First Peoples Child & Family Review
A Journal on Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy & Practice

Volume 3, Number 4, 2007, pp. 62-71

Inside Looking Out, Outside Lookng In

Cynthia C. Wesley-Esquimaux

Dr. Cynthia C. Wesley-Esquimaux, Assistant Professor, University of Toronto, jointly appointed to the Department of Aboriginal Studies and the Faculty of Social Work. Cynthia has dedicated her life to the restoration and protection of Aboriginal culture and spiritual practice. As a woman of Chippewa/Mohawk descent she overcame substantial social obstacles to earn a Ph.D. in Cultural Anthropology from the University of Toronto. When she is not teaching, she lives and works on her reserve on Georgina Island.

Introduction

Canada has been witnessing a revival of "First Peoples" strength and determination in recent decades. The impetus behind this revival takes many forms:

- The restoration of traditional systems of belief and practice;
- The resurgence and reclamation of languages;
- The growth of First Peoples sense of national identity and the re/deconstruction of Indigenous people's history worldwide.

There are many factors that have contributed to the renaissance of traditional First Peoples values and mores and the growing conviction that Indigenous people(s) are much more than victims of white invasion and colonization. At least one of those factors can be traced to declining pressure within the past fifty years of active and aggressive colonization processes. First peoples have been given enough cultural space and freedom to enable them to analyze and integrate concepts of "loss" and "impermanence" in their own terms. They have taken the opportunity over the past fifty years or so to inscribe a new relationship between themselves and the dominant culture and to create new and renewed links between themselves and their immediate world(s).

Questions or correspondence concerning this article may be addressed to:

Dr. Cynthia C. Wesley-Esquimaux
The Centre for Aboriginal Initiatives
563 Spadina Road, Room 226
N. Borden Building, 2nd Floor
Toronto, Ontario M5S 2J7
416-978-2208 (office)
cynthia.wesley@utoronto.ca

The perspective being presented is based on years of growing up in the Aboriginal community in Ontario, and from the last thirty spent working in the political and wellness fields in Canada and the United States. Thirty years of working closely with First Peoples in Canada and the U.S. has led to a hard look at the effects of historic and contemporary "psychogenic" (concerning the mind) trauma on Indigenous peoples. Researchers now believe that there is a relationship between continuing First Peoples cultural and family dysfunction, and the psychological "affect" generated by centuries of cultural dislocation, forced assimilation and the Indian Residential Schools experienced by Aboriginal peoples across Canada and the United States.

According to Alan Young (1995) our sense of personhood is not only shaped by our active or conscious memories, it is also shaped by our "conception of memory," which means that it is not 'direct' traumatic experiences that can create negative effect, it is also present interpretations of past events that can continue to impact our lives (Furst, 1967). Therefore, it appears that the way people remember their past, and then interpret those events as individuals or groups can also contribute to continuing dis-ease and individual and community health issues. In Aboriginal communities, the continuing legacy of forced assimilation, broken treaties, land

cessions, cultural and language losses, and a chronic lack of access to some of the things that the rest of society takes for granted, has left our people with a sense that they are on the inside looking out, with little recourse but to join the rest of the world. Of course, this is not true in a practical sense, but that sense of difference or lack of access is frequently at the bottom of the overall question of health in Aboriginal communities and where the future will lead them.

There are certain things that seem especially true when working from "a moment in time" as a social worker or even a clinician generally does. There is no other story than the one you are being told in the present. The acceptance and recording of the interpretations you are presented with by an 'informant' or 'client' must be accepted as given otherwise you are creating your own 'representation' of the observed. This must be especially problematic when working with people who have a different cultural orientation than your own. Then we have to step through our own cultural orientation and be in theirs as much as possible. In these circumstances, it might be more effective to take a broader or less academic perspective on illness and health, especially in regards to personal explanations that illnesses may be given in various communities.

This is an important area to be considered when looking at the question of Aboriginal health, because we want to protect against making people fit the symptom or disease from any other perspective than their own. Tseng (1997) suggests "culture joining" by using appropriate inquiry as a way of bridging the cultural gaps and ensuring not only a better understanding between people, but better medical care generally. Taking the time to listen to the observed in health settings and then responding to culture cues such as lowered eyes, closed arms or body posture, etc., and really listening to verbal statements will help towards the prevention of misinterpretation. This is an important consideration as we move into more aggressive pursuit of suitable medical models for Indigenous peoples and focus on and identify "best practices" in the Aboriginal health field. This is especially true in the context of child and family services where a large measure of sensitively is required to generate positive communication. As noted in the development of "Jordan's Principle" children are vulnerable members of our society. They are voiceless in decision-making, subject to the judgments and actions of others. First peoples are also vulnerable — victims of ill-will and broken promises and suffering from the worst social, economic and health conditions in Canada (CMAJ, 2007).

