reserve communities. The smaller populations and intimacy of the community provides a much better sense of how well people are proceeding in their healing process. For example, when asked how she evaluated her programs' effectiveness, a Kwakwaka'wakw counsellor explained,

> You know that you're doing really well when mine isn't the only car parked outside the Band office, there's other vehicles parked out there. Because now they've got cars and they're driving! I used to have to pick everyone else up. They didn't have cars. They didn't even have fixed addresses sometimes. It's so cool that they have a car and they're showing up there and they have jobs. (135TCp22)

Another counsellor from the same region said,

> I have no formal follow-up or evaluation form. These are people that rarely leave the reserve so you deal with them almost on a weekly basis. ... You watch by the way they live their life and the way they affect other people and the way they treat other people. It's an ongoing thing and you see it. (181LMp22)

The words of a Coast Salish Elder echo the hope and success available to First Nations communities who choose the route of renewing and embracing their traditional cultural/spiritual practices:

> Twenty-five years ago change started in [the community]. Back before that, the norm was to drink -- all the time, for every event. Everyone was in the bar on Fridays and Saturdays and even on Sundays. That was the pattern that the younger people saw -- everyone drank, all the time, at

> soccer games, at dances, at outdoor events, even at funerals -- drinking all the time. But the traditional Winter Dance came back 30 years ago and that's when the change began. People came in and started to participate in the Winter Dance and some didn't need alcohol any more.
>
> Now there's lots more sober people. Drinking's not the norm anymore. Being sober is becoming the norm. I am sober now 21 years. My daughter and son-in-law are sober now .... Their kids, my grandchildren, twins of 10 years old, have never witnessed their parents or grandma drunk or drinking. So, they know for themselves that drinking, using drugs and smoking are not healthy ways to live. (100DFp8)

SUMMARY

There is a distinct difference in communication styles between the Native and non-Native programs that permeates all levels of addictions services and needs to be recognized as an important element in program planning, delivery, evaluation and accountability.

The interview phase of this research involved speaking with 19 program facilitators from three non-Native and 13 Native recovery centres spread between Coast Salish, Kwakwaka'wakw and Carrier tribal territories. As was anticipated after completing the brochure analysis, the spiritual, cultural and social components of the holistic model were represented to a considerably smaller degree in conversations with the non-Native than with the Native individuals. Questions regarding these topics needed to be pursued by direct questioning with the former group and the answers tended to be considerably shorter.

In contrast, non-Native counsellors placed more emphasis on biological and psychological components, such as detoxification programs and the challenges of working with dual diagnosis clients. They also spoke at much greater length about mandated administrative issues such as intake, assessment, funding and accreditation processes. Due to the distinct lack in cultural or spiritual programs available for First Nations clients in the non-Native centres, the interviews from these centres offered little in answer to the basic research questions. Consequently, they were left out of this portion of the results section.

The interviews conducted with program facilitators at the Native centres, on the other hand, were rich in detailing cultural/spiritual programs and issues. Major differences

were revealed between the programs and services offered in urban and reserve centres. The urban centres catered to a multi-tribal client base. Consequently, these centres tended to utilize more syncretic programs and were very strong in their use of the Medicine Wheel as a treatment plan. They tended to act as investigators and guides, actively helping clients discover and reconnect to their cultural roots.

On-reserve counsellors were working with clients generally more grounded in their cultural traditions and tended to focus more on cultural renewal. Community members were much more likely to respond to programs that incorporated traditional activities than practices such as the AA 12-Step program or the Medicine Wheel. The Way of the Table was acknowledged as being a very effective method of delivering programs without labelling them as alcohol and drug programs. It was also used as a way to rebuild family and community ties and social structures that had been decimated by the residential school experience and the potlatch law. Sweat Lodge ceremonies, while being proactively introduced by the Plains groups, were meeting varying responses within and between reserve communities. The utilization of the Sweat Lodge in B.C. First Nations communities offers the best example of the process of building a syncretic healing model.

Evaluating addiction recovery programs' levels of efficacy remain difficult to ascertain from a quantifiable perspective because the components requiring measurement are situated in the realms of the spiritual and the sociocultural. New understandings of efficacy must be built with new kinds of intelligence and skills to counteract the biases inherent in biomedical understandings and methods. Longitudinal studies are more difficult to conduct from urban centres, both Native and non-Native, than from reserve centres due to the sheer size of urban populations and the nature of community within these centres.

In the final chapter, I summarize the research results through a synthesis of the different phases of analysis and a discussion of how I understand and make sense of the results. Lastly, I suggest areas that could benefit from further research.

CHAPTER 6
WRITTEN / ORAL INTEGRATION AND DISCUSSION

INTRODUCTION

British Columbia's First Nations and non-Native addiction health practitioners are mandated and accountable through their funding sources to provide accessible, confidential and professional treatment and prevention programs. The professional standards and levels of compassionate care exhibited at the outpatient and residential treatment centres examined in this study are high regardless of the cultural/spiritual orientation of their clients. However, with these administrative and professional similarities in mind, distinct differences in their therapeutic approaches exist and in the values and beliefs embedded therein. These differences divide the centres into the categories illustrated in Figure 6-1.

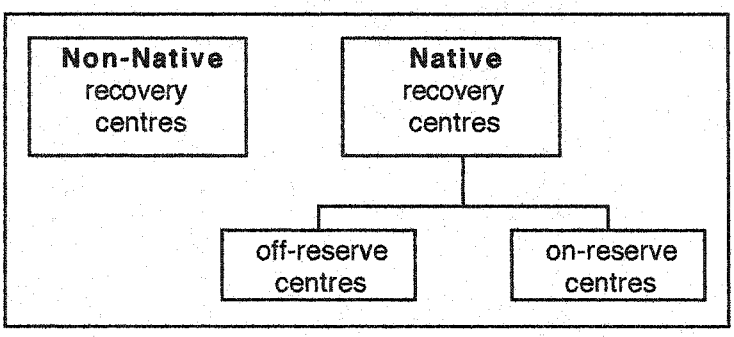

Figure 6-1. Categories of therapeutic difference by type of centre.

