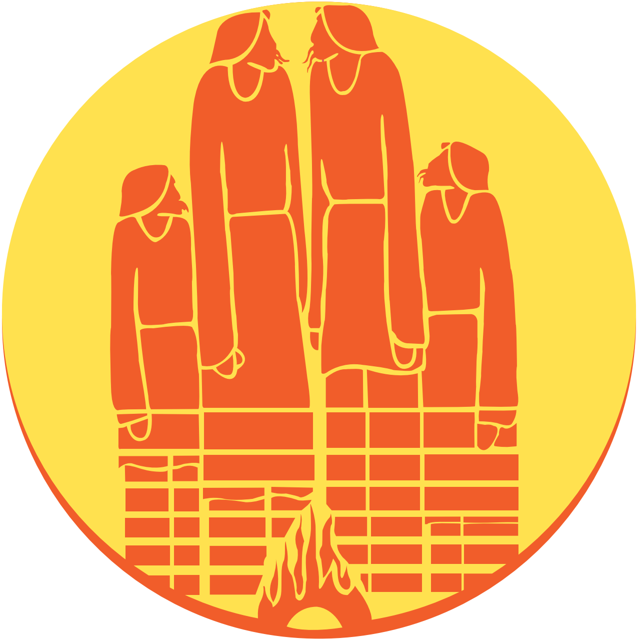
NATIVE SOCIAL WORK JOURNAL

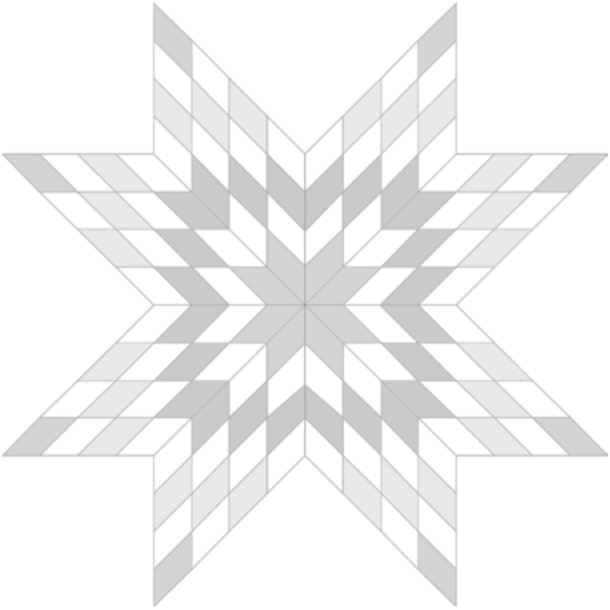
Promising Practices in Mental Health: Emerging Paradigms for Aboriginal Social Work Practices

Volume 7, November 2010



Circle represents the moon, the grandmother, the extended family.
Fire represents the sun, center of a family, warmth of a family.
Graphics represent light from the fire.
Lines from the mouth represent communication.

NISHNAABE KINOOMAADWIN
NAADMAADWIN



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Promising Practices in Mental Health: Emerging Paradigms for Aboriginal Social Work Practices

The Native Social Work Journal is registered with the Canadian Association of Learned Journals

Volume 7, November 2010

Published by the Native Social Work Journal
Laurentian University
Sudbury, Ontario

Printed by the Laurentian University Press
Sudbury, Ontario

Cover Artwork by Leland Bell

ISSN 1206-5323
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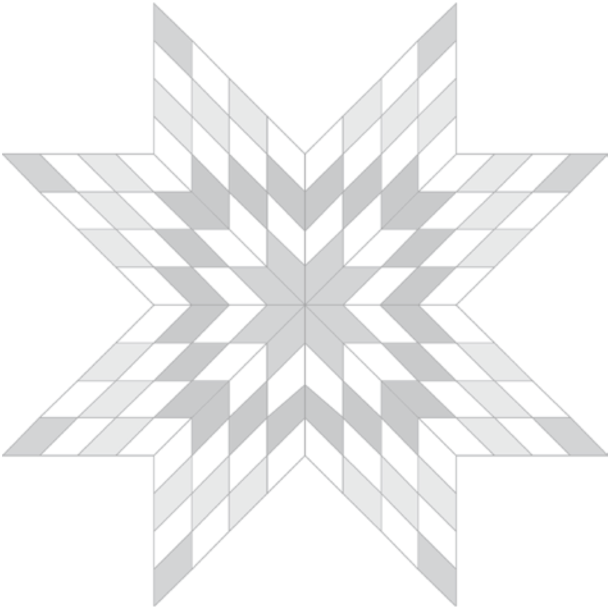
NISHNAABE KINOOMAADWIN NAADMAADWIN



PRAYER

Boozhoo; Aanii; Wachiya; Sago; Tansi;
Kia Ora; Kwekwe; Bonjour; Greetings.

Baybaamoosay-kwe n'dishnikaaz (My Spirit Name is Woman Who Leaves Healing Tracks), Migizi n'dodem (I belong to the Eagle Clan), winiizhoo Midewiwin (I am Second Degree Midewiwin), Wasauksing miinwaa Sudbury n'doonjibaa (I am from Wasauksing First Nation and I work in Sudbury).

Waynaboozhoo G'chi-Manido / Greetings Great Spirit

G'chi Miigwech / Thank you very much
for another beautiful day on Shkagamik-kwe / Mother Earth
and for those four directions.

G'chi Miigwech / Thank you very much
for our relatives; the four-leggeds, those who fly, those who
crawl and those who swim, without whom we could not live.

G'chi Miigwech / Thank you very much
for all our plant relatives, without whom we could not live.

G'chi Miigwech / Thank you very much
for the water, the life-blood of Shkagamik-kwe / Mother Earth,
without which we could not live.

G'chi Miigwech / Thank you very much
for the air we breathe, without which we could not live.

G'chi Miigwech / Thank you very much
for our relatives in the sky world; the stars, the moon and the sun,
without whom we could not live.

G'chi Miigwech / Thank you very much
for our eldest relatives; the rocks, the stones and the mountains
for their wisdom.

G'chi Miigwech / Thank you very much
for the sacred circle of life which is inclusive of all colours of man;
red, yellow, black and white.

G'chi Miigwech / Thank you very much
for the sacred circle paradigm which is our guide to spiritual,
emotional, physical and mental/intellectual wellness.

Cheryle Partridge

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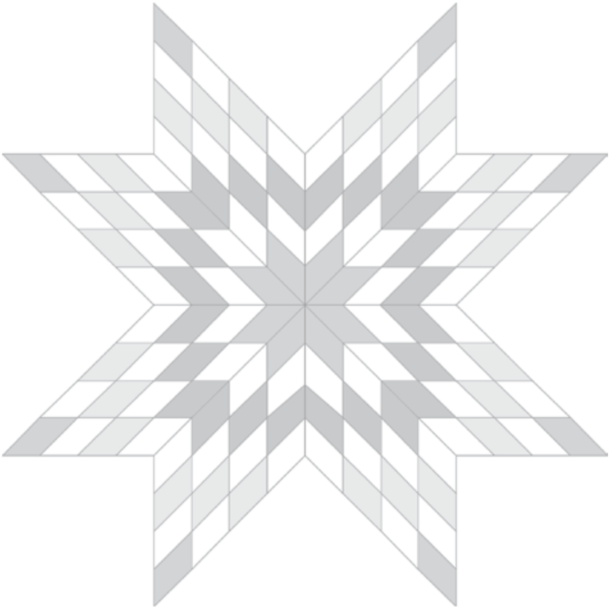

Established in 1988, the Native Human Services Programme utilized a regional consultation process involving twenty-seven (27) First Nations within the Robinson-Huron Treaty area. The consultation formed the basis of the curriculum and distance education component of the programme.

In June 2008, the Laurentian University Senate approved the Native Human Services Unit in becoming a School of Native Human Services separate from the School of Social Work. This was the realization of a request from the community in the original consultations of 1988. In April 2008, the School of Native Human Services with the support of Laurentian University, applied for stand-alone accreditation with the Canadian Association of Social Work Education (CASWE). Accreditation was granted in November 2008. The Native Human Services Programme is a fully accredited program with CASWE since 2008.

The philosophy, content, techniques and strategies that characterize the curriculum model represent a specialization for obtaining the knowledge and skills necessary as a social work practitioner with Aboriginal populations. The cultural content, practice methods and specific competencies reflect distinct realities of self-determination, cultural preservation and community empowerment.

The primary method within the curriculum model utilizes an applied approach that focuses critical knowledge in exploring strengths derived from holistic healing approaches. Other curriculum areas include: community based participatory research, Native child welfare practice, sociocultural ecology theory in family and community systems and case management. A necessary component to the curriculum is the historic political legislative and policy relations, which have defined and continue to have impact upon current socio-economic and political rights of Aboriginal populations.

Important and unique as a teaching and learning method is the incorporation of interaction activities with cultural relevance. Holistic healing practices expose students to the role worldviews, values, beliefs, and practices play in cultural based strategies. Additional benefits to students are the insights provided by participating in a process that examines culturally related perceptions of psychological growth and wellness. Finally, such experiential based cultural practices create opportunities for students to explore their own self-cultural awareness. Particularly relevant to this process is that such cultural based practices act as positive reinforcement in the development of cultural identity and serve to promote Aboriginal healing strategies as a source of interpretative balance, interpersonal renewal and community aspiration.

Field Education

The main objectives of Field Education are to impart to its graduates the ability to apply professional social work methods and approaches in a manner that is culturally appropriate to Aboriginal people.

Field Education involves the establishment of field placement opportunities in Native communities. A practicum setting provides the student an opportunity to apply the knowledge and skills learned in an actual practice setting. It is a planned and supervised learning experience for a 3rd year or a 4th year student, which fulfils the practicum requirements.

A Native Human Services Field Education Manual has been published to guide the students, the field instructor and the faculty consultants in the field practicum process. The manual is based on traditional Native teachings.

Distance Education

The distance component of the Native Human Services Programme is offered on a part-time basis through **ENVISION**: Laurentian University's Distance Education Program. All NSWK courses are alternated each year and require professional year acceptance into the programme.

For specific information on the Native Human Services Programme contact the Native Human Services Honours Bachelor of Social Work Programme at:

Phone: (705) 675-1151 ext. 5082
Fax: (705) 675-4817
Website: www.laurentian.ca

FOREWARD

Dr Sheila Cote-Meek
Associate Vice-President, Indigenous Programs
Laurentian University

There can be no doubt that the abuses suffered at the residential schools have had devastating effects on many Aboriginal peoples (AFN, 1994; Chrisjohn & Young, 1997; Miller, 1996; Milloy, 1999) including subsequent generations. Growing literature also exists on the impact of colonization (Adams, 1999; Battiste & Henderson, 2000; Chrisjohn &Young, 1997; Churchill, 1998; Fanon 1963; Lawrence, 2004; Monture-Angus, 1995). At the National Aboriginal Health Organization's Conference in November 2004 the Aboriginal Healing Foundation (AHF) discussed promising practices among projects that were funded by the AHF. At the time they emphasized the need to increase understanding of the long term and intergenerational impact of the residential school era as a mechanism to assist with dismantling resistance and denial in dominant society. The AHF also identified a framework for understanding trauma and healing which is reproduced here for easy reference:

THE NEED FOR HEALING

Historic Trauma and the Legacy of the Residential School System

---

CONDITIONS NECESSARY TO HEALING

1. Aboriginal Values & Worldviews	2. Personal & Cultural Safety	3. Capacity to Heal

---

THE THREE PILLARS TO HEALING

1. Reclaiming History	2. Cultural Interventions	3. Therapeutic Healing

---

CONTEXT

Individual and community resources, strengths and challenges

Figure 1. A framework for understanding trauma and healing (Aboriginal Healing Foundation, 2004).

This framework is particularly important in understanding the links between colonization, historic trauma and healing which have become recognized as important aspects of understanding mental health.

This issue of the Native Social Work Journal is particularly important in laying both theoretical and practice foundations for understanding colonization and its impact on the mental health and wellbeing of Aboriginal peoples. I am optimistic that as more and more Indigenous peoples take pen to paper, now to hands to keyboards, we will continue to add to the area of mental health as it relates specifically to Aboriginal social work practice. Chi-Miigwech to the contributions these authors have made to this issue of the Native Social Work Journal and more broadly, to the field of Indigenous social work.

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ACKNOWLEDGEMENTS

As Co-Editors, we are grateful for all those who have contributed to the publication of this journal. We would like to thank the authors of each of the articles in this edition who have devoted their time and knowledge in preparing the manuscripts. We also acknowledge your involvement, commitment and work in the area of Aboriginal Mental Health. We respect and admire your contributions to the field of Aboriginal theorizing, Indigenous knowledge and Indigenous research and practice. Chi Miigwetch.

Our gratitude also extends to both the Associate Editors of the School of Native Human Services and the Native Social Work Editorial Review Committee for reading and thoughtfully editing the manuscripts for this journal. Thank you also to Freda Recollet and Lissa Lavallee for your administrative and technical support. Chi Miigwetch to Cheryle Partridge for your prayer and to Dr Sheila Cote-Meek for your foreword. We are always grateful for the artistic and inspirational work by Dr Leland Bell and acknowledge you for the cover artwork.

We hope that the ideas and messages conveyed by the authors in this journal inspire you, inform you, confirm your practice and add to the increasing health and wellness knowledge base in the area of Aboriginal Mental Health.

Susan Manitowabi and Taima Moeke-Pickering

INTRODUCTION

Boozhoo, Aanii, Kwe Kwe, Sago, Wachiya, Tansi, Kia Ora, Bonjour and Greetings

The way Aboriginal people view mental health is distinctive, thus the way in which we work with our Aboriginal communities differs from strictly Western-based perspectives. Our philosophy and approach is based on relevant Aboriginal practices as opposed to a narrow clinical approach. In an Aboriginal worldview we tend to surround our people with the services that they need, therefore we "don't give up on our people". Our services are based on our philosophy, teachings and way of life. An Aboriginal approach to mental health is holistic (embraces the physical, emotional, cultural and spiritual), services do not separate children from adults, rather the focus is on the whole family and the community.

In providing services to our communities, the mental health worker does not shoulder the entire responsibility, it is shared amongst family and community and other service providers. There is a heavy reliance on community mental health workers and local community members to deliver health and wellness supports to fill the gaps in mental health services (Minore, Hill, Boone, Katt, Kuzik & Lyubechansky, 2007). Therefore, the success of wellness is seen in the strong collaborative relationships between agencies, services providers and families. This multi-disciplinary approach and collaboration with other services is also grounded in our sacred teachings. For example, the Seven Grandfather teachings comprise of respect, love, wisdom, honesty, bravery, humility and truth. When we base our work on our teachings we respect all peoples and are able to address the diverse issues that we are faced with.

Each of the articles touches on one or more of our Aboriginal teachings and philosophies. We believe that their work and philosophies extend the boundaries of mental practice with Aboriginal peoples and as such they are leaders in their respective fields (micro, mezzo and macro levels).

- The first article by Marlene Brant Castellano talks about research, insights and experiences at the macro policy level in particular the findings and recommendations of various mental health reports that supports culturally adapted community led programs.

- The second by Cheryle Partridge shares her experiences of residential schools from a personal and community level giving insight into the effects that residential schools have on the family and their communities. This article supports others into writing and talking about their personal history with residential schools thereby supporting others to give voice to their own experiences.

- Dr Peter Menzies also talks about trauma from a mental health perspective drawing on a research study. Dr Menzies shares a model for mental health professionals to examine the relationship between intergenerational trauma and social systems that Aboriginal people come into contact with. These findings might be invaluable for service providers working with family, communities and Nations.

- Dr Peter Menzies, Ana Bodnar and Vern Harper talk about the role of elders in a mainstream addiction and mental health hospital. They suggest that elders should be considered as full partners in a western therapeutic environment. This article provides insight into the roles of the elders especially with traditional teachings and healing.

- Colleen Dell, Terra Lyons and Kathleen Cayer share about the ‘kijigabandan’ and ‘manadjitowin’ philosophies of understanding and honouring peoples and they impart how traditional teachings like these can be useful for understanding harm reduction, policies and programs.

- The sixth article by Annie Wenger-Nabigon explores the traditional philosophies and teachings of the Cree Medicine Wheel as an organizing construct for examining contemporary theories of human development. We believe that this article has the potential to help others to deepen their understanding of the parallels between human development theories and traditional Aboriginal knowledge.

- The seventh article by Cynthia Howard is about cultural considerations in understanding positive youth development. She embraces a mental, emotional, social, spiritual and physical development approach to understand children. She shares how protective factors and risk taking behaviours influence youth development.

- The last article by Nancy Stevens through the use of anecdotes by clients - she highlights the importance of recognizing the strength of their spirit and the role spirituality plays in fostering resilience. This article endorses the importance of spirituality in mental health practice.

The authors behind each article are practitioners and advocates for mental health from an Aboriginal worldview and perspective. They share their practices as researchers, academics, service providers and teachers with their communities and the mental health fields. These authors are role models for "best practice" and "holistic practice". They are therefore revitalizing cultural traditions and reclaiming these for contemporary times, thereby reinforcing traditional healing methodologies and practices.

Miigwech
Susan Manitowabi and Taima Moeke-Pickering

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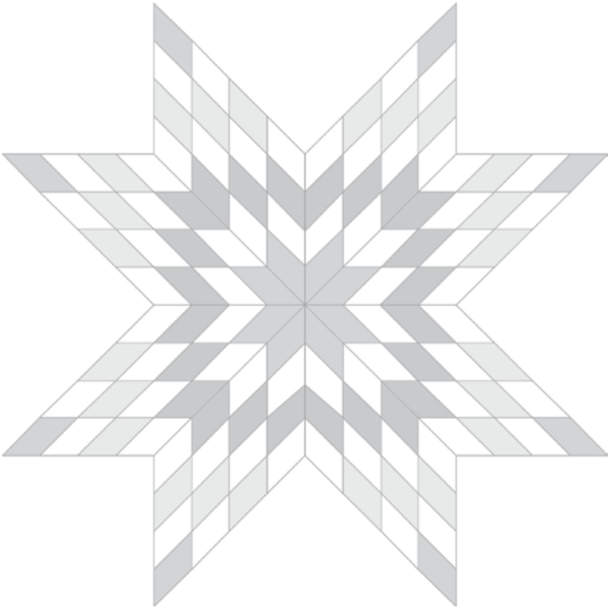

Healing Residential School Trauma
The Case for Evidence-Based Policy and Community-Led Programs

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Marlene Brant Castellano

Abstract

The paper outlines the emerging theory of historic trauma and its relevance to residential school experience. Recent research on suicide and economic development is cited to demonstrate the importance of restoring the bonds of community to achieve change in various sectors. Key findings of research and evaluation conducted by the Aboriginal Healing Foundation (AHF) are presented to identify healing strategies that are having an effect. The congruence between the AHF findings and recommendations of reports on mental health spanning the past decade is underlined. The article concludes with the argument that the evidence base for policy to support culturally adapted, community-led programming is well established. The time has come to translate knowledge into action.

Prologue

This paper is about the healing journey being walked by Survivors of the Indian residential school system and their relations, and the learning journey that has been walked by Board members, staff and supporters of the Aboriginal Healing Foundation (AHF) over the past eight years. The paper is also about my personal journey as researcher and writer of the AHF Final Report (2006), wrestling to find words that would convey the depths of insight opened up to me. My challenge was to bring together the stories shared by community members and the concepts developed by researchers to communicate effectively with Aboriginal readers of the Report and the policy-makers who would look for an evaluation of outcomes.

During the eighteen months when I was researching and writing *A Healing Journey,* Volume 1 of the *Final Report of the Aboriginal Healing Foundation* (2006) I was intensely involved in learning about the pain and dislocation in First Nation, Inuit and Métis individuals, families and communities. I was also learning about reservoirs of resilience in troubled communities, that are being revealed and deepened by community-led healing interventions. That resilience remains untapped in many of the helping interventions launched from outside our communities, from the base of western scientific expertise.

Holistic approaches to maintaining and restoring health have been advocated by Aboriginal people for many years. This means attending to physical, mental, emotional and spiritual dimensions of persons, across the life cycle for children, youth, adults and elders. It means addressing social and environmental conditions including education, housing, and a compromised natural environment. Holistic thinking is now being embraced in approaches to population health and recognition that determinants of health lie outside of the conventional medical domain, but practice is still firmly rooted in the medical model of treatment. The spiritual dimensions of healing remain mysterious and neglected.

Practitioners and observers of healing and mental health have heard reports over the years from people who grew up on the streets of Canadian cities or who wandered for years after release from residential school and were transformed when they heard the ceremonial drum or went into the sweat lodge. Something shifted, fell into place, and they experienced a profound connection to Mother Earth or the ancestors or their own fragile spirit. Those momentary experiences often mark the beginning of a life-long quest for knowledge and a commitment to serving the people.

Theory of collective and historic trauma says that we carry the hurts of past generations as well as the pain we have experienced in our own time. I believe that what we are witnessing in these accounts of culture-based healing is historic healing, awakening knowledge and wellness that have been dormant and layered over with personal and collective trauma that dulls our capacity to know who we are and to draw on our innate resiliency.

Some Aboriginal people speak of Blood Memory – the spirit within that carries ancestral knowledge that we don't even know we have until it is called forth by ceremony or dreaming or the stories of an Elder. Certainly it is beyond words and therefore inaccessible to talk therapies by themselves. Perhaps it is tacit knowledge acquired through touch and gesture and sound and smell when we were too busy learning words to notice.

We are only beginning to find the language to express what we mean by holistic healing, bridging the universe of our traditions and the world of western science and medicine. This paper is draws on the work of many people who contributed to the preparation of the *Final Report of the Aboriginal Healing Foundation* (2006), with the goal of making those connections clearer.

In the following pages I outline the emerging theory of historic trauma and its relevance to residential school experience. Recent research on suicide and economic development is cited to demonstrate the importance of restoring the bonds of community to achieve change in various sectors. Key findings of research and evaluation conducted by the AHF are presented to identify healing strategies that are having an effect. The congruence between AHF findings and recommendations of reports on mental health spanning the past decade is underlined. The article concludes with the argument that the evidence base for policy to support culturally adapted, community-led programming is well established. The time has come to translate knowledge into action.

Historic Trauma

Maggie Hodgson is a residential school Survivor who has been a pioneer in culture-based treatment and training in the field of alcohol and addictions and more recently an advisor on residential school redress and healing. Speaking at a hearing of the Royal Commission on Aboriginal Peoples in 1993 Maggie said:

> At one time I used to believe the myth that if our people sobered up, our problems would be solved. Now I know that all it does is take one layer off the onion…We are dealing with a number of different issues…related to our people's experience over the last 80 or 90 years…I believe that the whole issue of residential school [and its effects] is an issue that's going to take at least a minimum of 20 years [to work through] (Royal Commission on Aboriginal Peoples, 1995:75).

We have seen the powerful attraction that protests over lands have had recently at Caledonia, Ontario and, before that, at Oka, Quebec. The young and not-so-young individuals who don camouflage dress and camp out on disputed lands, recklessly defying police intervention, tend not to be the formal leaders of the community but they have the tacit support of many others who feel the injustices of the past. Why does the loss of land that happened generations earlier touch today's youth so deeply, rousing them to respond to a rallying cry? How does a people's history impact on present experience?

Native American psychologists working in clinical practice have shed light on these questions. Eduardo Duran and his wife Bonnie in California wrote in the early 1990s about the soul wound of Native American patients that was more than individual trauma, that was rooted in dislocation that affected the entire tribe and the community's collective sense of order and meaning (Duran & Duran, 1995). Maria Yellow Horse Brave Heart (1998) developed a theory of historic trauma based on research specifically with Native Americans of Dakota background. Historic trauma refers to responses to stress that are transmitted from one generation to another. The responses sit on a spectrum between adaptive and maladaptive.

The Aboriginal Healing Foundation commissioned a study that was published in 2004 titled *Historic Trauma and Aboriginal Healing* (Wesley-Esquimaux & Smolewski, 2004) which reviews the literature and, following Brave Heart, argues that Aboriginal communities have suffered successive traumatic events of huge proportion - epidemics, starvation as a result of destruction or depletion of food sources, confinement on tiny reserves, relocations for administrative convenience or to make way for development projects, removal of children to residential schools and child welfare placements, stereotyping and racism when they stepped outside of their reserves.

Television reports convey a sense of how large-scale disasters like the 2004 tsunami in Southeast Asia and hurricane Katrina in New Orleans affect whole communities. For Aboriginal communities, what they have experienced is akin to a flu epidemic followed by a hurricane followed by occupying forces on their lands, followed by disappearance of half the children in the community.

It is not readily apparent to Canadians in general why residential school experience has been traumatic for so many Survivors, why former students are in need of healing, and why the need for healing extends to the children and grandchildren of those who attended.

The fundamental violence of residential schools derived from their civilizing mission. They were established with the express purpose of detaching Indian, Métis and Inuit children from the savage or backward influence of their parents. These were not the equivalent of English boarding schools where children are sent to instill the values and replicate the connections of their privileged parents. Children were recruited with coercion, when they were as young as five years old. They were taken by rail and boat and plane to places entirely alien to them. Their hair was cut and subject to de-lousing whether they needed it or not. Their familiar clothing was replaced by quasi-uniforms or used clothing that arrived in bales from distant congregations. They were forbidden to speak their native languages on pain of punishment. It was common practice to keep the children at the schools for ten months of the year or longer, and their parents were discouraged from visiting even if they lived close enough to do so. Children were bombarded with messages that everything they had come from was worthless and pagan. They had to deal with being wrenched from their families and thrust into a bewildering environment where the core of their identity was under assault.

Beyond the emotional trauma of separation from family and the assaults on cultural identity the stories of residential school Survivors that circulate in families tell also of persistent hunger and punishment. In the last decades of the 20th century these accounts found their way into publications where the extent of humiliation, isolation, and physical abuse were brought to light. The stories of Survivors also documented their often failed struggle to find a place in either Aboriginal or mainstream society, burdened as they were with minimal education for survival in white society and no skills to contribute to their home communities.

According to the theory of historic trauma, these experiences have become imbedded, verbally and non-verbally, in the shared memories of Aboriginal communities and are major contributors to normalizing dysfunctional behaviours including violence, direct and indirect suicide and substance abuse. If we accept the hypothesis that the source of ill-health resides in the community, it has enormous implications for efforts to restore well-being. The question for practitioners is: How does this help us do a better job of assisting people-at- risk to make life-affirming choices? Recent research on the incidence of suicide and the success of economic development initiatives indicate the potential for positive change.

Cultural Continuity and Community Well-being

Based on studies of the incidence of youth suicide in British Columbia First Nations, Chandler, Lalonde and Sokol (1999) noted that:

> Among the 30 some Tribal Councils that organize British Columbia's 196 aboriginal bands, the rates of suicide turn out to be extremely variable. Over the 5-year window of the study (1987-

> 1992), more than half of the province's native bands suffered no youth suicide at all and, consequently, have overall suicide rates well below the national average. Others have suicide rates that are 500 to 800 times that of Canada as a whole (Chandler, Lalonde & Sokol, 1999).

Earlier work on youth identity development by the researchers had led to conclusions that while there were variations within study groups, non-Aboriginal youth tended to locate their personal continuity inside themselves, looking for some core characteristics or experiences that provided a common anchor for who they were and who they would become. First Nations youth, on the other hand, tended to anchor their continuity in a narrative of events involving themselves and others over time, in a story that became more stable and coherent as the adolescent matured.

Chandler and Lalonde (1998) theorized that if the narrative of community was disorganized as a result of repeated assaults, including residential school experience, then adolescents would be more at risk in their own development and this could manifest in higher rates of suicide. They constructed a scale to test the theory, charting evidence along six lines: action to assert title to traditional lands, assuming rights of self-government, control over education, health, police and fire protection, and establishing cultural facilities. Each of the markers of cultural continuity was found to be associated with a clinically important reduction in the rate of youth suicide and the observed 5-year suicide rate fell to zero when all six of the identified protective factors were in place in any particular community.

The researchers hypothesize that the markers chosen are not the fundamental features of cultural continuity but a subset of a larger array of protective factors that may hold real promise of reducing the epidemic of youth suicide in First Nation communities.

Can self-determination and self-government serve as a hedge against suicide? The evidence is not extensive enough to make generalizations, but it has been extended in further work by Chandler and Lalonde and it is sufficiently provocative that others are seeking to validate the findings in other settings and studies.

Research on what influences community well-being also comes from the field of economic development. The highly regarded Harvard Project on American Indian Economic Development led by Cornell and Kalt reported on research in fifty projects over a five-year period. The project attempted to determine why economic ventures in some tribes succeed and others fail. The findings, confirmed in subsequent studies, were that effective governance is a critical factor in fostering economic development. The characteristics of effective government were identified as: 1) having power to make decisions about their own future; 2) exercising power through effective institutions; and 3) choosing economic policies and projects that fit with values and priorities, that is, the culture, of the community (Cornell & Kalt, 1992, 8-10).

One interpretation of the findings of these studies is that what leads to improved well-being is not self-government, or fire and police protection in themselves. What is happening in particular British Columbia tribal councils and the successful subset of fifty American Indian tribes is the re-creation of communities bound together by shared values and ethical rules of behaviour. Through the assertion of self-government Aboriginal communities are reaching back into their traditions and outward with analysis of current realities to reconstitute the bonds of community. They are creating safe environments for adolescents to work out their identity as valued and valuable persons and bringing people together to pursue shared economic goals and strategies.

Turning over the reins of power and the resources to install self-government is not a panacea. If a community is detached from its ethical and spiritual roots, more power can actually mean more risk to vulnerable members of the population. Reports on the practical initiatives supported by the Aboriginal Healing Foundation confirm that community initiative can be found and nurtured in widely diverse circumstances, with responsible leadership operating as one of several conditions that foster community well-being.

The Aboriginal Healing Foundation, 1998-2005

The AHF was created in 1998 with a one-time grant of $350 million from the federal government to support healing of physical and sexual abuse in residential schools, including intergenerational impacts. The AHF was required by its funding agreement to commit the entire fund within a five-year time frame, although actual disbursement of the allocations could extend for an additional five years. In fact the original grant was committed by October 2003 with termination of all project funding scheduled for 2007 and closure of the AHF planned for 2008. The federal government announced an interim grant of $40 million in 2005 which allowed for extension of 88 projects but did not alter the projected closure date.

The Indian Residential School Settlement (2007) approved by Survivors, Christian churches who were partners in operating the schools and the federal government, provides for compensation to former students of residential schools and earmarks $125 million over five years for the Aboriginal Healing Foundation. In the latter half of 2007 efforts to secure bridge funding, to maintain 148 functioning projects until the settlement agreement was implemented, were finally successful. No further extensions past 2012 have been granted.

The three-volume *Final Report*, released in January 2006, provides detail on the activities and impacts of the AHF during its first mandate. The Foundation received close to 4,600 proposals of which about 40% or 1775 fell within the mandate and funding criteria relating to physical and sexual abuse and intergenerational impacts. 1,346 projects were funded in 725 distinct organizations and communities. The AHF did not prescribe the nature of healing activities that could be funded. The basic criterion for approval was that the proposal had to relate to physical or sexual abuse in residential schools or intergenerational impacts of such treatment. Beyond that, projects were required to demonstrate community support and reasonable prospects of achieving their goals through a project workplan and appropriate personnel.

Data for the Final Report were collected through a review of project files, three national mail-out surveys (2001, 2002, 2004), telephone interviews with AHF board members and personnel, five national focus groups, thirteen in-depth case studies, and 1,479 individual participant questionnaires that captured information about individuals' experiences in the therapeutic healing process. Twenty-seven research studies were commissioned and a questionnaire on promising healing practices was distributed to 439 projects in October 2002, yielding 103 detailed responses.

Projects set a priority on involving Survivors and employing Aboriginal persons, with the result that 90% of project staff were Aboriginal and, of these, 30% were Survivors. Staff effort was supplemented by volunteers who were contributing an estimated 13,000 service hours per month in 2001, effort that would add value of $1.5 million dollars per year if it were compensated at the rate of $10 per hour.

The data indicate a huge pent-up demand for healing involvement that is driven by community priorities, and a large, previously untapped capacity of community members to lead their own healing.

Evaluating Impacts of the Aboriginal Healing Foundation

The AHF Board initially wished to gather data on social indicators, such as rates of physical and sexual abuse, children in care, incarceration and suicide, to track changes brought about by funded interventions. It quickly became evident that this would not be possible in the limited time span of AHF funded projects.

As communities came forward with their own definitions of healing needs, and strategies that reflected their own views of what was appropriate to their situation, there was great variation in proposals presented. Individuals and communities started their healing journey from different places, with different levels of resources and experience to plan interventions.

The evaluation approach adopted was to look for evidence of individual progress along a healing continuum and increased capacity of communities to facilitate that progress. Two sources were particularly helpful in framing analysis of data: Judith Herman's seminal work: *Trauma and Recovery: The Aftermath of Violence -from domestic abuse to political terror (1992),* and the report of a national consultation funded by the Solicitor General Canada and the AHF: *Mapping the Healing Journey*. (Lane, Bopp, Bopp & Norris, 2002)

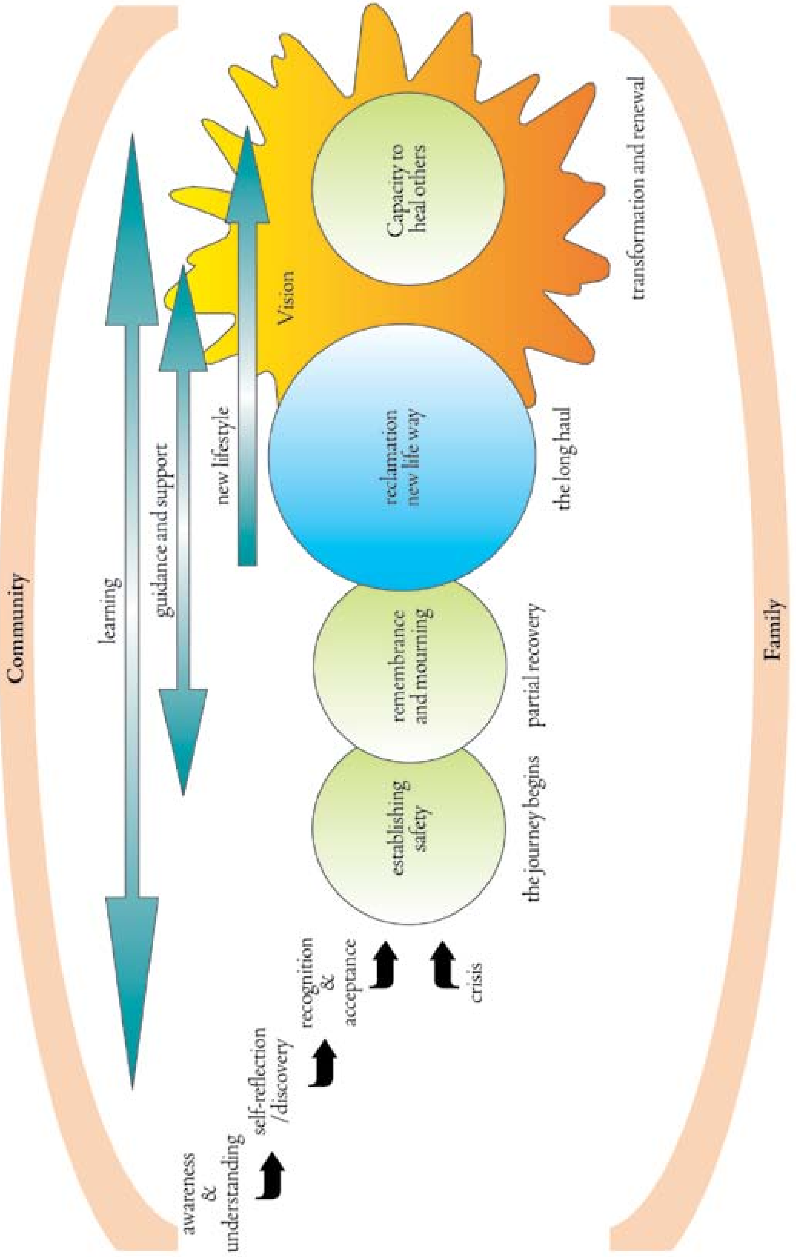
Evidence indicates that the individual Survivor's healing journey proceeds through four stages as represented in Figure 1: A Survior's Healing Journey [see page 22].