Available literature confirms that various physical illnesses or psychogenic illnesses cannot always be seen in a specific diagnostic light, in particular by those coming from what would constitute a foreign culture. The ability to provide a clear view of normal vs. abnormal seems to depend very much on where you are standing, and whether you are on the inside or the outside of a particular culture or community. At a minimum there needs to be a willingness on the part of diagnosticians to understand that people are not the same, not even when they live in the same community. From an interpretive side, practitioners must promote the need for recognition of cultural context and an understanding that what may 'look' like an illness to an 'outsider' may in fact be an accepted and normalized cultural 'behaviour' from the inside. Or not, as the case may be, but in some ways is it not up to the community in the present to decide what is and what is not going to work and what does and does not have to be treated? As Ruth Benedict noted so long ago and before our own people had their own assessments considered,

> *It is clear that culture may value and make socially available even highly unstable human types. If it chooses to treat their peculiarities as the most valued of human behavior, the individuals in question will rise to the occasion and perform their social roles without reference to our usual ideas of the types that can make social adjustments and those who cannot. Those who function inadequately in any society are not those with certain fixed abnormal traits, but may well be those whose responses have received no support in the institutions of their cultures (Benedict, 1934:270).*

Fortunately, there is a substantive base of literature that ties various disciplines together, and treats the diagnosis of psychological matters, if not physical maladies, with increasing sensitivity. The understanding that disease as perceived by healers, doctors, or even medicine people may not be similar to illness as perceived and experienced by the person suffering makes a lot of sense (Tseng, 1997:17). People from different cultural backgrounds, including Aboriginal people, may have different ranges or spectrums of commonly presented mental symptoms (Tseng:19), and obviously some of those symptoms are culture bound and must be interpreted from within that arena.

Practitioners make a distinction between disease and illness, with disease referring to the "pathological or malfunctioning condition that is diagnosed by the doctor or healer," and illness referring to the "sickness that is experienced and perceived by the patient" (Tseng, 1997:17). There are similar distinctions made between these two conditions and other states of unwellness or dis-ease by First People as well. Some distinctions are culturally constructed and relate to spiritual or psychological 'affects' specifically interpreted by some Aboriginal people as 'bad medicine,' although affects

© Cynthia C. Wesley-Esquimaux

would not necessarily be explained in those terms by medicine people. Linda Garro (1990) addressed the differences in southern Ontario between "good and bad medicine," as well as providing a detailed discussion on Aboriginal interpretations and diagnoses of a variety of what she references as "illnesses."

There is a significant amount of writing about shamans and medicine men (Hallowell, Benedict, DeLoria, Armstrong, LaDuke), and how their behavior is sometimes expected to be "abnormal or crazy" before they are deemed fit to practice conjuring. This can be regarded as an interpretation of the expression of specific types of behaviours and of the expectation that there will be visions or hearing of voices experienced by those "chosen" to practice Indigenous medicine. It was understood by earlier writers that these things must happen before other people would believe them "blessed" with special knowledge, insight, and access to other realms. However, as Czaplick (1914) noted, "neither to the institution of voluntary death nor to the hysterical fits of the shamans are we justified in applying the name of disease since these are not so considered by the natives themselves." There are numerous references to the idea that shamans or medicine people are often revealed through a bout of 'mental illness' and Devereux (1942) alluded to the acceptance of psychological instability in certain people when he stated,

> *Many native tribes believe that a seizure of insanity precedes the acquisition of shamanistic powers, and that a person receiving these powers, but unwilling to practice will become psychotic. One cannot but wonder how many Indian psychotics have turned into shamans while hospitalized in an institution, and been retained here, although they are ready to return to their tribes and to function as useful members thereof (Mental Hy. Vol. 26:82).*

Today, as more Aboriginal people take up the challenge of writing their own histories and providing cultural context to spiritual and family practice, there is a broader interpretation available and more clear explanations for issues like mental health and child welfare concerns in First Peoples communities (Trocmé, Knoke, Shangreaux, Fallon, & MacLaurin, 2005).

In a Toronto Star article (1998) a Mr. Lazare from Akwesasne was quoted on Longhouse healing modalities, and there is specific mention of an older woman who was in the care of a medical institution for having visions and hearing voices. While in this institution, she was being drugged to control or obliterate them. The traditional Longhouse (spiritual) community brought the woman home to the reserve, stopped her medication, and eventually incorporated her back into the community as a "seer," thereby giving her a place of refuge. Her skills rather than her perceived illness were recognized, acknowledged, and then utilized by her own people.

Clearly, the ideology of disease and illness is not straightforward, and in addition, concepts of trauma and mental illness among Indigenous peoples have generated much debate in the literature. First Peoples themselves are becoming very conscious of this debate and more recently have become active participants in the exploration and development of health and healing models that take traditional healing modalities and westernized treatment models into consideration. The blending of the two has in fact produced an entire field of health practitioners and modalities that are becoming increasingly accessible to Aboriginal people and even interested non-Aboriginal patients.