The brochures contributed to this study were subjected to a comprehensive content analysis of the text and visual imagery used by the centres to advertise their services and treatment approaches to potential clients. This analysis allowed the values and beliefs embedded in the brochures to be made more explicit, and magnified which were given precedence. The interviews conducted with the addictions counsellors, Elders and administrators were subjected to a thematic content analysis which allowed for richer detail to enhance the brochure analysis and to delve deeper into the research questions posed regarding the spiritual nature of addictions recovery and symbolic healing.

In this chapter, I attempt to overcome the analytic separation required in the content analysis by pulling together the themes and the stated values established in the brochures with the treatment approaches discussed in the interviews to determine if the stated values and goals are in fact implemented.

LINKING BROCHURE AND INTERVIEW THEMES

Holism

Balance is an important element in establishing holistic prosperity. Counsellors working in both the Native and non-Native recovery centres spoke of the importance of their clients establishing a healthy balance in their lives. The Medicine Wheel philosophy is the holistic model being used most frequently in off-reserve First Nations recovery centres. For centres supported by provincial funding agencies, the Biopsychosocial Theory is the model of treatment currently mandated for the delivery of addictions recovery programs in B.C.. Both models take a holistic approach. However, for First Nations counsellors, the sub-components of the models are thought of interdependently whereas comments from counsellors at the non-Native centres suggest that the sub-components continue to remain somewhat compartmentalized for many practitioners. For example, a First Nations counsellor at an urban centre described the process as follows,

> The holistic approach is looking at the different modules of their thoughts and their emotions, their physical well-being, their spiritual well-being and themselves. What they have to do is to balance all of the components out. ... The physical part is: they can get from their thought, if it's a negative thought, it can affect their emotions and their spirit -- which become negative -- and then they can get physically sick. (120DRp19-20)

A counsellor at a non-Native centre suggested that,

> There's some professionals that look at the whole person and there's some that look at pieces. ...We do that around the physical. "You want to talk withdrawal from heroin, go talk to your physician," or "If you want methadone...." We can do that when it's the obvious ones but when it's around the emotional and spiritual I don't think we have that to the same degree -- the understanding of that. (164BBp15)

The client-centred approach, also an element of the holistic models, suggests that it is up to the client to decide which façet needs to be initially addressed when beginning treatment. "Typically, each person's going to have a part of that system that's more important to focus on" (164BBp4). For example, they may need to begin with the physical. This could range from simply learning self care to reducing or eliminating their substance intake levels, which may require monitored assistance through the effects of drug or alcohol withdrawal. Often, healing of the spiritual aspect is primary due to the influence of the concept of spiritual bankruptcy which requires the prioritization of spiritual healing and reconnection.

Spiritual

When addiction is considered to be a spiritual disease then what is required for healing is a spiritual solution. The spiritual theme has a strong presence in both Native and non-Native brochures. However, the data indicates that the value placed on spirituality is greater in the First Nations programs. Not only is the spiritual theme present in a greater number of Native brochures than non-Native, but it is represented twice as often (i.e., the ratio of occurrence per brochure is 6:3. Figure 4-1). This was made explicit through the text and visual imagery present. Its importance was displayed further in the conversations of those interviewed at the Native centres as they tended to speak earlier in the interview, more frequently and for longer duration about spiritual issues than did the counsellors and administrators at the non-Native centres. Spirituality is therefore determined to be a very strong value embedded in the First Nations treatment strategies. As one counsellor at an off-reserve centre strongly asserted, "I am convinced that out of all the stuff that we do, the most successful part that we do is when people find their spiritual life. That's the success that I see" (169MBp12).

In the non-Native centres there is a much greater reliance on the AA 12-step program to supply the spiritual connection to their clients rather than to address it through their own centre's programs. As one of the administrators enthusiastically stated, "I personally think it [spirituality] plays a huge role. We advocate involvement with a 12-step program, all the time. We're *always* referring our clients to 12-steps of some sort" (123JKp15).

Nonetheless, it is important to note how the spiritual component continues to be de-emphasized in the non-Native programs, even though it has been mandated into treatment. Policy Number 4.A.d was originally written for the Ministry of Health and Ministry Responsible for Seniors, Alcohol and Drug Services, and was transferred to the Ministry for Children and Families along with the responsibility for Addiction Services in B.C.. The policy statement reads:

> Alcohol and Drug Services (ADS) designs and delivers treatment services to meet the needs of persons served in four dimensions: physical, psychological (thoughts and emotions), social/cultural, and spiritual. All treatment services/programs delivered on behalf of ADS will be consistent with the "biopsychosocialspiritual" (or holistic health) theory. (Ministry of Health 1996b:1)

However, when one turns to the document provided to support this policy statement with a description of the theory, the introduction states:

> the new theory incorporates the strengths of the older traditional theories while remaining a distinct entity with a unique set of hypotheses, and the addition of the spiritual dimension, which from the Alcohol and Drug Services' (ADS) perspective, has generally been underemphasized in most discussions of the biopsychosocial theory. ... [BUT] ... *the term "biopsychosocial" will be used for convenience* throughout this paper to represent the "biopsychosocialspiritual" or "holistic health" concept. [emphasis mine] (Ministry of Health 1996a:1)

This introductory statement speaks volumes regarding the continued undervaluation of spirituality in the vernacular of the non-Native centres. The inclusion of the spiritual is itself a phantom. The policy cannot truly represent a holistic approach if it explicitly names only three of its four façets for the sake of "convenience". As a non-Native centre

administrator stated, "I think there's some spiritual stuff involved in it but they didn't seem to want to call it the Bio-psycho-socio-spiritual Model" (1CMp4). Furthermore, the spiritual domain is also absent in the Overview of Treatment Services which states, "Counselling, support, and education are provided for ... areas such as family relations, work, legal, and physical and emotional health areas" (Kaiser Youth Foundation 1999:28-29). However, having perhaps overstated my case, it is important to point out that of the non-Native centres that included the theme of holism in their brochures (32%) most of them *did* explicitly identify the spiritual component in their description.