Individuals who have suffered trauma in childhood vary in their ability to integrate their experiences into the narrative of their lives. Reports from project participants confirmed that healing from painful or suppressed memories begins with awareness of barriers to a satisfying life and beginning recognition of the sources of distress. Awareness can develop gradually or be precipitated by a crisis such as a health problem, breakdown of a marriage or being charged with an offence. Projects typically found Legacy education about the history and impacts of residential schools, along with group events centered on cultural activities, supported readiness to engage in therapeutic activities and relationships.

In the first stage of their healing journey Survivors need to feel safe. Establishing *cultural safety,* affirming identities which had been forcibly suppressed, was an important feature of most projects. In stage two, sharing stories in talking circles fostered relationships among Survivors and encouraged remembrance and mourning of what had been lost. Mentoring by Elders, especially those who had survived comparable experiences, often helped to pave the way for entering stage three, the long haul of reclaiming a healthy way of life. The reclamation phase takes considerable time and discipline as well as support and guidance from family and community to establish stability. As personal healing progresses many Survivors feel motivated to share their emerging vitality with family, friends and community. Most Survivors would say that they are still progressing toward stage four in which they can mentor others on their healing journey.

The resilience of residential school Survivors is evident in the leadership provided by such individuals as Chief Billy Diamond in politics and

Figure 1: A Survivor’s Journey


Community
awareness & understanding
self-reflection /discovery
recognition & acceptance
crisis
learning
guidance and support
new lifestyle
establishing safety
the journey begins
remembrance and mourning
partial recovery
reclamation new life way
the long haul
Vision
Capacity to heal others
transformation and renewal
Family

[Source: Aboriginal Healing Foundation]

economic development and Maggie Hodgson in the healing movement. Some exceptional individuals such as Garnet Angeconeb, an AHF Board member, are asserting that finding the capacity to forgive the perpetrators of abuse is the final liberating stage of personal healing (Aboriginal Healing Foundation, 2006, 1:157).

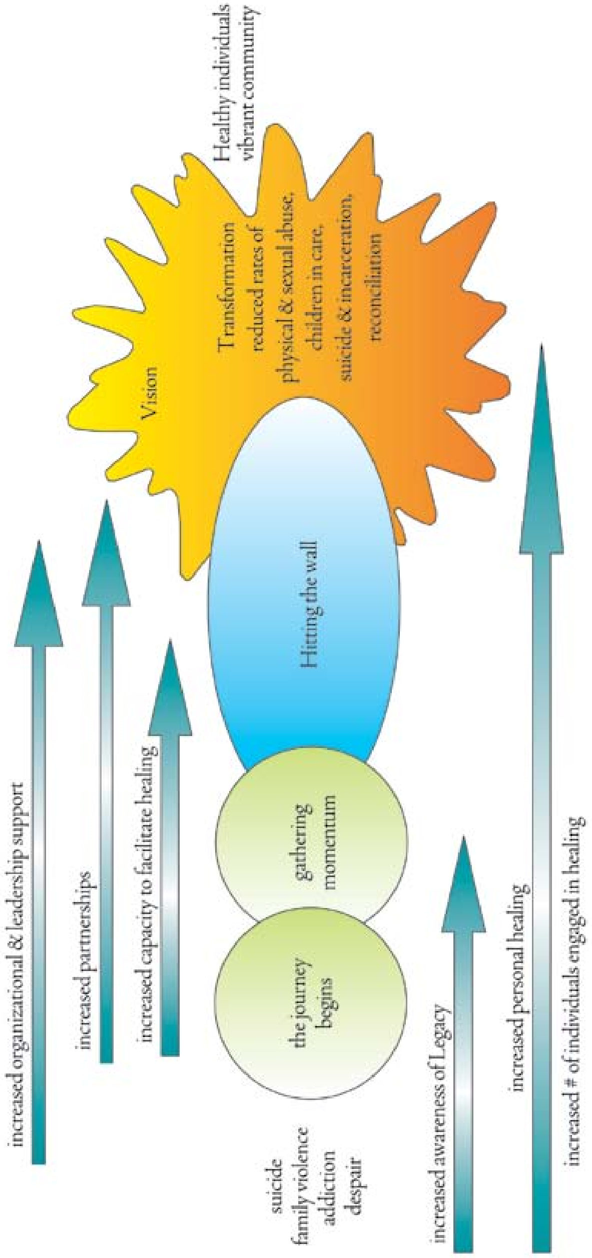
The most frequently used interventions to support personal healing were: healing/talking circles, Legacy education, workshops and ceremonies. The promising practices survey indicated that western therapeutic approaches were employed in 60 per cent of projects, almost always in conjunction with cultural interventions and/or Legacy education. Effectiveness of projects in reaching persons with unmet needs is indicated by evidence from individual questionnaires that two-thirds of participants had not previously participated in healing activities.

The path of community healing is also seen to follow four stages as represented in Figure 2: Community Healing Journey [see page 24].

Stage one is characterized by a prevailing sense of crisis or paralysis. The majority of people in the community are locked in destructive behaviours and there may be an unspoken acceptance that this state is somehow 'normal.' The possibility of a better tomorrow is sparked by a core group that is engaged in personal healing, forming support networks and seeking help for problems such as addiction. In this early stage, there is a beginning awareness of the Legacy of residential schools and increased disclosure of physical and sexual abuse, past and present.

The second stage sees the healing movement gathering momentum. More people are participating in healing activities and volunteering their assistance. There is a growing sense of hope, and determination to overcome obstacles of scarce resources and services, lack of trained staff and continuing denial in the community. People reach out to involve friends and elders and the numbers of children at risk are perceived as falling. Referrals from mainstream services to community-based healing initiatives escalate and healing teams may be inundated with requests to share promising practices.

Figure 2: Community Healing Journey


increased organizational & leadership support
increased partnerships
increased capacity to facilitate healing
suicide
family violence
addiction
despair
the journey begins
gathering momentum
Hitting the wall
Vision
Transformation
reduced rates of
physical & sexual abuse,
children in care,
suicide & incarceration,
reconciliation
Healthy individuals
vibrant community
increased awareness of Legacy
increased personal healing
increased # of individuals engaged in healing

[Source: Aboriginal Healing Foundation]

Stage three, described in *Mapping the Healing Journey* (Lane Jr et al., 2002) and validated in project reports, is called ‘hitting the wall.’ Visible progress has been made but momentum is beginning to stall. Hope and excitement evident in the second stage has dulled and frontline workers are beginning to burn out. While more adults are pursuing healthy lifestyles more participants are approaching projects for help with violence, life-threatening addictions and suicidal tendencies. Previously undisclosed abuses such as gambling, prescription drug use or youth crime may be revealed in the community.

Achieving the transformation envisaged in stage four, where healthy individuals are functioning in a vibrant community, will require sustained energy and resources and integration of healing with other dimensions of community development including employment and economic opportunity. Two-thirds of respondents in the 2004 survey credited AHF-supported projects with moderate or entire influence on enhancing mutual support systems, access to healing services, tools to teach and learn about the Legacy of residential schools and collaboration between helping agencies. Perceptions of reduced risk to children were more variable but approached statistical significance.

Healing the Legacy of residential schooling, whether at the individual or community level, is not a linear process. The stages identified above are only approximate models of complex real-life events. Survivors progress and then circle back on earlier stages when confronted with recurrent challenges. Community change was described as ‘like ripples unfolding in a pool, where each new circle contains the previous one’ (Lane Jr et al., 2002, 63).

Implications for Mental Health Services

The axiom has often been repeated that resolution of resistant social problems in Aboriginal communities must come from the people themselves. Research detailed in the *Final Report of the Aboriginal Healing Foundation* begins to map the ground of healing from the Legacy of residential schooling (Aboriginal Healing Foundation, 2006: 1:151-173). Conclusions are formative, based on self-reports from community projects and participants and point-of-time rather than longitudinal data. On the positive side, survey responses were obtained from close to two-thirds of the organizations receiving funding, including a cross-section of every region, type of project, community size and Aboriginal sub-group, and data from multiple sources was triangulated.

Some of the most significant findings presented in the AHF *Final Report* are summarized here.

1. *Culture is good medicine.* Individuals who had previously resisted interventions responded to culture-based outreach. Healing facilitated by residential school Survivors who had started on their healing journey, leadership of local personnel including Elders, use of Aboriginal languages, and spaces displaying cultural images and symbols helped to create a climate of safety. In such a climate, responsiveness to western therapies, adapted to the community context, also increased.

2. *Spiritual healing, involving community-specific features, is a critical element in reclaiming wellness.* Sometimes, for some people, spiritual healing is a mystical awakening that happens in a ceremonial setting, but it happens also in many ordinary ways. For residential school Survivors who were forcibly divested of their language, recovering their language was a profoundly healing experience. One participant exclaimed: “In residential school we were punished for speaking our language; now we are rewarded for it. It’s like residential school backwards!” For Inuit, going out on the land and engaging in traditional survival and harvesting activities was often key to healing. In Métis projects people researched their history and found that making contact with their relations was transforming. Women who had been isolated sat in a quilting circle and shared stories that opened up new awareness of themselves, their past and their common experiences. Fathers came reluctantly to parenting workshops and discovered how awesome it can be to look at the world through the eyes of a child. Sharing circles and healing circles facilitated by Elders and residential school Survivors created bonds of trust and mutual care. Looking for common threads in the healing that people referred to as “spiritual”, it seems that they were talking in different ways of making a connection to something greater than themselves and their individual griefs. The experience that *I am a part of it* was triggered in multiple ways, connecting with the natural world, the stream of history, family and

community, or in some cases, with a spiritual Being who is friendly. In different contexts any of those experiences could be pivotal in awakening an internal awareness of Being that was liberating, that touched people and created the sense: *I am alive and I can do something with this life.*

3. *It takes time to heal.* In virtually all projects the initial phase of outreach to dismantle denial had to be traversed, either at the outset or circling back after a therapeutic initiative had been launched. Because of the lead time required to develop trust in individuals and communities and the additional time necessary to consolidate learning and change, the AHF proposes that interventions should be supported over a ten-year span. Only a fraction of AHF-funded projects extended to 60 months Sixty-six per cent of projects surveyed in 2004 reported that they had accomplished a few goals but much work remained as AHF support was winding down.

4. *Community healing must complement individual healing.* The healing needs uncovered in the course of the AHF's work make it clear that one-on-one therapies delivered by mental health professionals are by themselves inadequate to respond to the pervasiveness and depth of trauma that continues to reverberate in Aboriginal communities. Because of the diversity of community characteristics local involvement in identifying needs and strengths is essential.

5. *Community capacity already exists in varying degrees.* Even in the most troubled communities a core of individuals who are working on their own healing can be found. Programs intended to build community capacity do not need to begin from ground zero. Locating sources of strength requires flexibility and time to build trust between potential animators and program personnel. Exchange of experience between communities through regional gatherings or user-friendly communications media is an effective means of stimulating involvement.

6. *Service infrastructure and continuity are necessary to consolidate individual healing and assist communities who are 'hitting the wall' in their healing journey.* Projects emerging from community initiatives typically operate on the margins of core and professional services and are of limited duration. The AHF encouraged collaboration with existing

services and funding that flowed to the community helped to promote partnerships where the leadership and expertise of community personnel were respected.

7. *As individuals and communities heal, the depth and complexity of needs become evident, generating demand for training.* We are learning about ways of healing from deep-seated trauma, ways of restoring the bonds of ethical community that provide an anchor for individual and collective well-being. It is important to note that community-driven, locally staffed healing initiatives did not create a cultural ghetto to pursue their healing goals. Fully 60% of projects reached out to engage western therapies and professionals, in equitable, respectful partnerships. Project personnel regularly identified a need to acquire training to deal with complex needs uncovered by culture-based interventions.

8. *Community personnel are ready to make a strong commitment to research to improve effectiveness of services.* Collaborative research undertaken by the AHF, applying professional standards of evaluation, elicited an extraordinary level of response. Hundreds of communities have demonstrated readiness to pursue longitudinal evaluation and further development of promising practices through research and training.

Toward Evidence-Based Policy

Empirical evidence assembled by the AHF indicates that services utilizing local capacity and Indigenous knowledge are effective and that such approaches also deliver significant economies (Native Counselling Service of Alberta, 2001). The administrative record of the Aboriginal Healing Foundation from 1998 to 2005 as detailed in the *Final Report* and summarized in a companion article (DeGagné, 2008) provides evidence that cultural fit between the services of a nation-wide Aboriginal institution and the diverse environments of Aboriginal communities can be achieved while concurrently meeting high standards of public accountability.

The approach to Aboriginal healing services endorsed by the Aboriginal Healing Foundation in practice and its *Final Report* is not new. The Royal Commission on Aboriginal Peoples in *Choosing Life, a special report on suicide among Aboriginal People* (1995) recommended setting a national priority on suicide prevention supporting community-led action. Further recommendations on integrating currently fragmented services were elaborated in *Gathering Strength*, Volume 3 of the *Report of the Royal Commission on Aboriginal Peoples* (1996).

The Mental Health Working Group of Health Canada, the Assembly of First Nations and Inuit Tapirisat of Canada in 2001 prepared a Comprehensive Culturally Appropriate Mental Wellness Framework that placed natural caregivers in the individual's immediate environment as the first line of support, followed by community-based wellness services and, as needed, specialized services (The framework is reproduced in: Aboriginal Healing Foundation, 2006, Appendix Q).

Out of the Shadows at Last, (The Standing Senate Committee on Social Affairs, Science and Technology, 2006) a Senate committee report on mental health, mental illness and addiction, recommended resolving jurisdictional questions that impede the development of sustained and coordinated services targeted to the varied sectors of the Aboriginal community. In line with general recommendations in the Senate committee report, community involvement in the development and delivery of services was endorsed, along with clear targets and regular reporting within a wellness framework. Independent community comment on the impacts of Aboriginal Healing Foundation project support was noted and renewal of the AHF mandate was recommended.

The evidence exists on which to establish policy parameters for a strategic, high priority mental wellness strategy serving Aboriginal people. Community engagement in promoting wellness has been stimulated through hundreds of projects supported by the Aboriginal Healing Foundation. The time has come to make the transition from short-term, fragmented, demonstration projects to sustainable, community-led programs supported by evidence-based policy.

Acknowledgements

While this article is attributed to a single author it is very much a collective effort. The research and analysis and often the form of expression contained herein are derived from the *Final Report of the Aboriginal Healing Foundation* (2006). The vision and leadership of the AHF Board, the sustained contribution of AHF staff, especially the late Gail Valaskakis, Director of Research, and the contribution of co-authors of the *Final Report*, Kim Scott (Volume 2: *Measuring Progress: Program Evaluation*) and Linda Archibald (Volume 3: *Promising Healing Practices in Aboriginal Communities*) are gratefully acknowledged

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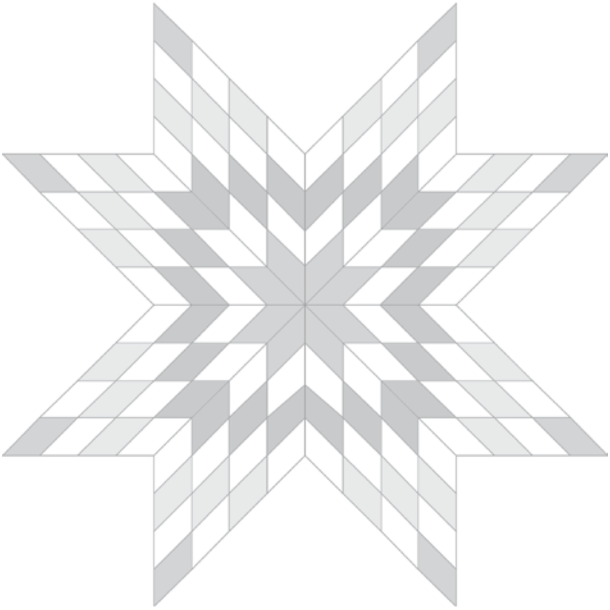

Residential Schools: The Intergenerational Impacts on Aboriginal Peoples

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Abstract

Many authors, historians and researchers concur with the idea that residential schools have impacted generation after generation of Aboriginal Peoples in this country. In the late nineteenth and early twentieth centuries, the federal government wanted Aboriginal peoples to abandon their traditional beliefs and adopt western-based values and religions. The investigation of the role and impacts of residential schools on Aboriginal traditional knowledge and mental, emotional, physical and spiritual well-being must be studied within the context of colonization and genocide. Residential schools were funded by the federal government, but were operated by various religious institutions. The goal of residential schools was institutionalized assimilation by stripping Aboriginal peoples of their language, culture and connection with family. Although the assaults on the first peoples of this land have been devastating and intergenerational, as discussed within this article, it is with pride that we celebrate the resilience and tenacity of the holistic well-being of Aboriginal peoples. We are still here.

Introduction

> What people didn't understand is that those boarding (residential) school terrorists thought that it (culture) could disappear in a generation, and they would have white thinking children. They couldn't erase it, and therein lies the hope. Right there. And when that spirit is reawakened it is more powerful than anything that I have ever met in my whole life. I am impressed with the strength of culture. Even though the missionaries tried, the boarding (residential) schools tried, all the well-intentioned little white people tried . . . But something hasn't died (Cleary & Peacock, 1998, p.102).

Boozhoo; Aanii; Sago; Wachiya; *Bonjour;* Greetings. *Baybaamoosay-Kwe n'dishnakaz*. My Anishinaabe name is Woman Who Leaves Healing Tracks. *Migiizii n'dodem*. I belong to the Eagle Clan. *Wasauksing n'donjibaa*. I am from Wasauksing First Nation. *Anishnaabe miinwaa Pottawatomi n'dow.* I am of Ojibwe and Pottawatomi descent. *N'winiishoo Midewiwin Kwe.* I am a Second-Degree Midewiwin woman. I am a daughter, sister, partner, mother, auntie, grandmother, and great-grandmother. I am the daughter of a residential school survivor. I (as well as my family), have been directly affected by the Residential School Syndrome.

> Residential schools had a specific goal which was . . . institutionalized assimilation by stripping Aboriginal people of their language, culture and connection with family. the results for many, have included a lifestyle of uncertain identity and the adoption of self-abusive behaviours, often associated with alcohol and violence, reflect a pattern of coping sometimes referred to in First Nations as, "The Residential School Syndrome" (McKenzie & Morrissette, 2003, p.254).

I was robbed of my Mother tongue, "*Anishinaabamowin*," by the residential schools and all that they represented. I am a statistic of what is known as one of the intergenerational impacts of those infamous 'schools'. My father attended two residential schools in northern Ontario, far from Wasauksing First Nation. He and two of his brothers were incarcerated in Chapleau, and later at Shingwauk Residential School. One of his brothers died while at Chapleau residential school. I cannot imagine the impact his death had on the two little boys who were left. They were hundreds of miles from home, with no one to comfort them in their loss. This is a thumb-nail sketch of my personal history, but my blood memory goes way back.

> Eddie Benton-Banai, a Midewiwin Elder stated that, “We the Anishinaabe people have a history that goes back 50,000 years on this continent, which is now known as North America, but which has been always known to us as Turtle Island. And 50,000 years is a long, long time (Peacock & Wisuri, 2002, p.16).”

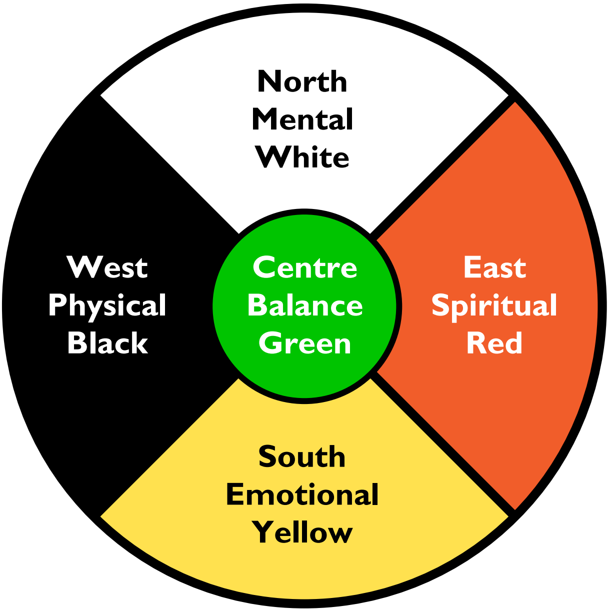
It is my intention to demonstrate how the Aboriginal / Indigenous learning systems operated prior to contact with the colonizers, how they operated during contact with the colonizers, how they operate at the present time and how we hope to see them operate for the next Seven Generations. It is also my intention to include my story in the research on Aboriginal / Indigenous learning systems. I have the right to locate myself ‘within’, because *I am Aboriginal*, and this is my story.

The purpose of this article is to explore the relationship of residential schools and their intergenerational impacts on Aboriginal Peoples and their mental, emotional, physical and spiritual well-being. This paper is organized into four sections. The Medicine Wheel paradigm will be utilized to explain each section and to place the reader into the reality of the world-view of this Anishinaabe-Kwe (Ojibwe woman) writer. (See Figure 1, pg 36)

Starting in the Eastern Doorway, from which direction is the beginning of all things, contextual information on Aboriginal learning systems prior to colonization will be briefly outlined. Aboriginal cultures have their own knowledge systems and means of knowledge transmission. There are many common characteristics of Aboriginal / Indigenous peoples worldwide regarding their means of transmitting their knowledge.

The second section will be represented by the Southern Doorway which is where relationships are formed. The colonization process took place at this time. This particular *time* period represents centuries and the development of the colonizer – colonized *relationship*. The process of colonization will be briefly outlined and the implementation of residential schools will be discussed. Aboriginal populations were tremendously impacted by residential schools (Adams, 1999; Chrisjohn & Young, 1997; Toulouse, 2006). The acquisition of our traditional knowledge was effectively halted at this time.

Figure 1: Medicine Wheel


North
Mental
White
West
Physical
Black
Centre
Balance
Green
East
Spiritual
Red
South
Emotional
Yellow

LEGEND
East – Birth, Vision, Renewal
South – Relationships, Time
West – Respect, Reflection
North – Movement, Action, Caring
Centre – Balance, Healing

(Nabigon, 1993, pp. 141-143)

The third section will be represented by the Western Doorway and will outline where Aboriginal peoples are located in relation to centuries of colonization and the generations of children who were incarcerated in residential schools. *Respect* is a fundamental aspect of this direction. Aboriginal peoples were not acknowledged or respected for their thousands of years of accumulated knowledge of their environment (Cajete, 1999; Peacock & Wisuri, 2002). The Aboriginal peoples of this land are *reflecting, remembering, revitalizing* and *reclaiming* their knowledge, their traditions, their culture and their identities during this period of decolonization (Assembly of First Nations, 1994).

The fourth section will be represented by the Northern Doorway and will demonstrate how *action, movement* and *caring* have assured the survival of Aboriginal peoples. Now that Aboriginal peoples are healing from the centuries of oppression, there is a dedication to the maintenance and transmission of traditional knowledge to the next Seven Generations of all our relations (Cajete, 1999; James, 2001; Smith, 1999).

The Eastern Doorway

All life begins in this doorway, we come into this earth-plane from this direction. Whether we begin a project, a paper or our life - this is where we start. (Nabigon, 1993; Nabigon, 2006) Figure 1 depicts the Medicine Wheel Teachings and the diagram is quite self-explanatory. I would like to expand on these teachings by adding many of the gifts which we were given by Gchi-Manido (Creator / Great Spirit). The list of these gifts is not exhaustive, but will help the reader to understand the Aboriginal world-view with a little more clarity. The Gifts of the East are: *light; beginnings; renewal; innocence; guilelessness; capacity to believe in the unseen; warmth of spirit; purity; trust; hope; uncritical acceptance of others; birth; rebirth; illumination; seeing situations in perspective; ability to see clearly through complex situations; leadership;* etc. (Bopp, Bopp, Brown, & Lane Jr., 1984, p. 72).

The circle, more than any other symbol, is most expressive of the Aboriginal world-view. It is, in essence, the first design Gchi-Manido drew on the darkness of the universe before creation began. It has, since that initiative, been the primary pattern by which all things begin, have being, change, and grows toward fulfillment and eventually begins again. Within creation, all life maintains and operates within this circular and cyclical pattern. The circle then is primal to all of life and process and is also of primary significance in relating to and understanding life itself in all its dimensions and diversity. Human beings, amongst other related beings, are in harmony with the life flow and grow to their greatest fulfillment when they too operate in a circular fashion, thereby strengthening the circle (Dumont, 1989, p. 48). Black Elk's famous soliloquy expresses this concept in a powerful way:

> Everything an Indian does is in a circle, because the power of the world always works in a circle, and everything tries to be round. The sky is round, and the earth is round like a ball, and so are all the stars. The wind, in its greatest power, whirls. Birds make their nests in circles, for their religion is the same as ours. The sun comes forth and goes down again in a circle. The moon does the same, and both are round. Even the seasons form a great circle in their changing, and always come back again to where they were. The life of a man is a circle from childhood to childhood, and so it is in everything where power moves (Neihardt, 1988).

The circle, being primary, influences how we as Aboriginal peoples view the world. In the process of how life evolves, how the natural world grows and works together, how all things are connected, and how all things move toward their destiny. Aboriginal peoples see and respond to the world in a circular fashion and are influenced by the examples of the circles of creation in our environment (Dumont 1989, p. 48).

From time immemorial, until the invasion of the ones who are now dominant, Aboriginal peoples lived their traditional cultural way and were in balance and harmony with the natural environment (Cajete, 1994; Cajete, 1999; Dumont, 1989; James, 2001; Johnston, 1988; McKenzie & Morrissette, 2003). Huntley (1998) says that, "Aboriginal pedagogy, our own world-view and teachings, served the needs of Aboriginal peoples for thousands of years before the arrival of a new and dominant pedagogy". Our belief systems reflected our unique understanding and perception of our place in the world. From our understanding of creation, we personified the forces of nature into such beings as the Creator, Mother

Earth, Grandmother Moon and elder brother Sun. The relationship to all things in creation is understood to be one of kinship (Antone, Miller, & Myers, 1986; Deloria, 1997; Dumont, 1989). The teachings tell us that the plants and animals are our elder brothers and that we can learn much from them if we listen and observe (Cajete, 1999; Dumont, 1989; Peacock & Wisuri, 2002).

Representations and Understandings

An exploration of the ways in which our cultures symbolically or concretely represented our understanding of nature in our arts, oral traditions, ecological practices, medicine, social organizations, and philosophy will be briefly discussed.

Historical Context

In more traditional times, older family members taught the history of their families, including their origins, family formations, how they were raised and prepared for adult life, how they made a living, their celebrations, their achievements and failures, and their hopes and dreams (Deloria, 1997; Huntley, 1998; Graveline, 2002; Mussell, Nicholls & Adler, 1991).

As other Aboriginal / Indigenous peoples, we sought fundamental truths and an understanding about our place in the cosmos. The genesis of an Aboriginal world-view emerged from a close relationship with the environment.

> A world-view can be defined as a set of related ideas or views to which members of a distinct culture subscribe. World-views represent religious, political, social and physical information about people and the societies they create. Once accepted, a world-view becomes a 'recognized reality' that serves to socialize its citizens and to create a political culture. A particular world-view is transferred to citizens through institutions such as the family, teachings, and religion; in that process, particular values, attitudes, beliefs, and opinions are adopted. Although specific beliefs and practices vary among different groups of Aboriginal

> people, it has been demonstrated that several common traditional values exist (McKenzie & Morrissette, 2003, p. 258).

Babies spent much of the first two years of their lives in a *dikinagan* (cradleboard), where they learned the important life skills of observation and listening (Peacock & Wisuri, 2002, p. 71). They watched life flow around them and were able to absorb almost by osmosis the daily routine of the members of their dwelling. At that particular time in our history, much of the daily routine took place outdoors, especially during the summer months. Women of the community had water to haul, berries to pick, hides to tan, cooking to do, children to watch and all the while socializing. Men of the community went hunting, taught boys and youth the art of weapon-making, ensured that their community was safe and they also socialized among themselves. During the time when Mother Earth was resting under a blanket of snow, there were clothes to make and repair, snares to check, cooking to be done, and in the evenings, stories to be told.

> As their parents worked, little Ojibwe children would watch the dance of life around them – the play of light and shadow, the movement of grasses, the sparkle of sun through branches, and the habits of people and animals. As young children they honed their skill of observation. This traditional attribute served the Ojibwe well as hunters and gatherers, as warriors, and as keen observers of the subtlety and nuances of both human and animal behaviour. Moreover, as the young witnessed the goings on of life from their dikinagan, they also learned the art of listening. All around them were the sounds of life, the chatter of squirrels, the whisper of grasses, the songs of wind through trees, and the inflection of voice in their parents, grandmothers and grandfathers, and aunties (Peacock & Wisuri, 1992, p. 71).

The skills of listening and observing are traits which are still prized by Aboriginal peoples. These inherent skills ensure the effectiveness of Aboriginal social workers. Personal Note: I am a social worker by profession and have always found that my listening skills are of the utmost importance when working with clients of any age. Listening means using every fibre of my being, not only my ears.

Cultural & Social Context

Cultural values and beliefs should transcend time and contribute to the uniqueness of a people (Antone, Miller & Myers, 1986; Dumont, 1989; Fournier & Crey, 1997; Graveline, 2002; Peacock & Wisuri, 2002). Antone et al (1986) state that, "Holistically, culture should be viewed as a living dynamic composed of all the social institutions that ensure the transference of beliefs, values, language, and traditions."

One of the traditional ways of transference was role modeling. Adults had to model their behaviour to young people, thereby passing down the traditions through the generations. When my great-grandmother used to make scone / bannock, she would always make sure I was right there beside her on a little stool. She would give me the opportunity to get my chubby little fists in there to knead the dough. When someone would ask, "Who made the scone? It's so good." I would always pipe up, "I did," and my Gchi-Nookomis (Great Grandmother) would always smile and nod in agreement. This is something that has stayed with me to this day, the pride and empowerment that were my family's gift to me when I was a very young child.

Storytelling was another important way of transmitting knowledge from one generation to the next. Cajete (1999) eloquently talks about this method in this way.

> In the telling of stories, the content of myth and everyday reality are integrated within the content of the learner. Stories kept listeners aware of the interrelatedness of all things, the nature of plants and animals, the earth, history, and people's responsibilities to each other and the world around them. Storytelling, like myth, always presented a holistic perspective, for the ultimate purpose is to show the connection between things (p. 131).

Storytelling fulfilled a vital role in the continuity of not only the tribal culture, but of the mindset concerning people's relationship to the natural world. In this respect, the storyteller was the philosopher-teacher of tribal knowledge (Cajete, 1994; Cajete, 2000; Deloria, 1997; Dumont, 1989; Mussell et al, 1991; Peacock & Wisuri, 2002; Rice, 2005; Toulouse, 2006). Traditionally, the transmission of knowledge occurred in a holistic social context that developed the importance of each individual as a contributing member of the social group.

Storytelling was an educational process that unfolded through mutual, reciprocal relationships between one's social group and the natural world. Spirituality was intertwined and interwoven within everyday life (Toulouse, 2006). Aboriginal people were raised in an environment characterized by respect, and as such, they learned to value their lives and the lives of other creations of Gchi-Manido (Creator). Personal Note: My maternal Grandfather was a great story-teller. He could tell stories about long ago happenings and make them come alive in the present. He would describe what the participants were wearing, how they looked, how they sounded and then he would describe the surroundings in detail. He would paint a picture that you could actually see in your mind's eye, then he would explain exactly how the person wasn't watching where they were going and fell off the dock into the water! He would laugh and you would laugh because it was so funny! But there was a seriousness to the story when you thought about it – he would be telling you how to behave around the water and to always be aware of your surroundings.

Aboriginal people had a sense of connectedness with everything in their universe; other people, the plants, the animals, the rocks, the water, the stars, the moon, the sun and their accompanying spirits. Through song, dance, prayer, ceremony, and other processes of sharing, all were honoured and respected (Cajete, 1999; Cajete, 2000: Dumont, 1989; Mussell et al, 1991; Peacock & Wisuri, 2002). Cajete (1999), reiterates that the ultimate purpose of story-telling was to show the connection between things and;

> Stories told about creativity – about how things came to be; they explained the what, why, and how of important phenomena; they related the myth behind the ritual; they described the way of healing, health, and wholeness; they presented practical information about how things are done and why; they illustrated and illuminated the universal truths and characteristics of human life. In all these dimensions, stories were rooted in experience and provided an intimate reflection of that experience. They were a

> way of retracing important steps in life's way and of developing an affective perspective of themselves, their people, and their world (p.131).

The transmission of knowledge in pre-contact times was through storytelling, through song, through dance, through prayer and through ceremony. Ceremonies were held throughout the year and there were ceremonies for many different community events, (e.g. Births, Namings, Deaths, Healings, etc.) as well as seasonal ceremonies (e.g. Spring, Summer, Fall & Winter Ceremonies), to celebrate the changing seasons and the gifts of each season.

In many traditional Aboriginal cultures dancing was important in grand ceremonials. Dances had many different purposes; healing and curing, celebrating animal and other natural spirits, renewal and thanksgiving, birth and marriage, greeting, joy and mourning, even clowning. Dancing is also a way to get in touch with the Spirit World (Reed, 1999, p. 24).

Our Ojibwe ancestors used a form of the written language to record history and spiritual teachings on rocks, song sticks, birch bark (scrolls), wood, hides, wampum strings and belts (sometimes made of sea-shells). These were preserved and passed down through the generations (Cajete, 1999; Dumont, 1989; Peacock & Wisuri, 2002). Our ancestors knew the importance of our interrelationships as brothers and sisters to everything animate and inanimate and their accompanying spirits (Toulouse, 2006). We used to communicate with the animals through dreams and thoughts. Many times the animals gave up their lives in order to give us life. They would reveal their location so that we would find them while hunting. Thanks were given to Gchi-Manido and the spirits of the dead game, in the form of offerings and prayers for having shared themselves with us (Dumont, 1989; Peacock & Wisuri, 2002).

Our responsibilities were handed down through the generations. We know this through "concrete" ways, such as our sacred scrolls, pictographs, and other tangibles as well as through "knowing" without question, through our ancestral memories and our dreams. Dreams are reality to Aboriginal peoples. We learn much knowledge about medicines, songs and also about our history through dreams. We are taught to take the knowledge that comes to us through dreams and use it, so it does not get lost.

Traditional stories, legends, songs, history, and all other forms of knowledge were passed on from one generation to another by constant retelling. A wide range of songs, chants, and prayers were also kept as parts of ceremonies practiced for centuries. Spiritual leaders, Elders, members of dance and Medicine societies and others kept the knowledge of these spoken forms in their memories (Reed, 1999, p. 30). This is what we know about how we lived pre-contact. Our contact with the Spirit World also tells us how things were at that time. The means of contact are through the Vision Quest, Fasting, Sweat Lodge Ceremonies and other ceremonies.

