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Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

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Contents

First Nations Child & Family
Caring Society of Canada

volume 9 | number 1

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Foreword

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The *First Peoples Child & Family Review*, in collaboration with the Alberta Centre for Child, Family and Community Research, is proud to present this special issue on Aboriginal child and youth mental, spiritual and cultural health. The issue seeks to broaden the conversation on 'mental health' as it relates to Aboriginal peoples, and particularly Aboriginal children. Mainstream definitions of mental health fail to recognize the holistic perspective embraced by many Aboriginal families and communities, which sees emotional and mental health as inseparable from spiritual and cultural well-being. These differing understandings have profound implications for how researchers, policy-makers and practitioners approach mental health work with Aboriginal families, as well as the experience and relative benefit of the services received. Indeed, an approach that addresses only the cognitive or emotional aspects of mental health will fail to meet the needs of many Aboriginal children. The articles in this special edition look beyond conventional approaches to explore a multi-faceted understanding that respects Aboriginal worldviews and privileges traditional knowledge.

We would like to thank Madelynn Slade, a Michel Cree and Metis youth advocate from Alberta for her insightful editorial to this special edition. In 2012, Slade was one of six First Nations Youth Ambassadors selected represent the interests of First Nations children and young people at the United Nations. The Ambassadors met with the Committee on the Rights of the Child in Geneva, Switzerland, to present evidence on the discriminations experienced by First Nations children in Canada, often drawing on personal experience to show how inequities in child welfare, education and health care have affected their communities. The Ambassadors were the only youth in Canada's delegation, and the first Indigenous youth from Canada to speak to the United Nations Committee on the Rights of the Child. Slade has remained a strong and active supporter of Indigenous child rights, and is currently pursuing a degree in Child and Youth Care. Her editorial situates child welfare as more than a policy and human rights concern, but an issue of mental, spiritual and cultural health affecting the everyday lives of First Nations children across Canada. She shares her personal experience as a youth in care to illustrate the lived experience and consequences of a child welfare system that has and continues to fail Indigenous children and families.

Slade's editorial contextualizes the six articles published in this edition by grounding research and policy in the lived experience of First Nations children and youth. The articles discuss issues of mental, spiritual and cultural health at various stages of the life cycle. Amrita Roy explores the concept of intergenerational trauma and the implications for mental health during pregnancy. Latimer et al., discuss the need for a

holistic approach when working with First Nations children to address experiences of pain, while Brownlee and colleagues look at the bullying experiences and behaviours of Aboriginal elementary students in northwestern Ontario. The issue then moves to explore various strategies and initiatives undertaken by families, communities and researchers to support and nurture the mental, spiritual and cultural health of Aboriginal children. Working collaboratively with the community of Saddle Lake, Alberta, Pazderka et al. discuss their research into culturally appropriate practices to promote early childhood attachment. Muir and Bohr also explore theme of traditional and cultural approaches to caregiving, offering a review of the literature on values and practices in Aboriginal parenting. The final article in this edition focuses on systemic strategies to protect and promote the health and well-being of First Nations children. Authors Sinha and Blumenthal describe the Federal government's administrative response to Jordan's Principle, a child-first policy to ensure First Nations children receive equitable access to government services such as health care. The article also provides an overview of an ongoing legal case, filed in 2011, seeking to enforce Jordan's Principle.

The editorial board of the *First Peoples Child and Family Review* and the Alberta Centre for Child, Family and Community Research would like to thank our authors and reviewers for their contributions to this important topic. We hope that readers will find the discussion to be thought-provoking, rich, timely and inspiring. Addressing the mental health needs of Aboriginal children and youth means acknowledging a broader definition that respects Aboriginal worldviews. We hope that this issue supports and assists readers to honour this approach in their own research, practice and policy work with Aboriginal children and families.

volume 9 | number 1

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Editorial - Resilience and Triumph: Moving Forward in a Good Way

Madelynn Slade[1]

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I am honoured to write the editorial for this journal that presents articles on the cultural, spiritual and mental health needs of Aboriginal children. This journal is a powerful and beautiful example of how our newest generation is already leading in a good way and how individuals and organizations, both Aboriginal and non-Aboriginal, are leading with best practices for the wellbeing of Aboriginal children. I have drawn from personal experiences to focus this editorial on the inequalities and overrepresentation of Aboriginal children and youth in the child welfare system.

The First Nations Child and Family Caring Society (the Caring Society) have given me, and thousands of other children and youth, the opportunity to lead in a good way. I first gained knowledge of the Caring Society in 2012 and was ecstatic to discover an organization that was, and continues to be, so passionate about Indigenous children's rights on- and off-reserve. This excitement continues to grow as the Caring Society continually provides strong support at the federal level for children in need of support and reaches out to former children in care, such as myself, to provide hope, guidance and mentorship for children currently in the child welfare system. With this support I have sought out the truths of the federal child welfare system and its relation to our communities.

The Canadian federal government has a sordid and tragic history with First Nation communities, especially in relation to the child welfare system. While residential schools and the 60's scoop are seen as events of the past, First Nations children continue to be taken from their homes and transplanted away from their communities, families, culture and the much needed teachings that are millennia old. This lack of connection to anything an Aboriginal child once knew is manifesting in our communities as a sickness. Addictions, mental illness, domestic abuse, child abuse, on and on are more prevalent in First Nations communities than in any other community group across Canada. These statements are not to paint a picture of a diseased and desolate nation; instead, it shows a nation that has not been adequately provided for.

These inadequacies continue to come to the surface as the Caring Society drives forward in the ground-breaking human rights tribunal complaint against the Federal government of Canada. The Caring Society has provided strong evidence that the government of Canada has provided inadequate and racially discriminatory services to First Nations communities on-reserve. The Caring Society also argues that

record numbers of First Nations children are being removed from their families due to inadequate services currently available.

I was a target for the inadequate and discriminatory practices of the child welfare system. I was a poor, 5 year old, Aboriginal child of a single mother and that was enough for the government to remove me from my home. I have been out of the system for 10 years, but I am still able to see the lasting, and devastating, effects of being taken from my home. After being removed from my home I was unable to connect culturally, I was never told that I was Indigenous and never knew the sanctity and importance of belonging to a nation. Years later, today, I recognize that this developed a streak of lateral violence within me. The culture, language and people I yearned for so much were unavailable to me so I began to resent what I could not have, and what I was not allowed to participate in.