Comparatively, counsellors working to reconnect First Nations clients to their cultural/spiritual roots understand that the rich fabrics of Native beliefs and cultural practices, such as the Medicine Wheel and the Longhouse, weave spirituality into most aspects of daily life. For those who fully embrace, or who are investigating the traditional beliefs of an interdependent holistic perspective, ordinary experience is not viewed as being fundamentally separate from transcendent realities but rather as arising out of, surrounded by, and interpenetrated by sacred powers. Migrations into the world of the sacred is a regular and potentially daily occurrence (Harrod 1987:160). As Bastien states,

> For tribal people, the sacredness of relationships are then expressed in each ceremony, each ritual, each sunrise, each breath inhaled and each hand shake. For example, as Indian men braid their hair each day, a prayer is said for the living as the right hand moves to braid a strand of hair, and consequently, as the left hand moves, a prayer for the dead. (1993:91)

One could venture to say that these basic elements of Native spirituality and values are universal across North American tribal groups. However, the manner in which the sacred manifests itself is not. First Nations people have a rich cultural diversity in their traditional interactions with the sacred which are ancient and meaningful. Therefore, when addiction recovery centres are planning the incorporation of culturally-relevant treatment programs, it is very important to recognize that "pan-Indian" approaches are often inappropriate, particularly in culturally diverse areas such as British Columbia.

Cultural

The cultural theme was almost exclusive to the Native centres' brochures. The bulk of references to First Nations culture in the non-Native centres' brochures related to listings of AA 12-Step meetings occurring in Friendship Centres. All other cultural content identified program and service availability for clients from Asian- and Indo-Canadian cultures. This lack of service for First Nations people at the non-Native centres was confirmed through the interview process. (See Chapter 5, Non-Native De-emphasis.)

In the brochures provided by the Native centres, the sub-category with the greatest presence (82%) -- matched only by the brochures' spiritual visual imagery -- was the cultural sub-category identifying the availability of "culturally-relevant programs". The notion of cultural identity and cultural-relevancy is discussed at length in the literature reviewed in Chapter 2. Often, health professionals, with the best of intentions, attempt to incorporate Native cultural elements into their recovery programs without being aware of the presence and extent of Native cultural diversity, and consequently take a more "pan-Indian" approach.

The pan-Indian approaches which are being adopted in B.C. tend to be those traditions practised by Plains groups such as the Lakota (Sioux) and Cree, among others. This is partially due to the fact that these groups are physically present in North America across a much greater geographic expanse, their practices have had much greater media exposure since contact, and currently Medicine Men (Mysterious Men) from these groups are proactively introducing their traditional healing practices in B.C.'s addiction treatment centres, correctional institutions, and reserve communities (i.e., the Medicine Wheel; Sweat Lodge, sweet grass, pipe and Yuwipi ceremonies; and smudging).

The Plains traditions are being accepted and adopted more readily by B.C.'s urban First Nations addictions centres where the programming needs to be more eclectic due to their tribally diverse client base. These centres often have a large proportion of their clients

orginating from Plains Bands and tribes who have relocated to the urban centres of B.C. or who are passing through as part of a transient population. The practices are also more readily adopted by individuals with little or no knowledge of their tribal affiliations due to the effects of such experiences as being raised off-reserve in non-Native homes or from residential school experiences. These individuals are searching for some kind of cultural/spiritual reconnection that resonates within them and that might help them to find their way back home to know their true selves.

A First Nations counsellor at an urban centre, who was herself raised on a B.C. coastal reserve, commented:

> It's going to bring out the cynicism of my own people, but allow me. I would say that it's [Plains traditional practices] used widely with Natives who want to be Natives. ... Somebody might have a *drop* of Native blood and that will be the focus. Or people just want to be Native and they will enter in and participate in drumming and circles and things like that. You don't have to *be* First Nations to do that. I have found that First Nations who actually lived on reserves and know what it is like to live on these reserves, they won't go in for it. (1MLp29-30)

This perspective is echoed by another First Nations counsellor working in a Kwakwaka'wakw reserve centre. When asked if there was much controversy surrounding people in her territory adopting the Sweat Lodge and smudge as part of their ceremonial practices, she answered,

> It depends on who you ask. Sometimes there is, sometimes there isn't. [It's being accepted more] by off-reserve First Nations rather than those that are living on reserve who tend to be more traditional. ... I've come across some people who are really quite closed to those sorts of things and say, 'That's not from here. We don't practice that.' They kind of look down on other people adopting it and practicing it. (135TCp3-4)

Coast Salish and Kwakwaka'wakw recovery centres located on-reserve are focussing their healing programs much more on a renewal of local traditions and beliefs such as those practiced in winter Longhouse ceremonies and the potlatch. Like all other addiction recovery centres in the province they offer individual counselling. However, a major difference in their programs is the incorporation of holistic programs intended for

community enhancement and healing. This interconnects with the next theme which addresses the social elements.

Social

At first glance, the social theme appears to have a fairly equal presence in the Native and non-Native brochures. However, the data indicates that the value placed on social aspects is greater in the First Nations programs. This is shown visually where it is depicted in twice as many brochures (55%) as in the non-Native (24%). Furthermore, while sub-categories of the theme are present textually in an almost equal number of brochures from both groups, the intensity of occurrences is double that of the non-Native brochures (i.e., the ratio of occurrence per brochure is 4:2. Figure 4-1). Its importance is further indicated in the interviews where the First Nations participants spoke at length about family and community issues. Therefore, concepts associated with the social theme, particularly interconnectedness and community enhancement, are determined to be very strong values embedded in the First Nations treatment strategies.

Comparatively, the program facilitators at the non-Native centres spoke very little about social issues. The social emphasis in these interviews consisted of brief comments about the importance of connecting individuals to groups in the community such as the AA fellowship, outreach through needle exchange programs, and justice where the discussion revolved around the fact that many of their clients were mandated to attend treatment through court orders or Child Protection Services, which is also true in the Native centres.

The social component of interconnectedness, as used in this study, also embraces the spiritual. This is evident in the Native perspective of holism and the Medicine Wheel that emphasizes the sacred interconnectedness of all beings in the natural and supernatural world. The *Pocket Oxford Dictionary of Current English* defines interconnection as connecting with each other in a meaningful or relevant relationship (Sykes 1978:170, 449). In addition, the Native perspective of interconnectedness includes the idea of 'communion'

defined as having intimate discussions, social dealings and fellowship or feelings in close touch with a friend or with Nature, especially on the basis of religion (Sykes 1978:161).