One of the teachings that were passed down from our relatives talks about our knowledge of the coming of the light-skinned race. It was prophesied by one of our old ones, whose great sanctity and oft-repeated fasts enabled him to commune with spirits and see far into the future (Dumont, 1989; Peacock & Wisuri, 2002). They came to this land and they changed the land, the water, the air, the environment and they tried to change the people.

The Southern Doorway

As we travel further around the framework of the Medicine Wheel, we arrive at the southern doorway, where contact with the invaders was made. This period of time will cover centuries of the relationship between the Aboriginal people who were occupying their own land and the non-Aboriginal people who came to their land. It will be helpful to refer back to the Medicine Wheel on page 4 to orient yourself regarding location. Again I wish to share with the reader some gifts of the South, which were given to us by Gchi-Manido. They include; *youth, generosity, sensitivity to the feelings of others, loyalty, noble passions, love, determination, passionate involvement in the world, emotional attraction to good and repulsion to bad, kindness, anger at injustice,* etc. (Bopp et al, 1985). Aboriginal / Indigenous languages contain generations of wisdom going back into time immemorial. Our languages contain a significant part of the world's knowledge and wisdom (Cajete, 1999; Cleary & Peacock, 1998;

Dumont, 1989; Huntley, 1998; Peacock & Wisuri, 2002; Smith, 1999). Language and culture are intricately intertwined, and one question which has gone around for awhile now is; if you do not know the language, can you really understand all the subtleties, nuances, and deeper meanings of culture? Further to that is, if the language dies, does the culture die too?

Historical Context

Contact with Europeans had a profound impact on Aboriginal peoples and their cultures. Diseases such as smallpox wiped out a large part of the original population. The loss in population weakened Aboriginal communities and undermined their cultures. (Reed, 1999, p. 8) The long history of contact between Europeans and Aboriginal peoples started out as mainly friendly. They were allies and trading partners. The early explorers needed the Aboriginal peoples to show them how live in the harsh environment. Aboriginal peoples helped Cartier's men survive their first winter in what is now Quebec. European powers realized the importance of the support they received from the Aboriginal peoples, especially in regard to their struggles to win political control of North America. The English for example, allied themselves with the Haudenosaunee (Iroquois) Confederacy against the French (Adams, 1999; Dumont, 1989; McMillan, 1995; Reed, 1999). Competition for furs due to government policies created a new element of instability in relations among Aboriginal people. While there were conflicts before the Europeans arrived, they were not generally widespread or destructive. The introduction of muskets and rifles increased the competition and the bloodiness of some conflicts. The ever increasing pressure of Canadian settlement and government policies under the Indian Act of 1876 forced some Aboriginal peoples out of their traditional territories.

"The imposition of a colonial framework on Canadian – Aboriginal relations has had powerful, negative effects on Aboriginal peoples over nearly four hundred years of contact" (McKenzie & Morrissette, 2003, p. 254). The schooling of Aboriginal children came under colonial control in 1867, with the British North America Act. In 1876, colonial control was further consolidated and centralized by the Indian Act. Over the years, one outcome of the Indian Act was the development of "Indian education policy," which included policies of assimilation, segregation, and integration, and the adoption of a residential school model for implementation of these policies (Assembly of First Nations, 1994; Brizinski, 1989; Miller, 1994; Reed, 1999; Royal Commission on Aboriginal Peoples, 1996).

There were three eras during which colonizers tried different tactics to 'educate' Aboriginal peoples of this land. Prior to the mid-1800's, the majority of Aboriginal children who were "schooled" attended "mission" schools located nearby their own communities.

Assimilation (1850 – 1909)

The federal government commissioned a report on the schooling of Aboriginal children. The Davin Report of 1879 recommended the adoption of the American model of residential schools with an added provision. Canadian residential schools were to be operated by various Christian denominations, since they already had missionaries who were committed to "Christianize and civilize" Aboriginal peoples. Thus the formalization of the policy of assimilation was systematically and all-encompassing and implemented between "church and state" (Barman, Hebert & McCaskill, 1986; Dickason, 1992). "Boarding schools and industrial schools were the preferred means of assimilation because they were more effective in separating and isolating Native children from the influence of the traditional culture" (Dawson, 1988). During this time, "Many traditional Indian dances and ceremonies – recognized as a vital element in the Native culture and spiritual identity – were outlawed as a result of amendments to the Indian Act in 1884 and 1885 (York, 1990)." These schools were generally located quite a distance from Aboriginal communities. Personal Note: A Cree friend of mine who is from a Cree Nation in Quebec was sent to residential school in Sault Ste. Marie, Ontario, where the majority of the inmates were Ojibwe. She was with other Aboriginal children, but they could not understand each other!

Segregation (1910 – 1950)

By the early 1900's, it was obvious that the policy of assimilation was not working. It was discovered that Aboriginal peoples who came out of the residential schools did not fit into their own communities or into the Euro-Canadian communities. By this time there had been a severe drop in the Aboriginal population due to disease and starvation. However, there was an increase in immigration which was able to meet Canada’s labour force. This resulted in a re-evaluation of the policy of assimilation, which caused a policy shift towards isolation or segregation of Aboriginal peoples (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Miller, 1990).

The purpose of the new segregationist policy of residential schools was to prepare Aboriginal children for adult life in their original communities. During this period, basic literacy through to grade 8 was provided. The ‘academic’ curricula taught was severely inferior to what was taught in Euro-Canadian institutions. In 1920, an amendment to the Indian Act made school attendance compulsory for all Aboriginal children between the ages of seven and fifteen, which meant that children were forcibly removed from their homes to attend residential schools (Assembly of First Nations, 1994; Barman et al., 1986; Chrisjohn, 1997; Miller, 1990). Personal Note: What is not mentioned in the books is that children as young as three and four years old were taken and placed in residential schools. My father was one.

Integration (1951 – 1972)

In the years following World War II, the government revisited its role regarding control of education policy and residential schools. In 1951, a further series of amendments to the Indian Act shifted policy from segregation to integration. Where possible, Aboriginal children were absorbed into mainstream schools; some Aboriginal communities which were isolated, children still attended residential schools. By 1954, the teachers at residential schools were employees of the federal government and academic curricula were similar to that of mainstream schools (Assembly of First Nations, 1994; Barman et al., 1986; Chrisjohn & Young, 1997; Miller, 1990). Personal Note: There was a school on my First Nation, called Ryerson Indian Day School. My Mother was fortunate as she was able to attend this school and stay on the reserve with her family. The school was run in a similar vein as residential schools – the children were punished for speaking their language. She remembers this well, as she did not know any English when she began school. I also attended Ryerson Indian Day School.

During the early 1970’s, Aboriginal peoples through the National Indian Brotherhood of Canada, were calling for the end to federal control of Aboriginal schooling.

Cultural and Social Context

In the late 19th and early 20th centuries, the federal government wanted Aboriginal peoples to abandon their traditional beliefs and adopt Christian and 'democratic' values. One example of a ceremony which was banned from being practiced was the potlatch. The potlatch was an important cultural and spiritual practice among the West Coast Aboriginal peoples. Chiefs used potlatches to name children, to announce an important marriage, to transfer titles and privileges from father to son, and to mourn the dead. The Chief and his family enhanced their honour and status at the potlatch by reciting their family history and by giving away valuable gifts. This ceremony showed their wealth, and guests who accepted the goods showed they agreed to the honours being claimed. The potlatch also served an economic function by redistributing wealth. The non-Aboriginal peoples did not see or could not see the value of the ceremony, and so the potlatch was banned in 1884 by the federal government (Reed, 1999).

The investigation of the role and impacts of residential schools on Aboriginal traditional knowledge must be studied within the wider context of colonization and genocide. One may say that by either design or default, the various mechanisms used by the invaders to try to conquer the Aboriginal peoples worked synergistically. Some of these mechanisms were pre-cursors to others, while others worked interrelatedly.

> Residential Schools were one of many attempts at the genocide of the Aboriginal Peoples including the area now commonly called Canada. Initially, the goal of obliterating these peoples was connected with stealing what they owned (the land, the sky, the waters, and their lives, and all that these encompassed); and although this connection persists, present-day acts and policies of genocide are also connected with the hypocritical, legal, and self-delusional need on the part of the perpetrators to conceal what they did and what they continue to do. A variety of rationalizations (social, legal, religious, political, and economic) arose to engage (in one way or another) all segments of Euro-Canadian society in the task of genocide. For example, some were told that their actions arose out of a Missionary Imperative to bring the benefits of the One True Belief to savage pagans; others con-

> sidered themselves justified in land theft by declaring that the Aboriginal Peoples were not putting the land to "proper" use; and so on. The creation of Indian Residential Schools followed a time-tested method of obliterating indigenous cultures, and the psychosocial consequences these schools would have on Aboriginal Peoples were well understood at the time of their formation (Chrisjohn & Young, 1997, pp. 3-4).

Residential schools were funded by the federal government, but were operated by the Catholic, Anglican, Presbyterian, and United churches. The goal of residential schools was institutionalized assimilation by stripping Aboriginal peoples of their language, culture, and connection with family (Chrisjohn & Young, 1997; McKenzie & Morrissette, 2003; Reed, 1999; Toulouse, 2006). Aboriginal children were removed from their homes and lived in the residential schools, where many were abused spiritually, emotionally, physically and mentally. They were forced to pray to an entity which whom they had no connection. The goal of the missionaries who taught at the schools was to convert the children to Christianity. Children were often severely punished for practicing traditional spiritual beliefs (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Reed, 1999).

Life at the schools was often harsh and rules were strict. Much of the day was spent in Christian religious instruction, learning English or French, and doing chores. Girls looked after the laundry, kitchen work, and learned other 'practical' skills, such as cooking and sewing. Boys did the outside work, such as cutting wood, learning to farm, looking after the animals, and learned trade skills such as carpentry and blacksmithing. The schools typically spent less than two hours per day on academic subjects. When the students did leave the residential schools they were ill-prepared for life outside the schools (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Reed, 1999).

The residential schools were regimented and strict. Aboriginal children were rudely awakened by ringing bells, they went to breakfast, lunch and dinner when the bell rang, they went to chapel when the bell rang, the lights were turned out when the bell rang, they changed classes when the bell rang, etc. "They lived by the bell" and they lined up and marched single file everywhere. Even when they had outings, they were very visible to the mainstream communities because they were all dressed the same, their hair was cut the same, and they marched along as if they were in the militia. When they marched through town, children and adults would point at them and laugh at them. One can't imagine what that did to their inner selves. When they were released from residential school, they had become dependant upon the regimentation and could not function on their own, they had become "institutionalized." Children lost their spontaneity, their joy for living, their independence, their self-esteem, and their problem-solving skills (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Miller, 1996; Royal Commission on Aboriginal Peoples, 1996).

The residential schools with their regimentation and bells taught Aboriginal children that time is important. Their days were broken up and compartmentalized into increments of minutes and hours. They were taught that everything happens at a certain time and that failure to abide by that would result in certain punishment. Aboriginal children had lived by the natural cycles of the days, months, seasons and years and now they were told that their traditional ways were wasteful and that their families were lazy (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Miller, 1996; Royal Commission on Aboriginal Peoples, 1996).

The residential schools taught English or French. Aboriginal children had to learn these foreign languages or else. They were forbidden to speak their Aboriginal languages, under threat of corporal punishment. Their self-esteem was undermined when they were told that their languages were primitive. Many children forgot their languages and adopted the language of the dominant society. With the loss of language came the loss of the ability to communicate with their parents, extended family and Elders back home (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Miller, 1996; Royal Commission on Aboriginal Peoples, 1996).

The residential schools taught Christianity. Aboriginal children had to learn to pray while kneeling on the cold, hard floor of the chapel, with hands clasped and eyes closed. They had to pay homage to a god who would punish them if they were disobedient, who would send them to burn in hell and who had to be sung to on a certain day of the week. Aboriginal children were mystified by the behaviour that they had to emulate, but they had no choice, they would be corporally punished if they did not do as they were told. Aboriginal peoples and spirituality were intricately intertwined and interconnected. One could pray to Gchi-Manito whenever and wherever one wished, we did not have to do it on a special day at a special time. To Aboriginal peoples, every single day that we walk on this earth plane is special. This connectedness and relationship with our natural environment was lost (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Miller, 1996; Royal Commission on Aboriginal Peoples, 1996).

The residential schools taught Aboriginal children that their parents were dirty, savage, pagans. They were told that their parents were no good and that the sooner that they forget their old ways the better. They were systematically and consistently brainwashed to believe that everything that they were learning was right. To Aboriginal peoples, their family, extended family, community and nation had been of utmost importance, now they were ashamed of their families and themselves for being Aboriginal (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Miller, 1996; Royal Commission on Aboriginal Peoples, 1996).

The residential schools taught Aboriginal children that their rituals, coming-of-age ceremonies, and seasonal ceremonies were works of the devil. They were told that if they practiced them, they would burn in hell forever. Consequently, when many Aboriginal peoples left the schools, they did not want to have anything to do with their traditions or their culture (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Miller, 1996; Royal Commission on Aboriginal Peoples, 1996).

The residential schools taught Aboriginal children that the story-telling of their parents and grandparents and their Elders, were not true. The priests and nuns told the children that they were make-believe stories and they were to forget anything they were told by their relatives. Many legends and valuable histories of Aboriginal peoples were lost in this way (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Miller, 1996; Royal Commission on Aboriginal Peoples, 1996).

The residential school taught Aboriginal children that they should be proud when they were hand-picked to serve as sexual playthings to their so-called protectors. Boys and girls alike, were sexually abused by their guardians. Aboriginal children lost their childhood, their trust, and their innocence in those acts of violence against their small, unformed bodies (Assembly of First Nations, 1994; Chrisjohn & Young, 1997; Miller, 1996; Royal Commission on Aboriginal Peoples, 1996).

THE WESTERN DOORWAY

Respect is the primary value which is representative of this doorway. In the words of Herbert Nabigon (1993), "Respect means to look twice at everything we do. The quality of our inner life is enhanced when we understand and implement the word respect" (pp.136-138). Aboriginal/ Indigenous peoples (world-wide) have been reflecting, remembering, revitalizing and reclaiming our knowledge, traditions, culture and our identities since the late 1960's and early 1970's. The reader may refer to the Teachings of the Medicine Wheel on page 4, in order to locate and orient self to the Aboriginal world-view. As before, this writer will add a list of gifts from Gchi-Manido in relation to this westerly direction. Please note that this list is not exhaustive. The Gifts of the West are; *darkness; the unknown; going within; dreams; perseverance; consolidating of personal power; spiritual insight; meditation; fasting; reflection; silence; respect for Elders; respect for others' beliefs; humility; love for the Creator; commitment to struggle to assist the development of the people etc.*

(Bopp et al, 1984, p. 73).

Historical Context

Colonialism is predatory and parasitic in nature. It drains not only the material wealth it seeks, but sucks the life-blood from host peoples. With "progress," it extracts increasingly with less brutality, by detached technological means (Davis & Zannis, 1973, p. 58). We see evidence of the destruction of our world; polluted water, animals becoming extinct, holes in the ozone layer, seasons out-of-whack, clear-cutting, Aboriginal/ Indigenous peoples who are now extinct, and the list goes on. Another prophecy which was foretold was that the light-skinned race would come to the Aboriginal / Indigenous peoples for help. (Cajete, 1994; Dumont, 1989; Neihardt, 1988; Peacock & Wisuri, 2002; Smith, 1999) They have come, but many of them only want our knowledge in order to use it for profit. So we are holding our 'sacred bundles' close to our hearts for the benefit of the generations to come.

Our ancestors used oral transmission as well as a form of the written language to record history and spiritual teachings on rocks, song sticks, birch bark (scrolls), hides, wood, wampum strings and belts (sometimes made of sea-shells) (Dumont, 1989; Peacock & Wisuri, 2002). We are told by our relatives that our sacred records are hidden in a place where only a few guardians know about. These records are inspected every fifteen years and if they are becoming decayed, they are replaced. The description of the sacred scrolls being stored away until the right time to bring them forth, highlights the close relationship of the philosophy, cultural teachings, and spirituality of the Ojibway to the language in both its written and oral form (Dumont, 1989; Peacock & Wisuri, 2002).

I wholly concur with Smith (1999) when she states in her book that, "The struggles of the 1970's seem to be clear and straightforward; the survival of peoples, cultures and languages; the struggle to become self-determining; the need to take back control of our destinies (p. 143)." We have been doing just that in our ongoing struggle to regain and reclaim some of which was lost through the auspices of the residential schools. Although the last school closed around 1984, the effects are still with us today. The aforementioned statement is reinforced by the following statement in Breaking the Silence (1994), "Residential school is an experience which has had the power to wound, dividing First Nation families and communities to this day" (Assembly of First Nations, 1994, p. 114). In Indian Country, there is agreement that the impacts will be felt for the foreseeable future.

Some of the intergenerational results not mentioned previously;

- ***Loss of Meaning*** – the trauma suffered by children resulted in their not knowing that they disconnected themselves from their terror and horrific experiences. One woman to whom I spoke talked about soap being forced into her mouth, allegedly so her 'caregiver' could wash the dirty Anishinaabe words from her. She was still angry about something that had happened to her sixty years ago.

- ***Loss of Family*** – some children never saw their families again, through death or not being able to go home during the summer. When they did go home – nothing was the same and they did not fit into community life. Personal Note: My Father tried speaking Anishinaabe but found that he had ‘lost’ the dialect and he never spoke it again. Our family (brother, sister, myself & subsequent generations) lost out on knowing our Mother Tongue due to residential school.

- ***Loss of Childhood*** – the best years of their lives (their childhood) were taken away from them when they were incarcerated in the residential schools, where they had to work in all kinds of weather without proper attire. Personal Note: This is how my Father’s brother died, he caught pneumonia when he was doing chores outside in the winter. He was the uncle my siblings and I would never know.

- ***Loss of Feeling*** – the children had no one to turn to when they needed to be comforted. They had no one to tell them that they were loved. I can not even imagine how my father and his brothers felt to be taken so far away from their home and family to be raised by so-called religious ‘care-givers’ whom they could not even understand. (Assembly of First Nations, 1994, p. 166-167)

These losses to the mental, emotional, physical and spiritual well-being of the children who attended residential schools have impacted our communities intergenerationally right up to the present day. Personal Note: We were extremely fortunate because we were raised with love, kindness, respect and generosity by both of our parents. I believe that my Father’s strength of character and resilience were such that he was able to give his children and grandchildren all the love, kindness, respect and generosity that he missed when he was a child.

Cultural and Social Context

There are differences *between* Nations / Tribes, as well as differences *within* Nations / Tribes. The Aboriginal peoples of this land, called Turtle Island, have more similarities than differences. We have the ability to connect or bond with other Aboriginal people within a moment in time.

It is something which has transmitted itself, in spite of the residential school experiences of family members. I would like to recount a personal anecdote to illustrate this phenomenon.

> I was working within a mainstream mental health agency in the Native Services Department in Sudbury. This particular mental health agency had clinics in many small communities in northern Ontario. At the time, a child psychiatrist and a non-Aboriginal social worker were traveling to one of the clinics, about a five hour drive away. They asked me if I would be willing to travel with them to the small community where one of the clients was an adolescent Aboriginal girl. They said the (non-Aboriginal) social worker in the clinic could not seem to make any progress with her, she was closed-down. I agreed to go with them to see if perhaps I could work with her. She was told that there was a new social worker for her to meet. We were all seated in the meeting room in a semi-circle; the psychiatrist, the worker from the clinic, the worker from Sudbury, and myself. The door opened and a beautiful, young lady walked in, followed by her foster mother. The instant she saw me, there was a recognition and an instantaneous bond established. The other worker from Sudbury saw the exchange and was shocked and amazed, he actually saw the instant connection almost tangibly. He told me this later. We were introduced and I began to work with her that day. The only way I can explain it is that this adolescent who had been "in care" for most of her young life, had *never had an Aboriginal social worker!*

This phenomenon or 'recognition' is something which happens many times in our life, we are able to connect with other Aboriginal / Indigenous peoples no matter where we are. Sometimes when we are far away, it is with happiness and joy that we meet another Aboriginal / Indigenous person and we greet each other accordingly. Personally, I believe that we are able to connect because our ancestors have had similar experiences and somehow these are communicated at a higher level of our being. It is the only explanation that comes to mind and the only one that makes sense.

Although we lost so much through the residential school system, we are in the process of healing through reflection, remembering, revitalizing and reclaiming our knowledge (Assembly of First Nations, 1994, pp.136-137).

Reflection – this is a necessary part of healing. It forces us to see the destructive nature of our lives. This is of particular significance in this doorway, we are “looking twice” at the past and are committed to the vision of a positive Aboriginal way of life, free from the destructive forces of alcohol and drugs. This means going back to a traditional, balanced way of life in all its aspects, spiritual, emotional, physical and mental (Antone et al, 1986; Assembly of First Nations, 1994; Mussell et al, 1991; Peacock & Wisuri, 2002). Personal Note: When I became aware of the impacts that residential school had on its survivors, I was a mature individual. Many things became clear to me and I now knew why my Father used alcohol and how it had also affected the next generations. I also learned that in order to live a traditional, balanced life – one must not put any harmful substances (alcohol / drugs) into their body which might affect their mental, spiritual, emotional or physical being. Upon reflection, I chose to live a healthy, positive Anishinaabe lifestyle.

Remembering – is the second aspect of healing. It involves breaking the silence with oneself and with others. Disclosure is acknowledged as difficult and painful, but it is necessary. It opens the possibility of breaking the isolation which has become unmanageable and destructive. Sharing the experience of residential school is considered important to the adults who survived. It tells them that they are ‘not alone’ (Assembly of First Nations, 1994, p. 137). I would like to share a personal anecdote that occurred in 1992, when I was going to conduct an interview with my Father regarding his residential school experiences for an academic paper. We got off to a fine start, we were seated in the kitchen of our home at Wasauksing First Nation with our coffee on the table beside us. I had a notebook ready to take notes. I asked him the first question, “What was residential school like?” Unbidden tears came immediately to his eyes, and he said with so much emotion, “Pure hell.”That was the end of our interview. I could not go on, because my eyes were overflowing, as were his. We sat in silence with tears running down our cheeks, we hugged each other, and we never mentioned the interview again. My Father suffered a stroke a couple of years after that and it affected his speech, so there was never again an opportunity to broach the subject. My Father passed on to the Spirit World on May 15, 2001, with his memories intact.

Resolving -- the issues means 'working through' the spiritual, emotional, physical, and mental wounds of residential school. For example, dealing with the anger and the grief, with a person who might use traditional methods of healing. They could use the Sweat Lodge ceremony, a healing circle, a healing dance or other methods (Assembly of First Nations, 1994; Dumont, 1989; Peacock & Wisuri, 2002). There are those Aboriginal peoples who would rather use the western methods and if this is their choice then they are accommodated. Personal Note: There was no chance for my Father to resolve the wounds he suffered at the residential schools. I feel that I am resolving the intergenerational wounds that have affected me by attending ceremonies, sweats, teachings and fasting upon the lap of Shkagamik-Kwe (Mother Earth). In other words, actively seeking and receiving healing so I can live my life in a good way. My family, including my Mother, my daughter, my grandchildren and my great-grandchild have also attended seasonal ceremonies. Attending ceremonies with the accompanying traditional teachings are very empowering for those in attendance.

Reconnecting – is the part of healing which shows individuals moving past their isolation and becoming actively involved with their families and their communities. Reconnecting with the family that has been 'broken' by residential school, opens the possibility of rebuilding that family and reclaiming one's place within that family. The individual is able to regain what they had lost; their meaning, their family, their pride, and their identity (Assembly of First Nations, 1994, p. 137). Personal Note: My Father never lost his pride in "being Indian." He used to dance, sing and drum. I was exposed to these practices at a young age and have continued these to the present day. I belong to an Aboriginal women's hand drum group and we meet bi-weekly to sing and drum. I also wrote a proposal entitled, "Pshe Genda Gok Miikaans" (Sacred Path) which was accepted and contributed to healing within my community for residential school survivors.

The Western Doorway is also the location where decolonization is taking place. Many Aboriginal peoples have taken back their spiritual, emotional, physical and mental beings and are living in balance with their cosmos. It is a phenomenon which has been gaining momentum since the early 1970's. Since then, more and more First Nations have begun to operate schools. By 1996, the number of band-operated schools had risen to 429 (from 64 in 1977). Band-operated schools are incorporating Aboriginal knowledge, language, and concepts into the curriculum (Reed, 1999, p. 71). Personal Note: The school in my community does incorporate the above into the curriculum and my great-grandson is reaping the benefits. The school also has a Sweat-lodge on the property.

Aboriginal peoples have achieved some aspects of self-government, such as social services, health care, education, resource development, culture, language and justice. With more and more Aboriginal peoples becoming educated, in areas such as medicine, social work, health care professionals, law, education, and politics, there is hope for the future that we will be able to hold onto what we have regained in order to pass it on to our succeeding generations. We, as Aboriginal peoples, are regaining, remembering, and picking up our Sacred Bundles that were dropped beside the trail and stayed there for so long, waiting to be recovered.

THE NORTHERN DOORWAY

This doorway is characterized by action and movement and caring. We can extrapolate by saying that we who are now in the Western Doorway, are decolonizing ourselves so that we can hand over the reins of what has been recovered and revitalized to the next Seven Generations. We are caring for the Sacred Bundles and when it is time, they will be given to our children and our children's children and so on. Our ancestors are always nearby and they will let us know when it is time to take action.

Personal note: I have had the privilege of being guided by my ancestors at crucial times in my life. During my first Fast, my ancestors were present to tell me what to do and actually guided my actions in carrying out my duties while I was sitting upon Shkagamik-Kwe (Mother Earth). I believe that with the Spirits always present, we can never forget our ways. The Spirits of our ancestors will always be there for us, they come to us in our dreams, our vision quests and during sweat lodge ceremonies.

Conclusion

I am the daughter of a residential school survivor. My Father lost his language while he was at residential school. He was very young when he was incarcerated, and when he was released, he was thirteen years old. Being a teenager, he was eager to reconnect with his friends. They were standing down the road and he ran up to them and started talking Anishinaabe to them, they burst out laughing! They could not understand what he had said, apparently he had lost the dialect. My Father never spoke another word of Ojibwe for the rest of his life, and he was 76 years old when he passed on to the Spirit World. My brother, sister and I were raised in a home where English was spoken, even though my Mother is a fluent speaker. When she did not want us to know what she was talking about, my Mother would talk to my Father in the Anishinaabe language and he would either reply in English or he would nod his head. He understood every word of Ojibwe, but he would not speak it. Residential school affected four generations of my family, but hopefully, the fifth generation will speak fluently. We are a family of five healthy generations: Mother, myself, daughter, grand-daughter, great-grandson. I am a social worker and therefore, an optimist. I look forward to the day that I will be fluent in my language and it will take hard work and determination but I know it can be achieved. My daughter has recently expressed a real interest in learning our language and it fills me with hope and pride knowing that we are role models for our progeny.

There are great expectations for the next Seven Generations, because this generation has taken up the responsibility to ensure that the culture, traditions, ceremonies, language, values and beliefs of our peoples will be there for them. I will ‘requote’ part of the introduction,

> What people didn’t understand is that those boarding (residential) school terrorists thought that it (culture) could disappear in a generation, and they would have white thinking children. They couldn’t erase it, and therein lies the **HOPE**. (emphasis added) Right there. **AND WHEN THAT SPIRIT IS REAWAKENED IT IS MORE POWERFUL THAN ANYTHING THAT I HAVE EVER MET IN MY WHOLE LIFE. I AM IMPRESSED WITH THE STRENGTH OF CULTURE.** (emphasis added) (Cleary & Peacock, 1998, p. 102)

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Intergenerational Trauma from a Mental Health Perspective

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Abstract

Over the past few decades, intergenerational trauma as an explanation for the array of social conditions that exist within Aboriginal communities has been put forward by a number of researchers (Braveheart-Jordon & De Bruyn, 1995; Hodgson, 1990; Kirmayer, Brass, & Tait, 2000; Phillips, 1999; Waldram, 1997). Through in-depth interviews, this study explored the men's personal and family histories, seeking links between personal homelessness and intergenerational trauma. An interpretation of the data from these interviews and from a focus group with other homeless Aboriginal men isolated the indicators of intergenerational trauma within four domains: individual, family, community, and nation. The indicators of intergenerational trauma within these domains are synthesized in the Intergenerational Trauma Model. This model is predicated on the assumption that public policies have disrupted relations among the four domains and the resulting trauma has incubated negative social conditions for Aboriginal people, making them significantly more vulnerable to a number of threatening social conditions. Subsequent refinements to the model provide the mental health professional with a generic lens to examine the relationship between intergenerational trauma and social systems that Aboriginal peoples come in contact with.

Reflections

Over the last fifty years, there has been an abundance of research on how Aboriginal people experience an array of mental health issues. Despite this plethora of research into mental health conditions, it has been difficult to locate research to explain why a disproportionate number of Aboriginals experience mental health challenges compared to the general population. In my practice as a mental health therapist, I was able to help community members explore their personal histories as a way of beginning their healing journeys. I began to recognize that many of the mental health conditions Aboriginal people are suffering from are a direct result of the relationship Aboriginal people have had historically to the Canadian government. Those of us who have been impacted by the vagaries of Aboriginal public policy can provide first hand evidence on the negative consequences that public policies have had not only on our lives but that of our families, community and nation.

Introduction

I am a member of the Sagamok Anishnawbek First Nation, and my childhood was not out of the ordinary for many Aboriginal children impacted by government public policies. From birth, I was placed in the care of the Sisters of St. Joseph's, and with the closing of the institution, I was discharged to the care of the Children's Aid Society. As an adolescent, I wrested with my feelings of anger, confusion, abandonment, and my "Indianness". I was called many derogatory names that made me feel ashamed of my cultural heritage. Through this struggle, I managed to complete high school and post-secondary education, graduating from the University of Manitoba, School of Social Work. The impact of public policy has left a legacy of trauma within individuals, their families, communities, and across nations. My own disconnection from my birth family, extended family, community and culture has made me sensitive to the needs of our people who are also separated from themselves, families, community and nation. As a mental health worker in the Aboriginal community, I recognize the need to ground our work in the experience of the individual, but also in the extended family and the community from which our ancestors existed.

It was during my PhD studies, I came across the concept of "Intergenerational Historical Trauma". After listening to Dr. Maria Yellow Horse Brave Heart's presentation, whose work in Aboriginal communities in the United States is grounded in this theory, I began to re-examine my own life and that of the people who I work with within the context of this model.

This paper begins with an historic overview of Canada's social policies that have impacted Aboriginal people and how they have contributed to our disconnection from our families, our communities and from one another. The issue of trauma, specifically Intergenerational Trauma is explored in great detail as a contributor to the explanation of the disproportionate representation of mental health issues among Aboriginal people. Finally, from my clinical experience I believe that many of the indicators of the Intergenerational Trauma Model developed can be applied across many social realities that Aboriginal peoples are enduring, recognizing that there will be other indicators if women and children were included in the study.

Public Policy and Canada's Aboriginal Peoples

Canadian social policy has been instrumental in creating institutions that have attempted to eradicate Aboriginal worldview and value systems that existed for thousands of years (Churchill, 1995), replacing them with doctrines that continue to disrupt life for Aboriginal peoples.

The Indian Act of 1876 established the federal government as the "guardian" of Aboriginal peoples. Artificial settlements were created, segregating individuals into groups that were defined by authorities outside of existing community networks. It set up authority within these artificial settlements and created hierarchy and decision-making authorities that did not reflect traditional values and practices. In effect, the Indian Act was an act of Parliament that gave authority to non-Aboriginals to control the everyday life of Aboriginal peoples across Canada (Royal Commission on Aboriginal Peoples, 1996, Vol. 3).

The Canadian government has used other mechanisms, including religious institutions, to transform Aboriginal communities. Between 1840 and 1983, it is estimated that over 100,000 Aboriginal children were placed in the residential school system (United Church of Canada, 1994) for the purpose of assimilation, segregation, and integration into mainstream Canadian society. A majority of these institutions were sponsored by religious organizations. Separation from family for months, even years at a time resulted in children loosing their language, culture, and spiritual beliefs, as well as sense of belonging to a family, community and nation. Children attending these institutions experienced many types of abuse including physical, sexual, emotional, spiritual and psychological (Breaking The Silence, 1994 and Royal Commission on Aboriginal Peoples, Vol. 3).

When the residential schools started to close, child welfare became the new instrument of government assimilation policies. Johnston (1983) introduced the phrase "the Sixties Scoop" (p. 23) to identify the overwhelming number of Aboriginal children removed from their homes and communities by child welfare authorities during this period. Taking a crisis intervention approach to child welfare meant that Aboriginal children were permanently removed from their homes and placed in foster care or made Crown wards (Andres, 1981; Johnston, 1983; Richard, 1989; Timpson, 1990). Even today, many Aboriginals still consider child welfare as a vehicle to assimilate as it is estimated that close to 27,000 Aboriginal children are in the care of child welfare agencies across Canada (Leadership Action Plan on First Nations Child Welfare, 2006).

Mental Health

Evidence suggests that Aboriginal people experience higher rates of suicide when compared to the national average (Health Canada, 2000). The rate of concurrent disorders is suspected as being as high as 70% within Aboriginal communities (First Nations and Inuit Mental Wellness Advisory Committee, 2005). There is evidence to suggest that high levels of depression exist within Aboriginal communities (Canadian Medical Association, 1994), and that Aboriginal Youth are two to six times more likely to use alcohol than non-Aboriginals (Health Canada, 1999). The data is collected but is not analyzed in terms of why Aboriginal peoples are experiencing higher rates of mental health issues. If we do not consider mental illness within the context of historical injustices then we are collecting and presenting information in a vacuum, and perpetuating the stereotype that Aboriginal peoples are more susceptible to mental illnesses then the general Canadian population.

Intergenerational Trauma

It is only recently that the intergenerational nature of trauma has been explored within Aboriginal communities (Braveheart-Jordan & De Bruyn, 1995; Lederman, 1999; Phillips, 1999; Waldram, 1997).

Gagne (1998) identified the residential school experience as a key component within the cycle of trauma experienced by Aboriginal peoples. In a discussion of the sociological etiology of intergenerational trauma among First Nations peoples, Gagne (1998) concluded that the effect of the residential school experience was felt beyond the generation that attended the school:

> At least two subsequent generations were also "lost". The children of these students became victims of abuse as their parents became abusers because of the residential school experience (p. 363).

The removal of children from the home for long periods of time has diminished opportunities for the transmission of family values, parenting knowledge and community behaviour between generations (Payukotayno, 1988; van de Sande, 1995). The cumulative impact of trauma experienced by both children and their parents as a result of Canada's residential school policy continues to have consequences for subsequent generations of children. Phillips (1999) summarizes the intergenerational impact of trauma:

> If we do not deal with our trauma, we inadvertently hand it down to the next generation. We often take out our pain and hurt on those we love the most – which is ourselves and those closest to us – our family and friends. So, intergenerational trauma is trauma that is passed down behaviourally to the next generation: if we're angry and act angry all the time to others, our kids will think that's normal and do the same. If we ignore each other and deprive each other of love and affection in our relationships, our kids see and feel that deprivation of love and might think it's normal (p. 6).

The Aboriginal Healing Foundation (2001) has noted that:

> Many passed the abuse suffered on to their children, thereby perpetuating the cycle of abuse and dysfunctional arising from the Residential School System. Subsequent generation of children were left with the consequences of what happened to their parents and grandparents. They grew up without the opportunity to learn their language, to have traditions and cultural knowledge passed down to them, or to be apart of a strong and healthy family and community (p.7).