Unfortunately, this is not an isolated incident unique to me. As the authors illustrate below, the pain of inequality and inadequacy runs deep. However, the brilliance of the mere existence of this journal is showing an even greater strength, coming from strong advocate voices, which are overcoming the inequality and inadequacy and providing for dazzling and hopeful coming generations of First Nations children and youth. In the following pages, the hope and inspiration of these articles is something to take encouragement from and to form a scaffolding of ideas surrounding the rousing and developed ideas.

This powerful journal highlighting best practices for children and youth's cultural, spiritual and mental health across Canada is a beacon of hope for First Nation communities. While the tragedies of the child welfare system have been highlighted above, the overall outcome of these tragedies across this nation has been incredible resilience and triumph. The Caring Society ongoing court case solidifies and stands in solidarity with this refusal to back down and willingness to move forward in our communities. The articles below go to show that First Nation children and youth are in need of cultural, spiritual and mental health, and, are seeking it out. I am proud to be a part of a journal that eagerly highlights the vital needs of children and youth who will be leading the way to a better tomorrow for themselves.

volume 9 | number 1

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Intergenerational Trauma and Aboriginal Women: Implications for Mental Health during Pregnancy

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Abstract

Intergenerational trauma (IGT) explains why populations subjected to long-term, mass trauma show a higher prevalence of disease even several generations after the original events. Residential schools and other legacies of colonization continue to impact Aboriginal populations, who have higher rates of mental health concerns. Poor maternal mental health during pregnancy can have serious health consequences for the mother, the baby, and the whole family; these include impacting the cognitive, emotional and behavioural development of children and youth. This paper has the following objectives: 1) To define intergenerational trauma and contextualize it in understanding the mental health of pregnant and parenting Aboriginal women; 2) To summarize individual-level and population-level approaches to promoting mental health, and examine their congruence with the needs of Aboriginal populations; 3) To discuss the importance of targeting IGT in both individual-level and population-level interventions for pregnant Aboriginal women. Various scholars have suggested that healing from IGT is best achieved through a combination of mainstream psychotherapies and culturally-entrenched healing practices, conducted in culturally safe settings. Pregnancy has been argued to be a particularly meaningful intervention point to break the cycle of IGT transmission. Given the importance of pregnant women's mental health to both maternal and child health outcomes, including mental health trajectories for children and youth, it is clear that interventions, programs and services for pregnant Aboriginal women need to be designed to explicitly facilitate healing from IGT. In this regard, further empirical research on IGT and on healing are warranted, to permit an evidence-based approach.

Key words: *intergenerational trauma; historical trauma; colonization; Indian Residential Schools; Sixties Scoop; pregnancy; maternal-child health; Aboriginal; women; children and youth; mental health; depression; health promotion.*

Introduction

The mental health of children and youth is closely linked to parental mental health – particularly maternal mental health. Maternal mental health during pregnancy is particularly pertinent in this regard. Mental health concerns during pregnancy are a serious public health issue. Prenatal depression, for example, is estimated to impact around 10% of pregnant women in Canada (PHAC, 2005); this number is believed to be higher in groups such as Aboriginal women (Bowen & Muhajarine, 2006a), though research is limited.

Prenatal depression and other mental health issues during pregnancy are recognized to have potentially serious maternal, foetal and child health consequences. These include neurological, cognitive and immune impacts on the mother; elevated risk of adverse pregnancy outcomes such as preterm birth and low birthweight; increased risk of postpartum depression and other postpartum mental health problems in the mother, which can negatively impact child behavioural and cognitive development, as well as general family wellbeing; and increased risk of mental health problems in the child later in life (Bowen & Muhajarine, 2006b; Swaab, Bao, & Lucassen, 2005). The latter may be due to various reasons. Firstly, there are possible foetal programming pathways that may physiologically predispose the unborn baby to future mental health concerns (Swaab, Bao & Lucassen, 2005). Moreover, poor maternal mental health can severely impact mother-child interactions, which in turn can greatly impact the mental wellbeing of children (Letourneau et al., 2012).

The symptoms and risk factors for prenatal depression are believed to be similar to those of depression at any other time of life (Bowen & Muhajarine 2006b). Diverse theories have been proposed on the aetiology of depression and other mental health disorders; these inform both individual-level and population-level interventions. Relative to non-Aboriginal populations, Aboriginal populations appear to experience a higher prevalence of various mental health disorders (Kirmayer et al., 2000; First Nations Centre, 2005; Bennett, 2005). Present-day social disparities, such as higher rates of poverty, likely play a role in explaining the above; however, there is increasing recognition that the mental health issues facing Aboriginal populations are rooted in intergenerational trauma from the legacy of colonization. In combining with intersecting racism and sexism, the impact of intergenerational trauma on Aboriginal women is particularly severe.

The objectives of this paper are as follows: 1) To define intergenerational trauma and contextualize it in understanding the mental health of pregnant and parenting Aboriginal women; 2) To summarize individual-level and population-level approaches to promoting mental health, and examine their congruence with the needs of Aboriginal populations; 3) To discuss the importance of targeting intergenerational trauma in both individual-level and population-level approaches to promoting mental health in pregnant Aboriginal women.

Intergenerational Trauma (IGT)

Various terms have been used in the literature to describe the phenomenon of the intergenerational transmission of historical trauma and unresolved grief. This paper will use “intergenerational trauma”, abbreviated as IGT. IGT theory is based on the observation that populations subjected to long-term, mass trauma (i.e., historical occurrences such as colonization, slavery, war, genocide) show a higher prevalence

of disease even several generations after the occurrence of the original events (Sotero, 2006). The symptoms of IGT "as a disease are the maladaptive social and behavioural patterns that were created in response to the trauma experience, absorbed into the culture and transmitted as learned behaviour from generation to generation" (Sotero, 2006, p.96). In particular, psychological problems and destructive behaviour associated with maladaptive coping, such as addictions, suicide and violence, are noted to be elevated (Sotero, 2006; Brave Heart & DeBruyn, 1998).