There is an excellent body of literature available on comparative studies regarding the cultural meanings associated with illness and their causes which also contrast historic meaning with contemporary meaning. There is a growing interest in the way many things have changed, while remaining very much the same for Aboriginal people (Salee, 2006), as in the previous examples. This is true in particular when referring to the interpretations of disease and illness that Aboriginal people articulate in various books and articles in regards to Indigenous forms of illness (what has been called bad medicine in earlier literature), contrasted with white man's illness (cancer), and as Garro (1990) records it, inaapine (a basic term describing something like fever) (432). Garro offers a comparative study based on the observations of Hallowell (1963) and her own more recent observations in an Aboriginal community in Southwestern Ontario. She suggests that the "way Anishnaabeg in this community interpret and respond to disease and illness is a product of both past and present, of continuity and change" (419), while Hallowell tended to neglect change in Ojibway culture and directed his attention towards discovering and understanding what she refers to as a "pre-contact" cognitive orientation (421). She notes that several anthropologists of that time frame had a similar orientation to the past, in particular B.J. James (1954, 1961, 1970), who specifically dwelt on acculturation and the "loss" of cultural orientation. Garro notes that Hallowell used the term "Anishnaabe sickness" to refer specifically to illnesses attributed to "bad medicine," but that the use of this term in contemporary (southern) communities is not restricted to this meaning, and that Aboriginal people do clearly recognize a distinction between various types of Aboriginal sicknesses. The term is also almost exclusively used internal to a community and not to provide an explanation of sickness to western medical practitioners. The bigger issues of attribution could be explained by the choice of words or descriptives, with semantics clearly playing a key role in understanding

what Hallowell was looking at and describing at his time, as well as what Garro was seeing, and what contemporary Aboriginal practitioners are seeing today. We can guess that there was limited use of the English language by Aboriginal people during Hallowell's tenure in the bush and this would have produced a barrier in descriptive interpretations as well.

Of additional interest is a section in Garro's paper that speaks to the premise that earlier researchers such as Hallowell (1939), Dunning (1959), and Rogers (1962), failed to address "with the exception of a few tantalizing comments," how people responded to illness and made choices between alternative forms of treatment" (418). How did they choose to address the peculiarities they were presented with and how many options for treatment did they actually have available to them? As late as 1983, Vecsey wrote that "traditional medical practices do continue to some extent," but that the "system of explanation and meaning has eroded" (159). This probably continues to be true today, although the resurgence of traditional forms of treatment for a variety of maladies is increasing, and the choices for treatment have in fact expanded. Although, on many reserves in the south conventional or orthodox medical care and medicines are generally utilized as the first recourse for meeting healing needs (Wesley-Esquimaux, 2004). The challenge remains for Aboriginal peoples to explicate traditional forms of treatment on their own terms and defined by their own uses.

In terms of cultural interpretations of health and illness, another problem in the cultural interpretation of disease and illness might be related to decreasing management in an historical context on the part of Aboriginal people themselves in regards to the health, and the expression of that direct care. A letter written by a Dr. Corrigan in 1946 indicates that there wasn't much happening in terms of Aboriginal people being able to take care of themselves, "…as there is no one at any place I visit who can nurse a sick person" (Corrigan 222). Dr. Corrigan flew into many of the northern remote reserves on a fairly regular basis and much of what he treated involved axe or hunting accidents. His comments about the ability to treat and heal illness had more likely been set aside, or pushed underground with other types of ceremony and cultural practice after direct contact with European medical mores. In the same regard, it has only been fairly recently that the medicine society known as the Midewewin Lodge has been very actively and broadly reviving itself in Ontario. In more recent decades things have changed at almost every level of organization and community development and Aboriginal people have been more vocal about their health concerns and the revival and practice of treating and healing their own people.

In an issue of the First Nations Messenger, the "fast facts" column noted that, "eighty-two percent of female respondents in the First Nations and Inuit Regional Health Survey (1999) said a return to traditional ways was the only way to promote community wellness" (April/May 2000:9) (my emphasis). In a similar light, James Waldrum (1997) made a good point a few years earlier in his book, *The Way of the Pipe*, in regards to healing and the use of traditional forms of spirituality when he noted, "Spirituality as a form of symbolic healing can be understood within the discourse of oppression, liberation, and cultural repatriation" (217). His observations speak very clearly in some ways to the stated need to return to traditional ways by Aboriginal people who are recognizing that some things have been and are amiss. Waldrum goes on to say that, "this form of healing speaks not only to the individual's affective or emotional state, but also to the whole of existence as understood in cultural as well as historic terms (217). This type of healing also serves to bring together old and new approaches for defining cultural constructions of health and well-being in Aboriginal communities. Taking a symbolic stance addresses the spiritual and historic continuum through which Aboriginal people create their own interpretations and understandings of self, personal, family, and community health and well-being. Religion or spiritual practice was an essential ingredient in the creation and maintenance of the social identities of all First Peoples, and religious energies were foundational in the construction of new social realities as they responded to either imposed or chosen alternatives in their environment (in Freisen, 2000:12).