Both mainstream and Aboriginal mental health practitioners are challenging the Diagnostic and Statistical Manual (DSM) diagnosis of Post Traumatic Stress Disorder (Waldram, no date). This diagnosis ignores the role of culture and intergenerational or community trauma and does not connect the individual's experience to broader, systemic conditions that perpetuate and exacerbate the individual's experience. Waldram (2004) suggests:

> Approaching trauma through DSM by and large precludes a meaningful discussion of culture, and virtually excludes notions of history and collective, community or cultural trauma (p. 235).

Root (1992) suggests that racism and discrimination compound the impact of direct or personal trauma by allowing for the oppression of a community of peoples. This "insidious trauma" becomes normalized to the point that the group does not realize how social conditions continue to oppress them. Rather than focusing on a singular event that makes the individual feel unsafe, this insidious trauma leads to a view that the world is an unsafe place for a whole group of peoples (Root, 1992). Dutton (1998) adds that this "matrix of traumatic experiences… may shape the lived experience of a person within a given cultural group" (p.1).

Kirmayer, Brass and Tait (2000) concur that the focus on individual trauma does not adequately reflect the Aboriginal experience. The authors suggest:

> The emphasis on narrating personal trauma in contemporary psychotherapy is problematic because many forms of violence

> against Aboriginal people are structural or implicit and so may remain hidden in individual accounts. … Individual events are part of larger historical formations that have profound effects for both individuals and communities (p. 613).

Duran and Duran (1995) concur with this assessment in their study of Native Americans in the United States. Critical of the focus on individual diagnosis, they note that, "the diagnostic process never takes a historical perspective" (Duran et al., 1995, p. 52). The authors advance the argument that many Native Americans are suffering from intergenerational post-traumatic stress disorders:

> Many of the problems facing Native American people today - such as alcoholism, child abuse, suicide, and domestic violence - have become part of the Native American heritage due to the long decades of forced assimilation and genocidal practices implemented by the federal government (p. 35).

Kirmayer, Brass and Tait (2000) present similar arguments in their review of a range of mental health studies of Aboriginal communities across Canada. They conclude that:

> Individual events are part of larger historical formation that has profound effects for both individuals and communities – effects that are harder to describe. These damaging events were not encoded as declarative knowledge but rather 'inscribed' on the body or else built into ongoing social relations, roles, practices and institutions (p. 613).

In a review of morbidity factors in Aboriginal communities, Waldram (1997) notes:

> The current state of affairs can be clearly linked to the traumatic effects of colonialism, including geographic and economic marginalization, and attempts at forced assimilation (p. 184).

Historical social policies have impacted multiple generations of Aboriginal peoples. The severing of family and community has left a legacy of traumatized individuals who may be unable to function in mainstream society. Left dependent on social institutions, many Aboriginal peoples are unable to address their individual needs. Research into what intergenerational trauma may actually look like from a clinical perspective has been lacking. The research presented in this paper helps to address this gap and provides intergenerational trauma indicators that can be used by clinicians in assessing how this particular type of trauma may present with specific populations.

Research

In 2004-05 I undertook a study to identify whether any link could be established between intergenerational trauma and homelessness. Although the growing body of research describes intergenerational trauma and notes its causes in historical processes, the research does not present a clear set of indicators of intergenerational trauma. This study led to the identification of the indicators of intergenerational trauma in a sample of homeless Aboriginal men.

The study employed a qualitative methodology, involving key Aboriginal stakeholders in the collection and evaluation of the data (Creswell, 1998; Neuman, 1997; Rubin & Babbie, 1997). The research was conducted at Native Men's Residence (NaMeRes), a 60-bed emergency hostel for men in downtown Toronto. The research participants included 16 adult Aboriginal men between 18 and 64 years of age who were using the services of NaMeRes and an additional five men participated in a focus group discussion. Quota sampling was used to ensure that the sample included men who were within the age ranges 18 to 24, 25 to 49, and 50 to 64. The sampling also attempted to include men from a variety of places of origin — urban centres, rural communities and First Nations communities.

Key Results

Indicators of Intergenerational Trauma Among Homeless Aboriginal Men

The participants were initially asked to reflect on their family history. Many were unable to provide details of their genealogy — particularly the nine removed from their home at an early age. While these participants had little knowledge of their birth family, others offered poignant details of their family history within the context of residential school experience, child welfare authority, and the impact of these systems on their personal identity.

Ned, age 42, was raised by his biological mother and maternal grandmother in an urban centre in Western Canada. His biological father is unknown. Ned struggled to describe his mother's experience in residential school and identified how it significantly influenced her own behaviour as a parent:

> My mother went to residential school and at that time she was, my mother was, totally scarred up from residential school … She did exactly what those people did to her in residential school … she was abusive.

Henry, age 52, was born in Northern Ontario but raised by his mother and paternal grandparents in the northern United States. At an early age, he was made aware of his family's experience in both Canadian residential schools and American boarding schools:

> She [his mother] don't like talking about it. Only when she was yelling at us how rough she had it compared to what we had … She said it [residential school] was really strict. The food, the rules, the discipline and nobody cared. She got punished — whippings and straps — and they took her away from my grandmother. She was very lonely. She wanted to go home and they wouldn't let her.

Ben attended residential school from age five to 11 in the 1950s. He remembers that most of his extended family attended residential school as well. He illustrated how the resulting isolation from family affected his relationship with his mother upon his return:

> I used to watch those movies, you know, back then about the kids with their parents … you know, *Leave it to Beaver* or something like that, yeah. You know, I saw him hugging his mom, and I tried

> that once — tried to hug my mom. And when I hugged her and all that … actually, I told her I loved her. And she didn't know how to react. She didn't know how to take it, you know. So after that, I just shut myself off from her.

While only a minority of the participants identified a direct personal experience with the residential school system, nine, or 56%, had personal experience with the child welfare system at some point in their lives.

Adopted as an infant by a Caucasian family who later had their own biological children, Adam described the emotional disconnect that permeated family life within his adoptive home:

> The support was lacking in the family. It was a little bit dysfunctional in that aspect … I don't know. Being adopted, I think a lot of attention went more to my younger brother and sister who were their natural kids … I don't know about, you know, love and being able to talk to somebody, you know, how you're feeling and whatever. There just wasn't a lot of that around.

Further along in the interview, Adam voiced his frustration with the disconnection from his birth family and the emotional isolation he felt in his adoptive home:

> You're adopted as a baby, taken away from your parents, and then you're in this other setting, and then they disown you, and it's just like, Christ, it just seems like an ongoing cycle I'm living.

Dan, age 40, recalled that before his adoption he lived with his biological family. He and his younger siblings were removed from their home because of his parents' drinking when Dan was five years of age. He was adopted separately into a non-Native family where he was the oldest of three children. His siblings were the biological children of his adoptive parents. Dan described the lack of connection he felt in his adoptive home:

> I was just there, taking up space … I didn't love any of these people in this family. A person from age five until about 14 or

> 15 could live with a family and not love anybody in the family. I thought that's just the way it has got to be.

Frank, age 42, commented, without emotion, that he has never felt any connection to the people who raised him. He described himself as particularly independent from an early age:

> I'm always picking myself up. I've never really had no mommy or daddy to run home to … I got to pick myself up … They were what they were. They were adoptive parents. I've never relied on [anyone], whether they're my adoptive parents or foster parents. I've never relied on those people.

Pat acknowledged that he has no close connections with the rest of his family or home community. His years in care have left him emotionally insecure:

> I have nobody to really get close to. That's been a problem for me … When things are really doing good, I feel I really don't deserve this. Even relationships — you try to be there for them, but you never could be.

More than 40 years later, John is able to recall the poignant details surrounding the removal of a child from the reserve where he stayed with his grandparents each summer:

> I remember once this kid came running over to [me] … I was fishing on these docks, and he dove in the water and he came up right under where I was standing, because you could breathe a little bit … And the police car comes flying over there… They were looking all over the docks, like under boats and stuff … They asked me and they asked the people hanging around the dock … Well, we said we haven't seen him. Meanwhile, he was under [the dock]. I could see the bottom of his feet. They were white because he was treading water and just hoping to God they didn't see him there. And they didn't. But eventually he ended up going … he got caught … [long silence].

John identified the chronic stress created within the community as a result of witnessing child welfare interventions with other families in the small reserve community:

> For me, I didn't see them as being any poorer than me, because I lived in the same conditions as them, and I had no idea why they were … why they would take them and not [me]? I don't know how they figured out which kids were … which ones to pick … I was angry. I was afraid.

Despite acknowledging that the rationale for removing them from their homes at a relatively early age was linked to family violence, alcoholism, or poverty, they felt that this break with their community and subsequent placement in non-Aboriginal foster care, group homes, or adoptive families had detrimental effects on them. In effect, these men were without a home — or homeless — from an early age.

Over many decades, negative stereotypes of Aboriginal peoples significantly influenced public perception of the value of Aboriginal culture. Several of the men interviewed for this study indicated that they found little support for affirming their cultural heritage from their immediate family and from the communities in which they were raised. Issues related to cultural identity were affected by the individual's physical characteristics, as well as his "blood heritage," as demonstrated by having "status" under the Indian Act. Mike summarized the internal battle waged by many throughout their youth:

> We didn't look the same colour as them so we were teased about it. Teased at school ... I didn't want to be an Indian because of the fact that I was getting teased. I wouldn't hang around them or I'd fight them. I'd tell them off, you know, I'd do everything in my power not to be Indian

Much of the research on trauma looks at psychological and social contributors that affect the individual, with an emphasis on family dynamics (Beisner & Attneave, 1982; Brasfield, 2001). Although there is a level of insight in this type of research, the trauma experienced by the men in this study must be viewed historically. Building on the precepts suggested by

Waldram (1997), Kirmayer et al. (2000), and Duran et al. (1995), the data suggest that indicators of intergenerational trauma may exist along four distinct realms: the individual, the family, the community, and the nation. Indicators arising from the data analysis have been isolated for each of these realms and are summarized below.

Individual Indicators

Individual indicators emerging from the data are:

- Lack of a sense of "belonging," identification, or affiliation with a specific family, community, culture, or nation
- Feeling of "abandonment" by caregivers
- Limited or no information about one's culture of birth, including language, customs, belief systems, spirituality
- One or more "flight" episodes from a caregiver environment as a youth
- Inability to sustain personal or intimate relationships
- Being present-oriented, not future-oriented
- Low self-esteem
- Limited education and employment history
- History of substance misuse
- History of involvement with the criminal justice system, precipitated by substance misuse
- Involvement with the mental health system

Rather than pathologizing the individual, as is often done, I would argue that these indicators should be viewed as resulting from a historical process. It is important that these individual indicators of intergenerational trauma be considered in relation to the indicators for family, community, and nation.

Family Indicators

Family indicators emerging from the data include:

- Chronic or episodic family violence, including physical, sexual, emotional, and/or verbal abuse of children by adults in the household

- Lack of emotional bonding between parents, siblings, and extended family members
- Denial of cultural heritage by older family members
- Perpetuation of negative stereotypes within the family of birth or caregiver environment
- Irregular contact or the absence of contact with caregiver family members
- Unconcealed and rampant alcohol and drug misuse that crosses generations

These factors suggest the individual's circumstances need to be considered within the context of their relationship with their family or caregiver.

Community Indicators

Additional factors that may be present in the community and that influenced the individual's early life history must also be considered:

- Unconcealed alcohol and drug misuse among community members
- Lack of cultural opportunities, including transmission of language skills, history, traditional values, and spirituality
- Unwillingness to "reclaim" community members
- Low levels of social capital (Putnam, 2000), including trust, reciprocal helping relations, and social engagement

It is important to recognize that within traditional Aboriginal culture, the community's support is critical for the development of individuals and families. Holistic healing is not achievable without the influence and guidance of a balanced and healthy community.

Nation Indicators

The data also indicate that a fourth element must be considered. The individual, family, and community are embedded within national structures that both historically and contemporaneously have had a profound impact on these other institutions. Some key national indicators that may contribute to homelessness include:

- Popularization of negative stereotypes through mainstream media
- Social policies that perpetuate colonialization of Aboriginal peoples on an individual, family, and community basis
- Lack of support for holistic programs and services targeting Aboriginal needs
- Lack of support for community self-determination

The impact of trauma on the Aboriginal nation must also be reconciled. The need to support the development of community beyond geographic boundaries to include all Aboriginal peoples is critical to the healing process.

Data Implications

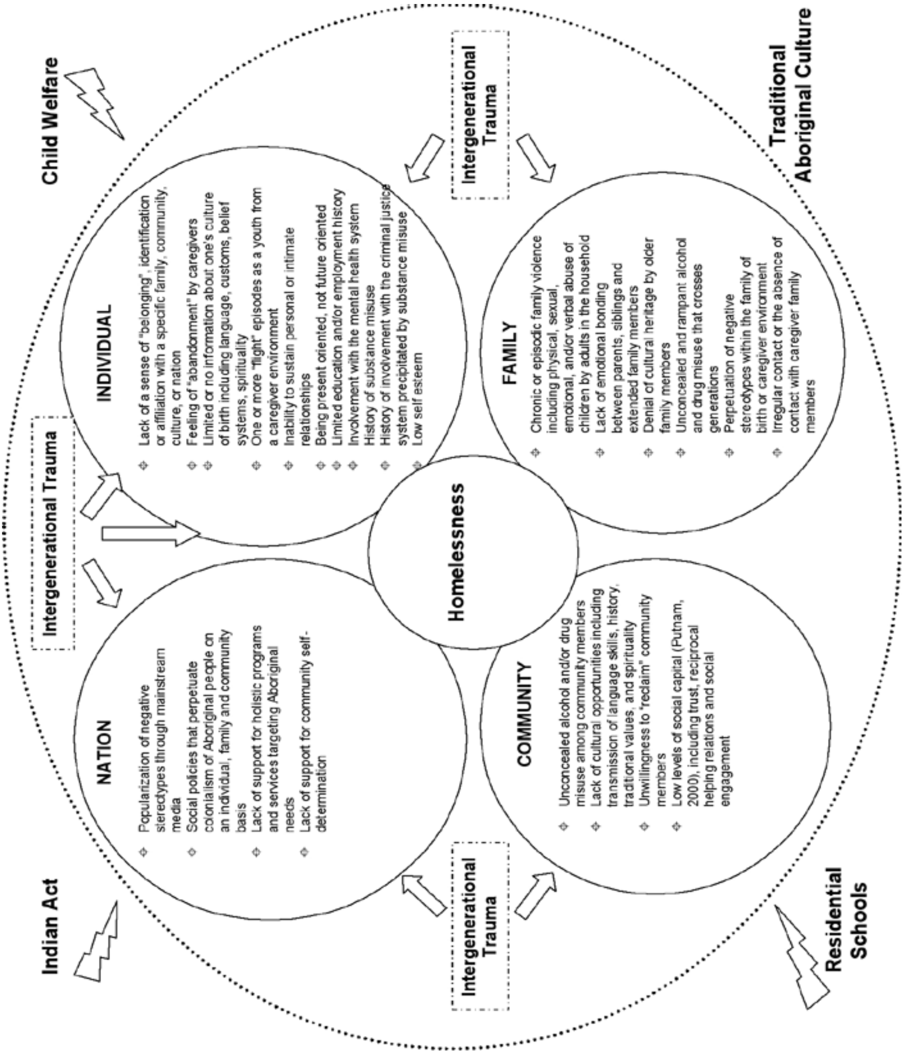
The data provided have identified how external social policies have corroded the links between critical elements within Aboriginal culture. Individual, family, community, and nation now exist in isolation of one another. Social policies, including the Indian Act, the residential school system, and child welfare legislation, have systematically negated Aboriginal culture and imposed values that are contradictory to our traditional ways of relating to one another (Cross, 1986; Good Tracks, 1973; Proulx & Perrault, 2000). The colonizing impact of these policies has resulted in many individuals experiencing “social anomie” — a feeling of disconnection from a particular cultural group (Brant, 1990). The pervasiveness of this condition has left the Aboriginal nation in a similar state — unable to draw upon common bonds to bring individuals, families, and communities together.

The Intergenerational Trauma Model

The indicators discussed above are integrated within the Intergenerational Trauma Model (see page 78).

The model is premised on the main constructs of the traditional teachings of the Aboriginal medicine wheel, a conceptual process that frames our understanding of the world as Canada’s First Peoples:

Figure 1: The Intergenerational Trauma Model


Child Welfare
Indian Act
Residential Schools
Traditional Aboriginal Culture
Intergenerational Trauma
Intergenerational Trauma
Intergenerational Trauma
INDIVIDUAL
Lack of a sense of "belonging", identification or affiliation with a specific family, community, culture, or nation
Feeling of "abandonment" by caregivers
Limited or no information about one's culture of birth including language, customs, belief systems, spirituality
One or more "flight" episodes as a youth from a caregiver environment
Inability to sustain personal or intimate relationships
Being present oriented, not future oriented
Limited education and/or employment history
Involvement with the mental health system
History of substance misuse
History of involvement with the criminal justice system precipitated by substance misuse
Low self esteem
FAMILY
Chronic or episodic family violence including physical, sexual, emotional, and/or verbal abuse of children by adults in the household
Lack of emotional bonding between parents, siblings and extended family members
Denial of cultural heritage by older family members
Unconcealed and rampant alcohol and drug misuse that crosses generations
Perpetuation of negative stereotypes within the family of birth or caregiver environment
Irregular contact or the absence of contact with caregiver family members
NATION
Popularization of negative stereotypes through mainstream media
Social policies that perpetuate colonialism of Aboriginal people on an individual, family and community basis
Lack of support for holistic programs and services targeting Aboriginal needs
Lack of support for community self-determination
COMMUNITY
Unconcealed alcohol and/or drug misuse among community members
Lack of cultural opportunities including transmission of language skills, history, traditional values, and spirituality
Unwillingness to "reclaim" community members
Low levels of social capital (Putnam, 2000), including trust, reciprocal helping relations and social engagement
Homelessness

> The teachings assume that all humans can exist in balance with themselves, their families, communities, and their natural surroundings. Where alcoholism, violence, abuse, or any kind of dysfunction exists, there is imbalance: the dark side dominates (Nabigon & Mawhiney, 1996, p. 19).

The medicine wheel breaks the main constructs of life into four elements, generally referred to as the four directions: east, south, west, and north. There must be harmony between the four elements of life for balance to be achieved (Morrisseau, 1998).[1] Similarly, the Intergenerational Trauma Model is predicated on the assumption that public policies have disrupted relations between the four systems and the resulting trauma has incubated negative social conditions for Aboriginal peoples, making them significantly more vulnerable to a number of threatening conditions. This has disrupted the balance of the wheel in which the individual, family, community, and nation exist. The Intergenerational Trauma Model identifies risk factors that may contribute to Aboriginal people's social conditions.

Starting outside of the larger circle in Figure 1, the influence of public policy is identified via the Indian Act, residential school system and child welfare authorities. These social policies are external elements that have penetrated traditional Aboriginal culture and caused change to occur within the traditional social systems, as illustrated by the four smaller circles.

The large outer circle represents Aboriginal culture, and the four smaller circles represent the four subsystems of individual, family, community, and nation. The four subsystems exist within a permeable boundary that is signalled by the broken line of the outer circle. The influence of external elements, such as public policy, has weakened the role of culture in supporting the inner circles of individual, family, community, and nation.

The proposed indicators of intergenerational trauma are noted in the centre of each of the four inner circles. The circles representing the individual, family, community, and nation exist in isolation from one another.

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[1] A detailed discussion of the medicine wheel is beyond the scope of this paper, but some excellent sources for interested readers include Cianci and Nadon (1991),Graveline (1998), and Nabigon and Mawhiney (1996).

If they operated as an adequate support system, they would intersect, but within the Intergenerational Trauma Model, they do not, symbolizing that they are not able to support one another. As indicated by the arrows in Figure 1, intergenerational trauma pushes the four inner circles apart. The balanced existence between the four systems is thwarted by the pervasive presence of intergenerational trauma, which has prevented the four "systems" from re-establishing their former balanced and linked existence and in effect is the barrier that thwarts the reunification of the four systems.

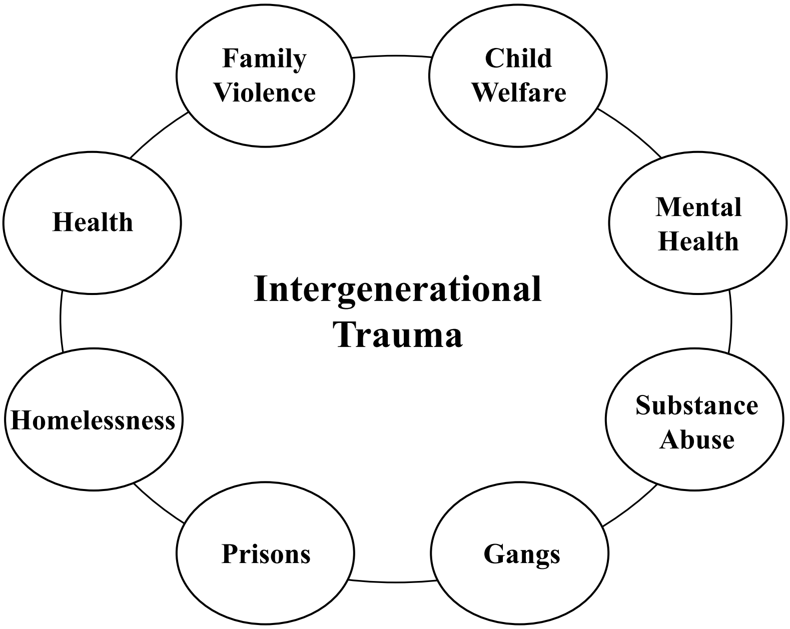
Although the impact of the trauma may be most visible in the individual, a holistic approach — as presented in this model — suggests that trauma affects all the four spheres. Within the context of the healing process, it is important to help the client contextualize their experience in the public policy domain by providing an understanding of how these pubic policies have impacted their lives, including their families, communities and nations. Issues like residential schools, Indian Act, child welfare, racism and the sense of dependency on government should be explored within the context of their lives. By allowing client to see the issues confronting them through a public policy lens gives them a sense that it was not issues of personal or genetic factors that contributed to their situation, but an array of public policies that shaped and defined their lives.

Macro Intergenerational Trauma Model Perspective

From a macro perspective, the model below (Figure 2) would provide another lens for social workers to look holistically and historically at the conditions that have impacted and continue to impact Aboriginal peoples. Traditionally, social workers use theories such as structuralism, systems theory, and the ecological model to help them understand the social forces that influence individuals, families, communities, and nations. This model allows the social worker to see the relationships between social service agencies and Aboriginal people experiencing intergenerational trauma. The model is meant to assist the social worker to move away from traditional assessments and consider that many Aboriginal peoples were and continue to be involved with many social systems because of unresolved past traumas. When individuals have not dealt with their trauma then it is most likely that they will become involved with other systems such as justice, homelessness, child welfare, treatment centres, and mental health.

This model may not explain schizophrenia or chemically induced mental health, however, it requires the social worker to look at how the assimilation policies had and continue to impact the individual, family, community and nation at multiple points. It is not meant to look at the individual as being separated from society, but to examine the behaviours in the context of past and present public policy. The model provides another paradigm when considering Aboriginal issues from a boarder context.

Figure 2


Family Violence
Child Welfare
Health
Mental Health
Intergenerational Trauma
Homelessness
Substance Abuse
Prisons
Gangs

Conclusion

Many studies on Aboriginal mental health have not acknowledged the psychological impact of social policies on Aboriginal peoples throughout Canada. This study demonstrated that intergenerational trauma can be an explanation for the array of mental health issues that are faced by Aboriginal peoples. The indicators can help the mental health worker in a therapeutic or counselling relationship. These indicators may also be helpful in understanding other social issues confronting Aboriginal peoples, such as family violence and substance abuse. As a result, mental health practitioners who focus their interventions with Aboriginal people on either personal or systemic issues will not adequately address the needs of their Aboriginal clients. We need to acknowledge the role of public policy in severing the physical, mental, emotional and spiritual ties between Aboriginal peoples, and consider the implications of intergenerational trauma on individuals, families, communities, and nations. By exploring the indicators of intergenerational trauma in mental health settings, we will be in a better position to work effectively with our people.

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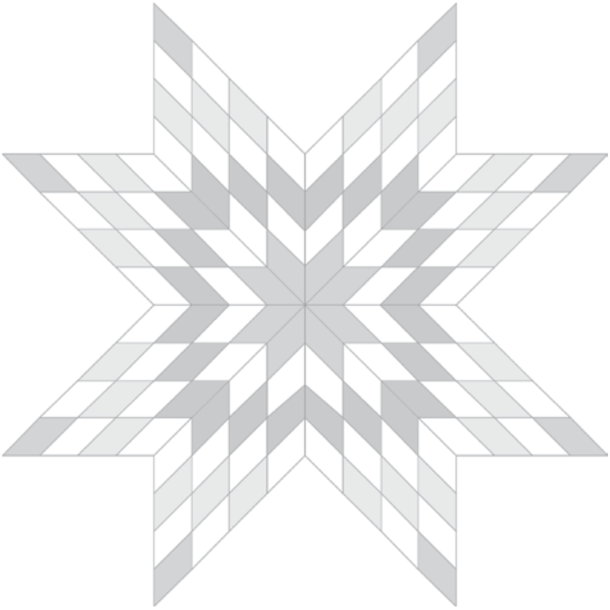

The Role of the Elder within a Mainstream Addiction and Mental Health Hospital: Developing an Integrated Paradigm

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We would like to acknowledge the following colleagues for their knowledge, insight and making this article possible:
Barbara Hurford, Bob Crawford, and Lizz Arger.
For the purpose of publication credit, all authors are first authors.

Abstract

This paper outlines the role of an Elder working as a full partner in a therapeutic environment with a Western trained mental health team. Research for the article is based on observation and interviews with the Elder and the team mental health staff. This article provides insight into one of the many roles that Elder Vern Harper has within a mainstream hospital setting. Elder Vern Harper participates in counseling sessions with Aboriginal clinicians trained in Western healing intervention. Within these sessions Elder Vern Harper provides traditional teachings and healing. Many clients have indicated that this two-pronged approach gives them the best of both worlds as they are provided insight into their problems both from an Aboriginal perspective as well as from a western clinical perspective.

Introduction

Research has shown that Aboriginals are reluctant to access mainstream services for reasons such as experiences of racism, being treated as second class citizens, impersonal atmosphere, lack of cultural practice and Aboriginal staff (Metropolitan Toronto District Health Council Native Steering Committee, 1996; Menzies, 2001 & Royal Commission on Aboriginal Peoples, Vol. 3, 1996)

In July of 2002 Elder Vern Harper joined the Aboriginal Services team at the Centre for Addiction and Mental Health to provide cultural teachings and healing. Before joining the team, Elder Vern Harper was employed by Aboriginal Legal Services of Toronto. Having been employed in the Toronto Aboriginal community, I learned about Elder Vern Harper through community members and Aboriginal Social Services agencies. Elder Vern Harper went through several interviews with myself to determine his suitability for a full-time employment in a mainstream hospital environment, and his ability to work with homeless Aboriginals and those Aboriginals coming out of provincial and federal corrections. At the time of the interviews, Elder Vern Harper was regarded by the Toronto Aboriginal Community as being committed, and was recognized as the Urban Elder. He was conducting community sweats on most weekends, and actively participated in the community life of Toronto. He attended correctional faculties, provided traditional teachings and doctoring, conducted healing circles and sweat lodge ceremonies, and sat on the Toronto Elders Council.

It is the intent of this paper to document the relationship that the Elder and therapeutic team developed and how it impacted the therapeutic environment. The first part of this paper provides a description of the hospital and program and then provides detailed information about the problems that the Elder and therapist are addressing when engaging an Aboriginal person seeking help.

CAMH Organization

The Centre for Addiction and Mental Health (CAMH) was created in 1998 through the amalgamation of the Addiction Research Foundation, Clarke Institute of Psychiatry, Donwood Institute, and the Queen Street Mental Health Centre. CAMH's primary focus is to ensure that all residents of Ontario have access to the comprehensive range of services they require. This commitment is enshrined in the Centre's vision, mission statement and core values. The vision reflects CAMH's leadership role in understanding issues of prevention and care in relation to mental health and addiction. The mission statement promotes the enhancement of the Centre's capacity and quality of addiction and mental health services in Ontario. Our core values invite communities to participate and benefit from the services offered by CAMH. Regardless of race or culture, the Centre invites partnership and accountability to the communities it enters into partnership with. With First Nations, CAMH recognizes that Aboriginal peoples have historical, legal rights and will work with First Nation with respect, inclusion, access, accountability and equity principles (Centre for Addiction and Mental health, 2003).

CAMH operates a full range of health care programs, including: emergency services, forensic, dual diagnosis, schizophrenia and continuing care, mood, anxiety, concurrent disorder, general psychiatry, addiction medicine, and addiction programs for general and specialized populations.

The Centre is also a teaching hospital affiliated with the University of Toronto. CAMH offers clinical and research facilities in Toronto as well as twelve community offices across the province of Ontario. The Centre has two principal tasks: advancing the understanding of mental health and addictions and translating this knowledge into practical resources and tools that can be used for internal program development as well as in the broader community.

Aboriginal Services

In May 2000 the Centre for Addiction and Mental Health created the Aboriginal Services (ABS) in response to the unique service needs of Aboriginal people. The mandate of the ABS is to develop culturally appropriate services in partnership with the Aboriginal community using a holistic approach that is based on Aboriginal values, beliefs and traditions. The vision of the Aboriginal Services is to provide mental health and addiction services to Aboriginals living in Ontario in a manner that embraces Native values, respects Native spirituality, and promotes self-determination in service design and delivery. In partnership with agencies and members of the Aboriginal community, the Centre for Addiction and Mental Health promotes holistic healing efforts and the development of services designed and delivered according to community needs. Currently, Aboriginal Services provides therapeutic intervention to Aboriginals residing in Toronto as well as s training, consultation, and capacity building at the provincial and federal level. The team is composed of three therapists, a part-time psychologist, a manager and clinical head. The service provides traditional and western healing interventions, which includes circles and sweat lodge ceremonies

Community Need

Aboriginal Peoples suffer from a range of health problems at higher rates than other populations (Health Canada, 1999). Aboriginal Peoples also appear to be more affected by substance abuse and mental health problems than other population groups, which includes:

- Aboriginal youth are two to six times more at risk for alcohol-related problems than non-Aboriginal youth (Health Canada, 1999)

- Unemployment for Aboriginals is twice the rate of non-Aboriginals (Statistics Canada, DIAND Core Census Tabulation, 1996)

- Suicide among First Nations people is 2.1 times that of the non-Aboriginals (Health Canada, 2003)

- In 1996-1997, 3.6% of registered “Indian” children were in the care of Children’s Aid Societies (Health Canada, 1999)

- In First Nations, potential years of life lost from injury was more than all other causes of death combined and was almost 3.5 times that of the Canadian rate (Health Canada, 2000)

- One in five Aboriginal youth reported that they have used solvents. One in three solvent users are under the age of 15, with over half of these indicating use of solvents before the age of 11 (Scott, 1997)

- While representing 2.7 per cent of Canada's population, Aboriginals represent approximately 17 per cent of all admissions to federal corrections (Demographic Overview of Aboriginal Peoples in Canada and Aboriginal Offenders in Federal Correction, 1999)

- The 1997 First Nations smoking rate was reported to be 62%. In Canada, 24% of the population aged 15 years and older were smokers in 2000 (Health Canada, 2000)

- Evidence of high levels of depression, accompanied by failure to achieve, has been identified among children in many Aboriginal communities (Canadian Medical Association, 1994)

Factors contributing to this high rate of addiction and mental health problems include: loss of cultural identity and community, intergenerational historical trauma, poverty, hopelessness, and social marginalization (Frideres, 1998).

Moreover, Census data reveal that the Aboriginal population in Canada will grow by 57% over the next decade, making it the fastest growing population group in Canada (Statistics Canada, 2003). Services must be able to respond to the growing demand from communities seeking assistance in designing and delivering both short term and long term interventions that will address the conditions contributing to the deteriorating health conditions in Aboriginal communities.

The Elder

Urban Aboriginal people face tremendous odds in defeating cycles of poverty, addiction and poor mental health. For Aboriginal people, the need to heal must be accomplished in a holistic manner. This includes addressing the physical problem, but the psychological, social and spiritual needs as well.

Elders do not become Elders because of their age, but must be recognized by the community as ones who have the knowledge and wisdom to guide and care for the people of their community. Elders are seen as gifted individuals with the knowledge to carry out this role. Elders have traditionally provided this support and have been identified as a critical component of the healing process for Aboriginal people. Elders are identified as community leaders, educators, spiritual directors and healers within the Aboriginal Community.

> Elders in Aboriginal communities are those recognized and respected for knowing, living and teaching the traditional knowledge. They see the world through the eyes of the ancestors and interpret the contemporary world through lessons passed down through generations. Their wisdom is transferred to young people who seek their teachings. The elders are a living bridge between the past and the present. They also provide a vision for the future, a vision grounded in tradition and informed by the experience of living on the land, safeguarding and disseminating knowledge gained over centuries (Royal Commission on Aboriginal Peoples, 1996, p7).

In addition, research has noted that the blending of Aboriginal traditions and mainstream services benefit the client and the overall direction and goals of support services. For example, an Elder may encourage a client to receive traditional spiritual guidance in addition to mainstream trauma intervention. In this way, Elders provide support to individuals in accessing health care services while meeting their spiritual and cultural needs. Stiegelbauer (1996) notes:

> The Aboriginal community has long recognized the role of the community Elder as integral in the healing process. Their skills, knowledge and ability to help individuals restore balance in their lives have earned them significant roles within native communities (39)

Research suggests that Elders can and do play a major role supporting the healing process (Morrisette, McKenzie & Morrisette, 1993). They can also act as a liaison between mainstream services and Aboriginal traditions. Elders are also seen as the bridge between the past and the present. They are the carriers of the history and can provide insight into the current problems of the individual within a historical context.

Role of the Elder at CAMH Aboriginal Services: Developing an Integrative Model of Service

What is the role of the Elder?

The traditional Elder has been an integral part of the Aboriginal Services Team for over five years. He is the first and only Elder that is a full time staff member at a teaching hospital in Canada. Our Elder, Vern Harper, brings a wealth of experience to the job. He is seventy-three years old and continues to work on a full time basis with true devotion to his work. Week in and week out, he helps many men and women in reconnecting with their traditional Native culture as well as with a variety of life issues. Our Elder works with status Indians, non-status Indians as well as non-Native clients who are interested in learning more about traditional Native culture. Our clients are drawn from both urban groups as well as those who have come to the city from rural reserves.

The Elder is seen as the connection to the spiritual world and supports both clients and staff in this role. He is seen as a book of living history and shares the oral history that he has learned throughout his life and which has been passed on to him from his own teachers. His role is to focus on the positive identity of each and every one of the individuals who consult him, based on the idea that having strong sense of identity is a strong healing force. Due to centuries of institutional oppression and discrimination, many Native people have developed a negative identity and have internalized self-hatred. Thus, the core of healing is to create a positive identity.

The Elder states that his philosophy of healing is that “We are spiritual beings in a material life, here for a short period of time.” He sees it as his role to help people remember this and to live their lives to the best of their ability. He challenges people to be free and overcome addictions, to say, “I am a free person and I come from free people”. In this philosophy, people have been placed here on the Earth by the Creator and have a mission to take care of Mother Earth. Before the Europeans came to North America, the Native people were a free people and when one is addicted to alcohol or drugs, one is a slave to this and no longer free. The Elder sees addictions as a form of slavery, the opposite of freedom.