Interconnectedness is an essential aspect of the human experience instilling a sense of belonging and equality. Spirit is the oneness that links us all together. This is of particular importance to people in recovery from the spiritual bankruptcy of addiction. The addictive process has a way of isolating an individual. It magnifies one's sense of aloneness. Consequently, a significant part of the healing process involves reconnecting with humanity and feeling as though there is a place for one in community with others. This concept is one of the strongest bonds that holds the fellowship of Alcoholics Anonymous together and contributes to its success. Through the AA fellowship there is an inherent sense of belonging because all members are alcoholics and/or addicts in recovery. The underlying similarities in their experiences create a situation where the need for entangled explanations are unnecessary. Everyone simply *knows*. They can commiserate, support and cajole.

The value of the AA fellowship is well known to addictions health professionals and membership is explicitly endorsed in the vast majority of off-reserve Native and non-Native recovery centres through their brochures and interviews. In one of the urban Native centres is a Kwakwaka'wakw Elder who is very committed to the AA program. He gives a surprising endorsement of AA over culturally-relevant treatment in the early stages of recovery.

> People look at my stuff [AA information on the table] and they say, 'Is this what you're going to give us -- Alcoholics Anonymous?' I say, 'No. I don't even know if you're an alcoholic'. ... If you want to ... go back to your Longhouse or you want to go back into your culture and try your ways of doing it, it's going to be hard. It's like walking into a church and saying, "I'm an alcoholic, could you help me?" They'll help you for awhile, they'll pray for you. Two services later they'll forget all about you. That's the way it is. That's what's going to happen in the Longhouse. In Alcoholics Anonymous somebody will be working with you or be beside you all the time, because we work together. You *will* walk into your culture again, though. You will'. (169MCp6,7)

The social issue of justice and its reflective psychological issue of violence, which both have quite a strong presence in the Native brochures (see discussion in Chapter 4), were addressed to the greatest extent in the interviews in reference to the residential school experience. First Nations counsellors, Elders and administrators spoke to the devastating effects, identified most often as the loss of cultural identity which, in turn, frequently led to violence and addictive behaviours requiring judicial input.

Similar to the way that all AA members have their addiction experiences in common, many of the First Nations community members have residential school experiences in common. Multi-generational healing is required to recover from the alcohol and substance abuses instigated by the residential school experience. It is common ground for mutual understanding among community members. "Residential school syndrome", is not listed in the DSM IV as an official disorder. Nevertheless, some mental health analysts view it as a component of a generalized "post-traumatic stress disorder (PTSD)" (American Psychiatric Association 1994:424) because individuals, communities and cultures are all profoundly affected. Psychologist Judith Herman attempts to redefine PTSD by proposing the "complex post-traumatic stress disorder" (1992:3) which, she argues, occurs when victims are exposed to long-term, unrelenting and sustained trauma, abuse and terror. Joe Couture insightfully suggests that "because of acculturation pressures, Aboriginal communities present, in many cases, a damaged collective self, reverberating through community and its component families" (Couture in Waldram 1997a:45). Waldram sums up the effects of this historic cultural trauma by stating:

> A whole community or society which is victimized by trauma is likely to develop aberrant moral reference points for its citizens, leading to the inter-generational transmission of pathological behaviours. The experience of trauma then becomes the lived experience of a whole culture. (1997a:46)

To heal a community requires community events. For First Nations in B.C.'s reserve communities whose fundamental belief structures include a sacred inter-connectedness with family and community, past and present, the use of the traditional

cultural practice, the Way of the Table, is a very successful healing approach. The Way of the Table provides a holistic approach involving not simply the sharing of meals (physical) together (social) but provides events where teaching (mental) and a renewal of NW Coast cultural/spiritual ideals and traditions (spiritual and cultural) can occur along with mutual support in times of special need (emotional).

For example, the events create ceremony with prayers, drumming and singing. They provide opportunities for oral traditions in the local language with story telling and speech making. They allow for witness and mutual understanding similar to a Sharing Circle. They provide a way to bring families back together to rebuild connections broken by residential school experiences. They provide a ready audience for the exchange of knowledge through workshops and teachings of both traditional First Nations and contemporary health-related knowledges. Of course, an important element found in the Way of the Table, is the factor of multi-generational inclusion. People of all ages can and do participate which heals the community holistically not only horizontally through the sharing of mutual experiences but vertically through all of the age groups. Elders can share their historical knowledge and children can share their hope and energy for a bright future. Social roles and traditional structure can be re-established.

For off-reserve First Nations people beginning their journey of reconnection to their Aboriginal roots as part of their healing process, an urban First Nations recovery centre can act as a self-contained community in its own right, a role the Friendship Centres play particularly well. Counsellors provide guidance to clients by introducing them to members of their tribal group, residing locally, who are associated with the Friendship Centre. For a client with no knowledge of their cultural origins, they can attend different tribal functions to get a sense of which culture group's traditional practices resonate the strongest for them. For instance, a First Nations administrator from a Native Healing Centre describes how his centre accesses these cultural groups for his clients:

> There is the Friendship Centre and they have family events for what we consider West Coast people, East Coast people, North and South. The Friendship Centre has been ... able to have those cultures represented every night. So we have a place now, and a resource, where we can bring these individuals in and say, "Here you go. This ... is a traditional culture and it is an *Aboriginal* one. It's *your* area of culture. These people in the room understand and know where you're from". (120APp14)

These clients can reconnect to community in this way even though they are far removed from their reserve or cultural homeland.