Of interest in Waldrum's' interviews are examples of men who have stepped outside their own "cultural experiences" and into a broader cultural expression by embracing an artificially constructed religious/spiritual identity in prison. Some of these men grew up in what could be called a "traditional" fashion, on the land, speaking their own languages, and with little outside experience of "other defined" contemporary native spirituality. In prison they participated in sweat lodges, smudging, and pipe ceremonies, as well as cultural activities that may have never even existed in their home communities. Yet somehow, they felt that they had in that cultural context finally found the meaning of being Aboriginal (168). Those who work in Aboriginal treatment centres have personal experience with this type of spiritual transformation in individuals, in many instances through the programs which treat alcohol and substance abuse with what are termed 'traditional activities.' We cannot however, be actively critical of the experience especially when it produces a positive change in people who are otherwise 'lost souls' through alcoholism and drugs, and who have been without a

© Cynthia C. Wesley-Esquimaux

religious/spiritual anchor. It does however say something about the fluidity of cultural construction and meaning.

According to Cohen (1994), "In contemporary anthropology, 'culture' is now to be used in a significantly differently manner, to refer to the manifold activities and experiences of the diverse people whom it aggregates. Culture is a framework of meaning, of concepts and ideas, with which different aspects of a person's life can be related to each other without imposing arbitrary categorical boundaries between them (1994:96). This diversity obviously exists even within the confines of a single cultural grouping like a First Nation community, but it is now accepted that there is no one or simple explanation for the "fate" that befalls various individuals through disease or other health problems throughout Aboriginal Canada.

In addition, in order to create and delineate clear models and best practices for continuing to strengthen and reinforce First Peoples capacity for social resolution and social action, it is necessary to understand the various mechanisms put in place historically by colonizers to marginalize and downgrade people's personal roles and lifeways. These mechanisms served to destroy Aboriginal culture and social domains, to restrict their social mobility, to disfavor them in access to resources, and to create or accentuate inequalities within and between Aboriginal communities (Wesley-Esquimaux, Smolewski, 2004). Some of those mechanisms were initially not consciously deliberate, but they have had the same effect nonetheless on Aboriginal identity, social capacity and the building of social capital (Salee, 2006). These other influences included waves of disease with the resulting deaths and dislocation of healers, medicine people, teachers, and spiritual leaders, outsider greed for land and resources, and unwanted or forced interpersonal interactions between invaders and Indigenous peoples across the continent.

We have come to refer to these impacts as "historic trauma," a phenomenon that has become a part of Indigenous peoples' common experience, and which has covertly shaped individuals lives and futures, and has had devastating consequences for entire communities, regions, and countries. Since first contact, First Peoples have experienced several waves of traumatic experience on social and individual levels that have contributed to the health crisis in Aboriginal Canada and have continued to place enormous strain on the fabric of Aboriginal societies across the continent. As an example, First Peoples experienced unremitting trauma and post-traumatic effect since Europeans reached the new world and unleashed a series of contagions among the Indigenous populations of this continent. These contagions burned across the entire continent from the southern hemisphere to the north over a four hundred year time span, killing up to 90% of the continental Indigenous population and rendering First Peoples in Canada physically, spiritually, emotionally, and psychically traumatized by a deep and unresolved grief (Wesley-Esquimaux, 1998).

In addition, it has been pointed out many times that historic colonialism produced a profound alteration in the socio-cultural milieu of subjugated societies. North American Aboriginal peoples do not stand alone in the annals of historic injustice. Glaring examples include the Jewish Holocaust, the internment of Japanese nationals in Canada, and the stolen generation of Indigenous peoples of Australia. Colonial powers introduced sharp status distinctions, imposed strict rules for governing conduct, controlled the system of social rewards and punishments, and manipulated power and status symbols (Wesley-Esquimaux, Smolewski, 2004). These alternations are generally discussed in reference to past events, but it can be readily argued that the impacts have contemporary and generational application and effect. A variety of discipline can be called upon to illustrate and elaborate on the phenomenon of generational impact and traumatic consequence, including history, anthropology, psychology, psychiatry sociology, social work, child welfare and political science. Each of the sciences can provide different perspectives and information on how historic trauma can be understood as a valid source of continuing dis-ease and reactivity to historic and societal forces in Aboriginal communities across Canada and the United States, and perhaps as importantly, among Indigenous peoples around the world.