There are many clients who come to our service who have not felt safe or comfortable in seeking out help in other agencies, both Native and non-Native. Some clients are hesitant to use Native agencies since the Native community is small and the staff may be familiar to them. In other situations, clients have had negative experiences with mainstream mental health agencies where they have experienced racism and discrimination. The clients of Aboriginal Services have stated on many occasions that they are very comfortable with the staff at our service. Some even feel that they get the best of both worlds Aboriginal and non-Aboriginal intervention.

Clients

When dealing with Aboriginal clients it is extremely important to know if they are non- traditional, neo-traditional or traditional. A non-traditional is a person who is assimilated and has no appreciation of Aboriginal traditional, a neo-traditional is one who can live in the mainstream and Aboriginal worlds comfortably, while a traditional is one who lives in the Aboriginal world. Clients who come to the program are given a choice to use this model or not. Those that do not feel comfortable with Aboriginal traditions tend to be struggling with their identity or simply do not believe in Aboriginal culture and beliefs. (Morrissette, V., McKenzie, B., & Morrissette, L., 1993).

Client Problems:

Clients come to Aboriginal Services with a variety of life issues. Many clients seek help to overcome addiction to alcohol and drugs and may have long standing substance abuse problems. Clients come to the service through self-referral, through referral from other mental health agencies and also from the penal system. Our counsellors work with many men and women who have recently been released from prison and want to make positive changes in their lives. Other clients want help to address psychiatric problems that have not been appropriately treated within the mental health system. Many clients have had negative experiences with the psychiatric system, having been misdiagnosed, overmedicated, or mistreated. For Aboriginal people, racism in mental health treatment is too common. Many Aboriginal clients have said to our staff that "It is about time" there is a service like this at the Centre for Addiction and Mental Health.

Other clients seek out our services to overcome difficulties relating to physical, sexual, spiritual and emotional abuse. Clients have had negative experiences with abuse during their attendance at residential schools. These abuses have been well documented in various reports that have examined the treatment of Aboriginal people in residential schools in Canada (Assembly of First Nations, 1994; Hodgson, 1990; Royal Commission on Aboriginal Peoples, 1996)

The issue of a positive cultural identity is a very empowering and healing element in the life of an individual and a group. An important role of the Elder at Aboriginal Services at CAMH is to provide a positive role model of an Aboriginal person. The very presence of an Elder as part of the Aboriginal Services team honours Aboriginal people and supports Aboriginal culture. After many centuries of the negative treatment of Aboriginal people by mainstream mental health services, the healing power of an Elder on staff is significant. The Elder also provides extensive instruction in traditional cultural teachings to individuals and groups at various community centres with whom we have developed partnerships. The Elder provides healing circles based on Native principles at drop in centres, community centres and also for the patients and staff of the Centre for Addiction and mental health.

Another exciting element of the Aboriginal Services program is the Sweat Lodge that is provided to our clients. The Sweat Lodge is a rite of purification that is a powerful therapeutic modality. This Sweat Lodge is offered on a regular basis to our clients as one of the approved treatments at CAMH, with appropriate protocols and established medical guidelines.

How does the Elder address particular problems?

One of the difficulties that clients bring to the Elder at Aboriginal Services is their suicidality. Suicide is a very serious problem in the Aboriginal population in Canada, with Native people showing a rate of suicide significantly higher than the general population (White & Jodoin, 2003; Choosing Life: Special report on suicide among Aboriginal people, 1995). When clients consult the Elder about suicidal thoughts or plans, he provides them with traditional teachings about the nature of suicide from the Native perspective.

From the traditional Native perspective, suicide is seen as a selfish act, since people do not have the right to commit suicide. Life and death are in the hands of the Creator and as such, suicide is seen as an individual's interference with the destiny of the Creator. In this view, people who commit suicide are not aware of the implications of this as well as of the effect of a suicide on others. In this view, the body is seen as sacred, and when the body is destroyed the soul is trapped and cannot move on to the spirit world. In the teachings, suicide is not seen as an answer, and will not bring an end to suffering but will in fact create further suffering. As such, suicide is not a solution to the pain of living. The challenge is to find other ways to deal with the pain of living, through prayer and healing.

The causes of suicide are complex, and have to be understood within the context of historic trauma. In this context, there has been significant family breakdown, which is seen as a contributing factor in youth suicide. With family breakdown, there has been the loss of traditional culture and teachings about the place of youth in society. As youth recover these teachings and pride in their own identity, suicide can diminish.

From a traditional Native perspective, a suicidal person can be helped by building up their self-esteem and by exploring with them how their suicide would affect other people. As an Elder, it is his responsibility to share teachings about the traditional belief system about suicide. In the Elder's view, it is crucial to be connected to one's own tradition and ancestors: "If you don't know your ancestors, you don't know who you are."

From a Western clinical perspective, suicide is often seen as having an element depression with a triggering event. In the clinical perspective, spiritual or social elements are usually not included as they are in the Native view.

How does the Elder provide teachings?

The Elder teaches through his very presence. By being a staff person at Aboriginal Services, he carries the tradition of Native people and portrays pride in Native culture. In his teachings, the Elder uses storytelling as the primary tool of teaching and healing. When clients discuss their difficulties, he shares personal stories that are relevant to the individual. The stories are often focused on overcoming difficulties, showing by example that problems can be overcome. For example, if a client is discussing a problem with loss and grief, the Elder will try to find something in his own experience or the experience of his teachers, to find a point of connection with the client, and tells a story where grief has been overcome. This gives the client hope in the possibility of their own healing.

Someone who is not familiar with a Native style of teaching and healing may think that there is no particular agenda in the counselling session, but the conversation is full of teachings, personal reflections, and symbolism. One example of this storytelling is the teaching on keeping a knife under the pillow in order to cut to the cord to the negative. In addition, the act of listening deeply to the client is very healing in itself, since many clients have not been truly listening to by others.

The Elder also places the current problems of the client in a larger perspective, by reminding them that nothing stays the same and everything changes in life, so that their current pain and suffering will also pass.

An important issue that is brought forward by clients concerns their identity as a Native person. There is confusion for some people about their identity since they were not brought up within Native culture, or have had negative messages about being Native. The Elder creates an environment where it is possible and comfortable to talk about being Native and to talk about confusion in this area in safety.

Clients talk about their experiences in residential school, where being white was “good”, being Indian, was seen as “bad”. There is discussion of self-worth and Indianness, and shades of one’s skin, where lighter skinned people were seen as having higher status. One of the questions that the Elder finds it difficult to ask is: “How comfortable are you with your Indianness?”

The Elder’s teachings support the view that Native people have to know about their cultural heritage. Even when individuals are successful in their lives, it is important to know about their culture, otherwise there will be something incomplete in their lives. This Native culture is very rich, alive and changing all the time.

The Elder has a direct and straightforward style in his teaching and healing work. His style is more direct and directive than Western trained counsellors, he “doesn’t want to waste time”. Sometimes he teaches in riddles, as did one of his teachers, Crow Dog, who encouraged people to think critically. The Elder uses the Circle as a basis of teaching. The Circle represents the circle of life and the phases of life. The process of healing is related to “stepping into the circle”. For example, a homeless person can have a sense of belonging when he “steps into the circle”.

He encourages people to get to know themselves and to find peace inside, to move from self -hatred to self-love. He discusses people’s belief systems and how they came to develop them, and he encourages people to value their lives and their time on earth, reminding them that they spiritual beings on the earth for a short time. He wants to give people hope and motivate them to work on themselves and their lives in a positive way. The Elder states that all people are looking for something to believe in, and he tries to inspire them to believe in themselves.

What kinds of problems to our clients bring to us?

The clients that come to Aboriginal Services represent a wide diversity of styles and problems. We are consulted by men and women, both older and younger people.

Sometimes, as is often the case in psychotherapy and counselling, the client will say that his or her problem is about addictions, but then the realities of the underlying unfinished grief or history of trauma emerges. Problems are multi-layered and may also be part of an intergenerational patter of trauma and grief, with unresolved problems being passed on from parents to children, and even grandchildren.

Substance abuse:

Many clients bring problems of substance abuse to our counsellors. Some individuals are referred to our service by Corrections Canada as they complete their sentences. They seek help to re-enter society and prevent their return to prison. Some clients have already been through treatment centres for their addictions, but have not been successful in leaving their addiction behind. By engaging with counselling that addresses issues of Native identity and intergenerational grief and trauma, there is more likelihood that treatment will be successful.

Psychiatric Problems:

Some clients that seek out our services have been dealing with long-standing psychiatric illnesses, which have been undiagnosed or misdiagnosed. The lack of appropriate mental health services for Native people has led to difficulties in accessing services and follow-up with treatment. With a service that is based on Aboriginal culture and values helps to increase access to needed services

Abuse:

The incidence of physical, emotional and sexual abuse among Aboriginal people is very high. This is generally understood within the context of intergenerational trauma, with abuse being an expression of the broken ties between parents and children that are connection to the experiences of cultural loss and residential schools. In this model of treatment, the Elder and the counsellors will not push individuals to disclose abuse, but focus on how to heal this abuse.

History of Adoption and Foster Care

Aboriginal people have experienced high levels of adoption and foster care as part of their history. In the adoptive or fostering situation, Native identity has not always been seen as a source of pride, and self-esteem can suffer. In our service, counselling and healing in response to these issues includes an understanding of the historical and cultural factors in adoption and fostering, and a healing plan is developed that supports the development of a strong sense of self and a positive Aboriginal identity.

Experiences of Incarceration:

Some individuals come to the Aboriginal Services Program following either short or lengthy incarceration. They are ready to make a new start in their lives and sometimes lack the faith, skills and motivation to make these changes. The Elder and the counsellors work with these individuals to help them come to terms with their history of imprisonment and inspire them to make a fresh start. The team also helps them to put a practical plan into place that will allow this hope for change to become a reality.

Issues of Aboriginal Identity

Many clients come to our service with very limited knowledge of their identity as Aboriginal people or may have internalized negative views of being Aboriginal. The presence of the Elder, other Aboriginal counsellors, and teachings on Aboriginal history and culture, all serve to support individuals in reclaiming a positive Aboriginal identity. In addition, there are discussions of the positive values of living in two cultures: both the urban culture and the Aboriginal world. The gifts and strengths of both cultures are explored and supported.

The Elder and the Counsellor: An Integrated Model of Counselling

In our program, the Elder and the counsellors work very closely together, often in the same session. The counsellors are trained in Western mental health treatment modalities as well as being versed in Aboriginal cultural values and healing approaches. Treatment includes both individual sessions with clients, as well as group healing circles.

In describing a typical session, the counsellors outlined a few key points, stating that in the Aboriginal view, life is an interconnected circle, where psychotherapy and spirituality are connected. In the Western psychological paradigm, the client is usually seen as an isolated individual, not placed within his or her historical or cultural context. In the Integrated Model of Service, the individual's difficulty is understood within personal history, collective culture, and intergenerational perspectives. It is believed that the history of colonialism has a personal impact on individuals, and that the healing process is to come to full consciousness of this impact, and then to learn how to heal this. In these settings, Western clinical modalities may also be employed to help people overcome these difficulties.

In response to a sense of alienation from Aboriginal culture, the Elder will act to welcome individuals back to their culture and support them to interact positively with their own history and culture. The attitude of healing is one of "welcoming" rather then fixing, or having a specific therapeutic agenda. Storytelling is a vital part of the healing process, with stories serving to connect to history, to inspire, to transform, and to provide knowledge about how to overcome difficulties. It is the story that carries the connection of history, language and pride.

In the setting of the Integrated Model of Counselling, a Western trained therapist has to be open to changing their style of practice and orientation. In these sessions, the therapist is often more silent, and has to learn to understand the power of story, community and history. In working alongside the Elder, the Western trained therapist will be more active when the discussion is focused on issues of addictions, abuse and relationships. When the discussion is more the realm of Native culture and identity, the Elder is more actively involved in the session. The Elder can act as the grandfather image, supporting individuals to return to the circle of community. The Elder, client and therapist become part of a community together and creates a sense of belonging that breaks down isolation and is healing in itself.

In this setting, the Western trained therapist needs to let go of prescribed role and "go with the flow": The therapists describe their experienced as "entering into the idea of a healing space, a sacred space for healing...the focus is on the experience, rather than the analysis of the situation. A situation of great respect is created, an I-Thou relationship."

In each situation, the counselling session is different, responding to the situation at hand. The counselling evolves organically from session to session. The Integrated Model to Counselling is a living entity, changing and adapting over time, and responding to situations as they develop. This open model of counselling is a departure from the more protocol-oriented modalities of Western clinical models of counselling.

In discussions with the Elder, he also shared that he too is learning about clinical mental health treatment. When it is appropriate, he also steps back and lets the counsellor lead the session.

Healing Modalities in the Integrated Model of Service

A variety of healing modalities are used in the Integrated Model of Service. In addition to healing circles and storytelling, the counsellors each have their own specific areas of expertise. The medicine wheel is often used as tool for self-reflection and supporting ideas of balance. One of the Western trained therapists works with family systems approaches to understand and locate historical trauma and its impact on the individual and also to understand intergenerational views and impacts. Another therapist has been trained in expressive arts therapies and uses the arts to help people to be in the moment, and uses expressive arts to provide safety and containment in treatment.

The Elder specializes in storytelling as a healing form of treatment. In his style, clients are made to feel very comfortable and it is more like a “fireside chat” rather than a therapy session. The particular Elder that works with the program is well known and respected in our community, and this creates positive transference by clients, in that they feel somehow special to be working with him.

Reflections on working with the Integrated Model of Service: Differences between Aboriginal and Western models

In preparing this article, the team spent considerable time discussing various forms of treatment used, and focused on some of the differences between traditional Aboriginal cultural teachings and Western psychotherapeutic modalities. These are some of the differences that were discovered:

In Traditional teachings, there is more focus on healing and balance, in Western therapy; the focus is more on developing better coping strategies. In Traditional healing, the healing sessions are more open-ended, with a lot of value being given to emotional content, while in Western psychotherapy, there is often more focus on techniques and protocol. In Traditional approaches, there is more specific focus on bringing the client back into Native culture and a sense of belonging, while this issue is seldom discussed in Western style psychotherapy.

The role of boundaries and self-disclosure can be different: in the Aboriginal style there can be more self-disclosure in the interest of healing, healing through example and role model, while Western trained therapists are taught to be very private about their personal lives.

The role of spiritual and cultural teaching is the core and foundation of Aboriginal healing, so that healing incorporates the Teachings of the Seven Grandfathers; while in Western psychotherapy, spiritual teachings are not included in most approaches.

The role of power is also handled differently in the two traditions: in the Aboriginal healing style, the power difference is less striking, with the Elder sharing power and stories with the client.

In the Integrated Model of Counselling, the healing encounter is seen as occurring in sacred space, where the client and the therapist can come into a respectful connection and the client can be experience a sense of safety and acceptance. The person of the Elder and the therapists provide a healing presence for the clients seeking help. This approach is traditional to the Aboriginal view of healing, and can also be found in some Western spiritual psychology approaches.

In addition, the Elder is very interested in learning about Western counselling models and feels that other Elders would also benefit in gaining expertise in these areas

The Elder and the therapists are developing unique ways of working together and learning from each other. They are engaged in developing a vital healing style that is based on Aboriginal traditional values and incorporates Western therapeutic techniques. The Elder also provides vital support and teachings for the team overall, and keeps the work grounded in an Aboriginal spiritual paradigm.

Sweat Lodge

Aboriginal Services provides a Sweat Lodge ceremony in conjunction with mainstream therapeutic intervention. As indicated, many of the people accessing the Aboriginal Services are either homeless, on probation or parole, and are not actively engaged in the Toronto Native community.

The Sweat Lodge ceremony is offered to Aboriginal clients participating in CAMH services who are seeking a traditional healing approach. Within the Sweat Lodge, individuals can make a connection with cultural and spiritual forces for healing and release the difficulties that they experience in their lives. The element of heat that exists within the Sweat Lodge is also seen as purifying on the physical, emotional and spiritual levels. For many clients, this may be their first experience of this powerful healing modality, and it helps them to connect with their traditional culture, which is also empowering to them.

Elder Vern Harper sees the Sweat Lodge like a church, a hall, a temple, or a synagogue. He sees it as a place where people come to be cleanest and healed. He sees it as an important part of the clients healing journey.

> “The Sweat Lodge should be apart of the addictions and mental health healing – we need to clean our soul, mind, body and heart to be whole and just me the good people we should be” (Elder Vern Harper, 2007)

Elder Vern Harper sees this as an important step of bridging Aboriginal and mainstream intervention. He also noted that many of the clients that he sees are medically vulnerable and need to be taken care of in the sweat lodge. Each client is medically screened before they enter the sweat lodge to assure that it is appropriate for them.

Conclusion

The Integrated Model of Counselling that is being developed at Aboriginal Services at the Centre for Addiction and Mental Health is a vital and exciting model of service that combines Traditional Native healing with Western clinical approaches. By offering this integrated model, clients who access our services benefit from the presence and healing power of the Elder as well as from clinical interventions. Each therapeutic encounter honours the client at exactly the place that they are, and supports them to heal in a holistic manner. The Elder and therapists are evolving a unique model of healing and therapy that is based on the recognition of the power of traditional Native healing and identity. We look forward to the further development of this model and opportunities to share this with our colleagues.

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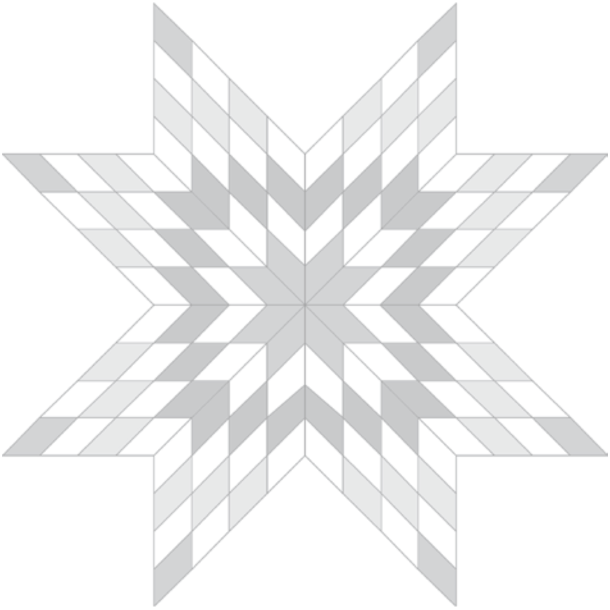

The Role of 'Kijigabandan' and 'Manadjitowin' in Understanding Harm Reduction Policies and Programs for Aboriginal Peoples[1]

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Abstract

Harm reduction policies and programs are gaining increasing acceptance as a promising practice to address high-risk substance use in Canada. A common premise of Western harm reduction initiatives is respect for substance users and their choices. An Aboriginal worldview extends this to understanding individuals, communities and their choices. This paper examines how the Algonquin concepts of 'Kijigabandan' and 'Manadjitowin' can be used to explore harm reduction's value as a promising practice for Aboriginal social work. 'Kijigabandan' means to attempt to understand and develop personally from the process. 'Manadjitowin' means to honour someone or something once it is understood. This is a timely paper because at present there is no uniform starting place to address the value of harm reduction policies and programs as they relate to Aboriginal peoples.

Introduction

Harm reduction is a controversial term. It frequently incites debate and at times brings forth moral-based responses. For example, a very lively public dialogue has surrounded the establishment and operation of Canada's only supervised injection facility, Insite, in Vancouver's Downtown Eastside (Beirness et al., 2008; The Province, 2008; Wild, 2002). Empirical-based and opinion-based deliberation has variously surfaced; it has spanned from the corridors of federal and provincial legislatures, to academic journals and public newspapers. Similar debates, although of a lesser magnitude, surround other harm reduction programs and policies, such as the distribution of crack pipe kits and needle exchanges for injecting drugs. In spite of the controversy that surrounds harm reduction, one element remains constant: there is a wide disparity of understanding across the country and in various groupings, including among Aboriginal peoples, of what harm reduction is, and its value as a promising practice for Aboriginal social work.

The purpose of this paper is to examine how the Algonquin concepts of 'Kijigabandan' and 'Manadjitowin' can be used in Aboriginal social work to explore the role of harm reduction policies and programs in increasing the health and well-being of some Aboriginal peoples from problematic substance use. We begin by reviewing the extent and contexts of Aboriginal peoples' use of alcohol, drugs and other substances. This review relays the unambiguous need for efforts to address the harmful consequences of substance abuse. We then discuss harm reduction as an increasingly popular promising practice in Canada for high-risk substance use. We specifically consider what this means from a Western worldview1, and in particular harm reduction's emphasis upon respect for users and their choices. We compare this concept of respect against that of 'Kijigabandan' and 'Manadjitowin' from an Aboriginal worldview. 'Kijigabandan' means to uninhibitedly look at and study something in an attempt to understand it, and develop personally from the process. 'Manadjitowin' means to honour someone or something once it is understood. An Aboriginal worldview indicates a need to understand the interconnectedness of individuals and communities and raises the question of why respect is being offered.

We use the example of needle exchange programs to illustrate the potential of the concept of 'Kijigabandan' to further understanding about harm reduction for Aboriginal peoples. Only once this undertaking (Kijigabandan) is achieved, can it be claimed that an individual 'Manadjija' (refers to someone) or 'Manadjito' (refers to something); that is, someone or something is honoured or celebrated. We also illustrate how the concepts can assist social work with addressing two key barriers that often impede Aboriginal-specific harm reduction discussions: widespread support for abstinence, and the entrenched belief that harm reduction and Aboriginal culture are incompatible.

The problematic use of alcohol, drugs and other substances[2]

Information on the general health status of Aboriginal peoples in Canada is lacking (Adelson, 2005; Cardinal & Adin, 2005). Data that does exist indicates that Aboriginal health is well below the national average (Health Council of Canada, 2005; National Aboriginal Health Organization, 2004a). There is a similar absence of data on the problematic use of alcohol and other drugs among Aboriginal peoples. That which exists does convey however that detrimental consequences may be greater for some Aboriginal peoples than among the general Canadian population.

Alcohol[3]. Although Aboriginal peoples have among the highest rates of abstinence from alcohol, and drink less often than the general population (17.8% vs. 44.0% reported drinking weekly), there are high levels of heavy use, such as binge drinking (Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000). The 2002-2003 First Nations Regional Longitudinal Health Survey concluded that the proportion of heavy drinkers among First Nations adults is higher than in the general Canadian population (First Nations Centre, 2005). Although the relationship is complex, alcohol has a documented role in personal and social harms, including violence, injury and suicide. The rate of death due to alcohol abuse among Aboriginal peoples is nearly twice that of the general Canadian population: 43.7 per 100,000 vs. 23.6 per 100,000. Rates for alcohol-related hospitalization among First Nations and Inuit are also well above national and regional rates for the general Canadian population (Single, Robson, & Scott, 1997).

*Illicit drugs***.** Studies indicate that indigenous Canadians, as a group, also experience disproportionately high rates of illicit drug abuse (Scott, 1997; Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000). According to the 2002-2003 First Nations Regional Longitudinal Health Survey, although the documented rate of illicit drug use in the past year is low (7.3%) among First Nations, it is still more than double the rate of the general Canadian population (3.0%) (First Nations Centre, 2005). The overall morbidity rate from illicit drug use is almost three times higher for Aboriginal peoples than for the general population: 7.0 per 100,000 vs. 2.6 per 100,000 (Scott, 1997).

Injecting illicit drugs is a key mode of transmission for the human immunodeficiency virus (HIV) among Aboriginal peoples in Canada (Public Health Agency of Canada, 2004). In a 2003 study of the residents of the Downtown Eastside in Vancouver, HIV infection was found to be double the rate of non-Aboriginals (Craib et al., 2003). Of specific concern, between 1998 and 2003, 66.9% of all HIV-positive tests among Aboriginal women in Canada were attributable to IDU (Poole and Dell, 2006). In a 2006 Vancouver study, the mortality rate for Aboriginal female injection drug users mainly from drug overdose, homicide and HIV/AIDS, was nearly 50 times that of the province's general female population (Spittal et al., 2006).

*Prescription drugs***.** There is a need for increased understanding about the problematic use of prescription drugs among all Canadians (Health Canada, 2006). Although dated, a 1995 study found that prescription drug abuse "is increasing among First Nations and Inuit people who are referred to NNADAP (National Native Alcohol and Drug Abuse Program) in-patient treatment programs" (Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000, p. 50). A more recent study (2002) carried out in Calgary, concluded that "[i]nappropriate prescription medication use was a significant problem among an Aboriginal population that sought addiction treatment" (Wardman, Khan & el-Guebaly, 2002, p. 355).

*Volatile solvents***.** Similar to the situation with prescription drugs, there is a need for more understanding about volatile solvent abuse (VSA) in

Canada. The current rate of VSA among Canada's Aboriginal youth as a whole is not known (Dell and Beauchamp, 2006). High rates of VSA have been documented, however, among some First Nations and Inuit youth living in various rural and remote areas of the country. For example, a 2003 report from Pauingassi First Nation in Manitoba concluded that half the children under 18 living on reserve abused solvents (O'Brien, 2005, August 24).

The problematic use of substances by First Nations, Inuit and Métis is interrelated with historical experiences (Arbogast, 1995; Framework Subcommittee of the National Native Addictions Partnership Foundation & Thatcher, 2000; Inuit Circumpolar Conference & Inuit Tapiirit Kanatami, 2005; National Aboriginal Health Organization, 2004b). The erosion of a traditional way of life has had a negative impact on Aboriginal communities, families and individuals, including multi-generational losses of homeland, traditions, language and culture. This is very much rooted in government legislation (including the Indian Act), systemic racism and discrimination, the deliberate killing of wildlife and sled-dogs, placement on reserves and relocation, and the historic impact of residential schooling. These experiences have affected individuals' health and wellness in general, and have contributed to high rates of poverty, poor social and economic structures, violence, unemployment, crowded living conditions and family breakdown. Of particular importance is the health status of Aboriginal women; their lives are disproportionately affected by family violence, sexual harassment, inequality, discrimination, single parenting and poverty (Boyer, 2006; Canadian Aboriginal AIDS Network, 2002).

Together, the available data and recognition of the impact of historical influences on the current health and well-being of Aboriginal peoples indicate a need for efforts to address the problematic use of alcohol, drugs and other substances. Harm reduction policies and programs are gaining increasing acceptance in Canada as a promising practice for addressing high-risk substance use. Specific consideration must be given to harm reduction's value as a promising practice for social work with Aboriginal peoples.

Defining harm reduction

The concept of respect

Harm reduction is a "health-centred approach that seeks to reduce the health and social harms associated with alcohol and drug use, without necessarily requiring that users abstain. Harm reduction is a non-judgmental response that meets users 'where they are' with regard to their substance use…" (Thomas, 2005, p. 1). Harm reduction includes a broad continuum of responses, from safer substance use (e.g., needle exchange program) to abstinence (e.g., refraining from the consumption of alcohol). Essential to a harm reduction approach is that it offers users a choice of how they will minimize the harms from their substance use.

According to the Canadian Centre on Substance Abuse National Policy Working Group, harm reduction has five key features. They are:

- Pragmatism: Harm reduction accepts that some use of psychoactive substances is inevitable, and that some level of substance use is expected in a society.
- Humane Values: No moralistic judgment is made, either to condemn or to support the use of substances, regardless of level of use or mode of intake. The dignity and rights of the person who uses alcohol and other drugs are recognized.
- Focus on Harms: The extent of a person's substance use is of secondary importance to the health, social and economic harms resulting from that use.
- Balancing Costs and Benefits: There is a need to assess the relative importance of drug-related problems, their associated harms and the costs/benefits of harm reduction interventions.
- Hierarchy of Goals: Most harm reduction programs have a hierarchy of goals; the most pressing needs are addressed first (1996).

A common premise of Western harm reduction initiatives is respecting users and their choices surrounding substance use. To illustrate, a 2002 background paper on harm reduction published by the Centre for Addiction and Mental Health states that "[a] central tenet of harm reduction that is compatible with CAMH's mission and client-centered philosophy is the respect for individual decision-making and responsibility" (Erickson et al., 2002, p. 3). The Alberta Alcohol and Drug Abuse Council's (AADAC) policy on harm reduction similarly declares "…persons with alcohol, other drug, or gambling problems are [to be] treated respectfully as legitimate members of the community who need help…" (AADAC, 2004, p. 1). The work of Ormond (2002) in Manitoba with Aboriginal peoples likewise identifies that "[t]he central principle of respect and valuing the strengths of people should be the focal point of [harm reduction] initiatives" (p. 37).

Respect is defined in this context as feeling or showing deferential regard for someone or something (Funk & Wagnalls 1986, p. 1145). Respect is a deep-seated attribute in the Western worldview. It is evident, for example, in time-honored traditions (e.g., bowing or curtseying to the Queen of the British Monarchy) as well as in popular culture (e.g., Aretha Franklin's 1967 hit song 'respect' was celebrated among the feminist movement of the time). Central to contemporary applications of the term is that it is, in various ways, nearly void of understanding *why* respect is being offered.

The etymology of the term respect is the Latin term *respectus*, the past participle of Latin *respicere*, which refers to the act of looking back. More precise, it means to pay attention to or consider something (Ayto, 1990, p. 442). This is a very different meaning in comparison to our contemporary understanding that emphasizes deference, and in fact, the heritage of the term relates more closely to that of 'Kijigabandan' and 'Manadjitowin' from within an Aboriginal worldview.

The concepts of 'Kijigabandan' and 'Manadjitowin'

As illustrated above with the concept of respect, the meanings of words can change over time (Model Languages, 1995). The history of language is able to offer insight into a particular worldview of a particular historical period. The meanings of words among different languages can similarly offer understanding. As well, beliefs surrounding and the various roles of language (e.g., acquisition and transmission of traditional knowledge) can likewise relay important understanding. This is well illustrated in a 1998 report of the BC First Nations Education Steering Committee. The report explains that "[t]he Aboriginal Languages were given by the Creator as an integral part of life. Embodied in Aboriginal languages is our unique relationship to the Creator, our attitudes, beliefs, values, and the fundamental notion of what is truth" (Ignace, 1998, np).

Given that the concept of respect is a common premise to most Western harm reduction initiatives, one of the authors of this paper, Kathleen Cayer, spoke with an Elder, linguist and language teacher in her home community4 of Kitigan Zibi Anishnabeg, near the town of Maniwaki, Quebec, to gain more insight into the term's relationship with Aboriginal peoples. Through the wisdom of the Elder, linguist and language teacher, it was relayed that in the Algonquin language there is no comparable word to respect5. Aboriginal worldview centres on the interconnectedness of all life and life processes. The closest term to respect is the combination of 'Kijigabandan' and 'Manadjitowin'. "Kijigabandan' means to uninhibitedly look at and study something in an attempt to understand it. It suggests that while something is being studied, or looked at, understanding is being gained and an individual develops personally from the process. It does not take as a given, however, that understanding will be achieved. 'Manadjitowin' refers to bestowing honour onto someone or something once understanding has been gained. Clearly this does not parallel the individualized Western definition of respect, and in fact, certainly posses the question of why respect is being given.

To illustrate, consider Canada's growing preoccupation with 'protecting the environment'. We are told as members of a Western civil society that we are to respect the environment—we are to recycle, conserve energy, protect wildlife, celebrate Earth Day, and so on. However, if individuals do not have an engaged understanding of why they are 'respecting' the environment, it will impede their active participation in doing so. Partaking in an activity without fully internalizing its meaning, or understanding why you are involved in it, is not sustainable in the long-term. It also does not contribute to an individual's personal development, and nor does it contribute to the honouring or celebration of animate beings and objects.

Conversely, consider what is meant within a traditional Aboriginal worldview to respect Mother Earth and all her gifts. There is a deep sense of understanding of what this means, and it translates into actions. Aboriginal peoples traditionally pay reverence to earthly objects such as trees, herbs, and fruit because according to their belief system, these objects contain an honourable spirit. For example, the earth and its abundances are acknowledged in prayer and thanks are given for everything provided. Permission is asked to take from the earth and resources are not wasted (e.g., unneeded branches of a tree are used for firewood). Also, when resources are taken from the earth, such as trees, they are replenished (e.g., most First Nations today have by-laws that govern the number of trees that can be cut and replanting is mandatory). Applying this logic to an examination of the potential for any Aboriginal-specific harm reduction initiative to contribute to individuals' health and well-being, it is possible that applying the terms 'Kijigabandan' and 'Manadjitowin' offers an important starting place.

Although it has been suggested that an insightful understanding of why respect is being offered is generally lacking in contemporary Western applications of harm reduction, there is recent indication of progress. Drug user groups and individuals' lived experiences are increasingly being included in consultations on problematic substance use (Canadian HIV/AIDS Legal Network, 2005). Canada's national user's group was established in 2006 and held its inaugural meeting in conjunction with the International Harm Reduction Conference in British Columbia. The experiences and expertise of localized user groups across the country have also been recognized. The Vancouver Area Network of Drug Users (VANDU), for example, has been instrumental in the establishment of harm reduction programs, such as Insite, in Vancouver's Downtown Eastside. Incorporating lived realities into discussions of harm reduction programming and policy naturally contributes to increased and discerning understanding of the potential need for and value of such initiatives.

Considering community

An Aboriginal worldview not only contributes to understanding harm reduction through the concepts of 'Kijigabandan' and 'Manadjitowin', it also offers insight into the role of and the need to provide choice to communities alongside individuals. As discussed, a Western approach to harm reduction emphasizes the offering of choice to users on how they will minimize the harms from their substance use. Aboriginal worldview indicates a need to understand the interconnections between individuals, communities and their choices. “An individual’s inner spirit is [understood to be] intertwined with their family, community, and the land and cannot be understood apart from them” (Dell et al., 2008:86). Once again this highlights the importance of acknowledging the interconnectedness of all life–individuals cannot be separated from their communities. An individual is understood to be at the same time their inner spirit (internal) and relations with their collective community (Dell et al., 2006)

It follows that any discussion of harm reduction measures among Aboriginal peoples must start by acknowledging that the development of effective policies and programs needs to be founded and directed by communities and their members. The work of Gray and Sputore (1998) supports the “open negotiation of realistic, achievable project goals, that are responsive to the needs of Aboriginal communities as they define them, instead of forcing them into the mould of uniform program objectives” (Gray and Sputore, 1998, p.46). The importance of this is illustrated in a 2004 study on the use of stop-smoking aids by First Nations. The study found that aids developed by Western society were rarely used among First Nations and concluded that “medication use, [such as the nicotine patch], may not be appropriate for [First Nations] smokers whose beliefs involve primarily behavioral modification” (Wardman & Khan, 2004, p. 691). The size and scope of needs and strengths (e.g., ranging from the historical impacts of colonization through to the importance of cultural knowledge and tradition to healing) specific to Aboriginal peoples and their communities must be acknowledged in any discussion of harm reduction. This highlights the necessity of community consultation in discussions of harm reduction policies and programs (Wardman & Quantz, 2006; Canadian Aboriginal AIDS Network, 1998). This understanding is generally practiced in Aboriginal social work’s holistic approach (e.g., account for the impact of colonization and indigenous ways of knowing) (McKenzie & Morrissette, 200)

Learning from 'Kijigabandan' and 'Manadjitowin'

A range of harm reduction policies and practices specific to substance abuse are in use by Aboriginal peoples and their communities (both urban and rural) across the country.6 For example, the Western Aboriginal Harm Reduction Society has a managed alcohol consumption program where it provides beer to alcohol-dependent individuals to prevent them from using more harmful substances when they cannot obtain beverage alcohol (Vancouver Area Network of Drug Users, n.d.). Some Aboriginal communities have implemented regulated consumption harm reduction policies. These are instances where policies that support moderate drinking practices and reduce problems related to alcohol misuse have been designed and implemented by the community (e.g., not allowing youth to attend community events where alcohol is being sold) (Drake, 2002; Landau, 1996; Lauzon et al., 1998).