Psychological

The expression of the psychological theme in the interviews maintained a similar pattern in emphasis as was expressed in the brochure analysis. Issues of grief, suicide and violence tended to be emphasized more during the interviews at Native recovery centres than at the non-Native. Dual diagnosis and other explicit mentions of mental health were emphasized in the non-Native centres. The sub-category of violence was spoken of to the greatest degree and, as discussed above, for the First Nations people the central feature of the discussions related to issues of abuse as experienced in residential schools. It was also pointed out that these experiences tend to cycle down inter-generationally leading to issues of family violence in association with substance abuse. As one First Nations administrator on-reserve stated,

> That's good now that people are seeing beyond that, beyond the abuse and the hurt and the anger which stems a few generations. It's really difficult to work through that. I don't think it will change until we finish working with the children that we're working with right now. They become parents and it's our future generations that are going to make an impact on how unwell we all are in the community. (11LBp3)

Biological

Similar to the psychological theme, the biological theme was minimally represented in both the brochures and the interviews with a slightly greater emphasis in the non-Native recovery centres on biomedical issues. These were found built in to a portion of their

mandatory educational series where information was related to clients regarding the physical effect of substances on the body, and through their home detox programs. There was some acknowledgement from both Native and non-Native counsellors of the relevance of the Chemical Dependency Theory (Chapter 2) but the general consensus of the non-Native counsellors can be summed up in the following, "We certainly have gone from being a medical-based model ..., to being bio-psycho-social and using the whole theory around that one" (123JKp18).

The biological sub-categories touched on in the interviews with First Nations counsellors, particularly from the on-reserve centres, were encouraging participation in traditional physical activities such as canoe races and medicine walks. Other health-related themes not mentioned in the brochures were introduced in the interviews. In particular, diabetes and HIV/AIDS were discussed at several centres due, in a large part, to the role alcohol plays in both of these diseases.

CONCLUSION

In contemporary anthropological literature, notions of 'hybridity' and 'creolization' are being used to evoke the flux and flow of cultural ideas as the very concept of culture accomodates itself to the realities of shifting and overlapping identities. In this thesis, I refer to the notion of 'syncretic' healing models which attempt to unify or reconcile differing schools of thought. In this case, the traditional teachings of Plains people are being injected into the addiction recovery programs of B.C. with varying degrees of acceptance.

Traditions are created. Sometimes they are born from divine spiritual guidance, sometimes from practical environmental constraints. Traditions undergo change over time as knowledge is gained and lost and as environments and power structures shift. In B.C., First Nations cultural diversity grew and developed over millenia establishing rich

traditions. After contact, colonization practices and the residential school experience came close to eradicating this rich diversity. Children were separated from their families and communities for long periods of time. They were taught that their culture was inferior. They were forbidden to use their language. This led to a loss of self-esteem, a loss of respect for Elders, and, consequently, a loss of cultural and spiritual knowledge. Many of these individuals found themselves adrift, in the shadows of two cultures, feeling alienated from both and in a psychic state referred to as "anomic depression" (Jilek 1982:52). One of the most common methods of escaping these untenable situations was to dull the pain through alcohol and substance abuse.

However, the Medicine Wheel teaches continuous movement and change. The Wheel has turned again. Cultural renewal is occurring at an increasing rate reconnecting the wounded and spiritually bankrupt to their true souls. First Nations' national pride is experiencing a strong resurgence as self-government and issues of sovereignty are being negotiated. As a Coast Salish counsellor says, "How do we do that now, on the other side of the wheel? That's when you start looking at individual renewal and family renewal as a result of a national renewal" (162JUp2). The healing is well on its way. But the traditions are shifting as Plains Medicine Men travel throughout the province teaching their traditional ways, sharing their healing ceremonies to anyone who wishes to use them as tools for addiction recovery. One of the Kwakwaka'wakw counsellors pointed out,

> There's the changes that are going on, are happening. The environment is changing and we're changing with the environment around us. We learn how to go along with it and work in harmony with it. (182JBp39)

Therefore, it is essential to avoid the attitude that First Nations cultural practices and beliefs are locked in an unchanging definition of what constitutes traditional healing practices.

Some traditions are more easily borrowed and adapted than others. Those that are adopted illustrate the existence of common ground. The Medicine Wheel philosophy can be embraced by many because it teaches the fundamental Aboriginal doctrine of holism, a

sacred interconnectedness and balance. It holds a position of primacy in the off-reserve healing centres, but not so on-reserve, at least not by that name. Spiritual purification and cleansing is another aspect where cultural common ground can be found in the healing process. However, there are significant differences in the means and rights involved in achieving the purified state between the Plains and the Northwest Coast peoples. For example, the purification ceremonies of the Plains cultures (i.e., Sweat Lodge, smudging and sweetgrass ceremonies) are relatively mobile and are shared freely whereas the Coast Salish Winter Spirit Dances and *sxwayxwey* involve personal guardian spirits, family ownership, status and inheritance through potlatching.

To some extent the success of a syncretic healing approach appears to depend on the committed energy and the political clout of the counsellors, healers and Elders who introduce and deliver the programs. Those who are more open-minded take the attitude, "where there can be healing is to take in the old and to take in the new and to bring them together. It's *always* bringing them together because we can't go without either one" (140RGp27). However, traditional family structures are powerfully influential in B.C. coastal reserve communities. If an influential family member is against the integration of a traditional ceremony from another culture group, that person is likely to ensure that other family members, including their extended family, will boycott the ceremony as well. Of course, this family structure can also work to advantage -- when that same family member supports the ceremony.

B.C.'s non-Native addiction programs tend to leave the healing of First Nations clients in the hands of First Nations counsellors and programs. This is due in part to a lack of funding to support culturally specific programs including the hiring of First Nations staff as part of their counselling team; partly because their First Nations client base is small due to (1) an inherent lack of trust of non-Native people by First Nations substance abusers, and (2) a difference in communication styles; and partly because of the assumption among

non-Native health professionals that First Nations people are getting help from their own people. This is true to some extent. However, as a Carrier administrator points out,

> The formula-driven division of healthcare dollars has created a situation where the funding is now inadequate and reserves are scrambling for money to train qualified Native alcohol and drug counsellors. When we advertise available positions for Native alcohol and drug counsellors, no one applies because no one is trained. And if we put non-Native people on reserve to work in these positions, it just leads to heartache. So this is a big problem. We really need qualified Native people to work with our people. There is more trust. (75JMp1)

First Nations addiction counsellors who practice the philosophy Culture *Is* Treatment believe that for their people to heal from the spiritual bankruptcy of addiction, they need to reconnect to their own deep souls, to claim back their First Nations identity. Will the integration of Plains cultural traditions with B.C. cultural traditions create a new more globalized healing First Nations culture or will the integration attempt lead to increased national pride and reassertion of the diverse traditional B.C. First Nations identities? This is a question for future researchers. However, in the meantime it is critical for health professionals working in addictions recovery to ensure that individuals, families and communities, who turned to alcohol and drugs in the first place to dull the pain of their traumatic life experiences, are not further abused by being forced into yet another constructed culture. They must be allowed the time and the freedom to find their own way back into their culture, *if* that is where they wish to go.