According to many, issues such as colonialism belong largely to the historic past and have been replaced by inequality and domination in other forms. My research, and that of the Takini Network (Yellowhorse Braveheart, 1998, 1999), has proposed that the historical experiences of First Nations peoples which disrupted the process of Aboriginal cultural identity formation has continued to resonate loudly into the present, and that the harm done in the past has continued to manifest inter-generationally into the present. This can be extrapolated into virtually any area of Aboriginal lifeways, including health, well-being, education, and social and community development, including,

- Physical, associated with the first stages of white colonization and the introduction of infectious diseases that decimated Indigenous populations and resulted in an inter-generational and culturally propagated form of Post Traumatic Stress Disorder.
- Cultural, associated with the wave of Christian missionization intended to bring about religious transformation and cultural destruction through prohibitions imposed on Aboriginal culture and

Aboriginal belief systems, and which emphasized the boundaries between private and public spheres.

- Psychological, associated with the marginalization of Aboriginal people as their social self became largely diminished and impoverished, and as any perception of control that they might have had over their lives became reduced and badly undermined, ultimately placing perceptions regarding "locus of control" on the colonizers.
- Social, associated with the stages of native displacement through white settlement which brought with it alien social structures, introduced non-traditional coping mechanisms and silenced "knowledgeable subjects" within the Aboriginal population, and diminishing cultural values and mores.
- Economic, associated with a violation of native stewardship of land and a forced removal of people from their natural habitat and lifeways (Wesley-Esquimaux, Smolewski, 2004).

There are inter-linkages between these specific areas of historic impact and more contemporary forces that have continued to play themselves out over time. Native people across the country are presently in the process of critiquing the dominant culture, forging individual strengths, and renewing their collective unity. To do this, they are looking both inside and outside of their cultures and political structures for the tools that will address and hopefully rectify the societal and cultural breakdown they have been forced to grapple with since contact.

What does societal and cultural breakdown mean? Soon after contact with non-Aboriginal colonizers, the First Peoples were stripped of their social power and authority. Once they realized that they could neither control, nor escape, catastrophic events, they began to exhibit helpless "giving up" behavior patterns. Many, by default, withdrew socially, thereby lessening their social and psychological investment in communal and societal relationships. They reduced their cultural and religious/spiritual activities, sending some underground, and became engaged in displaced re-enactments of conflict which led to disruptive behavior, social alienation and profound psychological problems such as alcoholism, drug addiction, domestic violence, child neglect and sexual abuse (Wesley-Esquimaux, 1998). Acquired maladaptive behaviours, particularly during the residential school period has left a cyclical dysfunction and disruptive patterning that can be directly related to upset cultural identity formation. Coupled with increasing external and internal reactive abuse, is the loss of storytelling as a traditional deterrent because of spiritual and government suppression of cultural activities and mores.

Judith Herman Chart: Complex Post-Traumatic Stress Disorder

1.	A history of subjugation to totalitarian control over a prolonged period [of time] (months to years). Examples include hostages, prisoners of war, concentration camp survivors and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse and organized sexual exploitation (Herman, 1997:121).
2.	Alterations in affect regulation, including: • persistent dysphoria; • chronic suicidal preoccupation; • self-injury; • explosive or extremely inhibited anger (may alternate); [and] • compulsive or extremely inhibited sexuality (may alternate).
3.	Alterations in consciousness, including: • amnesia or hyperamnesia for traumatic events; • transient dissociative episodes; • depersonalizationderealization; [and] • reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation.
4.	Alterations in self-perception, including: • sense of helplessness or paralysis of initiative; • shame, guilt and self-blame; • sense of defilement or stigma; [and] • sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand or non-human identity).
5.	Alterations in perception of perpetrator, including: • pre-occupation with relationship with perpetrator (includes preoccupation with revenge); • unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's); • idealization or paradoxical [relationship]… • sense of special or supernatural relationship; [and] • acceptance of belief system or rationalizations of perpetrator.
6.	Alterations in relations with others, including: • isolation and withdrawal; • disruption in intimate relationships; • repeated search for rescuer (may alternate with isolation and withdrawal); • persistent distrust; [and] • repeated failures of self-protection.
7.	Alterations in systems of meaning, [including]: • loss of sustaining faith; [and] • sense of hopelessness and despair.