Post-traumatic stress disorder (PTSD) is recognized by the Diagnostic and Statistical Manual (DSM-5) (APA, 2013) as a psychological disorder. PTSD, however, is at the individual level, and is in reference to traumatic incidents within the individual's own past. By contrast, IGT involves collective historical trauma. IGT theory sprung largely from work studying World War II Holocaust survivors and their children, and has since been applied to other populations subjected to long-term, mass trauma (relevant literature reviewed by Brave Heart & Debruyn, 1998 and Sotero, 2006). The term "American Indian Holocaust" has been used to describe the atrocities committed over the course of colonization against Aboriginal peoples in North America and elsewhere, resulting in "massive losses of lives, land, and culture" (Brave Heart & Debruyn, 1998, p.60). The historical events of colonization include: seizures of land and forced relocation to reserves (termed "reservations" in the United States) and settlements; widespread mortality through colonization-driven disease epidemics, starvation and mass murder; the horrors of residential schools (termed "boarding schools" in the United States); disruption of traditional ways of life; tearing apart of communities and families; and, assimilatory policies that meet the United Nation's definition of cultural genocide (Brave Heart & DeBruyn, 1998; Kirmayer et al., 2000; Sotero, 2006; Menzies, 2008). The experiences of these events put Aboriginal populations in a constant state of grief and despair; however, since traditional Aboriginal customs of mourning were prohibited throughout much of history, the grief could not be properly resolved (Brave Heart & DeBruyn, 1998). Thus, there is the transmission of unresolved historical grief from generation to generation. In IGT, historical grief mingles with grief, anger and trauma from present-day experiences, such as loss of family members and friends to addictions, suicide and violence; personal experiences of violence; poverty and other social disparities; and personal experiences of oppression (including racism and sexism), which reinforce the stories of ancestral oppression (Sotero, 2006).

Social, environmental and even biological methods of transmission are proposed to explain how the psychological and emotional consequences of mass trauma and unresolved grief are passed on from generation to generation (Sotero, 2006). Among the transmission pathways proposed include impaired capacity to parent (Brave Heart & DeBruyn, 1998; Sotero, 2006; Menzies, 2008). In this regard, the legacies of residential schools and the "Sixties Scoop" era of assimilatory child welfare policies offer particularly illustrative examples. The explicit purpose of residential schools was to assimilate Aboriginal children into mainstream Canadian society. Children in residential schools were seized by force from their families and communities, mistreated, overworked, denied basic needs like food, water and appropriate medical care, and both witnessed and personally experienced brutal physical, sexual and psychological abuse at the hands of school staff. Children in residential schools were taught that Aboriginal ways were "savage" and shameful; they were taught to reject their ancestors, their families and Aboriginal cultural and spiritual traditions. Students left schools dissociated from their traditional culture yet still not accepted by mainstream society, lacking a sense of identity, lacking basic life skills, and highly traumatized from the chronic mistreatment and abuse they had endured. The experience impaired

survivors' ability to form meaningful interpersonal relationships involving trust or intimacy. Isolation from family and community further resulted in a lack of preparedness for marriage, family life and parenting. The trauma of their experiences led many survivors to substance abuse, criminal activity, self-harm, as well as domestic violence against partners and children. Children of survivors thus faced abuse, neglect and the consequences of their parents' self-destructive behaviour, such as substance abuse. As a result, survivors' children in turn were more likely to become involved in abuse or domestic violence and to engage in substance abuse and other self-destructive behaviour. What has ensued is a vicious intergenerational cycle of violence, addictions, self-harm and trauma (ANAC & Planned Parenthood Federation of Canada, 2002; Chansonneuve, 2005; NWAC, 2007).

Although the last residential school closed in the 1990s, "by the 1960s child welfare agencies successfully replaced residential schools as the preferred system of care for First Nations children" (Bennett et al., 2005, p.18). What ensued over the next two decades is referred to as the infamous "Sixties Scoop" (Johnston, 1983): the mass removal of Aboriginal children, for adoption and foster care in non-Aboriginal homes far away from their communities. Like residential school survivors, these children were dissociated from their traditional culture, yet still faced racism and exclusion by mainstream culture (Bennett et al., 2005; Johnston, 1983; Mandell et al., 2007; Sinclair, 2007). Some were abused by their foster or adoptive parents, including the high-profile cases of Cameron Kerley (a First Nation teenager who killed his adoptive father in 1983 after years of sexual abuse at his hands) and Richard Cardinal (a Métis teenager who committed suicide in 1984 after years of abuse and neglect in foster care) (Mandell et al., 2007). The lack of senses of identity, stability and belonging became especially acute at adolescence, during which time many of these children turned to maladaptive and destructive behavior, such as substance abuse, rebelliousness, aggression and suicide. A disproportionate number of these children ended up in the criminal justice system (Bennett et al., 2005; Johnston, 1983; Mandell et al., 2007; Sinclair, 2007). It has been noted that Aboriginal peoples were underrepresented in the criminal justice system at the turn of the twentieth century, and were represented at about the same proportion as in the population prior to World War II. By the early 1990s, however, the proportion had skyrocketed; in Manitoban jails, for example, nearly 70% of men, 90% of women, 70% of boys and 80% of girls were Aboriginal (Aboriginal Justice Inquiry - Child Welfare Initiative, as cited in Mandell et al., 2007). Various studies show a compelling association between involvement in the criminal justice system and experience in the child welfare system (Mandell et al., 2007; Sinclair, 2007).

Although there now is greater Aboriginal control of child welfare services for Aboriginal children, the consequences of the "Sixties Scoop" continue to play out as the now-grown survivors of the "Sixties Scoop" become parents themselves. The legacy of the "Sixties Scoop" thus converges with the legacy of residential schools, and other events of colonization, via the ongoing transmission of trauma and dysfunction across generations.

IGT and Aboriginal women

IGT is gendered; while colonization and the ensuing trauma has impacted all segments of Aboriginal populations, the impact has been especially heavy on Aboriginal women. The explicit patriarchy embedded into Aboriginal societies by missionaries, residential schools, and the Indian Act have yielded inequities and oppression based on gender (LaRocque, 1994). Internalized racism and sexism, in concert

with the normalization of violence and abuse in residential schools, have contributed to disproportionately high rates of gender-based violence against women within Aboriginal communities (LaRocque, 1994). At the intersections of both racism and sexism, Aboriginal women's mental health is shaped both by present-day traumatic experiences as well as by historical trauma. Domestic violence has been suggested to be a key reason for the much higher proportion of lone-parent, female-headed households among Aboriginal populations; such families, in turn, are at greater likelihood of facing poverty (LaRocque, 1994), which further intersects with present-day and historical trauma in women's lives.