Just as there is a range of accessible harm reduction policies and programs, so too is there diversity in degrees of understanding of harm reduction generally and offering services specifically to Aboriginal peoples and communities, including within Aboriginal social work (Landau, 1996; Korhonen, 2004). It is well known that within social work programs generally in Canada, substance abuse specific courses are not widely available. The concepts of 'Kijigabandan' and 'Manadjitowin', coupled with recognition of the interconnectedness of individuals to their communities, will be the starting point for discussing the potential of harm reduction initiatives to contribute to the health and well-being of Aboriginal peoples. Initiating this discussion from an Aboriginal worldview should prove to be more meaningful in comparison to a Western worldview's concentration on the individualized concept of respect. The example of needle exchange programs (NEPs) for intravenous drug users will be used.

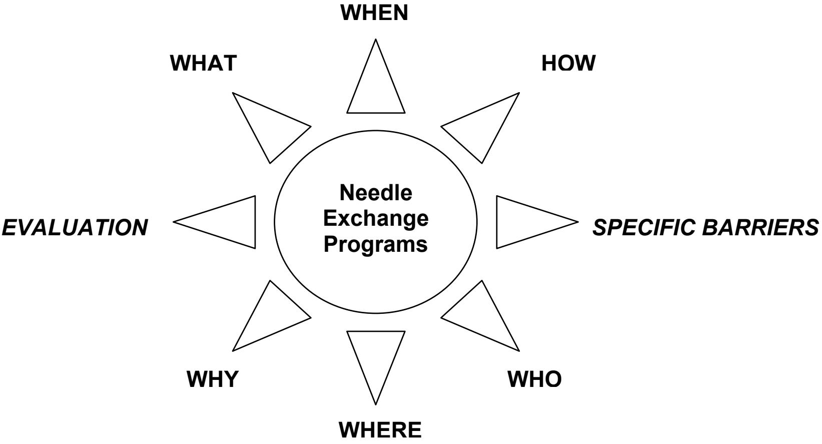
Our aim with the NEP illustration is to provide information that relays understanding about them. Again, from the perspective of 'Kijigabandan' and 'Manadjitowin', not only is the goal to examine NEPs in an attempt to relay information about and thus understand them, but it is also to develop personally from the process of doing so, and ultimately develop honour for someone and/or something. Although the reader will likely not be able to achieve ‘Manadjija’ or ‘Manadjito’ with our brief example, it does relay the potential utility of this as a starting point.

To initiate an understanding of NEPs, we applied the framework of Acoose’s (2007) writing on her personal experiences as a First Nations woman healing from illicit drug and alcohol abuse. The intent of Acoose’s work is to have the reader gain an ‘in-depth’ understanding of her lived experiences. She communicates this in her introduction:

> This…will be a window to review the past and a means to discover what it was like living in a world that was dark, bleak and filled with alcohol, drugs and crime. It will give you a wealth of information and help you gain a better understanding of why Indian women drink, do drugs and commit crime(s). There is a world out there that many people will never understand no matter how many books they read or how many University degrees they have. Education does not reveal why, when, where, how or what an Indian woman endures living in violence and/or running and hiding from the law or her man or herself or a combination of these things. Finally, it is important for people to understand that as Indian women we did not just wake up one morning and say: “Hey, I think I will become addicted to drugs” or “Hey, I think I want to be an alcoholic” or “Hey, I think I will sell my body and become a prostitute”! NO, hell no, we did not just wake up one morning and make these decisions. It was all there waiting for us lurking in the dark. Eventually, without care, compassion or anyone to love us, we would follow a spiral staircase, and evolve ever so gently, sensually, and maliciously into a life of crime (Acoose 2007, 1).

Acoose’s work relays how imparting understanding can be facilitated by providing insightful information in six key areas: who, what, when, where, why and how. We have added a seventh and eighth area: methodologically-sound and culturally-appropriate evaluation, and addressing specific barriers (see Diagram A). Evaluating the outcomes, impacts, benefits and weaknesses of harm reduction programs and policies are a fundamental part of ‘Kijigabandan’, and if achieved, then ‘Manadjitowin’. Without systematic empirical review, it is not possible to determine the effectiveness and appropriateness of harm reduction programs for Aboriginal peoples (Dell & Lyons, 2007). In addition, when attempting to gain understanding about an issue, it is important that key barriers to understanding, whether individually-based or socially-based and specific to the issue at hand or not, must be acknowledged. This recognizes the inter-connectedness of individuals with their communities. Again, although the needle exchange example below does not provide in-depth information, it is a starting point for relaying information for Aboriginal social work, alongside its grounding within Aboriginal culture, values and philosophy, to initiate discussions and further understanding.

Diagram A



What is a needle exchange program?[7]

Generally, NEPs provide injection drug users (IDU's) with clean needles and injection equipment as well as safe disposal for used needles. NEPs also offer information on safer injecting practices and addiction resource services that span an individual's physical, emotional, social and spiritual well-being. Federal, provincial/territorial and local governments fund NEPs across Canada (Weekes and Palmer, 2004). There are a variety of funding arrangements with cities and health authorities and the organizations that serve them (e.g., AIDS PEI in Atlantic Canada).

When was the needle exchange program introduced?

The first official NEP opened in 1989 in Vancouver, British Columbia. Unofficial NEPs were operating prior to this (e.g., Toronto). NEPs were introduced in response to the spread of blood borne diseases, particularly HIV, through needle sharing. Today there are more than 100 official NEPs operating across Canada (Kaiser Foundation, 2003). There are many other satellite NEPs in operation at drop in centres, shelters, and community health offices. There are also ad hoc exchange programs available at Aboriginal AIDS service organizations serving on and off reserve populations, as well as at local health centres and nursing stations (e.g., Atahkakoop, Saskatchewan) (Dell and Lyons, 2007). NEPs are more much common in urban than rural communities, with key reasons being the stigma attached to accessing them, too high a cost for small populations, and the proximity of urban centres to many small communities, including reserves.

With mobile NEP services, workers distribute needles and supplies to IDUs by foot or van. These NEPs meet users at various locations ‘on the street’ and are open a range of hours not offered at a fixed NEP. The mobile vans frequently have a social worker and nurse on staff.

How does a needle exchange program work?

When an individual attends a NEP at a fixed location they ask to see the person in charge of the service. They go in a designated room and request the supplies they need, including needles, vitamin C8, sterilized water, disinfectant, cookers, and cases to carry needles. The supplies are then packaged and issued at no charge. Some places have injection kits already made up with supplies. Condoms are also commonly distributed (Weekes & Palmer, 2004). It is generally a quick process. As mentioned, there are also mobile NEPs that distribute the same materials.

Who uses a needle exchange program?

People who inject drugs use needle exchange programs. People who do not have access to or do not feel comfortable obtaining needles from pharmacies also use NEPs. Although site-specific information is often collected for funding purposes, generalized characteristics and backgrounds of individuals who use NEPs are not available (Weekes & Palmer, 2004). There are specific studies, however, that offer some insight, including the Vancouver Injection Drug User Survey that found Aboriginal peoples (First Nations, Inuit and Métis) made up 25% of IDUs in Vancouver and of which 79% lived in unstable housing (cited in Nguyen et al., 1999).

Where are needle exchange programs located?

Needle exchange programs are located throughout Canada. As discussed, they exist at fixed addresses, in mobile vans, and through community outreach workers. As well, there are examples of ad hoc exchange programs available at Aboriginal AIDS service organizations serving on and off reserve populations, as well as at local health centres and nursing stations (e.g., Atahkakoop, Saskatchewan).

As discussed above, it is imperative that decisions about the locations and appropriateness of harm reduction programs begin at the community-level. Aboriginal harm reduction programs and policies need to be directed by Aboriginal communities and their members (Gray and Sputore, 1998; Canadian Aboriginal AIDS Network, 1998).

Why is a needle exchange program important?

Intravenous drug use through the sharing of used needles is a prominent mode of transmission of HIV, Hepatitis C and other blood borne diseases among Aboriginal peoples in Canada (Prentice, 2004). Before 1993, 10.9% of reported AIDS cases among Aboriginal peoples were attributed to injecting drugs and by 2003 this rate increased to 58.3% (Public Health Agency of Canada, 2004). This is especially true for Aboriginal women; they make up a disproportionate percentage of HIV and AIDS cases (Spittal et al., 2006). As discussed, NEPs reduce risk to IDUs through the exchange of needles and supplies, along with offering prevention and education strategies such as providing information on safer injecting and high-risk behaviours. NEPs also act as a bridge to other services, such as health, housing, counselling and mental health. For example, the Quesnel Tillicum Society Native Friendship Centre in northern British Columbia provides a needle exchange program where needles, condoms and needle disposal containers are provided at no charge to community members. They also offer harm reduction education, including prevention information and awareness about HIV/AIDS and Hepatitis C.

Needle exchange programs are important specifically at the community level, as injection drug use is a serious public and social problem. There are broad public health impacts, ranging from dirty needles discarded in the streets to the transmission of blood-born pathogens, such as HIV and Hepatitis C.

What has the evaluation literature found?

The majority of evaluations have found that NEPs result in less high risk practices such as needle sharing and decreased rates of HIV and Hepatitis C among IDUs (Hurley, 1997: Des Jarlais et al., 1995; Gibson et al., 2001; Ouellet, 2004). Others have found that NEPs also increase the likelihood of individuals accessing treatment (Wodak and Cooney, 2006). Some studies have however questioned the ability of NEPs to reduce rates of HIV transmission (Bruneau et al., 1997) and needle sharing among IDUs (Strathdee et al., 1997).

It is important to consider the methodologies used in evaluations to determine whether they are empirically-based and culturally relevant for Aboriginals peoples. It is recommended that evaluations of Aboriginal harm reduction programs be undertaken and conducted by, for, and with Aboriginal communities and organizations.

We have attempted to show with the NEP illustration that by addressing the questions of who, what, when, where, why, how and evaluation, that understanding about harm reduction and its relationship to Aboriginal social work practice can be furthered. The concepts' of 'Kijigabandan' and 'Manadjitowin' focus on attaining an in-depth understanding for individuals and communities, personal development, and ultimately applying honour. This extends beyond Western harm reduction's emphasis on respecting users and their choices. 'Kijigabandan' and 'Manadjitowin' help to relay *why* respect is being offered. This is a necessary starting point for exploring harm reduction as a promising practice for Aboriginal social work. It allows for the focus of Aboriginal social work on indigenous ways of knowing, addressing colonization and supporting indigenous practice, for example, to be accounted for in this discussion.

Barriers to understanding

As relayed, individuals and their communities are interconnected in an Aboriginal worldview; they cannot be separated from one another. In this final section of the paper, we identify how addressing two intertwined individual/community grounded barriers may also assist Aboriginal social work with initiating Aboriginal-specific harm reduction discussions, including needle exchange. They are: (1) wide-spread support for abstinence among First Nations, Métis and Inuit peoples and communities (Canadian Aboriginal AIDS Network, 1998; Erickson, 1992; Wardman & Quantz, 2006), and (2) an entrenched belief that harm reduction is incompatible with Aboriginal culture (Dell & Lyons, 2007; Wardman & Quantz, 2006).

1. Wide-spread support for abstinence

Many Aboriginal communities and treatment programs today adhere to models of abstinence (Chalmers et al., 2002; Daisy et al., 1998; Korhonen, 2006; Landau, 1996; Lauzon et al., 1998). There are a number of reasons for this, including the destructive impact of the introduction of alcohol on the lives of Aboriginal peoples, a desire by Aboriginal peoples to redefine themselves as distinct from the assimilative practices of mainstream society, and the devastating level of alcohol and drug abuse a number of communities face today (Canadian Aboriginal AIDS Network, 1998; Korhonen, 2006). The abstinence-based focus of many of the National Native Alcohol and Drug Abuse Program (NNADAP) treatment centres stems in part from the fact that they were established at a time when disease-based theories and abstinence models were the norm.9 There also exists a belief that the identification of problematic substance use as a disease adds legitimacy to it, and without this label there would be an increased risk of losing treatment funding. Underlying these tensions and concerns is a common belief that abstinence and harm reduction are incompatible.

Contrary to what many people believe, abstinence and harm reduction are not totally incompatible. Common to both is the goal of assisting individuals with the harms they are experiencing because of their problematic substance use. It is not well-known that some programs and policies offer clients a continuum of approaches. For example, All My

Relations, a harm reduction program for Aboriginal injection drug users in Manitoba, offers abstinence as a potential goal, but does not make it a requirement (McLeod, 2001). Similarly, the Mamisarvik Healing Centre, one of only a few Inuit-specific residential substance abuse programs in Canada, offers its clients the choice of a harm reduction treatment program or a treatment program based on abstinence. As well, Canada's national Inuit organization, Inuit Tapiriit Kanatami, notes in its alcohol policies that there is a need to develop effective, community-based alcohol counselling programs based on both harm reduction and abstinence strategies that are appropriate to Inuit situation, culture, language and values (Inuit Tapiriit Kanatami, 2005a).

Further, abstinence-based programs and policies that exclude any attention to the reduction of harm still share commonalities with harm reduction. Consider, for example, Alkali Lake, a Shuswap Indian Reserve near Williams Lake, B.C. that took action against problematic alcohol use through leadership, commitment, support and honouring spiritual and cultural foundations (Four Worlds International Institute, n.d.). Probably the best-known example of self-imposed alcohol prohibition by an Aboriginal community, Alkali Lake looks at first like a clear example of an abstinence-based approach, yet it drew upon features that are common to harm reduction. For example, the community reduced its overall level of drinking over a period of several years and, in the spirit of harm reduction (see 5 key features reviewed), rarely resorted to exiling users.

2. Incompatibility of harm reduction and Aboriginal culture

The concept and practice of harm reduction has generally evolved outside of Aboriginal culture. The need to reduce harm because of substances was not an original concern for Aboriginal peoples. It was only with European contact and the introduction of alcohol that associated problems began to surface. This does not mean, however, that harm reduction and Aboriginal peoples and culture are incompatible. In fact, fundamental features of harm reduction, such as its focus on humane values, overlap with traditional Aboriginal values and the Seven Gifts of Aboriginal peoples' ancestors (Kindness, Understanding, Acceptance, Truth, Humility, Courage, and Generosity) (Banni, nd). The principles of harm reduction are not unknown to Aboriginal peoples and some observers have pointed to similarities between harm reduction and a holistic Aboriginal approach to substance abuse treatment, including the importance of links between community and individuals (Peele, 2003).

There have also been notable accomplishments in incorporating harm reduction features into social work with Aboriginal peoples and the provision of culturally-appropriate services (Jackson, 2005). This includes incorporating Aboriginal culture, history and language into available and emerging services; developing culturally-specific programs and policies for First Nations, Métis and Inuit; and increased awareness and understanding about Aboriginal peoples among non-Aboriginal specific harm reduction services. It is well-recognized that if programs are not culturally appropriate and holistic, they will not be accessed or show to be effective (Canadian Aboriginal AIDS Network, 1998; Wardman & Quantz, 2005). Organizations such as Anishnawbe Health Toronto adheres to a holistic model of care in which individuals set their personal goals for healing and wellness in consultation with their health care providers. People are given a choice of the best way for them to minimize potential harms related to their substance use.

It is important to acknowledge in any discussion of harm reduction among Aboriginal peoples that for some, Aboriginal traditions, customs and cultural ways are incompatible with the use of mood-altering substances. Individuals who use substances such as alcohol or methadone are often viewed as being "out of balance". This does not imply however that these individuals are to be shunned from their community and culture. The Ontario Aboriginal HIV/AIDS Strategy explains that "[h]aving an addiction …mean[s] that the Body will always speak first. But this does not mean that the Heart, Mind and Spirit cannot be reached while the Body is under the influence of a substance" (n.d., p. 1). In a Centre for Addiction and Mental Health harm reduction document discussing drug use as a personal choice, it explains that "[t]he philosophy of harm reduction encourages us, [Aboriginal peoples], to reach those outside of the circle and welcome them back in… [we] recognize that everyone in the circle is affected and thus has a responsibility to make this circle whole." (n.d., p. 1). The same is true of the majority of abstinence-based NNADAP treatment programs; individuals are regularly welcomed back into treatment after relapsing and attending to the required length of absence from the program.

Conclusion

For problematic substance use to be addressed in a comprehensive manner, fundamental inequalities faced by Aboriginal peoples must be addressed. In Australia, for example, organizations are starting harm reduction programs that “aim to minimize the use of alcohol by improving the overall social, political and economic well-being of Aboriginal people” through job creation and recovering land rights (Gray & Sputore, 1998, p. 43). There are also many examples in Canada of tribal councils and bands adopting economic development, job creation and business entrepreneurship as part of a population health strategy. Such harm reduction models must be grounded in community choice, consultation, understanding and leadership. Societal factors, including the social determinants of health and their links to problematic substance use, also play a role in developing effective, long-term responses.

The interconnectedness of all life must be acknowledged. In other words, harm reduction is “important, but not enough” (Sellman et al., 1997, p. 87). Aboriginal approaches to social work, by their very nature (e.g., accounting for the impacts of colonization and indigenous knowledge), can offer a starting point for furthering understanding of harm reduction programs and policies and exploring their value as they relate to Aboriginal peoples.

We began this paper with acknowledging, through a review of the extent of and reasons for Aboriginal peoples’ problematic substance use, that there is a need for efforts to address the harmful consequences of substance use among Aboriginal peoples and within their communities. An increasingly popular promising practice in Canada to high-risk substance use is harm reduction. Aboriginal specific harm reduction initiatives exist, but they are limited. A key barrier to their development is the absence of an in-depth understanding about what harm reduction is, and its value as a promising practice, including within Aboriginal social work. We proposed that an Aboriginal worldview may help to address this, in comparison to the contemporary Western world’s concentration on giving respect to individuals and their choices. To address this, we suggested gaining an in-depth understanding through the concepts of ‘Kijigabandan’ and ‘Manadjitowin’. The concepts focus on attaining in-depth understanding for individuals and communities, personal development, and ultimately applying honour. We used the example of needle exchange programs to illustrate the potential of 'Kijigabandan' and 'Manadjitowin' to further understanding about harm reduction for Aboriginal peoples. We also suggested how the concepts can assist Aboriginal social work to address two key barriers that often impede Aboriginal-specific harm reduction discussions: widespread support for abstinence and prohibition, and belief that harm reduction and Aboriginal culture are incompatible.

Although the example of a needle exchange program appears at first glance to be an individualized approach to dealing with problems that arise from problematic substance use (e.g., an individual exchanges a used needle for a clean one to reduce the risk of HIV transmission when injecting drugs), when viewed through a holistic lens it is about an individual, their community and choice. Hopefully, the discussion of 'Kijigabandan' and 'Manadjitowin' in this paper, and their potential for contributing to understanding harm reduction for Aboriginal peoples, will provide a starting point for Aboriginal social work to move the discussion beyond the individual, and into a framework that is more reflective of the worldviews of Aboriginal peoples.

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Endnotes

1 There is no one Western or Aboriginal worldview, but for the sake of presentation, the commonalities within each are focussed upon and presented as one in this paper.

2 The majority of available information in this section of the paper is specific to First Nations, in particular Status Indians living on-reserve. The unique histories and vast differences between First Nations, Inuit and Métis, as well as the commonalities, must be kept in mind when reviewing the data.

3 Substances are separated here by category (alcohol, illicit drugs, prescription drugs, volatile solvents) but they are frequently used in combination.

4 Thank you to the following individuals for sharing their wisdom and expertise for this paper: Pauline Deconti, Elder and Algonquin Linguist/ Language Professor; Annette Odjick-Smith, Algonquin Linguist; and Joan Tennesco, Algonquin Language Teacher. Without their contributions this paper would not have been written.

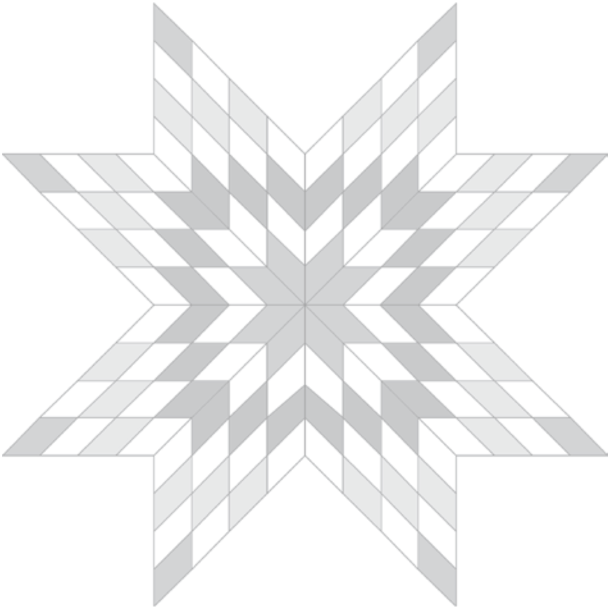
5 This is not meant to imply that respect is not an important part of Aboriginal people's lives and teachings in contemporary society.

6 For a comprehensive review of Aboriginal-specific programs and policies, see **Dell, C.A. & T. Lyons** (2007). Harm Reduction Policies and Programs for Persons of Aboriginal Descent. Ottawa: Canadian Centre on Substance Abuse.

7 Thank you to Wendy Hyndman for sharing her expertise and time in developing this section.

8 Helps with dissolving heroin and crack cocaine.

9 NNADAP is a network of 54 treatment centres located in First Nations and Inuit communities across Canada. NNADAP is largely controlled by First Nations communities and organizations and is the main source of treatment for Aboriginal peoples in Canada for all forms of substance abuse.



The Cree Medicine Wheel as an Organizing Paradigm of Theories of Human Development

Annie Wenger-Nabigon

Abstract

This paper explores the Cree Medicine Wheel as an organizing construct for examining some contemporary theories of human development. Various aspects of Medicine Wheel concepts are discussed along with aspects of knowledge about human development from the mainstream paradigm (Eurocentric) that is dominant in the academy. Perspectives on indigenous wisdom and ways of knowing are presented from an ecological position linking human development concerns to a wholistic view of human development through the Cree Medicine Wheel. The article highlights aspects of the teachings which deepen understandings of parallels in human development theories. Medicine Wheel teachings support development that maintains positive adaptation to a natural world, and can provide a description of contemporary human developmental theory from the perspective of traditional Aboriginal knowledge. Theories about different stages of human development and knowledge about assets that facilitate positive development at each stage are presented, illuminating current concerns in human development theoretical perspectives.

Introduction

This article uses the foundational structure and teachings of the Cree Medicine Wheel (Nabigon & Mawhiney, 1996) as an organizational structure for examining some contemporary understandings of human development. Human development is defined as the physical, social, emotional, intellectual, and spiritual development of the individual human being, as well as the cultural, social, and technological development of human families and societies.

The Cree Medicine Wheel mirrors and explains concepts of human development in an elegant and comprehensive manner, but its origin from within the paradigm of non-western Aboriginal traditions has generally confined it to a position of academic discredit. Medicine Wheel concepts have experienced a rise of influence in academic writing in the recent past. Figure 1 gives an outline of the basic concepts of the Cree Medicine Wheel referenced in this article.

The article begins with a brief literature review of Medicine Wheel concepts, followed by a brief description of the fundamental teachings of the Cree Medicine Wheel. (Readers are encouraged to reference Nabigon and Mawhiney (1996) for additional explication of the concepts used here.) This is followed by a discussion of several contemporary approaches to individual human development contextualized by the Cree Medicine Wheel teachings.

Concepts of human development arising from the Eurocentric paradigm dominant in the academy cannot be completely integrated into Medicine Wheel models, nor do they subsume Indigenous teachings. The different paradigms do not articulate the other, yet they can be contextualized in relationship to each other through deepening our understandings of parallels. (A visual image of the Two-Row Wampum Belt and accompanying teachings comes to mind). This article contrasts and contextualizes different paradigms of understanding human development, and, while attempting to avoid evaluation, is intended to provide a framework for relationship. The goal is to open discussion in the academy of deeper understandings of Indigenous knowledge regarding human development.

The Medicine Wheel

There exists a range of presentations of differing concepts of the Medicine Wheel, by writers who are both Aboriginal and non-Aboriginal, who have written with various purposes, some more notable than others. A First Nations Films documentary by Richard Hersley, "The Medicine Wheel", presents an artistic, balanced and integrated overview of the Medicine Wheel and includes research on stone Medicine Wheel sites worldwide (Hersley, 2005). This film conveys the integral idea of spirituality which is embedded in the concepts of the Medicine Wheel across time, place and culture.

The Medicine Wheel has also been used clinically in various treatment settings. Coggins (1990), a therapist, acknowledges his own heritage (Ojibwa and Ottawa) as well as influence from other Canadian, Alaskan, Mexican and American Southwestern cultures, but does not make clinical distinctions among different cultural representations of the Medicine Wheel (p. 80).

Blackwolf Jones, a licensed psychotherapist and national speaker of Ojibwa heritage in the United States, has published in professional journals on the integration of his understandings of the Medicine Wheel, and other traditional ceremonial approaches, into his work as a counselor. In one of his several books he states, "The Sacred Hoop is the circumference of the Medicine Wheel, a healing symbol of balance" (Jones, 1996, p. 307).

Lewis Mehl-Madrona, M.D., of Cherokee-European descent from the U.S., is a widely published medical doctor and researcher who has made a practice of combining western medical treatments with wholistic and Aboriginal methods of treatment. Lessons from Native American healing practices are described in his books, *Coyote Medicine* (1997) and *Coyote Wisdom* (2005), and include teachings on the Medicine Wheel from various North American Aboriginal cultures. Some of his most significant uses of Medicine Wheel concepts and other teachings are demonstrated in his work with natural childbirth, mental illnesses, diabetes, cancer and other severe illnesses (Mehl-Madrona, 1997; 2005).

Nabigon and Mawhiney (1996) provide a deep description of the Cree Medicine Wheel in the context of social work treatment theories. They present this model as an "…approach to healing individuals, groups, and communities" (p. 18). The primary author (of Oji-Cree descent) acknowledges the original teachings and training he received over many years from Cree Elders, including Elder Eddie Bellerose from Alberta, and others, who guided his work and provided the foundational knowledge and theory found in the chapter. Nabigon (2006) goes deeper into the Cree Medicine Wheel concepts through his autobiographical account of its use as a personal healing tool.

Jones, Coggins, Mehl-Madrona and Nabigon all work from the stance of the Medicine Wheel as a sacred source of healing. The theme of sacredness is at the heart of all Medicine Wheel teachings used by Aboriginal peoples in North America. Sacredness is not generally an aspect referred to in western, or Eurocentric, models of knowledge and healing, but is fundamentally integral to understanding Aboriginal theory and praxis. The Medicine Wheel is a pathway for healing among many Aboriginal peoples across the continent, used in reclaiming identity and purpose for individuals and communities.

Seeing the World with Aboriginal Eyes: A Four Directional Perspective on Human and non-Human Values, Cultures and Relationships on Turtle Island (2005), by Brian Rice, Ph.D., is an exploration of the world view of Aboriginal traditional knowledge through concepts of the Four Sacred Directions. This work provides a window into the following: patterns of thought; concepts of time, sacredness and the natural world; development and role of consciousness, perception, language, dance and song; understandings of relationships (metaphorical and literal); morality and ethics; the environment; knowledge, wisdom stories and creation stories; and many other aspects of Aboriginal traditional knowledge. The author works to provide a bridge between traditional knowledge and western knowledge, and explores some connections of understandings from the different ways of knowing, including the perspectives of Aboriginal cultures from other continents.

Rice (2005) states, "There are a number of correlations that one can make between Aboriginal understandings of consciousness and Jungian psychology" (p. 65).

Jung's development of the theory of the collective unconscious, its composition of "…archetypes or primordial thought patterns that can become conscious and give form to psychic contents" (p. 65) comes very close to an understanding of the development of the Aboriginal psyche that "…play[s] an integral part in forming the Aboriginal consciousness…" (p. 66). Rice's work encompasses all the concepts of human development from birth through death as perceived through Aboriginal knowledge systems, compared to western knowledge systems based on technology that has "…advanced by leaps and bounds in the past few centuries…" (p. 83). He writes, "What is being lost in this process is knowledge that is learned through introspection such as the introspection practiced through prayers, dreams and meditation" (p. 83).

The Cree Medicine Wheel

Few academic works exist describing specifically the Cree Medicine Wheel theory, necessitating reliance on first generation peer-reviewed publications. Hart (2002) includes the Medicine Wheel, and the Cree Medicine Wheel, as part of his excellent foundational approach to Aboriginal helping, but does not focus solely on teachings from Cree Elders. The Cree version of the Medicine Wheel as put forth by Nabigon and Mawhiney (1996) appears in the academy for the first time in a theory textbook for Social Work (Turner, 1996). In their work, human development concepts are described through discussion of the Four Sacred Directions in terms of two aspects of life – external and internal. They write:

> There are two parts of life that each person needs to pay attention to or risk imbalance…We cultivate our external self to fit into the current culture and times…We take care of our inner life by personal reflection…Through reflection we change and grow spiritually (p. 21).

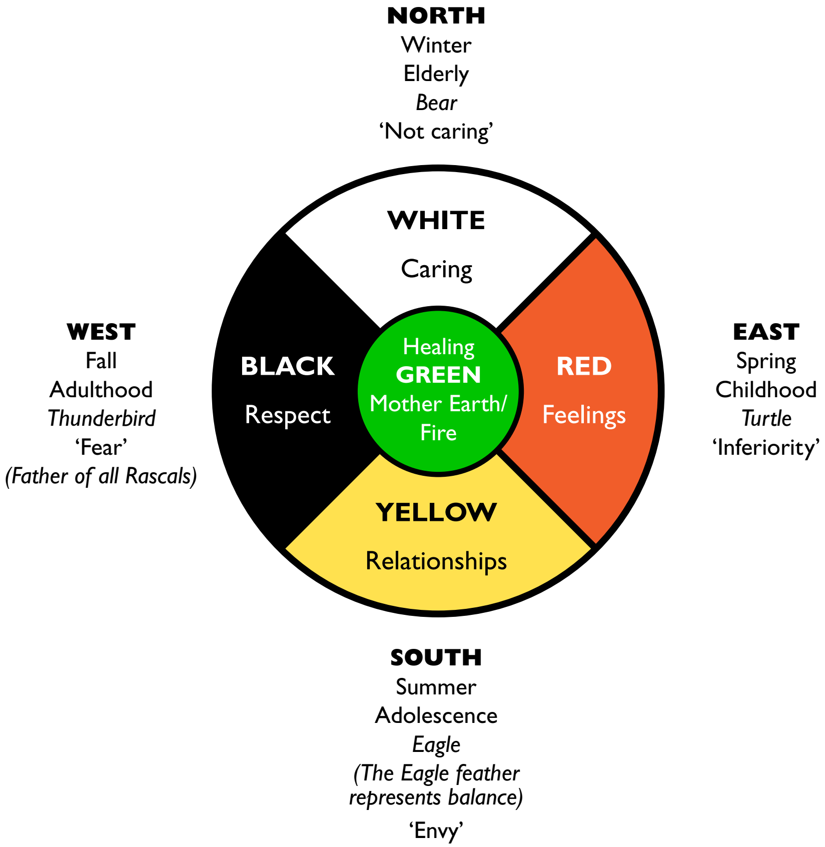
The Cree Medicine Wheel is conceptualized as a circle divided into four quadrants. The inside of the circle represents the positive (light), the outside represents the negative (dark), with the center representing the core of the person, which also has a light and dark side. This establishes a visual structure (refer to Figure One) of the Aboriginal theory which is applied to understanding human development, providing problem identification tools and solution identification pathways when things are out of balance. “Native people who walk the red road attempt to balance their lives between positive and negative cycles of life” (p. 22). The use of the Cree Medicine Wheel facilitates balance, thus promoting health, growth, and positive development, and minimizing risk factors that impede balance.

The literature review did not reveal sources which explore Medicine Wheel concepts regarding specific human development theories. The following figure, adapted from the work of Nabigon and Mawhiney (1996), depicts the Cree Medicine Wheel, and locates the stages of individual human development in the four quadrants. Childhood is represented in the East Door, adolescence in the South Door, adulthood in the West Door, and the elderly stage in the North Door. Other aspects of the development of human society are also located around the Cree Medicine Wheel (see pg. 145).

To better understand teachings of the Cree Medicine Wheel, concepts are usually oriented on the “Doors”, or directions, of east, south, west and north. The center represents the Self, “…the spiritual fire at the core of one’s being” (p. 21), which also has a light and a dark side, either healing or jealousy. The Four Colors represent the four races of humankind. Traditional Cree teachings convey the belief that at one time all four races lived together in peace on one body of land before it broke into separate continents. This teaching contributes to multi-cultural perspectives in understanding human development.

The East Door (spring) represents beginnings, positive aspects of renewal, good feelings, good food, vision, purpose and direction. Being able to have an awareness of emotions and an ability to share them with appropriate language and expression, as well as being able to reduce stress through laughter and sharing is integral to mental health. Having a core sense of self-esteem and self-love makes it possible to deal with inferiority, which is the “rascal” of the East Door, or the negative (dark) side of life. This negative aspect of the East Door creates shame, anger, feelings of inequality, powerlessness and victimization. “Let us not forget that we co-create our lives with our souls (minds), and so we must learn how to empower ourselves so that we can create the kind of life we really want” (p. 22). Teachings about affection, sexuality, companionship, sac-

Figure One – The Cree Medicine Wheel


NORTH
Winter
Elderly
Bear
'Not caring'
WHITE
Caring
WEST
Fall
Adulthood
Thunderbird
'Fear'
(Father of all Rascals)
BLACK
Respect
Healing
GREEN
Mother Earth/
Fire
RED
Feelings
EAST
Spring
Childhood
Turtle
'Inferiority'
YELLOW
Relationships
SOUTH
Summer
Adolescence
Eagle
(The Eagle feather represents balance)
'Envy'

rifice and loyalty help to create balance. This is also the direction containing teachings about childhood.

The South Door (summer) teaches about relationships with self, family and community, and is the place where values and identity are learned. Nabigon and Mawhiney write:

> Adolescence is often a time of crisis. For young Natives, it is a time to define their Nativeness. The process of defining cultural heritage takes precedence over all activities, including education. It is during this period of self-exploration that a young person's academic grades may begin to decline…Elders and traditional teachers can help to understand and defuse the crisis. (p. 30)

The negative side of this direction is the "rascal" of envy, defined by the Elders as wanting something without being willing to work for it. Patience is taught as a gift of time which helps build strengths and create better balance. Spiritual reflection, quietness and self awareness are taught as ways to "…become aware of our mind, body, and spirit" (p. 30).

The West Door (fall) represents respect, reason, and water. This is also the Door which is entered when it comes time for a person to go into the Spirit world, thus death is often referred to as "through the West Door." Resentment is the "rascal" of this direction, which prevents individuals from showing respect for self and others, contributing to imbalances and problems in personal development and community relationships. Humility – "looking twice" – is taught as recognizing "our place within nature" (p. 31), the way to learn and earn respect. Nabigon and Mawhiney write:

> Caring is represented at the north door…It is action…being willing to change, and keeping the focus on ourselves rather than what others do are the keys to action… Some cultures say it is selfish to think of ourselves first. This is a misunderstanding of the dynamics involved. Providing space to care about ourselves allows others the space to start caring for themselves without being overly dependent (p. 25).

Understanding the North Door (winter) holds a key to understanding the process of change. This is the direction of caring, change, movement, and air, which has the power to move things around. The teachings instruct how to deal with the "rascal" of this direction, "not caring", through natural methods of healing by "…yelling, laughing, sweating, crying, yawning, and shaking. These can help a person move through fear" (p. 31). Consequences of misunderstandings in this direction create imbalances in individuals, families, communities and even the larger world as the impact of apathy, thoughtlessness (not caring) and disregard for others impacts all directions. The teachings are clear, "…we cannot receive caring from another unless we already care about ourselves" (p. 23). Between the West Door and the North Dorr is the "rascal" of fear.