The myriad effects of historic trauma, also known as a "complex or cultural post traumatic stress disorder" (see Judith Herman Chart above), have become deeply imbedded in the worldview of Indigenous peoples, together with a sense of learned helplessness. Historic

© Cynthia C. Wesley-Esquimaux

factors strongly influenced First Peoples locus of personal and social control, engendered a sense of fatalism and reactivity to historic and social forces, and adversely influenced inter and intra group relations. In the eyes on non-Aboriginal populations, Aboriginal peoples became silent, powerless constructions of "otherness"; a representation of which was bounded but never relational (Wesley-Esquimaux, Smolewski, 2004). These complex processes, located between the inscriptions of marginality imposed on Aboriginal people by the dominant culture, and Aboriginal integrity translated into negative cultural propositions, were never fully understood by Aboriginal people or non-Aboriginal societies (ibid). Only by deconstructing historic trauma and (re)membering the past, will Indigenous peoples see each other from the oppositional realms they occupy in existing dominant and resistant cultural structures.

Judith Herman (1997) gave description to the walking, talking social disasters that have peopled many contemporary First Peoples worlds. Individuals did not always cope well, or they coped through alcoholic hazes or drug induced silences. They suffered intensely often without any visible reasons for their suffering, and being around many of the 'survivors' of places like residential school made others extremely uneasy. Using Herman's chart on complex PTSD it is possible to see why social behaviours did not match cultural contexts. What people were demonstrating was "learned affect" which kept the feelings they had unconsciously learned to deny, suppress, and hide within themselves, unavailable to them for healing. These feelings were acted out through alcoholism and violence that has plagued Aboriginal families, especially affecting the children through a lack of healthy role modeling. The problem was that feelings and behaviours were not given appropriate acknowledgement and therefore any accurate expression. They were not brought into consciousness where they could be processed and healed. Worse, over time the negative behaviours that were generated out of an unconscious anger and grief became "normalized" in many First Nation homes and communities, and consequently for many children and youth (CECW, 2006).

A variety of books have been written that speak to this inner hurt and the needs of Aboriginal people at the community level. Barbara-Helen Hill (1995) and Calvin Morrisseau (1999) have published personal stories of growing up in alcoholic homes, their own subsequent alcoholism, their return to their traditional teachings, and the ultimate easing of their inner grief. These books are useful to the younger generations who are trying to understand the behaviour of their parents, caregivers, family, and community members. Neither Hill or Morrisseau mention the status of the political representation on their home reserves, or how it did or did not have an effect on their healing journeys, but it has become very clear that political and social role modeling and the availability of programming for community care and integration has had a dramatic effect on how well a community will fare in areas of health and well-being over time.

The stories that have been related by Aboriginal people, not only Hill and Morrisseau, but by an increasing range of Indigenous authors are heartbreaking and sometimes gruesome in their detailed, painful recollections. Questions regarding the oppositional behaviours of adults are being answered through stories of what went on behind the walls of far too many residential schools. In many instances the grief and trauma that people refer to at the community or reserve level can be directly tied to residential school experiences they, their parents, or their grandparents had. Residential school policy and efforts of assimilation through education go back to as early as 1820 when a proposal was brought forward by the Governor of Upper Canada, Sir Peregrine Maitland for "ameliorating the condition of the Indians on the neighbourhood of the [Colonial] settlements" (Milloy, 1999: 14-15). These policies of assimilation were relentlessly pursued and enforced up until at least 1972 when the Assembly of First Nations published their policy paper on "Indian Control of Indian Education" (Mallea, Young, 1990:423).

There are parallel issues to be addressed, and a stream of changes that have more forks than can be navigated or even foreseen. Taiaiaki Alfred (1999) in his book, *Indigenous Manifesto*, directly confronts the divisions between the political and the social in First Nation communities. He speaks to traditional learning experiences and the contemporary (westernized) educational experiences that our children and youth are subjected to, and the need to bring these two realities together. In his book, he examines the political and social split between community leadership and community membership. The split between the political and social is a wide one, and sadly they are not, in too many instances, even facing each other across that divide.

Alfred asks that First Nations be aware when educated youth and adults return to reserves, that we are not pulling them into an unhealthy political or social arena. There is a strong sense of division around paths they undertake, and they are often encouraged to either take a political path which can mean standing looking out(ward) to money providers, or taking a social path which for many may mean standing outside looking in(ward) to the inner community and trying to confront social issues and concerns that are not readily open to examination. Both paths contain multiple layers of issues and divisions that they must learn over time to contend with.

Aboriginal people are beginning to understand that they cannot function with their people walking in different directions, something that has been demonstrated in the healing movements that are rippling across the continent today. Thankfully, these movements have continued in spite of a sometimes astonishing lack of support and participation of First Peoples political representatives, although there are good examples where the political and social have been brought together and where there is mutual movements towards systemic change and unity. There are also many instances where the movement towards health and restoration of community integrity is a movement embraced almost solely by women. Women are frequently the agents of change in community, and youth, who now represent 56% of the Aboriginal population across Canada, are anxious to find a place for themselves in the future of their nations. The lack of equal participation and representation reinforces a sense of division and an inability for people to find acceptance and peace in their relations with each other at a community level (CECW, 2006).