IGT and mental health during pregnancy

In the context of IGT, the stresses of pregnancy and parenting may further exacerbate Aboriginal women's mental health concerns. As such, pregnancy can be argued to be an especially important time to offer healing-oriented interventions around IGT. Additionally, given the key role that parenting has in transmitting trauma to the next generation (Sotero, 2006), pregnancy also offers a meaningful point of intervention for breaking the vicious cycle of IGT. Accordingly, both clinical and population-level interventions for pregnant Aboriginal women's mental health should address IGT and incorporate appropriate healing processes.

Individual-level Approaches to Mental Health

A wide range of theories, spread across biological and psychosocial camps, have been proposed to explain mental illness at the individual level. The biomedical model for mental illness advances biological mechanisms as explanations for mental illness. Biological systems proposed to be involved include the monoaminergic systems of neurotransmission (Elhwuegi, 2004), structures of the brain (notably in the limbic system, which is implicated in emotional and cognitive functioning) (Joca, Ferreira, & Guimaraes, 2007), proinflammatory immune function (Schiepers, Wichers, & Maes, 2005), and the hypothalamic-pituitary-adrenal (HPA) axis, which is the body's key stress response system (Swaab, Bao, & Lucassen, 2005). Disruptions in one or more of these systems are believed to be at the root of mental illness (Sadock & Sadock, 2007). Psychosocial theories of mental illness offer explanations based on factors such as emotional and cognitive disposition, nature of relationships with others, and the mental impact of life experiences. Traditional perspectives in psychology include the psychoanalytic perspective, the behavioural perspective, the cognitive perspective, the humanist perspective, and the sociocultural perspective, which each offer various theories to account for the aetiology of mental illness (Sdorow & Rickabaugh, 2002). Contemporary conceptualizations of mental health generally embrace a biopsychosocial approach; such an approach recognizes that the complexity of mental health requires a broader view than can be offered with any single traditional theory (Engel, 1977). A biopsychosocial approach to understanding depression, for example, would explain the aetiology of depressive disorders in terms of the interaction between biopsychological vulnerabilities (stemming from biological, cognitive, emotive, environmental and social factors, which either predispose or protect against distress) and stressors, such as stressful life events (Garcia-Toro & Aguirre, 2007; Roy & Campbell, 2013; Schotte, Van Den, De, Claes & Cosyns, 2006). The biopsychosocial approach to understanding health is similar to Urie Bronfenbrenner's bioecological model for understanding child development; there is a focus on understanding the entire system in which health occurs (Bronfenbrenner, 1994; Engel, 1977).

In mainstream medicine, clinical diagnoses of mental disorders are based on criteria laid out in the Diagnostic and Statistical Manual (DSM-5) (APA, 2013), which are assessed during a clinical interview. Depending on the type and severity of the disorder, treatment may involve pharmaceutical approaches, or psychotherapeutic approaches, or a combination of both (Sadock & Sadock, 2007). Pharmaceutical treatments may bring about prompt relief of symptoms in some (though not all) patients; however, side effects and risks do exist, notably in the context of pregnancy and breastfeeding (Belik, 2008). Furthermore, pharmaceutical approaches do not address the underlying psychosocial roots of distress; therefore symptom relief may be difficult to sustain in the longer term. In this regard, psychotherapeutic strategies can help individuals recognize issues in their lives contributing to poor mental health, and develop coping skills and strategies in the face of those issues (Sadock & Sadock, 2007). However, many mainstream psychotherapists are not familiar with IGT and the colonial context of Aboriginal peoples' health, or with Aboriginal values and worldviews. As discussed by McCormick (2008), mainstream counselling services have had only limited success with Aboriginal clients due to "cultural misconceptions of what is normal; an emphasis on individualism; fragmentation of the mental, physical, emotional, and spiritual dimensions of the person; neglect of Aboriginal history; and neglect of the client's social support system" (p.342). Furthermore, a lack of cultural safety in mainstream mental health services, as discussed later in this paper, can reinforce IGT by subjecting Aboriginal clients to further oppression (NAHO, 2008; ANAC, 2009). Most importantly, both pharmaceutical and psychotherapeutic approaches promote the internalization of solutions (i.e., therapies are aimed at creating biological, cognitive or behavioural changes within the individual); as such, these approaches to do not address the broader social, economic and political factors that determine health at the population level. Given the collective nature of IGT and its colonial and neo-colonial roots, population-level interventions are also required to bring about meaningful transformation of individuals and communities.

Population-level Approaches to Mental Health

The Government of Canada has defined a population-health approach as one that "uses both short- and long-term strategies to improve the underlying and interrelated conditions in the environment that enable all Canadians to be healthy, and [to] reduce inequities in the underlying conditions that put some Canadians at a disadvantage for attaining and maintaining optimal health" (ACPH, 1999, p.xv). Over the last few decades, there has been considerable discussion and debate as to the best way to execute a population-health approach.

The 1974 Lalonde Report speaks of "populations at risk" - i.e., those people exposed to risk factors of interest. Lalonde suggests that prevention strategies should target these groups of people, notably to help them make better lifestyle "choices" (Health and Welfare Canada, 1974). This approach to prevention is countered by Rose (1985), who suggests that the causes of incidence are not the same as the causes of individual cases of illness; in simpler terms, Rose explains that understanding the reasons why individuals get sick will not necessarily explain differences in rates of illness between populations. Rose suggests that prevention strategies aimed at the entire population, that target environmental and policy factors, may lower disease incidences by shifting the population distribution of the health characteristic of interest in a more favourable direction (Rose, 1985).