At the center of the Cree Medicine Wheel is found the fire of the soul (Figure 1), the identity of the person. The color green represents Mother Earth. Here is the place of healing, the positive side, and the place of jealousy, the negative side. Nabigon (2006) writes:

> If we do not honour the negative side of life we as humans either fall very ill or, worse, inflict our pain upon each other. Touching the negative aspects of life can be beneficial. If we learn to honour and recognize all of our emotions, including the negative qualities, we can and will become the bearers of our own pearls of wisdom (pp. 53-54).

Perspectives on Aboriginal Knowledge

Traditional teachings regarding relationships with Mother Earth, the Spirit World, and relationships with the Creator and all of the Creation contribute to a full understanding of the Cree Medicine Wheel concepts. Aboriginal teachings encompass a totality of the human condition – physical, spiritual, mental and emotional – and the significance of balance is emphasized. All aspects of life are intricately interconnected. Relationships are fundamental to understanding the nature of events, and establishing standards of behavior. Separating things out from each other and studying them as singular entities without a wholistic viewpoint as an organizing point does not fall within the natural way of thinking in Aboriginal epistemology. Dominance, subordination and aggressiveness are not valued, but assertiveness and strength are taught. Theories of human development which incorporate wholistic perspectives are more closely compatible with Medicine Wheel concepts than those theories which segment various stages of development.

Traditional Aboriginal approaches to knowledge development have not been warmly welcomed by the Eurocentric model of the academic world. There are several possible explanations: first, traditional approaches are not seen as scientific and therefore it is not possible to validate these ways of knowing using the highly valued standard of scientific models established in the academy; secondly, Aboriginal scholars have been cautious in articulating traditional concepts in ways that are readily applicable to the dominant paradigm. There are some good reasons for that caution.

Protecting traditional knowledge is a focus of concern for Indigenous people worldwide, and for governmental bodies that seek to protect and preserve the knowledge ways of Aboriginal people. Battiste and Henderson (2005) correctly state:

> Survival for Indigenous People is more than a question of physical existence. It is an issue of protecting, preserving, and enhancing Indigenous worldviews, knowledge systems, language, and environments. It is a matter of sustaining spiritual links with ecosystems and communities. Unfortunately, these ecosystems and communities are often critically endangered. The awareness that the demise of Indigenous populations and the loss of their languages are causing the demise of Indigenous knowledge and the loss of biological diversity has not stopped the rush on Indigenous knowledge systems by outsiders. These outsiders have not attempted to prevent the extermination of Indigenous Peoples or their ecosystems; instead they have intensified their efforts to access, to know, and to assert control over this endangered knowledge and these endangered resources. This is such a tragic response…. (pp. 242-243).

Better understanding of indigenous knowledge worldwide may be a key to the survival of people and the planet. It will certainly be a key to the survival of indigenous peoples; however, expropriating concepts such as the Medicine Wheel in order to gain control and management over

Aboriginal people is an abhorrent prospect. Rice (2005) writes:

> Based on a tradition of some non-Aboriginal academics misrepresenting or not acknowledging elders' teachings, Aboriginal authors are reluctant to delve deeply into Aboriginal spiritual knowledge for fear of being exploited. There is some truth to these concerns. However, based on my experiences as an Aboriginal academic involved in ceremonial life, and on others who are more knowledgeable than myself, there is no truth to the fear of giving away the secrets of sacred knowledge by writing them down. Most written literature provides only some basic fundamentals of sacred knowledge; … years of training in sacred knowledge cannot be replicated by simply writing about the experience…Therefore, our fears of exploitation must not prevent us from writing about Aboriginal spiritual or cultural knowledge. It cannot be exploited (sic) only misrepresented. (Rice, p. xi)

Jane Korkka (2005), in her literary analysis of Rudy Wiebe's writings (a non-Native Canadian author whose works often feature Native themes or characters), asks:

> Does this, then, suggest that native (sic) peoples may still find themselves pushed into a marginal position, in danger of being deprived of their own voice? Yes, it does. What it does not mean is that no white person should ever be involved in telling native stories. An injustice will not be remedied if all dialogue is severed. Though clashes of views will emerge as long as the dialogue continues, they do reflect the ongoing interaction between Native people and the mainstream Anglo-Canadian society… If there is no one willing to work as a mediator, or no one who is allowed to do so, there is no chance at all of changing an unbalanced relationship between different peoples (p. 372).

What is called for is an approach of working cooperatively and in balance with Aboriginal "ways of knowing". The Medicine Wheel concepts convey the wisdom traditions of cultures with tens of thousands of years of knowledge evolution embedded within the traditional ways of life and worldviews. Working within these concepts provides potential for re-establishing balance between peoples, and with the environment.

Medicine Wheel concepts teach the idea of balance in human development in order to maintain the sustenance of all living beings, including all aspects of the planet, which is considered a living being. Healthy human development is inextricably linked with healthy environmental conditions, both physical and social, and it is possible to seek, and find, approaches to sharing together in the promotion of human development in healthy environments in a balanced manner. No one "owns" knowledge and wisdom, and indigenous ways of knowing provide much that is fundamental for adequate understandings of human development.

Indeed, it could be said that the final front of conflict between forces of colonization and traditional societies lies in this area of indigenous, or Aboriginal, knowledge. The struggle currently seen to restore cultural ways of knowing in Aboriginal communities everywhere is becoming more urgent and significant as the world faces calamities such as economic collapse and global climate change. The heritage of colonization on every continent continues to contribute to upheaval in social and economic stability. The pressure from an increasingly complex technological world presents challenges for families and individuals, especially in Aboriginal communities, at the most basic of levels. The heritage of a colonial history simply cannot be ignored. It must be addressed in order to adequately understand the human developmental challenges facing communities today.

When Albert Memmi first published his classic work, *The Colonizer and the Colonized* (1965), he could not have foreseen its far-reaching impact. First published in French in 1957, the description of the social and psychological effects with which colonialism impacts both colonizer and colonized became both anathema to the oppressive colonizer and those who profited from the effects of colonialism, as well as inspiration to those who would bring down the colonial system. The developmental impact on human populations is devastatingly described in his work. His words of fifty years ago sound a challenge, "To refuse colonization is one thing; to adopt the colonized and be adopted by them seems to be another;

and the two are far from being connected" (p. 22-23). His stance could be seen to be compatible with those who make efforts toward indigenization of the academy.

Memmi's challenge for connection remains to be addressed adequately, but certainly one approach is to increase understanding of how human development is conceptualized by those within differing paradigms and systems. For this purpose, the following section will endeavor to place contemporary models of human development within the paradigm presented by the Cree Medicine Wheel.

Contemporary Theories of Human Development

Human beings in all times everywhere have been integrally social creatures, observing and studying each other and their environments, learning the best possible ways of surviving and developing competence. The study of the human development field is very broad, encompassing the disciplines of Biology, Sociology, Psychology, Political Science, Anthropology, Education, Economics, Multi-Cultural Studies, Women's Studies and others. The discussion here will be limited primarily to psychological and sociological perspectives, highlighting key concepts.

In Uranjnik, Levin & Garg (2008) five major areas of child development are examined: maturation and learning, motor development, cognitive development, language, and emotional and social development (pp. 386-389). Biological aspects of development are referred to in each of these areas and growth is described as being guided by an "inborn maturational blueprint". They refer to Jean Piaget's contribution, a biological blueprint of the process by which children move through the stages of development he names as sensorimotor, pre-operational, concrete operational, and formal operational. They acknowledge that criticism of Piaget's work has been noted by contemporary psychology, but also cite the extensive research that has been conducted on Piaget's developmental theories which have contributed to understanding the cognitive processes of children and adolescents. The majority of research has been conducted with Eurocentric models, settings and "subjects", but aspects of his theories can be located at various points on the Cree Medicine Wheel.

Piaget's perspective can be seen in teachings surrounding the East and South Doors. Good food (spiritual and physical) is represented in the East Door, which is applicable to the importance of appropriate biological, physical, cognitive, spiritual and psychological development of the child. As the child is born and develops within the safety and nurturing that is taught in the East Door, she learns about identity, choice and personal power. Children reared in traditional Aboriginal societies learned by observing (Vision) and making their own choices. Language development is also located in the East Door. Nabigon and Mawhiney (1996) state:

> Unless children are allowed to feel they have some power of choice over their own lives as they grow up, they are likely to feel they are victims, or at the very least, they will fear people they perceive as having authority over them. This perception is often carried over into adulthood and can lead to a sense of powerlessness…and other psychological problems…we con-create our lives with our souls (minds), and so we must learn how to empower ourselves… (p. 22).

It is believed that developmental difficulties in the East Door will result in a sense of shame and inferiority, impeding the development of self-esteem, personal agency and co-creation necessary for healthy adult role function in humans.

In the South Door the aspects of adolescent development are located within the primary function of learning about relationships with the self and with others. Patience, listening, and development of self identity are emphasized. Learning how to work for what one wants, to deal with emotions of envy and longing (both in the material and spiritual aspects), and to correctly exercise responsibility for oneself and one's actions are primary tasks to accomplish in this Door (pp. 23-26). Feelings of anger and alienation are believed to arise from not learning how to listen to the Self, from not having good relationships with others or healthy connections to community. Development of identity is a primary task of adolescence, a time when impulsivity is difficult to manage. Traditional teachings encourage adults and youths to interact as a way of teaching patience. Relationships with people, with the natural world, and with the spiritual aspect of life are seen as resources to assist youth in development.

New research in brain function sheds light on aspects of human development. The complex neural and neurochemical development that occurs in the human brain, before and after birth and continuing into adulthood, mirrors in physicality the states that Piaget outlines in behavioral and emotional development (Kolb & Fantie, p. 31). Good pre- and post-natal nutrition is crucial for adequate brain development, which is recognized in the East Door. The impact of developmental deficits in the brain resulting from poor nutrition, the effects of environmental chemicals, and various medications and drugs has a lifelong effect. Communities around the world that are heavily affected by neurotoxins, impoverishment and poor nutrition face monumental challenges in assisting their populations to achieve the conditions of positive human development.

Keating and Hertzman (1999), in *Developmental Health and the Wealth of Nations*, highlight the ways in which labor market economies place almost inhuman amounts of stress on families. They identify the "gradient effect" (pp. 2-3; 9), illustrating how societies which carry great disparities in socioeconomic (SES) gradients among their population also have significant indicators for poor health and developmental health. Families and communities at the lower end of the scale in wellbeing, experience greater SES "gradient effects" and face difficult challenges in meeting developmental requirements for good nutrition and protective neurobiological factors for developing human beings.

Keating and Hertzman indicate that there may be a limit to the adaptability trajectory for human beings, and warn that concerns regarding the breakdown of social structures fostering adaptability should be heeded by leaders, politicians, economists, educators, and others. Parts I and II of their book present an elaboration on the concept of biological embedding of these SES gradients in developing human beings. Lack of assets and support in early stages of development has implications for developmental hindrances across the life span. They indicate more understanding is needed about humans who demonstrate resiliency against the negative effects of the SES gradient in order to develop methods of prevention and intervention in "problematic developmental pathways" (p. 12).

The words of Keating and Hertzman (1999) and Kolb and Fantie (2009) can be seen to correlate with the West Door, the place where concerns of adulthood emerge. "Respect is represented in the west on the middle circle. The literal meaning of respect is to look twice…The power of reason is placed in the west door. With reasoning power we can think twice…" (Nabigon & Mawhiney, 1996, pp. 24-25). The responsibilities of adulthood imply that harmful thoughts and actions to self and others are to be avoided. Growth in this direction involves assuming responsibility and showing respect for others. Societies where these values are deeply embedded in the culture will be less likely to have steep SES gradients, as responsibility for the community as a whole is an integral concern of everyone. Care, concern, respect and non-judgmental attitudes facilitate behaviors and practices that contribute to the welfare of all members of the community. Contemporary societies would do well to move to the West Door and "look twice" at the developmental concerns facing their citizens. Current research indicates that the breakdown of macrosystems is having negative effects on human development across the lifespan (Keating & Hertzman, 1999) and around the world.

The elderly are notably absent in contemporary western theories of human development, although Bronfenbrenner (2005) indirectly addresses this concern in his work. He writes, "Human development may be defined as *the phenomenon of constancy and change in the characteristics of the person over the life course*" (p. 108) (his italics). His Process-Person-Context Model is an "analysis of variations in developmental processes and outcomes as a *joint function of the characteristics of the environment and of the person*" (p. 115) (his italics). He adds the dimension of time, the concept of the individual contributing to his own development, and the role of culture in human development, and puts forward the understanding that human developmental processes continue into old age.

While his article primarily focuses on child and adolescent development he acknowledges the need for research on the "…macrosystems most salient in modern life" (p. 152) which include the adult worlds within which child development occurs. This would include not only children's families but their neighborhoods, subcultures, and larger societal cultures. He develops the concept of "nested environments" within which the developing human grows. He writes:

> The psychological development of parents is powerfully influenced by the behavior and development of their children. This

> phenomenon occurs through the life course…often becomes especially pronounced during adolescence…the impact of the latter's behavior on the subsequent development of their parents has yet to receive the systematic investigation that it deserves (p. 12).

Bronfenbrenner goes on to say:

> Over the life course, the process of attachment exhibits a turnaround. In the beginning, it is the children who are the beneficiaries of the parents' irrational commitment, whereas toward the end the roles are reversed. Then it is the elderly parents who receive the love and care of their now middle-aged children… (p. 13).

He continues by noting that his literature search revealed no information on the influence of parent-child attachment "…in the future development of the *parent* in contrast to that of the child" (p. 13) (his italics).

The Medicine Wheel, in contrast, does give some indication of a path to understanding the process of relationship development between the generations and of the role of the elderly in the life span of developing humans. In the North Door, "Caring can be defined by our level of interaction, within family, school, community, and nation" (Nabigon & Mawhiney, 1996, p. 31). Elders teach caring as a common sense activity that all humans are capable of, no matter what their age. Every action has consequences – the wisdom and guidance of the elderly are essential to the necessary caring function of the community. Not caring implies that dependency will be the outcome, inhibiting growth and change:

> Caring is more than a feeling. It is action. It is important to remember the reasons for caring as well. Taking risks on behalf of ourselves, being willing to change, and keeping the focus on ourselves rather than what others do are the keys to action and are all important aspects to caring. This always involves persistence. (Nabigon & Mawhiney, 1996, p. 25).

Engagement in risky activities is generally looked at in human development studies as a negative thing, "…associated with some probability of undesirable results (Boyer, 2006, p. 292). Boyer's extensive and comprehensive review of the literature in cognitive, emotional, psychobiological and social developmental research highlights what is emerging regarding the topic of risk, acknowledging that risk-taking is sometimes necessary and positive. The role of elderly people, as described by the Medicine Wheel, assists developing individuals in being able to understand and handle risk, thus supporting the community in being able to provide a protective network for its members.

The greatest opportunities for understanding risk taking, as well as aversive, behaviors may lie in new studies in the field of neuroscience. The ability to have access through new technology to the processes of normal brain activity, as well as to the effects of damage and/or developmental deficits, is opening up exciting new understandings of human development and behavior. The modulation of fear and the various mechanisms of brain chemistry that vary from individual to individual are better understood. More is understood about the role of brain function in processing decision making and risk.

Medicine Wheel teachings in general contain much to assist humans in learning the techniques, methods, and practices involved in making decisions, taking risks, maintaining relationships, handling emotions, learning difficult tasks, practicing caring behaviors and taking responsibility for oneself. The Medicine Wheel has strong roots in Aboriginal histories, helping maintain healthy communities in pre-colonial cultures.

Several researchers of human development address the issue of culture in psychological studies. Ratner (1999) and Valsiner (2001) have written and researched extensively on this subject. Ratner (1999) highlights the reality that "…psychological phenomena are cultural in their essence… [include] practical social activities… [are] organized by social concepts… [and arise] through participating in broad, collective social activities" (pp. 22-25). Culture cannot be divorced from human development and behavior or psychological phenomena, and varies in human societies around the world. Culture is pliable, influenced over time and space by multiple factors.

Myopic cultural assumptions impede researchers' ability to conduct inquiry without bias. Valsiner (2001) addresses this challenge with his concept of "cultural blinders" and calls for an effort to, "…create general developmental science [which] can transcend the historically established blinders of child psychology" (p. 167). Vygotsky attempted to transcend the cultural myopia of the past through his studies of child development in his present, yet he was also a product of his Russian post-revolutionary Marxian context (Blunden, 2001) and equipped with his own set of blinders. Lerner (2006) writes:

> Any individual may have a diverse range of potential developmental trajectories and, as well, all groups – because of the necessarily diverse developmental paths of the people within them – will have a diverse range of developmental trajectories. Diversity…is both a strength of individuals and an asset for planning and promoting means to improve the human condition (p. 11).

The underlying assumption here seems to be that humans have a developmental trajectory that is linear in nature, moving from lower to higher levels of development. This assumption is not shared by indigenous worldviews. Medicine Wheel teachings are based on the wisdom of the past, providing stability and continuity, one of many essential protective factors for positive youth development identified in Benson et al. (2006).

Medicine Wheel teachings support development that maintains positive adaptation to a natural world. The natural world is increasingly encroached upon by pressures of technology, population growth, economic upheaval, societal disruptions, global climate change, etc. It would be culturally myopic to assert that ancient traditions have nothing to offer human developmental understandings in currently relevant ways, or that contemporary findings in human development have nothing to offer indigenous communities worldwide.

Benson et al. (2006) offer much in terms of assets to human growth and development (refer to Appendix One), but cite almost no significant major studies done in cultures other than western Eurocentric societies. Benson describes the assets of positive youth development as, "…competence, confidence, connection, character and caring (or compassion)…[and] contribution" (pp. 905), characteristics most human societies incorporate in their conceptualizations of human development.

Conclusion

Medicine Wheel concepts can provide a description of human developmental theory from the perspective of traditional Aboriginal knowledge. The Cree Medicine Wheel provides theories about different stages of human development, appropriate developmental tasks of each stage, and knowledge about assets that facilitate positive development at each stage. The Cree Medicine Wheel illuminates the role of relationships with humans and all of Creation, the role of spirituality, developmental plasticity, diversity, the interconnectedness of "nested environments", and the concept of co-creation between self and Creator. The characteristics of Medicine Wheel wisdom from various nations correspond with theories of human development from the western knowledge paradigm. Future research on Medicine Wheel teachings in the human development field has the potential to expand understandings of their relevance, and applicability of indigenous knowledge and wisdom in contemporary communities.

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Appendix

Pyramid of Developmental Assets by Benson et al. (2006) In Positive Human Development

Intimacy

Person has gained affective attachments to others that reflects solid sense of self in healthy, loving ways; has ability to make and keep commitments & respect boundaries

Family/Peer

The developing human is linked to growing relationships within a lifelong network of stable people; within the family the relationships extend through the generations; within the peer group the developing human experiences the give and take of caring, safe interpersonal connections

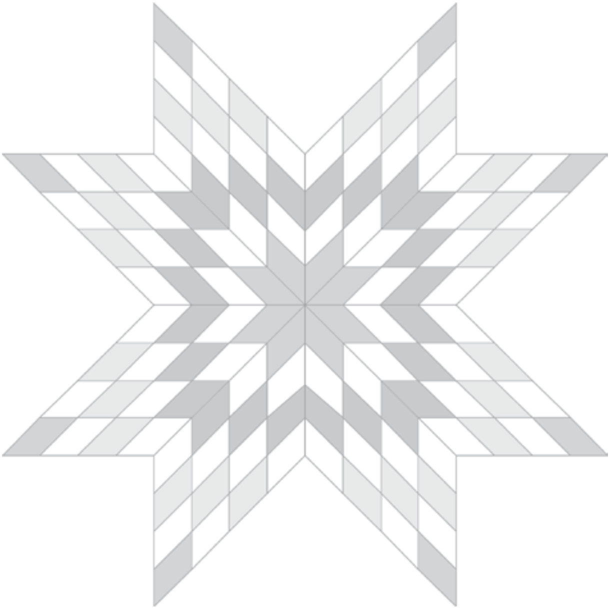
Personal Assets

The growing human is capable of developing his/her own inner assets in the following areas: Intellectual, emotional, social, spiritual, physical, and will. Personal assets will manifest in following ways: curiosity about self and the world; willingness to learn and put effort into mastering new tasks; develops moral capacity to see how the self impacts on others; the ability to make choices that demonstrates respect, responsibility, honesty, courage, compassion, empathy; ability to be pro-social; ability to care for self

Contextual Foundation

The human being is developing within a community and societal context that promotes capacity in the following areas:

- physical needs are adequately met (food, shelter, clothing, medical care, safety and security); person is learning at developmentally appropriate levels the strategies for assuming responsibility in all the above areas.
- in the context of the community the developing human gains an intellectual/affective capacity which promotes problem-solving skills, emotional management skills, mastery of environment, and ability to effectively negotiate a variety of relationships; develops positive feelings about self, others and the surrounding world with an ability to contribute to the community; the community values the growing human in tangible ways readily apparent to all and provides adequate support to parenting and educating children and youth; opportunities for meaningful activities that contribute to a healthy community are available and support & encouragement given to all members of community



Suicide and Aboriginal Youth: Cultural Considerations in Understanding Positive Youth Development

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Abstract

The importance of positive youth development cannot be overstated. We strive to foster healthy mental/emotional, social, spiritual and physical development in our children. Alarmingly high Aboriginal youth suicide rates in some areas call for an increased understanding of how protective factors and risk-taking behaviours influence youth development. This may help us develop strategies to increase positive outcomes for Aboriginal youth. This paper will provide an overview of the impact of loss of cultural continuity and identity on positive youth development.

Native Social Work Journal Vol 7, pp. 163-180

Suicide Rates and Juvenile Offences in Canada

Suicide rates of Canadian adolescents differ significantly between Aboriginal and non-Aboriginal youth. Kirmayer (1994) states "Canadian Aboriginal peoples currently suffer from one of the highest rates of suicide of any group in the world" (p. 3). He further reports "over a third of all deaths among Aboriginal youth are attributable to suicide" (p. 3).

A Canadian Government Royal Commission Report in 1995, submitted by Nancy Miller Chenier, entitled "Suicide Among Aboriginal People" states that the suicide rates reported were felt to be an underestimation due to reporting and data gathering issues. The report states:

> Although the true rate of suicide was considered to be higher than existing data suggested, the Commission estimated that suicide rates across all age groups of Aboriginal people were on average about three times higher than in the non-Aboriginal population. The suicide rate was placed at 3.3 times the national average for registered Indians and 3.9 times for Inuit. Adolescents and young adults were at highest risk. Among Aboriginal youth aged 10 to 19 years, the suicide rate was five to six times higher than among their non-Aboriginal peers (Magnitude of the Problem section, 2-3).

Suicidal behaviour is not the only area where Aboriginal youth fair less well than their non-Aboriginal counter-parts. Other high risk-behaviours including criminal activities are problematic with Aboriginal youth. This is reflected in the Canadian prison population that is over represented by those with Aboriginal heritage. According to a Statistics Canada report authored by Caverley (2005) entitled 'Youth Custody and Community Services in Canada':

> In 2004/2005, there were about 31,700 young persons (aged 12 to 17 years) admitted to correctional services. Of those, 15,900 (50%) admissions were to custody and 15,800 (50%) admissions were to community supervision, with the majority (12,900 or 81%) of community supervision admissions being to probation.… Aboriginal youth are highly represented within correctional services. Nearly one-third of all females and just over one-in-five

> males admitted to sentenced custody were Aboriginal. Overall, Aboriginal youth made up one-quarter of all sentenced custody admissions in 2004/2005, yet they represent approximately 5% of the total youth population (p. 1).

Why is it that there are poorer outcomes regarding positive youth development in Aboriginal youth compared to non-Aboriginal youth? Can we tease out some answers by sifting through what we know about both protective factors and risk factors impacting youth? Is there a way to better understand cultural differences that affect positive youth development?

Loss of Cultural Continuity and Identity

It seems apparent that loss is an important aspect of suicidal behaviour, more specifically the loss of cultural continuity and identity. Health Canada (2005) in their report entitled "Acting on What We Know: Preventing Youth Suicide in First Nations" describes cultural continuity as follows:

> Cultural continuity has to do with the transmission of knowledge, values and identity from one generation to the next. Where this transmission is conducted with a sense of individual and collective health and wellness, belief in an optimistic future, and ability to make decisions today for tomorrow, there will be cultural continuity. Culture and community are not static entities but constantly evolving and changing in response to changing social realities. As such, continuity does not mean simply maintaining the past or repeating actions prescribed by tradition, but re-creating and re-inventing communal practices in ways that maintain connections, honour the past, and incorporate a sense of shared history (p. 100).

This report also discussed identity and stated:

> Sense of identity can be defined as being conscious of the specific group you are part of, in terms of language, values, beliefs and practices.…The lack of a stable sense of identity in relation to other groups is a key risk factor for suicidal behaviour among First Nations and other Aboriginal youth (p. 87).

Culture

Cultural differences often set Aboriginal youth apart from their non-Aboriginal peers, sometimes causing misunderstandings with detrimental results. The concepts of loss of identity, cultural continuity and culture are intricately woven together. In order to appreciate their impact on positive youth development an understanding of how culture influences people is necessary.

Jerome Bruner (1990) contends that we, as humans, have an innate drive to create meaning and it is the culture that we participate in that provides the experiences by which we construct our world and our 'meanings.' These meanings form our cultural identity as well as our individual identity. He believes we search for and are predisposed to make associations using language in order to create meaning in our lives. He discusses our pre-linguistic 'readiness for meaning.' This enables us to learn language; developing associations by using symbols (internalized) which then help us create meaning in our world. Participating in our culture is necessary in order to form associations and thereby create meaning.

Bruner's view is supported by Valsiner's (2001) idea of semiotic mediation conveying the idea that being part of a culture allows creation of meaning to take place. Vygotsky (1931) also believed that the environment and/or culture in which a child is raised helped determine the cognitive skills and patterns of thinking, which went into language development. Language then becomes the tool the child uses to think.

Keating and Hertzman (1999) discuss this "readiness for meaning" from a biological perspective. They contend that:

> Critical periods are defined as periods during which the experiences of the organism will be encoded, especially in the neural system. Before and after critical periods, the same experiences will have little or no effect on the developing organism … for some biological systems, there are very narrow and well-established critical periods. If the right kind of stimulation is not available at the right time, that system will simply not get hooked up (p. 11).

This concept is further explained in the research on biological embedding. Hertzman (1999) discusses the "hypothesis that spending one's early years in an unstimulating, emotionally and physically unsupportive environment will affect the sculpting and neurochemistry of the central nervous system in adverse ways, leading to cognitive and socioemotional delays" (Keating & Hertzman, p. 31).

This lends support to Bruner's idea of pre-linguistic readiness for meaning. Interaction between the individual and culture is bidirectional. Individuals create meaning through interaction with their culture that changes them. They in turn interact with culture causing cultural changes. This interaction between individuals and culture promotes cultural and individual progression.

Cultural Change

What happens when this change is not gradual, but radical? Keating and Hertzman (1999), when discussing stresses on Canadian families, cite Keating & Mustard (1993) stating, "during periods of profound social change, such as the present, some sectors of society are at high risk of encountering a decline of social support and hence adequate nurturing of developmental needs" (p. 1). Bronfenbrenner (cited in Keating and Hertzman, 1999) adamantly proclaims that profound cultural changes are detrimental to youth. When examining the health and well-being of youth he discusses:

> troubling scientific evidence that pointed to a societal breakdown in the process of 'making human beings human': 'The signs of this breakdown are seen in the growing rates of alienation, apathy, rebellion, delinquency and violence we have observed in youth in this nation in recent decades'….Today they have reached a critical stage that is much more difficult to reverse. The main reason is that forces of disarray, increasingly being generated in the larger society, have been producing growing chaos in the lives of children and youth (p.1).

Growing chaos seems to be an apt term for what is happening with our Aboriginal youth. They often identify with two cultures - their traditional

Native culture and the western non-Aboriginal culture. Canadian non-reserve and reserve youth are integrated into western culture especially when attending secondary schools, colleges and universities. At this time in history both Aboriginal and non-Aboriginal cultures are experiencing rapid, profound changes. The possibility exists that the challenges of living between or within two cultures while both of those cultures are experiencing upheaval may be greater than challenges faced when living within one culture as it undergoes profound change. Aboriginal youth are facing a weakening of their historical cultural grounding while they are entering into an increasingly chaotic, changing, present day western culture. Aboriginal youth often feel disconnected from both the dominant society and their traditional culture, at home in neither.

Attitude Towards Cultural Differences

The magnitude of the cultural differences between Aboriginals and non-Aboriginals are profound. That is not to say one is better than the other, just different. Differences cause misunderstandings. When members of one culture interpret behaviours of another culture, they do so through what Valsiner (2006) calls 'cultural myopia'. Valsiner believes that we, as individuals, have our own views and assumptions. These terministic screens, the lens through which we look, develop through interaction with our culture. When we view other cultures, it is through these screens, which inevitably colour our understanding creating paradigm blindness.

Investigating the cultural differences between Aboriginal and non-Aboriginal culture by putting aside culturally myopic perspectives of the dominant western culture is difficult. It is however one of the keys to gaining an understanding of why Aboriginal youth fare less well than their counterparts. It may also be a beginning to understanding how we can foster positive youth development for this population, giving us clues as to both risk and protective factors that will make a difference with this population.

Positive Youth Development

Prior to the exploration of positive youth development, children and adolescents were often studied from the perspective of pathology - trying to figure out how to fix what is seen to be wrong. The focus has been to look at the problems, weaknesses and negative aspects. In contrast to the 'pathological view' positive youth development "takes a strength based approach to defining and understanding the developmental process. More precisely, it emphasizes the manifest potentialities rather than the supposed incapacities of young people" (Damon as cited in Benson et al., p. 895). In order to gain insight into the concept of positive youth development it is necessary to look at both protective factors and risk factors.

Protective Factors

Benson et al. (2006) define protective factors as "safeguards identified in epidemiological research that help individuals cope successfully with risk" (p. 901). These factors can be protective from the following two perspectives: positive asset development, and buffering against and/or reducing risk.

Protective factors function through community, schools, family, peers and the individual. Some factors include community involvement, caring community, engagement in school, safety, family support and caring, role models, positive peer influence, honesty, integrity, responsibility, interpersonal competence, self-esteem, agency, sense of purpose, and belief in a positive future.

It is generally thought that the more protective factors a person possesses the better the outcome. Benson et al. (2006) describe the concepts of vertical and horizontal pile-up as follows. Vertical pile-up

> has to do with the additive or cumulative nature of the elements called assets. The assumption is that 'the more assets the better'.... adolescents with more personal and social assets…have a greater chance of both current well-being and future success (p. 908).

Horizontal pile-up refers to the idea that "the more settings that adolescents experience reflecting these features, the more likely they are to acquire the personal and social assets linked to both current and future well-being" (p. 908).

Risk

Boyer (2006) states “risk is defined in the developmental literature as engagement in behaviours that are associated with some probability of undesirable results” (p. 291). While learning to take risks is necessary for human development (an infant risks falling when learning to walk) other risk-taking behaviours can be detrimental. Risk-taking behaviours (seen as increasing during adolescence) include alcohol consumption, cigarette smoking, drug use, sexual behaviours, dangerous driving, interpersonal peer aggression, school misconduct, theft, lying, gambling, and criminal acts.

Risks factors associated with suicide in Aboriginal youth were assessed and presented in the Royal Commission Report, submitted by Nancy Miller Chenier, (1995). “The Commission report identified four groups of major risk factors generally associated with suicide; these were psycho-biological, situational, socio-economic, or caused by culture stress. Culture stress was deemed to be particularly significant for Aboriginal people” (The Contributing Factors section, ¶ 1).

Psycho-biological Factors

In addition the report states:

> “while mental disorders and illnesses associated with suicide (such as depression, anxiety disorders and schizophrenia) were documented less often among Aboriginal people, community health providers suggested that unresolved grief may be a wide-spread psycho-biological problem” (The Contributing Factors section, ¶ 2).

It is perhaps significant that although mental disorders and illnesses were less documented, unresolved grief was suggested as a predominate factor. Grief is a reaction to loss, and unresolved grief can be debilitating. As a culture, Aboriginal people are facing the loss of their culture, identity and many of their people through suicide; a grief that has not been resolved.

Situational Factors -

The Commission goes on to state:

> Situational factors were considered to be more relevant. The disruptions of family life experienced as a result of enforced attendance at boarding schools, adoption, and fly-out hospitalizations, often for long-term illnesses like tuberculosis, were seen as contributing to suicide. To this was added the increasing use of alcohol and drugs to relieve unhappiness. Studies of Aboriginal people who have committed suicide have found that as many as 90% of victims had alcohol in their blood. Brain damage or paranoid psychosis as a result of the chronic use of solvents is reported as a major factor in suicides by youth. (The Contribution Factors section, ¶ 3)

Situational factors displaced Aboriginal people, plucked them out of their culture and dropped them into a new and foreign culture. Residential schools forbade any use of their mother tongue, traditional ceremonies or discussion of their values or beliefs. This was often accompanied by sexual, physical and emotional abuse. As a mental health counsellor, I had the honour of listening to residential school survivors who finally gave voice to their experiences. Many survivors had not been able to disclose prior to our sessions. Their information was given in trust to form their psychological impact statements. These were presented in class action suits in the past few years and reflect the horror these people, as children, suffered and the damage caused. These experiences led to mistrust of the dominating culture, loss of language and knowledge of their own culture, having to hide one's participation in their culture (including language use and beliefs) and feelings of alienation, shame and despair. Generations of individuals have felt disconnected from their own culture and not part of the dominating culture. In keeping with Bronfenbrenner's idea of the growing chaos in children's lives, Aboriginal people, their youth in particular, are in crisis.

Socio-economic Factors

Miller Chenier in The Royal Commission states:

> Socio-economic factors, such as high rates of poverty, low levels of education, limited employment opportunities, inadequate housing, and deficiencies in sanitation and water quality, affect a disproportionately high number of Aboriginal people. In conditions such as these, people are more likely to develop feelings of helplessness and hopelessness that can lead to suicide. (The Contributing Factors section, ¶ 4)

Keating and Hertzman (1999) discuss developmental health or well-being in the context of physical and mental health, behavioural adjustments, literacy and mathematics achievement. They report that "in societies that have sharp social and economic differences among individuals in the population, the overall health and well-being is lower than in societies where these differences are less pronounced" (p. 3). Research indicates that Canada's socioeconomic gradient is steep. This means that as a society, overall developmental health outcomes are lower. The portion of the society that is impacted most significantly is that of the lowest income, which is often the Aboriginal population.

Cultural Stress Factors

The Royal Commission states:

> Cultural stress is a term used to refer to the loss of confidence in the ways of understanding life and living that have been taught within a particular culture. It comes about when the complex of relationships, knowledge, languages, social institutions, beliefs, values, and ethical rules that bind a people and give them a collective sense of who they are and where they belong is subjected to change. For Aboriginal people, such things as loss of land and control over living conditions, suppression of belief systems and spirituality, weakening of social and political institutions, and racial discrimination have seriously damaged their confidence and thus predisposed them to suicide, self-injury and other self-destructive behaviours. (The Contributing Factors section, ¶ 5)

It has been established that culture is one of the most significant underpinnings of our identity and development as human beings. The impact of this degree of cultural stress on Aboriginal people, particularly adolescents is paramount.