The healing process has generally been seen as a very individual thing in westernized society, and it is increasingly the same within Aboriginal communities. This is probably tied directly to the conventional manner in which health care has been approached; through one on one counseling and attendance of individuals at treatment and medical centres. This orientation is being altered somewhat with the broader use of "medicine wheel" teachings. These teachings are presented as an illustration of action, which moves around a circle from the individual, to the family, to the community and finally to the nation as a whole. Each aspect identifying and creating a well environment for the next, until ultimately, and theoretically, a healthy nation is producing healthy individuals. We have not yet come to the point of healthy nations because we are still concentrating on producing healthy individuals, and still sorting out the impacts of physical and sexual abuse perpetuated in previous and subsequent generations, much of which continues to be passed to contemporary families. However, we should reiterate that it isn't always physical manifestations that create intergenerational dysfunction; it can also be the residual grief and intergenerational trauma that has not been identified and resolved from previous generations and which continues to surface in families and communities. We must all work together to heal our people. "Us Elders and the psychologists can come together and share so that the [men] the people can heal and our communities can be safe" (Elder cited in Ellerby and Ellerby, 1998:ii).

As we have acknowledged throughout this paper, there are many factors that are significant to the diagnosis of mental or physical illness, or even to the concept of 'wellness' that must be taken into consideration in any exercise to assist or design healing modalities that will have specific and long term effect. There is still a recovery process going on from hegemonic influences such as Indian Residential School and continuing, although more general, assimilationist tactics perpetuated by the Canadian government. Granted, there is a more proactive response by Aboriginal people today when psychological or psychogenic illnesses such as trauma and stress disorders resulting from incarceration, abuse, or alienation, are identified. The establishment of the Aboriginal Healing Foundation, the Organization for the Advancement of Aboriginal Peoples Health, and the National Aboriginal Health Organization in Ottawa, speak very clearly to the proactive nature of addressing the health and healing needs of Indigenous peoples today.

Also of significance is the reality and demands of continuing change in Aboriginal communities which affect health status, health care directions, and even how health care services are delivered on reserves today. First Peoples are responding to these influences in a very different way than in the past, and in most instances are dealing well with the devolution of health into their own hands and out of the purview of the Provincial government. In 1990, Garro (424) elaborated on some of the most pressing issues noting that,

> *With reference to health status, Indian communities are currently undergoing what been referring to as an "epidemiological transition".*

In recent years, a decline in the incidence of infectious diseases has been paralleled by an increase in chronic, degenerative diseases, such as diabetes, cancer, heart disease, and other cardiovascular and system disorders, these are the so called "new epidemics" (for overviews see T.K. Young, 1988).

Today, there are other kinds of 'new epidemics' tearing through Aboriginal communities as well, although these epidemics relate more to psychological 'dis-ease' rather than to more physically based disorders. Most obviously affected by the trauma of alcohol abuse, sexual assault, and family violence are the youth of many northern communities where suicide rates and gang formation have soared over the past two decades (Chettleburgh, 2007). Southern communities are also affected, but the youth of the southern reserves seem to have more recourse to distraction and help outside of First Nation boundaries and the suicide rate is significantly lower. The adults may be suffering from increasing diabetes, cancer, and heart disease, but the youth have not been exempted from their own epidemiological scourge (Wesley-Esquimaux, 2004).

© Cynthia C. Wesley-Esquimaux

Judith Herman suggests that the experience of traumatic stressors, whether historic or contemporary, has profound effect on positive valuations of self, or even the ability to make meaningful order out of creation (51). This means that the legacy of hurt is all encompassing and profoundly impacts the building of what Nan Lin (2000) called social capital and healthy psychological responsiveness.

In conclusion, we want to reiterate that a better understanding, not only on the part of non-Aboriginal interveners and practitioners, but also on the part of Aboriginal peoples themselves, of the many factors that have contributed to the status of First Peoples' health today is an excellent starting point to identifying and designing effective and culturally sensitive healing modalities, as well as contributing to the promotion of best practices in addressing health and well-being in all Aboriginal communities, both on and off-reserve.

As early as 1983, a practitioner named Meredith McGuire raised the possibility of bringing traditional (in this case Anishnaabek) and conventional (meaning biomedical) healing modalities together, and legitimizing them. He noted that there was an,

> *Obvious broader policy issue ... whether effective alternative healing might be integrated with orthodox medical practice. If primary care physicians had greater understanding and tolerance for their client's beliefs and practices, they could communicate more effectively with their client's broader belief systems (McGuire, 1983: 221-240).*

We have asked this same question many times, and so have many others in the Aboriginal community. Time really is of the essence here, and if we are to stem the tide of systemic disease, put an end to the suicide epidemics in the north, and help Aboriginal people organize their health and healing practices into viable and rich sources of care and support, we all have to take action now.