IMPLICATIONS FOR FURTHER RESEARCH

This thesis project was designed to take a broad comparative look at the alcohol and substance abuse recovery programs provided by Native and non-Native treatment centres in British Columbia. It is hoped that it has established a base of information which can be used as a resource by other researchers and by program facilitators at the recovery centres themselves. In the process of completing the project, several issues have come to light that would benefit from further investigation.

Efficacy In Recovery

Efficacy can be viewed from many different perspectives. These perspectives can include whether a person or community is being cured or healed and whether the measure is established through empirical or symbolic proofs. The applications of different languages to the same health problem can also affect the concept of efficacy. As funding agencies in the addictions recovery field require evidence of successful treatment outcomes, more work needs to be done to develop an understanding of how the perception of efficacy differs between traditional medicine or symbolic healing and biomedical measures of efficacy. Research with healers and their patients is required to explore and comprehend how efficacy is understood at the different phases of recovery within traditional healing systems. This understanding could result in the establishment of more effective outcome measures which, in turn, could support requests for increased funding.

First Nations Systems

The differences in communication styles identified in this research suggest that First Nations people who deal with government agencies on a regular basis, especially the Aboriginal mother or family, would benefit from the definition of a structure more responsive to First Nations. One of the administrators at an urban Native Healing Centre pointed out that First Nations people require specialized approaches because from the First Nations perspective there's a different way of looking at things, a different way of approaching things and a different way of understanding things. She stated:

> People who need the help of any Ministry have to follow a certain rule. I feel there is still lots to be done there in redefining or defining a structure that will be responsive to First Nations. You're always made to feel like you're the round peg being shoved into the square hole. ... We need to evolve a system that will be responsive to First Nations. ... We need more humane systems to respond to our people somehow, to assist them in this process. ... We try to get our own systems going which creates a tension between *us* and *them*. (118MAp13, 15)

First Nations systems, and quite possibly non-Native systems, would benefit from an examination of the communication styles inherent in the collaborative holistic approach to healing so as to build administrative bridges which support requirements for accountable financial reporting.

Residential School Recovery

The healing required from the abuses experienced in residential schools is extensive and desperately requires research into effective healing approaches. Most addictions counsellors need effective techniques to address this particular 'syndrome' because most of their First Nations clients have experienced trauma through the residential schools. Many counsellors are unwilling to open that door because the healing required is more than their program is able to handle at this time. As one administrator said,

> People do want to heal, but their pot is overflowing. ... There is really very little help out there when it comes down to it. People are spouting off here and there and triggering people here and there. ... Sometimes I feel like we've just got our finger in the dyke. A lot of work needs to be done everywhere. I don't think the magnitude or the scope of what really needs to be done has even been thought about. (118MAp16)

Dual Diagnosis in First Nations Recovery

The Mental Health field believes that 80% of the non-Native addictions case load are dual diagnosis with a very large portion of this co-morbidity diagnosed as depression. Dual diagnosis clients are usually referred for treatment to mental health professionals with a different funding source. A non-Native centre administrator who is also a member of a coastal Mental Health team, noticed that as Mental Health's funding grew 300%, the definition of depression also grew at a similarly steep pace. However, there is a lack of data regarding dual diagnosis in First Nations populations. Research in this area could benefit addictions counsellors and other First Nations health workers through an understanding of the complexities involved in working with individuals suffering from comorbidity, and through access to additional funding sources for treatment.

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APPENDIX 4-1

Sample directory listings

Non-Native outpatient listing

Langley Family Services Alcohol and Drug Program
5339-207th Street
Langley, B.C. V3A 2E6 — Cost to Client: None
Phone: (604) 534-7921 Fax: (604) 534-3110 — MCF(AS) funding

Services: Screening and assessment; referral; brief intervention; individual, family, and group counselling; access to childcare for clients. Provides programs for family and friends of persons with substance misuse problems.

Approach: Uses a biopsychosocial, client-centred approach. Employs motivational interviewing strategies and brief solution-focused strategies to facilitate behaviour change. Strong emphasis on personal responsibility for change, as well as on relapse prevention management and decision-making skills. Provides prevention services in schools, workplaces, and the community at large.

Native outpatient listing

Friendship House Association of Prince Rupert
744 Fraser Street
Prince Rupert, B.C. V8J 1P9 — Cost to Client: None
Phone: (250) 627-1717 local 34 Fax: (250) 627-7533 — MCF(AS) funding

Services: For Aboriginal people primarily, but all welcome. Screening and assessment; brief intervention; individual, family, and group counselling for substance misuse and gambling problems; referral; lifeskills training; programs for family and friends of persons with substance misuse and or gambling problems. Offers talking circles, which are open to general public.

Approach: Harm reduction; aims to improve the health and family social functioning of clients. Recommends attendance at 12-step groups. Includes a modified program that respects the cultural, spiritual, and traditional beliefs of First Nations people. Prevention activities include workshops in schools and community and networking with other pertinent service providers.

APPENDIX 4-2

Letter to Native treatment centres inviting participation

Dear ;

Re: Opportunity to Promote Understanding

There is a sizable gap in the field of knowledge regarding the variety of substance abuse treatment approaches available to the various segments of the British Columbian population. No one has examined the similarities and differences of the recovery programs available, as they reflect their client base, until now. This is (Centre/Organization name)'s opportunity to make a valuable contribution to a research project designed to fill this gap. The research will determine whether there are distinctive values, symbols and/or beliefs in the approaches used by the various treatment centres, or if these aspects are more universal in nature.

The project constitutes part of my Master's Degree in Medical Anthropology at the University of Victoria. The result of the project will be a pragmatic piece of comparative knowledge that will establish a baseline of knowledge which can be used as a resource by recovery centres, like yours. But it won't stop there. It will also act as a spring-board for future understanding of program potency with positive implications for policy and First Nations community development planning. If requested, I will be pleased to send you a copy of the final report.