Frohlic and Potvin (2008) commend Rose for highlighting the importance of structural factors on health, while pointing out the victim-blaming implications of Lalonde's considerable emphasis on the notion of

individual lifestyle "choices". However, Frohlic and Potvin criticize Rose's population approach on the basis that non-targeted interventions may not have uniform impacts on all segments of the population. They argue that advantaged segments of the population are likely to benefit substantially more from the population approach to prevention; therefore, such an approach runs the risk of increasing population inequities. They speak of "vulnerable populations" (under which they include Aboriginal populations) who are at "higher risk of risks" (p.218) due to various structural barriers, and argue the importance of targeted interventions for such groups (Frohlic & Potvin, 2008). McLaren and colleagues (2010), however, have critiqued the interpretation of Rose offered by Frohlic and Potvin. McLaren and colleagues have argued that whether or not a population approach to prevention leads to inequities depends on the nature of the intervention; namely, whether or not the intervention is focused on structure or agency. McLaren and colleagues further caution that the concept of "vulnerable populations" (those at greater risk of risks) is open to being conflated with Lalonde's concept of "populations at risk"; such a conflation leads back to an emphasis on risk exposure rather than on the structural factors driving health (McLaren, McIntyre & Kirkpatrick, 2010).

From the above discussions and debates, it is apparent that the conundrum of prevention at the population level lies in adequately addressing both downstream factors surrounding risk exposure, as well as upstream structural issues that impact health and wellbeing through the social determinants of health. Through an exploration of recent population-level interventions aimed at promoting maternal-perinatal health, it is apparent that there has been a greater emphasis on downstream factors than on upstream factors. Risk factors for maternal mental health issues, such as prenatal depression, include factors such as low socioeconomic status, unmarried status, experiences of domestic violence, high psychosocial stress, poor diet and low social support (Bowen & Muhajarine, 2006b). Social support has been targeted as a potentially modifiable factor in a number of recent perinatal health interventions. For example, a randomized-control trial of a prenatal intervention involving in-home nurse visits showed different patterns of success among pregnant women in Calgary, based on whether they were high-risk or low-risk for poor maternal and perinatal health outcomes. Not surprisingly, the needs of high-risk women were not being fully met with a conventional prenatal intervention (Tough et al., 2006). Other interventions have targeted women defined as "high-risk" based on depressive symptoms screening (Dennis, 2010; Jesse et al., 2010; Smith et al., 2011). These interventions have met with little (Smith et al., 2011) to only moderate success (Dennis, 2010; Jesse et al., 2010). The lack of dramatic success is likely because these interventions do essentially nothing to change the broader, structural factors impacting women's mental health. It is clear that more needs to be done to address upstream factors. This is particularly true in the context of Aboriginal women, whose health is impacted by the structural factors driven by the legacy of colonization. Furthermore, given the unique social, cultural and historical context of Aboriginal populations, tailoring prenatal and mental health interventions to meet the needs of pregnant Aboriginal women is also important to ensure both effectiveness and cultural safety.

The health promotion function of public health suggests that a multi-pronged, multi-sectoral approach is required in the process of "enabling people [and populations] to increase control over, and to improve, their health" (WHO, 1986, p.1). Health promotion interventions use strategies of building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services (WHO, 1986). Health promotion interventions have been suggested to be especially effective in mental health, given the complexity of the determinants involved (Herrman,

Saxena, & Moodie, 2005). Because health promotion "focuses on achieving equity in health" (WHO, 1986, p.1), a health promotion approach to mental health among pregnant Aboriginal women would advocate tailoring interventions for the specific needs of pregnant Aboriginal women. Furthermore, a health promotion approach focuses on action on the broader determinants of health beyond simply behavioural and biological factors - such as political, economic, social, cultural and environmental factors (WHO, 1986).

The Government of Canada's document "Toward a Healthy Future: Second Report on the Health of Canadians" discusses the health disparities facing Aboriginal populations, and links these health disparities to the social disparities faced by Aboriginal populations along social determinants of health such income, education, employment and housing (ACPH, 1999). What is conspicuous by its complete absence in this report, however, is identification of colonization as the broader driver behind present-day social and health inequities. Similarly, colonization and IGT are also not explicitly discussed in the program descriptions for First Nations and Inuit Health Branch (FNIHB) community-based health promotion programs on maternal and child health (Health Canada, 2011). Reference is made in the program descriptions to the social determinants of health, health promotion, community capacity-building, and the incorporation of traditional culture (Health Canada, 2011); however, concretely-defined components to explicitly address IGT in the mental health of pregnant Aboriginal women are not mentioned. Of the mental health promotion programs offered by FNIHB, the Indian Residential Schools Resolution Health Support Program description refers explicitly to IGT, in the context of residential school abuses. Otherwise, explicit reference to colonization and IGT are similarly limited in the program descriptions (Health Canada, 2011). In the last few years, largely through the work of the Truth and Reconciliation Commission of Canada, there has been increasing awareness of the traumatic experiences of students who attended residential schools, culminating in a formal apology from the Government of Canada on June 11, 2008 (Truth and Reconciliation Commission of Canada, 2011). However, the impact of the history of residential schools on *subsequent* generations of Aboriginal peoples has not received as much media or political attention. This may in part be due to the limited empirical research on the issue, as discussed below.

Addressing IGT in Mental Health Interventions for Pregnant Aboriginal Women

As discussed earlier, historical trauma and unresolved grief are reinforced and augmented with the trauma and despair stemming from present-day circumstances, including experiences of racism and sexism. In the context of health and social services, a lack of cultural safety contributes to oppression of Aboriginal peoples, and therefore to IGT. Cultural safety expands the notion of cultural sensitivity by focusing on structural inequities based on various sociocultural factors, and the resulting power differentials in relationships - notably in the relationship between service providers and patients or clients. In order to provide a culturally safe environment in which patients or clients can feel respected and empowered, service providers must be self-reflexive. This is particularly important in the context of Aboriginal patients and clients; Aboriginal peoples' historical relationship with health and social services is entrenched in colonization, making lack of trust a major concern (NAHO, 2008; ANAC, 2009). The literature has suggested a number of best practices for health and social services for Aboriginal patients and clients, to ensure both safety and responsiveness. The Society of Obstetricians and Gynaecologists of

Canada, for example, offers a list of recommendations for health services in the area of Aboriginal women's health. These include: ensuring that professionals have an adequate understanding of the sociocultural, historical and population health context of Aboriginal peoples, notably the legacy of colonization; embracing a holistic view of health and wellbeing, in line with Aboriginal worldviews; supporting community-directed services, programs and initiatives; and supporting health promotion and prevention (Smylie, 2000). In the context of pregnant and parenting Aboriginal persons, Smith and colleagues (2006) found that participants of their study seek health care that is respectful, strengths-based, client-directed, holistic, that permits healing and trust, that is culturally appropriate, that addresses the "mind, body and soul" (p. E39), and that includes fathers and other family members.