References

Alfred, Taiaiake. (1999). *Peace, Power and Righteousness: an Indigenous Manifesto.* London & Toronto: Oxford University Press

Benedict, Ruth. (1934). *Patterns of Culture.* Boston: Houghton Miffling & Company.

Canadian Medical Association Journal, (2007). *Jordan's Principle, governments' Paralysis,* August 14, 2007; 177 (4). Noni MacDonald and Amir Attaran.

Centres of Excellence for Children's Wellbeing, (2006). *Building a Future Together: Issues and Outcomes for Transition-Aged Youth.* Child Welfare League of Canada.

Chettleburgh, Michael C. (2007). *Young Thugs: Inside the Dangerous World of Canadian Street Gangs*. Canada: HarperCollins.

Cohen, Anthony P. (1994). *Self Consciousness: An alternative anthropology of identity.* Routledge: London & New York.

Corrigan, Cameron M.D. (1946) "Medical Practices among the Bush Indian of Northern Manitoba." *Canadian Medical Association Journal,* 44: 220-23.

Czaplicka, M.A. (1914). *Aboriginal Siberia*. Oxford Press: London.

Dunning, R.W. (1959). *Social and Economic Change among the Northern Ojibwa*. Toronto: University of Toronto.

Ellerby, L.A. and Ellerby, J.H. (1998). *Understanding and Evaluating the Role of Elders and Traditional Healing in Sex Offender Treatment for Aboriginal Offenders*. Ottawa: Solicitor General Canada.

Freisen, John. (2000). *Aboriginal Spirituality and Biblical Theology*. Calgary, AB: Detselig.

Furst, Sidney S. (ed.). (1967). *Psychic Trauma*. New York, NY: Basic Books.

Garro, Linda C. (1990). Continuity and Change: The Interpretation of Illness in an Anishnaabe (Ojibway) Community. *Culture, Medicine and Psychiatry*, 14, 417-454.

Herman, Judith L. (1997). *Trauma and Recovery: The aftermath of violence-from domestic violence to political terror*. New York, NY: Basic Books.

Hill, Barbara-Helen. (1995). *Shaking the Rattle: healing the trauma of colonization.* Penticton, BC: Theytus Books.

Mallea, John and Jonathan C. Young (eds.). (1990). *Cultural Diversity and Canadian Education: Issues and Innovations*. Ottawa, ON: Carlton University Press.

McGuire, Meredith B. (1983). Words of Power: personal empowerment and healing. *Culture, Medicine and Psychiatry*, 7, 221-240.

Milloy, John S. (1999). *A National Crime: The Canadian Government and the Residential School System, 1879-1986.* Winnipeg, MB: University of Manitoba Press.

Morrisseau, Calvin. (1999). *Into the Daylight: A Wholistic Approach to Healing*. Toronto, ON: University of Toronto Press.

Salee, Daniel (2006). Quality of Life of Aboriginal People in Canada: An Analysis of Current Research. *Institute for Research on Public Policy, IRPP Choices,* Vol. 12, no. 6, November 2006.

Trocmé, N., Knoke, D., Shangreaux, C., Fallon, B., & MacLaurin, B. (2005). The experience of First Nations children coming into contact with the child welfare system in Canada. The Canadian Incidence study on reported child abuse and neglect (Ch.2). In *Wen:De: We are coming to the* light of day. Ottawa, ON: First Nations Child and Family Caring Society of Canada, pp. 60-86.

Tseng, Wen-Shing, M.D. and Jon Streltzer, M.D. (eds.). (1997). *Culture and Psychopathology: A Guide to Clinical Assessment.* New York, NY: Brunner, Mazel.

Waldrum, James B. (1997). *The Way of the Pipe: Aboriginal Spirituality and Symbolic Healing in Canadian Prisons*. Peterborough, ON: Broadview Press.

Wesley-Esquimaux, C. (1998), *And Then There Were None: A Comparative Study of the Bubonic Plague and Epidemics in the New World.* Unpublished Master's thesis, University of Toronto.

Wesley-Esquimaux, C. and Smolewski, M. (2004). *Historic Trauma and Aboriginal Healing.* Ottawa, ON: Aboriginal Healing Foundation.

Yellowhorse Braveheart, M. (1998). The return to the Sacred Path: Healing the historicalTrauma response among the Lakota. *Smith College Studies in Social Work,* 68(3), 287-305.

Yellowhorse Braveheart, M. (1999). Oyate Ptayela: Rebuilding the Lakota Nation through addressing historical trauma among Lakota parents. *Journal of Human behavior and the Social Environment*, 2(1/2), 109-126.

Young, A. (1995). *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. New Jersey: Princeton University Press.

Young, T.K. (1988). *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*. Toronto, ON: University of Toronto Press.

© Cynthia C. Wesley-Esquimaux