The research needs no personal information about clients or staff be disclosed. It is investigating the philosophies and beliefs that underlie the treatment activities. To participate, simply mail copies of any published materials which describe the philosophies, strategies and goals of (Centre's name)'s recovery treatment programs, along with the enclosed response card, in the self-addressed, stamped envelope provided. If you have no previously published materials, a letter outlining the above would be very useful. Once I have examined your information, I may contact you further to request a brief interview. If you do not wish to participate in any way, please return the enclosed response card, stating your preference. Otherwise, if I have not heard from you by (date), I will telephone you.

(Centre's name)'s involvement will make a vital contribution to this research project as British Columbia's First Nations programs appear to contain unique and important aspects to serve their significant constituency. Your participation will ensure that the First Nations perspective is well-represented in this timely project. If you have any questions or concerns regarding your participation, I invite you to contact me by telephone, e-mail or regular mail. Thank you very much for your time and consideration. I look forward to receiving your positive response.

Sincerely,

Susan E. Evans
Enclosures

APPENDIX 4-3

Types of materials received from treatment centres

Item		Description
1.	response card	
2.	business card	
3.	letter	
4.	memo	
5.	post-it note	
6.	brochure	folded single sheet of paper
7.	booklet	>1 sheet of paper, folded & stapled
8.	info sheet	unfolded sheet(s) of paper
9.	info card	unfolded single sheet of card stock
10.	poster	
11.	advertisement	
12.	handbook	program/centre instruction/information manual
13.	program paper	paper describing program techniques and/or approach
14.	program proposal	paper describing programs/needs/directions/plans
15.	policy paper	paper describing policy(ies)
16.	lesson plan	
17.	report	unspecified time frame or reporting purpose
18.	quarterly report	
19.	semi-annual report	
20.	annual report	
21.	evaluation report	
22.	consent form	form requiring participant consent
23.	questionnaire	form requiring participant answers and/or personal data
24.	work form	form requiring participant input with goals/plans/concerns
25.	workbook	book requiring participant input
26.	workbooklet	booklet requiring participant input
27.	book	
28.	journal article	
29.	newsletter	
30.	newspaper	

APPENDIX 4-4

Program brochures contributed but excluded from analysis

Native	Non-Native
PART I: Include A&D issues	**PART I: Include A&D issues**
• Family Therapy • Men's Only Healing Circle • Aboriginal Headstart Program • Lifestyle-Healing Program for Men who are Abusive • (Centre #142) Family Life Society • Family Support Program • Outpatient Alcohol and Drug Counselling	• Youth and Family Services • Dual Diagnosis Services • An Employee & Family Assistance Program for Your Business • Explorations Group • Relapse Prevention Group • 16-Step Empowerment Group for Women • Day Intensive Program • Support Group • Insite Program
PART II: Exclude A&D issues	**PART II: Exclude A&D issues**
• Suicide Awareness and Information • Child and Family Services • Sexual Abuse (from two centres) • Parenting Program and Traditional Pre-Natal • Empowering First Nations Youth in Unity • Provincial Care and Custody Abuse Program • Family Violence Program	• Bingo! • Problem Gambling Services for Seniors (+55) • Teens and Gambling • Women and Gambling • Problem Gambling Program

APPENDIX 4-5

Descriptive examples of text and visual imagery for brochure content analysis coding

SPIRITUALITY

VISUAL IMAGERY	
Explicitly Spiritual	**Implicitly Spiritual**
NW Coast designs • Mythical spiritual creatures: Thunderbird, Whale, *Sisiutl* • Sapling cedar: "tree of life" • Split whale copper Medicine Wheel and associated symbols • Drums and/or shields • Pipes	NW Coast designs • Man/woman/baby wearing traditional clothes beside sapling cedar • Split whale copper (pieces) • Animal face [bear?] • Eagle feathers • Eagle in flight • Native lodge (tipi) • Border graphics implying four directions • Sun - full or rising with rays extending • Rainbows and/or over-arching semi-circles • Head with outstretched wings - silouette

TEXT	
Sub-Category	**Descriptive Examples**
AA, NA, 12-Step, 16-step	"support with 12-step programs"
Spiritual beliefs respected	"learn about your own spirituality, other beliefs"
Aboriginal teaching & beliefs	"Red Road"; "enhance traditional Aboriginal values"; "*Sisiutl*"
Christianity	"staff includes ... chaplains"; "Christmas"
Prayer & meditation	"journey towards inner knowledge"

continued...

APPENDIX 4-5
(continued)

HOLISM

VISUAL IMAGERY	
Explicitly Holistic	**Implicitly Holistic**
• Medicine wheel • four-directional circles	• border lines inferring four-directions, may or may not be interconnected • cogged circle

TEXT	
Sub-Category	**Descriptive Examples**
Holism - full	"all areas of health, including physical, psychological, social, cultural and spiritual"
Holism - partial	"affects a person's overall health including physical, emotional, family, vocational and social well being"
Holism - undefined	"holistic methods of healing" ; "balance"

CULTURAL

VISUAL IMAGERY	
Explicitly Cultural	**Implicitly Cultural**
• baby in decorated cradle board • people with Native features • traditional Native dress • red & white hands clasping inside circle • tribal band names written in circle • obvious Native art style and elements • Native paraphernalia (i.e., drums, shields, pipes, eagle feathers, coppers)	• eagle in flight • blanket pattern

TEXT	
Sub-Category	**Descriptive Examples**
Native client base	"meeting the needs of urban Aboriginal people"
Visible minorities	"offer services to the Indo-Canadian community"
Culturally-relevant Native programs	"implements a cultural component in each of the groups" "an Elder works with our people"
Cross-cultural issues	"provide a cultural bridge between aboriginal and non-aboriginal cultures"

continued...