Various scholars have suggested that healing from IGT is best achieved through a combination of mainstream psychotherapies and culturally-entrenched healing practices (Brave Heart & DeBruyn, 1998; Brave Heart, 2003; McCormick, 2008; Menzies, 2008). McCormick (2008) comments that, when facilitated by therapists with "adequate understanding and respect for Aboriginal cultural values [such that] the therapist [does not] mistakenly try to change core cultural values of their Aboriginal clients" (p.342), there are certain mainstream psychotherapeutic approaches that have proven to be helpful for Aboriginal clients. In addition to individual psychotherapies, group and family therapies have proven to work well, given the congruence with the emphasis of family and community in Aboriginal worldviews (McCormick, 2008). However, it is important that mainstream therapies be complemented with traditional healing practices that allow connection with one's Aboriginal identity, and promote healing through balance; interconnectedness; relationships with family, community and nature; spirituality; and the use of Aboriginal rituals and traditions (McCormick, 2008). Traditional Aboriginal healing practices vary between communities, and include smudging, sweat lodges, sun dances, pipe ceremonies, potlachs and healing circles (University of Ottawa, 2009); healing circles, for example, can be incorporated into group therapy (Heilbron & Guttman, 2000). The focus on holism is reflected in traditional approaches such as the Medicine Wheel, and the four sacred medicines of sage, sweet grass, tobacco and cedar (Little Brown Bear, 2012; University of Ottawa, 2009). Drawing on traditional healing practices is especially important in the context of IGT, given that part of the assault of colonization that led to unresolved grief was the banning of traditional cultural practices (Brave Heart & DeBruyn, 1998). Brave Heart, DeBruyn and colleagues at the Takini Network in the United States have developed the Historical Trauma and Unresolved Grief (HTUG) Intervention, which has shown success. This group trauma and psychoeducation intervention combines processes for acknowledging and confronting historical trauma, with traditional Aboriginal rituals for grief resolution and healing. The intervention is congruent with mainstream group psychotherapies done for PTSD, and allows reconnection with Aboriginal identity and cultures as a powerful means of healing (Brave Heart & DeBruyn, 1998; Brave Heart, 2003).

In addition to individual-level interventions, population health promotion interventions are also important, that address structural and community-level factors that influence healing from the legacy of colonization. Chandler and Lalonde (1998) suggest that "cultural continuity" in a community can impact mental health. Their markers for cultural continuity include community involvement in land claims, evidence of self-government, existence of health and social services, and existence of cultural facilities. Although termed "cultural continuity", various scholars (e.g., Kirmayer et al., 2000) point out that these markers speak to broader issues of community participation and capacity, in addition to engagement with traditional culture and Aboriginal identity. Community capacity and local control are powerful counters to

the historical and present-day oppression associated with colonization, and in which IGT is largely rooted. As stated by Kirmayer:

> Community development and local control of health care systems are needed, not only to make services responsive to local needs but also to promote the sense of individual and collective efficacy and pride that contribute to mental health. Ultimately, political efforts to restore Aboriginal rights, settle land claims and redistribute power through various forms of self-government hold the keys to healthy communities. (Kirmayer et al., 2000, p.614).

While various conceptual models have been proposed to explain IGT (Brave Heart & Debruyn, 1998; Sotero, 2006; Menzies, 2008), they are largely rooted in qualitative research and theoretical discussion. The inductive approach of qualitative research allows for considerable depth in insight; given the complexities of IGT, qualitative research is certainly integral to fully understanding the intricate issues at hand. However, qualitative research cannot address questions of generalizability of results to a target population of interest (Morse & Niehaus, 2009; Roy, 2014; Sandelowski, 2000). Accordingly, quantitative and mixed-methods research approaches are also required, to ensure that IGT is considered in evidence-based decision-making around services and policies (Blackstock, 2009; Roy, 2014). There has been some quantitative work done in recent years. Whitbeck and colleagues (2004), for example, have developed historical loss scales. Recent studies have also attempted to assess IGT through indicator variables about life experiences associated with IGT in Aboriginal populations (e.g., sexual abuse, child abuse, family violence, alcoholism, being taken away from birth parents), or by inquiring about family members' attendance at residential schools (Balsam, et al., 2004; Cedar Project Partnership et al., 2008). However, as argued by Sotero (2006), discussion of IGT in the literature is largely theoretical and qualitative in nature. Similarly, although there is considerable discussion of the concept of healing in the context of Aboriginal mental health, "the major part of the literature that examines healing for Aboriginal people tends to be based on opinion and conjecture, not on research. ... [The] literature does not provide empirical evidence [as] support" (McCormick, 2008, p 341). Given the increasing focus on evidence-based decision making in the design of both clinical and population interventions, more empirical studies are needed on both IGT and Aboriginal healing, drawing on both quantitative and qualitative approaches. In particular, further research of these issues in pregnant Aboriginal women can help to provide context-specific evidence to address the overall lack of explicit consideration of IGT, discussed earlier in this paper, in both individual-level and population-level interventions aimed at Aboriginal maternal mental health.

Given the link between experiences of interpersonal violence and an array of health and social problems, Elliott and colleagues (2005) have suggested that all health and social services for women should be "trauma-informed"; in other words, "service delivery [should be] influenced by an understanding of the impact of interpersonal violence and victimization on an individual's life and development" (p 462). Elliott and colleagues' paper is concerning personal trauma from interpersonal violence; however, extrapolations of their points can be made to the issue of IGT and Aboriginal peoples. Given the link between IGT and social, behavioural and health problems in Aboriginal populations, an argument can be made that health and social services for Aboriginal peoples in general should be influenced by the recognition of the legacy of colonization and the need to heal from this legacy; in other words, they should be IGT-"informed". While the above should apply to services for all Aboriginal peoples, it is particularly pertinent for pregnant Aboriginal women. Qualitative research conducted by Smith and colleagues (2006)

suggests that Aboriginal parents see pregnancy as a time for reflection on the intergenerational legacy of colonization, driven by the strong desire to give their children a better future. As such, pregnancy is "a powerful opportunity to support and facilitate people to choose a healing path" (pp E34-E35), to heal themselves and break the vicious cycle of IGT for the sake of their children. As discussed earlier, IGT has a large role in Aboriginal women's overall mental health. Given the importance of pregnant women's mental health to both maternal and child health outcomes, including mental health trajectories for children and youth, it is clear that interventions, programs and services for pregnant Aboriginal women need to be designed to explicitly facilitate healing from IGT.