Cultural differences: Understanding cultural underpinnings

From a cultural perspective, the differences between traditional Aboriginal society and non-Aboriginal society are fundamental and deeply rooted. When exploring cultural differences what begins to emerge is a vast difference in the underpinnings of cultural values, beliefs and traditions. What we, as societies, need to realize is that there may be some differences in the risk and protective factors from what we might expect.

In order to gain a clearer understanding of the cultural differences the following story is conveyed by Ross (1992), a Crown Attorney working with First Nations in remote North-Western Ontario. A Mohawk tribe from Tyendinaga was hosting a sports function, with Cree from James Bay attending. It is customary Mohawk (agricultural) tradition that more food than could be consumed be presented as a way of demonstrating generosity and wealth. Cree who are hunter-gatherers always eat everything offered to demonstrate respect for the successful hunter and his generosity. Ross writes:

> Needless to say, a problem arose when these two sets of rules came into collision. The Cree, anxious to show respect, ate and ate until they were more than a little uncomfortable. They considered the Mohawk something akin to gastro-intestinal sadists intent on poisoning them. The Mohawk, for their part, thought the Cree ill-mannered people intent on insulting the Mohawk generosity….The significant point is that each group believed that the other was *intentionally* being insulting and disrespectful when, in fact, each group had been going to great pains (especially the Cree!) to show exactly the opposite. The problem lay in the fact that each group could only see the other through its own rules, could only interpret the behaviour of others from within their own perspective (p. 2-3).

This story illustrates two important points. First, members of a given culture have a "culturally myopic view" of cultures they are not part of. This leads to misunderstanding and incorrect judgements. Second, Aboriginal people are from different tribes with different customs. Believing that all Aboriginal people are the same because they are Aboriginal would be like saying that English and French people are culturally the same because they are white.

Ross discusses five underlying principles guiding Aboriginal reality that are very different from the guiding principles of western culture. These are: 1) the ethic of non-interference, 2) the ethic that anger not be shown, 3) the ethic respecting praise and gratitude, 4) the conservation-withdrawal tactic, and 5) the notion that the time must be right. It is important to understand that these guiding principles have been culturally engrained over a very long time. When discussing the ethic of non-interference Ross states:

> the ethic of non-interference is probably one of the oldest and one of the most pervasive of all the ethics by which ... Native people live. It has been practised for twenty-five or thirty thousand years, but it is not very well articulated (p. 14).

The ethic of non-interference, simply put, means that you never interfere in any way with the rights, privileges and activities of another person. It is considered rude and is forbidden. This includes dealing with children. They are not told what to do. Aboriginal parents often raise their children without set bedtimes, rules regarding homework and school attendance, etc. Children learn through experience, through doing.

Role models are used, ideas may be put forth through story telling but decisions are left to the individual. When this is seen through the myopic vision of the dominant culture parents are often viewed as unfit or uncaring. Ross states Aboriginal people "are very loath to confront people. [They] are very loath to give advice to anyone if the person is not specifically asking for advice. To interfere or even comment on their behaviour is considered rude" (p. 15). Note here that even commenting on behaviour is a violation of the ethic of non-interference.

It is believed that the ethic that anger not be shown developed thousands of years ago as a survival tactic. People lived in close quarters and had to work together supporting one another. “There was a sacrifice of individual feeling and their expression and discharge for the sake of the group unity” (p. 33). According to Ross, this is often reflected in courtroom when witnesses refuse to testify, not wanting to embarrass families. By western standards, it is often seen as non-cooperation.

The third ethic concerns praise and gratitude. Native people often show appreciation by requesting continuation of their contribution, not by giving overt verbal praise. This ethic also has its roots in survival. The lack of overt praise is often seen by outsiders as a lack of caring or ingratitude when in fact it is just the opposite.

The ethic of conservation-withdrawal also goes back to survival issues. Traditionally, in times of stress and danger it was extremely important to think things through, to do thorough mental preparation before taking action. To do otherwise could be fatal. Native youth follow this learned response as a way of coping, which can be seen when they are arrested. Ross states:

> the greater the unfamiliarity of the new context, the more pronounced will be the withdrawal into physical immobility and silence.…A few have been observed to enter into an almost catatonic state and to remain there for days at a time, prompting any number of mis-diagnoses (p. 42).

The final ethic discussed by Ross is the ethic that the time must be right. Again, it can be understood from a survival perspective that there is a right time to hunt, fish, and gather. When the time is “not right” to hunt etc., it is time to prepare mentally and physically. This is complementary to the ethic of conservation of energy and withdrawal as time to think.

Understanding the cultural underpinnings of Aboriginal society is mandatory when dealing with issues of positive youth development, specifically in regards to risk behaviours and suicide. Addressing the issues using values, beliefs and perspectives that are counter to their cultural traditions have not worked. Something must be done; the dilemma is to figure out what.

Revisiting the Stats; The rest of the story

Statistics show that Aboriginal youth have a higher suicide rate than their non-Aboriginal counterparts. This however, is painting all Aboriginal tribes and bands with the same brush. A closer look presents a different picture. Chandler and Lalonde (1998), when reporting on suicide rates in British Columbia found:

> In over half of the communities studied (111of 196) there were no known suicides during the targeted five-year period, while the remainder contains communities which suffer rates of youth suicide some 500-800 times the national average. Obviously, if there is something about the lives of certain First Nations communities that is conducive to, or serves as a protective factor against, suicide, it cannot be something that is equally true for all First Nations people (p. 207).

It becomes important then to understand what forms of knowledge and practices are effective in Aboriginal communities with low suicide rates. Further exploration of how knowledge transfer can occur with other communities must keep in mind that within these communities there are different languages, beliefs, customs and cultures.

An Alternate Approach

Focusing on problems faced by Aboriginals from a "pathological perspective" has not solved them. Therefore, we need to turn to strengths that can be fostered on both an individual and community level. Current literature indicates that a return to traditional practices is a path toward improved mental health and reduced suicide. Kirmayer, Simpson and Cargo (2003), in their review of mental health and Canadian Aboriginal people, state:

> There is clear and compelling evidence that the long history of cultural oppression and marginalisation has contributed to the

> high levels of mental health problems found in many communities. There is evidence that strengthening ethnocultural identity, community integration and political empowerment can contribute to improving mental health in this population. (p. 15)

Other researchers have looked more specifically at what the differences are between Aboriginal communities that have no reported suicides and those that have extremely high rates. Hallett, Chandler & Lalonde (2007) investigated Aboriginal youth suicide rates in British Columbia finding that rates varied from one community to another. They found language to be an important factor in cultural continuity:

> The results reported demonstrate that not only did this simple language-use indicator prove to have predictive power over and above that of six other cultural continuity factors identified in previous research, but also that youth suicide rates effectively dropped to zero in those few communities in which at least half the band members reported a conversational knowledge of their own "Native" language (p. 392).

Promoting traditional cultural identity, including language, and traditional beliefs and values is a proactive approach. Spirituality is also found to be important. Unfortunately, spirituality is often viewed as unscientific. Spirituality is however, an important component in the healing of Aboriginal communities.

For centuries, Aboriginal people have understood the importance of prayer and ceremony. Until recently there was no "hard scientific evidence" that native traditional ceremony was beneficial. Wagemakers Schiff and Moore (2006) studied the impact of the sweat lodge ceremony on dimensions of well-being. Results indicated "an increase in spiritual and emotional well-being of participants was directly attributable to the ceremony" (p. 48). Support for the importance of spirituality is found in the Health Canada Report (2005). It states:

> Spiritual inter-relatedness with Creation is kept strong through cultural belief systems and practices. The cultural spiritual belief system works from and with whole person wellness. When

> one aspect or energy of the person is not in balance, the cause is treated to regain balance--balance of the whole person as well as balance within Creation. Spirituality, therefore, is an important partner in the prevention of suicide. Where traditional societies are still able to operate with their own value system, they can also maintain positive physical, mental, spiritual and emotional health. Life is in balance, and there is order, harmony and control....Most striking is the emptiness found in our youth at risk, which is often masked temporarily by another culture or spirituality....That is why the values which guided our ancestors must be restored and honoured in our communities. Without them we will continue to witness adolescent suicide as the most painful expressions of our loss of tradition, culture and belief in ourselves (p. 96-97).

Conclusion

Suicide is a problem of the individual as well as a problem of society. Not only are adequate, culturally appropriate mental health services needed for the individual, change is needed at a community level. There are strengths within Native communities that serve as protective factors against suicide. It is time for non-Aboriginals to be supportive in a non-imposing way, offering support while allowing Aboriginal communities to share amongst themselves to find solutions. Bringing together community members from various bands to share ideas and concerns is imperative. Bands with low or zero suicide rates have important knowledge and practices that can be implemented in other communities. With bands supporting each other and non-Aboriginal people giving support in culturally appropriate ways, death from suicide can, perhaps, be reduced or eliminated. Finding ways to understand one another and honour each other’s differences is an important first step.

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From the Inside Out: Spirituality as the Heart of Aboriginal Helping in [spite of?] Western Systems

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Abstract

The degree of reclamation of culturally-based spiritual practices varies by and within communities and families, but appears to be gathering momentum. From the anecdotes provided by clients it appears that healing takes its firmest roots when the spiritual aspects of the individual's life are attended to. More clients and helpers are recognizing the need to look inward, to recognize the strength of their spirit and the role spirituality plays in fostering resiliency. Working as a helper, particularly within western systems, however, the challenges can be daunting and frustrating with respect to incorporating spirituality into the helping process. Although many helpers have begun the dialogue, spirituality – and more particularly Aboriginal spirituality – remains on the margins, raising questions and concerns that have no simple solutions. This paper is a beginning in my personal and professional consideration of how to more fully explore and integrate spirituality with individuals, families and communities.

Introduction

This paper builds on a presentation that two friends (and colleagues[1]) and I prepared for the 2006 Native Mental Health Association of Canada conference held in Vancouver. Called *The Paradox of Spirit in Aboriginal*[2] *"Mental" Wellness* (unpublished), it was a presentation that drew some thoughtful and thought-provoking responses from the attendees[3]. It is also an issue that I personally and professionally consider integral as I continue to work with Aboriginal communities throughout the northeastern region of Ontario; the degree of reclamation of culturally-based spiritual practices varies by and within communities and families, but, as evidenced by other events I have participated in, appears to be gathering momentum. From the anecdotes provided to me by clients, as well as from my own personal experiences, it appears that healing takes its firmest roots when the spiritual aspects of the individual's life are attended to.

It is encouraging to me that more clients and helpers are recognizing the need to look inward, to recognize the strength of their spirit and role spirituality plays in fostering resiliency. Working as a helper, particularly within western[4] systems, the challenges can be daunting and frustrating. Having spent most of my post-secondary years in Aboriginal programs, we are taught that we must know ourselves first in order to provide effective service to clients, but to bring that knowledge from the inside out also places us at risk in western systems that do not understand other ways of knowing and living. It also can provide avenues for growth for those same systems, and for ourselves, and the people we service. The following is an exploration of a number of issues that I have encountered. It is far from exhaustive, but is an opportunity for me to consider a number of elements of the healing, living and helping[5] processes I am engaged in.

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[1] Janice St. Germaine, Anishinabe-kwe of Wasauksing First Nation, and Tracy Holman both worked at B'saanibamaadsiwin-Native Mental Health during my tenure there. While the three of us come from differing backgrounds with respect to our spiritual beliefs, we each felt strongly that spirituality is a crucial aspect of healing and wellness.

[2] I use Aboriginal in this paper to refer to the many cultures and identities of Canadian indigenous peoples. I acknowledge that this may not reflect the terms used by individuals or groups, and that there is an ongoing debate regarding identifiers and identity across this country. Where "indigenous" is used, I am referring to cultures in other parts of the world.

[3] Interestingly, a number of the attendees—psychiatrists, psychologists and other mental health professionals of various socio-cultural backgrounds—shared anecdotes that affirmed the direction of the presentation. All had some experience working with Aboriginal communities and/or clients, as well as other clients from other backgrounds.

[4] Western is those sets of cultural values, beliefs and systems that originated in Europe. Western paradigms tend to separate things and people, to place a high degree of reliance on empirical science, and to assume an ethnocentric stance of being the only valid and universally relevant way of conceptualizing the world. (Coates, Gray & Herington, 2006; Kirmayer, Brass & Tait, 2000). In addition, there are hierarchical structures and systems that serve to classify, marginalize, oppress people and invalidate other ways of knowing and living.

Before moving on, a few words of introduction and definition are needed. My own sense of identity is cloudy, having been adopted as an infant, and raised in southern Ontario. As a mother and grandmother of Anishinabek children, however, I understand I have responsibilities to the upcoming generations, to help where and how I can to enhance the well-being of individuals, families, communities and nations. Over the past six years I have worked in the field of Aboriginal mental health[6], providing direct service, as well as teaching for the Anishinabek Educational Institute. Currently, I am working to establish a regional Aboriginal mental health outreach service in northeastern Ontario at the Northeast Mental Health Centre[7]. I am also a Ph.D. student at Trent University in the Indigenous Studies Department. These experiences have left me with an unshakable sense of being caught between two worlds, acutely cognizant of the ramifications, should I step too far into one or the other world. They also affirm in many ways, however, the need to pay more attention to the spiritual dimension of peoples' lives in the helping process.

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[5] Throughout this paper, I use the term "helping" to include any form of helping practice, such as social work, nursing, psychiatry, etc. It also includes stages and activities ranging from prevention to tertiary intervention.

[6] "Mental health" is a misleading term, particularly for Aboriginal workers and clients, because of the limitations it imposes. Rather, we work from a holistic perspective, recognizing that all aspects of self—mental, emotional, physical and spiritual—must be balanced within the individual's life context (i.e. historical, environmental, socio-political, etc.)

[7] Establishing a culturally appropriate Aboriginal service within a western institution, from past experience, will be fraught with many challenges. It also places my co-workers and me in a position of tension, as we will be working to educate the non-Aboriginal staff to work with Aboriginal clients in ways that may go very much against western paradigms. As well, to work in Aboriginal communities and with clients requires a different mindset and set of expectations, such as the amount of time that one spends, and how it is spent. The internal conflicts that we may experience, too, will likely stem from the historical context of western institutions vigorously attempting to assimilate Aboriginal peoples. Hence, it is critical that the work we do be fully grounded in community and culture, and be guided by the communities themselves.

As many writers before me, I define "spiritual" and "religious" as distinct concepts. Spirituality is that sense of connection to something greater than self. Fyre Jean Graveline states, "A spiritual connection helps not only to integrate our self as a unified entity, but also to integrate the individual into the world as a whole. Spirituality is experienced as an ongoing process, allowing the individual to move toward experiencing connection—to family, community, society and Mother Earth." (Graveline, 1998, p. 54). An Elder, quoted in Ellerby and Ellerby (1998, p. 39), states "Spirituality is the foundation of everything and I don't care what colour you are." Vine Deloria Jr. (1994) discusses how for Aboriginal peoples, "Tribal religions are actually complexes of attitudes, beliefs and practices fine-tuned to harmonize with the lands on which the people live." (p.70). Thus, it is with little surprise that land, and the spirit of the land, are central to a sense of identity and balance, in addition to being a key political focal point. Without that connection to the land, the spirit becomes disconnected, thus impacting the wellness of individuals, families and communities (Ponting, 1997). Spirituality, in lived experiences, takes many forms: intuition, dreams, creativity expressed through dance, music, art, visions, and so on. It is seen in the way a meal is prepared, in the sharing of food and laughter, the thoughts that are present during the making of a drum or an outfit, and in the greeting of a new day. It allows people to live well in balance with all their relations, to find meaning and purpose in life, and when necessary, to heal.

Religion, on the other hand, is a structured, formal set of practices that express "an integrated belief system that provides principles of behaviour, purposes of existence, meaning of death, and an expression of reverence for a supernatural being (or beings)." (Canda 1989, p. 37 cited in Baskin 2002, p. 2). One can be religious without having a spiritual connection. One can be spiritual without being religious. Or both may co-exist. Perhaps the most harmful impact of western religions has been the rigidity that has developed over the centuries, where any belief system that is different or questions religious authority has been harshly dealt with. The Crusades, witch-hunts, Inquisition and residential schools are pointed evidence of this. The persecution and relentless missions to convert indigenous peoples across the world has left entire cultures with fractured remnants of odd, garbled mixtures of the traditional[8] indigenous and western colonial knowledge (see Adelson, 2000; Deloria, 1994). This splintering is still evident in communities that clash over traditional ceremonies, which have been thoroughly demonized by the various churches and missionaries during the past few hundred years.

Spirituality, as a critical component of healing, is still very much on the fringes of the dominant therapeutic modalities, generally seen as the purview of the religious institutions, although both indigenous and non-indigenous therapists, counsellors (secular and non-secular) and healers, are bringing it back from the margins (Young, Wiggins-Frame & Cashwell, 2007; Graham, Coholic & Coates, 2006; Coholic, 2005)). For Aboriginal peoples however, spirituality is a central element in the development of positive identity, resilience, and purposefulness, and is manifested in daily living[9] (see for examples Ellerby & Ellerby, 1998; LaBoucane-Benson, 2005; Baskin, 2002; Kirmayer, Brass & Tait, 2000; Riecken, Scott & Tanaka, 2006; Iwasaki & Bartlett, 2006). In mental health, as with other western health fields, the role of spirituality is too often ignored (Hill & Coady, 2003). My experiences confirm for me, however, that, as the teachings indicate, we are—first and foremost—spirit having a human experience. And, until we connect with that spirit, our wellness and capacity as humans is not fully realized[10].

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[8] I want to acknowledge the many difficulties that are attached to using the word "traditional." I use it in this paper to refer to Aboriginal practices that have been utilized, and have their origins in life before European contact.

[9] The significant difference between western-based religions and Aboriginal understandings of spirituality is that one cannot separate spirituality from any other aspect of life. Thus, the sense of connectedness is constantly present. The perception of the sacred includes all of creation, and rather than humans being at the top of the heap, instead we are understood to be the most dependent on all other life forms. There is no need for intercessors, such as a priest, to pray on behalf of others, pronounce judgment on the behaviours of others, and so on. There is a distinct recognition of the equality and interdependence—and thus the internalized sense of respect—of all, rather than power-based hierarchical structures that have historically marginalized entire groups, such as women, children, or people of non-western cultures.

[10] Edward Benton Banai (1988), in *The Mishomis Book*, relates a number of teachings through storytelling, which underline the need for a balanced connection between the spiritual and physical dimensions of our lives. To step too far into one this traditional form of knowledge transmission also reinforces culturally based concepts and practices. The time at which this book was written being Aboriginal was not quite as acceptable as it has since become. But this book, along many others, in addition to other venues of information sharing, have revived some of the cultural pride that is a key element of positive identity formation. The spiritual elements within the stories form core practices, values and beliefs, are a major part of that cultural foundation.

A positive sense of identity is a strong protective factor, and is inextricably linked to culture and cultural worldviews (e.g. Homel et al., 1999; Wilson, 2004; Kirmayer, Simpson & Cargo, 2003), of which spiritual concepts are a key factor. This understanding has been and continues to be a central message in all areas of Aboriginal wellness (Kirmayer et al., 2003; Carriere & Scarth, 2007; Young &Nadeau, 2005; Adelson, 2000). As western mental health services become more open and supportive of addressing Aboriginal-specific needs, the incorporation of spiritual practices is not only more possible, but also poses more questions—and concerns—at many levels.

Interestingly, a development bearing many similarities to Aboriginal healing paradigms, called the "recovery" movement, has been developing in western or mainstream mental health, propelled by the individuals (and their families and friends) who have survived *(in spite of?)* the mental health system, with a corresponding development among many service providers to move beyond the oppressive, paternalistic mindset that has been—and to some degree still is—the hallmark of mental health (Jacobson & Curtis 2000; Jacobson & Greenly, 2001). The recovery movement is providing the impetus for changes within mental health services not only in Canada, but also in other parts of the western world. It is a movement that demands that helpers and systems look at the individual as a whole person, existing within the context of family, community, culture, and environment, and that they foster conditions that provide hope, healing, empowerment, and connectedness (Jacobson & Greenly, 2001).

For Aboriginal individuals and communities—indeed, for indigenous societies across the world—these are key elements in the development to reclaim recognition and autonomy as distinct peoples, to engage in decolonizing processes (even as colonization continues in more subtle forms, such as cognitive, religious and economic imperialism[11]) and to re-strengthen cultural life ways and worldviews, and are not limited to just the "mental" health field (Young & Nadeau, 2005; Kirmayer, et al.,

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[11] See for example, Kirmayer, Brass & Tait (2000), Coates, Gray & Hetherington (2006), Martel & Brassard (2006), Waldram (2001). The various appellants utilized to describe the continuing experience of colonization include "intellectual" and "professional." In effect, although colonization originated as a set of oppressive, genocidal practices during the early colonial period, there is no sign that colonization has ceased to exist. It has simply moved into more insidious and subtle forms with far-reaching global impacts.

2000; Coates, Gray & Hetherington, 2006). The emphasis on recovering and fully integrating the spiritual aspect of self has implications that are linked to identity and resilience of the individual, family and community, as well as for the practice of clinicians. “What is considered mental illness is influenced by cultural and religious factors, and the Western definition of mental illness is not always applicable to individuals from different ethnic and cultural backgrounds…manifestations of mental illnesses and how people describe and interpret their symptoms vary with race, ethnicity and culture” (Agic 2003, p.5).

But incorporating the spiritual elements of healing (or recovery) poses particular issues for Aboriginal individuals and their helpers, especially when those supports are in western-based health settings. For example, western health organizations, when presented with the notion of engaging Aboriginal healers, may raise concerns of supervision (i.e. clinical and legal liability issues). Other issues that come to light are the divergence of values, ethics and cultural practices. For example, once a relationship is established within Aboriginal communities, it is expected that the relationship will endure, regardless of the initial context or purpose of that relational development. Thus, it is not uncommon to hear of complaints raised when helpers (and others, such as researchers) enter into a relationship with a community (i.e. through provision of helping or other services), and then leave to take a position elsewhere. To paraphrase Rupert Ross (1996, p.67), we are relationships, and those relationships extend beyond a specific set of functions and time. This requires an understanding that wherever we are, we are bound to our relationships, and thus have responsibility to those relationships beyond the office door.

As well, Aboriginal paradigms do not limit relationships to human-to-human, but are inclusive of animals, plants, rocks, water, spirits and all of Creation. Aboriginal ethics, or values, encourage positive, balanced relationships, not only with other humans, but also with all beings. Healing and restorative methods work to restore harmony and balance, ensuring the spirit is at the heart of the process. For example, where herbal medicines are used, the spirit of that medicine is acknowledged from the outset and is seen to be the active agent in the use of the medicine. Tobacco—a taboo material for many in the health field because of its association with cigarettes and negative health impacts—is given in some cultures as a way of affirming a relational "contract" (e.g. asking for specific knowledge) to a depth that is untouched by signing a piece of paper. Medicines convey not only the physical element, but also the spiritual element of healing, balance and relations. Placing spirit at the core of healing requires a perception of the sacred in all life forms, both seen and unseen. It allows for the acknowledgement and fostering of strengths and gifts regardless of the form they come in, reconciliation and restoration of harmony when hurt has occurred, for the awareness that respect must be shown in thought, word and action because none of us exist in a vacuum and we cannot act carelessly with impunity.

Ethics, as a set of values or principles, guide the behaviour of helpers and their relationships with those they are helping. In *God is Red*, Vine Deloria Jr. (1994) states, "Ethics flow from the ongoing life of the community and are virtually indistinguishable from the tribal or communal customs" (p. 68). Values, stemming from spiritual beliefs, are embedded within each culture and, although there are many common values across cultures and belief systems (e.g. sharing, caring, honesty, and so on), engaging in the helping process requires that the helper be able to fully function within the range of culturally defined expectations, acting in congruence with cultural values or ethics. This includes being able to acknowledge and support the spiritual needs and practices that assist the healing process for Aboriginal clients. This can be problematic for western systems, which have a somewhat different set of ethics and values. This can include the limitation of time spent with clients, interactions with clients beyond the scope of the therapeutic setting[12], being able to smudge where and when needed, and so on.

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[12] I do not suggest that the helper should deliberately become involved with clients in a social or intimate sense. The helper must remain cognizant of the potential power imbalance inherent in the client/helper relationship. However, the reality of working in Aboriginal communities for most Aboriginal helpers is that they are dealing quite often with family members and community members whom they may have known since childhood. Even in urban centres, it is common to come into contact with people known in prior contexts. Community events also bring people together, which may or may not be interpreted as having a social relationship with a client, depending on one's perception. Western ethics generally demand a clear-cut relationship between helpers and clients, which is not always possible, or necessarily desirable at times. (At times, clients will only trust someone from their community and/or family.) In essence, this particular set of ethics presents significant challenges for Aboriginal helpers, with no simple answers.

Within a number of helping professions' ethics guidelines, there is no mention of spirituality, or there are limitations on when or how the helper may discuss spirituality within the helping relationship (as an example, see the ethics guidelines of the Ontario College of Social Workers and Social Service Workers, which has no reference to spirituality, and the Canadian Professional Counsellors Association, which states the helper must not "introduce spiritual concepts unless…previously known to the client as providing spiritual or pastoral counselling"). Relationships are seen to be limited strictly to the helping process, which fails to recognize the nature of relationships as experienced in Aboriginal communities (as well as non-Aboriginal rural areas), including the idea that there are times where the individual receiving help may also be an individual who carries a specific set of knowledge (e.g. ceremonial, herbal) needed by the helper. This type of interdependence may fulfill the principle of reciprocity appropriately within Aboriginal contexts, but jeopardizes the helper's position professionally. Reciprocity is a principle that is strongly embedded in many Aboriginal cultures (Graveline, 1998; Little Bear, 2000), maintaining the connectedness between people (and other beings) and fosters values of sharing and caring. On the other hand, western ethics indicate that helpers should not accept gifts or engage in relationships that may be seen as a conflict of interest, as there are implications of favouritism, or inappropriate boundary issues. The constrictions imposed on helpers, working in an Aboriginal context, are established by western urban professional, and may be inappropriate at times, or even detrimental to the strengthening of the helping relationship[13]. Negotiating a path between two sets of expectations is complex, and can leave helpers feeling abandoned, misunderstood, and frustrated.

Issues like these remain an ongoing ordeal when working in western systems, although changes are slowly occurring. In some areas, there is increased flexibility in the methods of service delivery. As well, we are seeing a gradual opening up to the possibility there is more to healing and wellness than simple pathologization and medicating away of problems; families and individuals living with challenges currently labeled depression, schizophrenia, personality disorders, and so on, have strengths and gifts that are worth sharing and building on, and are fully capable of having a valued role[14] in community. In essence, living with a "disorder" is not so different than living with a "disease;" individual identity and capability are not defined by the illness, but adapt to cope with the limitations imposed by it. Similarly, families and communities are capable of adapting to meet the needs of the individuals experiencing various challenges. Helpers need to be able to approach their work from a strengths perspective, focusing on the potential for positive change, healing and wellness.

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[13] Again, I am not suggesting that helpers should willfully disregard the ethics of their respected professions, particularly where the safety and vulnerability of an individual is concerned. I am suggesting, however, that for those of us regulated by a professional body, there must be some in-depth discussion regarding a more responsive set of ethics to address the realities of working in Aboriginal communities, as well as within other family/community centred cultures, and for rural workers. Alternatively, we could have a separate professional body to guide Aboriginal helpers, utilizing Aboriginal ethics. Again, there are no simple answers.

In western mental health, much of the push to have helpers begin to regard their clients as whole persons has come from individuals[15] utilizing (*not always willingly*) mental health services who experienced marginalization as a result of, and often at the hands of the very system that was intended to help. As mental health services in many parts of the so called developed world have begun to shift focus, individuals directly affected by the system have advocated and agitated for a recovery-focused philosophy to be incorporated by organizations and institutions. Researchers have shown that individuals living with schizophrenia in Third World countries, with limited or no access to pharmaceuticals have a much stronger recovery rate than individuals in western societies (see Leff et al, 1992; Hegarty et al, 1994). This has called into question the use and benefits of medications, which also have significant serious side effects. Where various psychotherapeutic modalities have been touted as each being more effective than the others, researchers have been showing that, instead, there are core helping behaviours that are far more indicative of positive outcomes—all of which are directly involved in building any relationship or connectedness with another person (see for example Miller, Duncan & Hubble, 2004; Norcross, 2007; Riolo, 2004). What this points to is that, as helpers, we must interact with clients, understanding both the clients and ourselves as being fully human: heart, mind, body and spirit. It is the quality of our relationships—our connectedness to those we are helping—that will support the healing process and is guided by our sense of spirituality, our values, our beliefs and how we make meaning of our experiences.

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[14] A valued role is not limited to the narrow scope of earning an income or being a parent. The gifts of some individuals may not be perceived by western society as "productive," and yet these same individuals manage to effect profound changes for those around them. If a smile or laughter of a child is not "productive," perhaps it is only because the values are skewed.

[15] The current label for individuals using mental health services is "consumer/survivors." While I can fully appreciate the idea of surviving a *system* that has too often been less than helpful, I take issue with this label as it continues to place people in that position of being "Other-ed." In addition, I have never heard Aboriginal clients use the "consumer/survivor" identifier. There have been more than enough pejorative stereotyping labels attached to Aboriginal people over the centuries, that this is likely just one more unwanted, inappropriate and useless tag.

Even more critical is the issue of examining how we define experiences too often labeled "psychoses" or illnesses. As previously mentioned, the cultural and religious (spiritual) lens through which experiences are viewed has a critical impact on the helping and healing processes. This is particularly relevant in light of the current push by the mental health system's development of early psychoses intervention programs. As Cyndy Baskin (2002) so eloquently states, "I view the line between a spiritual and a psychotic experience as blurred." Aboriginal concepts—other than western-based—are too often ignored in the mental health system's push to address "problem" behaviours (Kirmayer et al., 2000, Timpson, McKay, Kakegamic, Roundhead, Cohen, & Matewapit, 1988). Current helping practices are firmly rooted in the development of the industrialization of western society, and the need to encourage conformity with colonial and contemporary corporate business philosophies (Sinclair, 2004; Wade, 1995; Morrissette, McKenzie & Morrissette, 1993; Hill & Coady, 2003; Duran & Duran, 1998). Wade (1995) notes that "Freud remained firmly anchored in Eurocentric notions of primitivism and deficiency…[and] many of his ideas are so thoroughly embedded in the assumptions underlying psychotherapy that they are rarely even noticed, let alone questioned."

The impacts on Aboriginal peoples are wide ranging, such as feeling unable to share one's experiences fully or safely in many environments, largely because of the negative stereotypes held about Aboriginal peoples and cultural practices. According to a study conducted with Mi'kmaq patients at a community health centre, over 50% of the patient's accessed Mi'kmaq medicine, with the majority of those feeling it to be more effective than western medicine. In addition, in this study, more than 90% of the users of traditional medicine did not tell their physician (Cook, 2005).

This chasm of distrust cannot be crossed easily[16]. This presents a serious dilemma for the helper, as the dominant medical beliefs generally outweigh the interpretations of meaning by Aboriginal clients, their families and too often their helpers (Kirmayer et al., 2000). The end result, though, may be individuals experiencing negative interactions from the mixing of traditional and western pharmaceuticals.

Linked to this is the language used to communicate. Many Aboriginal languages are process-oriented, whereas English is more object-oriented (Duran & Duran, 2000; Little Bear, 2000). In addition, translation of concepts from one language to another can be incredibly difficult; too often there is no equivalent notion. Even though cultures (and thus languages) evolve over time due to various factors, this does not mean that ancient ideas, such as spirit illness and soul wounds should be replaced by psychoses and hallucinations as the only viable diagnoses. It does mean, however, the helper has full responsibility of being open to the client's sense of his/her challenges, to hear how meaning is made of those challenges, to grasp the client's needs and to be willing to walk the path with him/her for a while, even—or especially—when the person's spiritual needs are identified. This may not mean attending ceremony or church with the client, but the helper must be willing to take those actions that support the client's reconnection with his/her heart and spirit. The helper must understand his/her own sense of the sacred, be able to identify, or be open to the many ways in which spirituality is experienced and expressed. The client, in this relationship, is fully responsible for taking those steps to reconnect, restore and re-balance internally and externally—to live as well and fully as possible, in harmony with his/her relations in ways that are appropriate for him/her.

In conclusion, I acknowledge that this paper is more of a beginning point of exploration and discussion. As helpers working from Aboriginal paradigms in western institutions, we are faced with a number of tasks in order to restore the spirit to the heart of helping, none of which are clear cut or easy. We have that large mountain to climb as we work to decolonize, to educate, and to support individuals, families and communities, regardless of the setting they are in. We also need to encourage our young people to take on the responsibility of picking up those healing bundles, to carry the knowledge of the ancestors forward and to engage in those dialogues about what living well and in balance means for the coming generations. We need to ensure we care for ourselves as helpers to function effectively, to deepen our own, unique sense of spirituality, to understand our own worldviews and perceptions to avoid imposing our judgments on others, so that we are fully capable of walking with those we are helping in ways that are appropriate for them, supporting them in reconnecting with their heart and spirit, to live that good life—mino-bimaadsiwin.

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[16] It should be noted that the problem of utilizing traditional medicines also has ramifications with respect to knowledge rights, and due to appropriations of resources and knowledge by unscrupulous individuals in the past, Aboriginal peoples in Canada (and indigenous peoples across the world) are reluctant to enter into conversations where sacred knowledge may be stolen or used against them.

Chi miigwetch.

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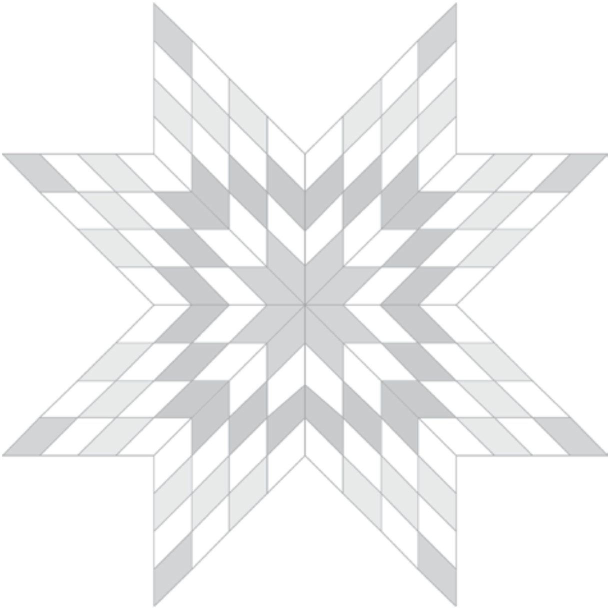

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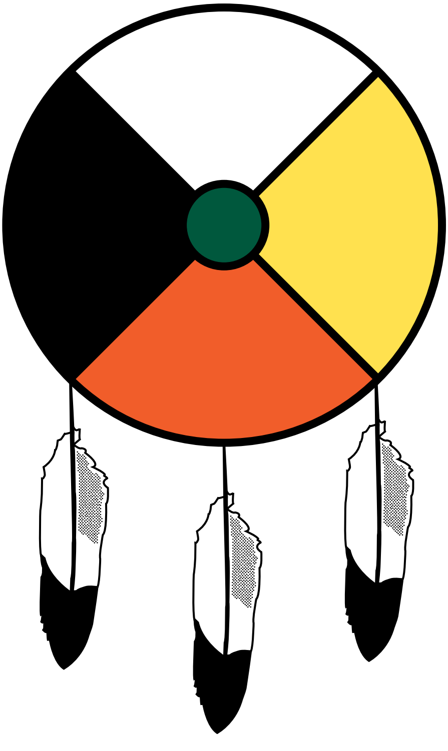For further information or to receive copies of previous volumes, please contact our office at the phone number above.