APPENDIX 4-5
(continued)

SOCIAL

VISUAL IMAGERY	
Explicitly Social	**Implicitly Social**
• Native band names written to join in circle • two or more individuals interacting • family groups including single parent and child	

TEXT	
Sub-Category	**Descriptive Examples**
Interconnectedness	"Intertribal Rally"; "healthy relationships"
Outreach	"hospitalized clients and local schools"; "home visits"
Community enhancement	"promote community self reliance"; "elders luncheons"
Community involvement	"to become part of a planning process"; "memberships"
Justice	"Victim/Witness program"; "Native Courtworkers"

PSYCHOLOGICAL

TEXT	
Sub-Category	**Descriptive Example**
Grief & loss	"grief and loss"
Suicide	"family dynamics such as ... suicide"
Violence	"sexual abuse awareness"; "cycle of violence"
Dual Diagnosis	"mental illness"; "mood disorders"; "dual diagnosis"; "PTSD"
Addiction is a symptom	"addiction as a symptom of inner pain and past trauma"

continued...

APPENDIX 4-5
(continued)

BIOLOGICAL

VISUAL IMAGERY	
Explicitly Biological	**Implicitly Biological**
• medical logo • laboratory paraphernalia • recreational and physical activities	

TEXT	
Sub-Category	**Descriptive Example**
Biomedicine	"chemical dependency"; "addictions trained physican"
Addiction is a disease	"we see addiction as a family disease"
FAS/FAE	"permanently affected (FAS/FAE)"
Physical activity	"exercise"; "sports and recreation"

APPENDIX 5-1

List of interview questions

The following questions are identified only as a guide. It is hoped that *you* will establish the bulk of the interview structure and content by discussing what *you* believe are the important aspects of your recovery programs, past, present and future.

PROGRAM DESCRIPTION:

- Who are the people who come to your centre for help?
- How long has your centre been offering programs in alcohol and/or substance abuse recovery?
  - Where do you deliver your programs? On site? Off site?
  - What language(s) do you use to deliver your programs?
  - Where else, if anywhere, do you send the people for help?
- How many people are actively involved in the delivery of your programs?
  - What do they do?
  - Where did they learn what they practise?
- How do you and your personnel define "addiction" and "recovery"?
  - Who or what do you believe is responsible for a person's addiction and recovery?
  - What do you see as the goal for successful recovery?
- Describe the entire process a person goes through when they come to your centre for help.
- What approach(es) to recovery does your centre use?
  - Has it changed it's approach(es) over time? How?
- Does family and/or community play a role in your centre's recovery programs?
  - How great a role? What type of role? Can you offer some specific examples?
- Does spirituality play a role in your centre's recovery programs?
  - How great a role? What type of role? Can you offer some specific examples?
- Does culture play a role in your centre's recovery programs?
  - How great a role? What type of role? Can you offer some specific examples?
- Does biomedicine play a role in your centre's recovery programs?
  - How great a role? What type of role? Can you offer some specific examples?

PROGRAM EFFICACY:

- How do you evaluate the effectiveness of your programs?
- What do you feel is the most effective aspect of your programs?
  - Why?
  - What do you need to make it more effective?

FUTURE RESEARCH PRIORITIES:

- Does your centre and/or community have any health-related issues it needs to have addressed through research?
  - If yes, what are these research priorities?
  - Would you be interested in participating in a collaborative community-based research project to address these needs?

APPENDIX 5-2

Letter of consent

You are being asked to voluntarily participate in a project entitled "*Looking for Spirits in all the Right Places.* A Comparison of Native and non-Native Substance Abuse Recovery Strategies in British Columbia" that is being conducted by Susan E. Evans, a graduate student, as part of the requirements for the Masters in Medical Anthropology degree at the University of Victoria. If you have any questions or concerns about the project, you may contact either Ms. Evans at (250)721-1615, e-mail (see@uvic.ca), or her graduate supervisor, Dr. Leland Donald at (250)721-7045, e-mail (lhdonald@uvic.ca). You may also contact the Associate Vice President Research at the University of Victoria if you have any additional concerns about the study.

The purpose of this project is to gain a deeper understanding of the similarities and differences between the Native and non-Native models of substance abuse healing strategies utilized in outpatient and residential centres across British Columbia through examination of the values, beliefs, and goals that underlie the treatment programs and activities, along with perceptions of the programs' effectiveness.

The prime benefit of participating in this study is the creation of a pragmatic piece of comparative knowledge which your centre can use as a resource to enhance understanding of the potency of culturally sensitive addiction recovery programs. Other potential benefits include the establishment of evidence with positive implications for affecting change in health policy and community development planning, and the identification of relevant community-based needs and research priorities.

You are being asked to spend approximately one hour of your time (more, if you so wish) at a location of your choosing, in the interview process with Ms. Evans. You will be asked questions relating to: a general description of your centre, its programs and client base; in-depth program specifics; program efficacy; and future directions and needs. You will also be encouraged to guide the direction of the interview to areas you believe are most relevant and important. The interview will be audio-taped, and a copy of the interview transcript will be forwarded to you, prior to it's inclusion in analysis. This will provide you with the opportunity to review, delete and/or add to the information you provide, to ensure that it accurately reflects your intended meaning, and that you have not been misrepresented in any way.

Your participation in this project is entirely voluntary and you are free to refuse to participate, to withdraw from it, or to refuse to answer certain questions, without any negative consequences whatsoever. In the event that you choose to withdraw from the study, your interview data will not be used and will be either destroyed or returned to you.

No personal information about clients or staff need be disclosed, neither will any individual treatment centre be highlighted. Your anonymity and confidentiality will be protected through the assignment of an alpha-numeric code for each interviewee and each treatment centre. This coding system will be the method of individual or centre reference in any resulting documentation. Rights to the data will be shared between your centre and Ms. Evans. The raw information will be stored in a secure cabinet, held for a period of approximately two years, at which time it will be destroyed, unless you request a return of the information.

continued ...

APPENDIX 5-2
(continued)

The results of this study will be prepared for presentation at a special thesis defence meeting with Ms. Evans' supervisor and thesis committee. A copy of the final report will be available to all project participants who request one, and copies will be placed in libraries. In addition, results may be presented at conferences and/or community forums, and may be rewritten for academic, popular and/or community publication. Presentations and supporting documents will also be available to your centre and/or organization if requested.

Having understood the above information and been given an opportunity to have my questions answered, I agree to participate in this project:

Signature of Participant _____