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Understanding the Impact of the Pain Experience on Aboriginal Children's Wellbeing: Viewing Through a Two-Eyed Seeing Lens

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Abstract

Pain is a universal experience all humans share but can be unique in how it is expressed. The pain experience is influenced by several dynamic factors, including family, community and culture. When it comes to pain expression children are among the most vulnerable often due to difficulty conveying their discomfort. Childhood pain can have significant physical and developmental effects that can last into adulthood. These negative health outcomes may be more pronounced in Aboriginal children given (a) the high prevalence of painful conditions, (b) potential cultural differences in pain expression, (c) the lack of culturally relevant reliable pain assessment approaches; (d) the subsequent shortcomings in pain care resulting in persistent pain (e) impact on wellbeing and untreated childhood pain. Standardized pain scales are based on Western ways of interpreting pain and may not capture the complexities of this experience through Indigenous understandings. Integration of both Western and Indigenous knowledge is accomplished when employing a Two-Eyed Seeing approach which utilizes the best of both Indigenous and Western knowledge. We want to establish reliable means for Aboriginal children to convey pain and hurt from a holistic perspective. By using a Two-Eyed Seeing lens to examine these issues, we hope to learn how to improve health care encounters, reduce hurt and enrich the wellbeing of Aboriginal children.

Keywords*: children, youth, pain, pain assessment, First Nations, Aboriginal, culture*

Introduction

Pain is a universal experience all humans share but is unique in how it is expressed. The pain experience and the subsequent expression can be influenced by several dynamic factors, including family, community and especially culture (Kristjánsdóttir, Unruh, McAlpine, & McGrath, 2012). When it comes to properly assessing pain expression children are among the most vulnerable, often due to difficulty conveying their discomfort. Untreated pain can interfere with a child's ability to learn, eat, sleep, grow and achieve life goals (Blanchard et al., 2012; Cooper, Kohler, & Blunden, 2012; First Nations Regional Health Survey [FNRHS], 2012; Jackson, Vann, Kotch, Pahel, & Lee, 2011; Leake, Jozzy, & Uswak, 2008; Schroth et al., 2009; Zumach, Gerrits, Chenault, & Anteunis, 2010).[1] These disruptions in healthy developmental activities are highly concerning as they may be more pronounced in Aboriginal children given (a) the high prevalence of painful conditions (b) potential cultural differences in pain expression, (c) the lack of culturally relevant reliable pain assessment approaches; (d) the subsequent shortcomings in pain care and resource inequities resulting in persistent pain; and (e) impact on wellbeing and untreated childhood pain.

Because culture plays such a prominent role in pain socialization we use a *Two-Eyed Seeing* approach to discuss this issue. The *Two-Eyed Seeing* framework was proposed by Mi'kmaq Elders and educators Albert and Murdena Marshall at Cape Breton University's Institute for Integrative Science and Health program. The *Two-Eyed Seeing* philosophy embodies the best of Indigenous and Western worldviews, acknowledging no single perspective is ever complete or superior (Martin, 2012). It challenges the extension of previously held perspectives to encompass new ways of thinking and recognizes the overlap between two distinct, yet evolving knowledge systems (Martin, 2012).

Western based pain assessment involves three areas of assessment; behavioural (crying, grimacing, etc.), physiological (heart rate, blood pressure, etc.) and self-report (Huguet et al., 2010; Jain, Yeluri, & Munshi, 2012). Minimal research has been completed to evaluate whether these assessment strategies are appropriate for use with Aboriginal people (Jimenez, Garroutte, Kundu, Morales, & Buchwald, 2011, Latimer, Rudderham, Finley, Young, Francis & Inglis, in press) and research that has been completed suggests that Western-based behavioural and self-report pain assessment may be inappropriate for use with Aboriginal children and youth (Latimer et al., in press).

This Western perspective of one eye's view is already well established in existing pain literature and clinical practice. However, the Indigenous viewpoint needs to be advanced as it has yet to be incorporated into pediatric pain care. Our *Two-Eyed* team believes considering both views offers a more balanced perspective and will lead to more meaningful pain assessment and treatment in Aboriginal children and youth. We outline in our discussion why we believe pain in Aboriginal communities may be under assessed and under managed as well as the implications of untreated pain on overall development and wellbeing including academic performance and biopsychosocial impacts. Next we describe how western

[1] Several other authors have identified similar trends in the literature, including Bidadi, Nejadkazem & Naderpur, 2008; Bowd, 2005; Casamassimo, Thikkurissy, Edelstein, & Maiorini, 2009; Cooper, Kohler, & Blunden, 2012; Langan, Sockalingam, Caissie, & Corsten, 2007; Lawrence, Binguis, Douglas, McKeown, Switzer, Figueiredo, & Reade, 2009; Milnes, Rubin, Karpa, & Tate,1993; Peressini, Leake, Mayhall, Maar, & Trudeau, 2004; Ratnayake & Ekanayake, 2005; Shepherd, Nadanovsky, & Sheilham, 1999; Spady, Saunders, Schopflocher, & Svenson, 2004; Thorne, 2004.

knowledge underpins the pain assessment practices of new and practicing clinicians. Our discussion concludes with next step suggestions to help achieve our underlying goal of raising awareness and encouraging the creation of new understandings in pediatric pain knowledge which reflect the best of each perspective on how to enhance the health care encounter, reduce the hurt and increase the wellbeing of Aboriginal children.

We recognize there is not one uniform 'Aboriginal culture', and for this paper we acknowledge that the three main groups of Aboriginal people, including First Nation, Métis and Inuit, have distinct cultures, languages and beliefs.. The specific three group identifiers used in this paper, as well as terms such as Native American, are not intended to suggest that these terms are interchangeable or diminish the rich diversity amongst all Indigenous groups, but rather reflect the language used in the original research from which they were derived. Further, references are made specifically to research conducted by several of the authors with the Mi'kmaq First Nation. To the best of our knowledge no other comparable Aboriginal children's pain research has been conducted in Canada to include in our discussions here. One study has been conducted by Ellis et al (2009) to develop a pain assessment scale for Inuit children however pain expression was not included in their research.

Pain and Aboriginal People

One in five Canadians aged 12-44 years, or roughly 3.6 million people, experience chronic pain. The incidence is highest in Aboriginal households, those with low educational attainment (Statistics Canada, 2012) and Aboriginal women (Meana, Cho, & Des Meules, 2004). While Canada ranks third out of 177 countries on the Human Development Index (a measure of education, life expectancy and income), the ranking slips to an appalling 68th place if only Canada's First Nations communities are considered (Canadian UNICEF Committee, 2009). This indicates there are serious impediments to optimizing wellness in Aboriginal communities; we believe pain may play a central role. In a recent comprehensive review of the epidemiology and management of pain among US, Alaskan and Canadian Aboriginal peoples, only five of the 28 studies included children and/or adolescents and only one was based in Canada (Jimenez et al., 2011). Results indicated higher rates of dental pain (Leake et al., 2008), chest pain (Rhee, 2005), headaches (Rhee, 2000), musculoskeletal pain (Buchwald, Goldberg, Noonan, Beals, & Manson, 2005; Rhee, 2005) and pain related to juvenile rheumatoid arthritis (Mauldin, Cameron, Jeanotte, Solomon, & Jarvis, 2004) in Aboriginal children and adolescents; yet these children were less likely to be treated for it (Leake et al., 2008; Maudlin et al., 2004; and Rhee, 2000). The recent First Nations Regional Health Survey (2012) also identified a higher prevalence of dental, ear and musculoskeletal pain among Aboriginal children and youth, which is further supported in the broader literature (Bowd, 2005; Langan et al., 2007; Lawrence et al., 2009; Leake et al., 2008; Schroth et al., 2009; Spady, et al., 2004).

We believe many Aboriginal children are suffering with untreated pain, receiving inequitable healthcare and experiencing negative pain-related health outcomes that could be addressed in part by clinicians' ability to properly assess and treat pain in a culturally relevant manner. The context of compromised social determinants of health inflicted by the effects of colonization efforts (Greenwood & de Leeuw, 2012) and health inequities likely play a factor in the prevalence of pain conditions. Stewart et al., (2013) conducted a Canadian study to identify health inequities in Aboriginal children with respiratory conditions. In Stewart's study both parents and children reported that health inequities included

substandard educational resources, exclusion, isolation, barriers to health-service access, inadequate health care, disrespectful treatment and discrimination by health-care providers as well as deficient health insurance. These unacceptable inequities continue to place Aboriginal children at a disadvantage and likely result in a greater burden of ill health (Kay-Raining Bird, 2011; Egeland, Faraj, & Osborne, 2010; FNRHS, 2012; Greenwood & de Leeuw, 2012; Ning & Wilson, 2012).

While Aboriginal people comprise 4% of the Canadian population, Aboriginal children represent the fastest growing demographic of all Canadians. Between 2006 and 2011, there was a 20% increase in population rates, compared to 5% in the non-Aboriginal population (Statistics Canada, 2011). In 2011, Aboriginal children under 14 years of age made up 28% of the total Aboriginal population and 7% of all children in Canada (FNRHS, , 2011). With such a youthful population, the health and development of Aboriginal communities may be compromised by the absence of culturally safe pediatric pain care.

How Do Practitioners Know When a Child is in Pain?

Pain is something that is experienced by all individuals throughout the lifespan. It is the most common presenting issue in Emergency Departments (Cohen et al., 2008; Cordell et al., 2002; Jimenez et al., 2011; Le May et al., 2009; Rogovik, Rostami, Hussain & Goldman, 2007; Todd et al., 2007; Zempsky & Cravero, 2004). The ability to accurately identify pain location, intensity and quality is essential for appropriate pain management (Cohen et al., 2008; Fanciullo, Cravero, Mudge, McHugo & Baird, 2007; Stevens et al., 2012).

Much of what is known about pain care is derived from studies based in Western settings. Three main categories of evaluating pain intensity in children from a Western knowledge perspective are physiological (heart rate, blood pressure, etc.), behavioural (facial grimacing, body posturing, etc.) and self-report (Huguet et al., 2010; Jain et al., 2012). In western-based practice self-report measures are considered to be the 'gold standard' in pediatric pain care. In recent reviews of pediatric self-report tools, the Pieces of Hurt (Poker Chip Tool) (Hester, 1979), Faces Pain Scale-Revised (Hicks, von Baeyer, Spafford, van Korlaar & Goodenough, 1993), Oucher (Beyer, 1984) and Visual Analogue Scale were considered some of the best validated measures available in clinical practice (Jain et al., 2012; Huguet et al., 2010). Evaluation of the cross-cultural relevance of existing pain tool adaptations through acculturation tests are rarely provided (Finley, Kristjánsdóttir, & Forgeron, 2009). The ability to accurately assess pain in Aboriginal children and youth using these tools has not been determined; confirming their reliability or developing methods that produce meaningful valuations is the first step toward addressing high rates of pain and delivering culturally safe care. This raises questions as to whether Western-based pain assessment tools can effectively translate the Aboriginal pain experience.

To say there is limited research on pain expression in Aboriginal children is a glaring understatement. As far as we know the *Two-Eyed Seeing* work conducted with one Mi'kmaq community (Latimer et al., in press) is the sole published work in Canada. Minimal research has been completed on the use of self-reported pain tools within Aboriginal communities (Ellis et al., 2009; Jimenez et al., 2011; Latimer et al., in press). We wonder whether the standard use of numbers through the numeric rating scale (NRS) to quantify pain would be inappropriate or ineffective in the Aboriginal population. Aboriginal people historically communicate through storytelling and oral descriptive methods. Depicting pain or hurt with a single number on a one-dimensional scale may not be sufficient. Burhansstipanov and Hollow (2001)

explored the use of numeric scales in Native American communities; the significance of numbers selected aligned more closely to the sacred meaning of the number as opposed to the severity of pain. It has been suggested that the use of a more descriptive tool that employs a narrative may capture more accurate pain information (Barkwell 2005; Fenwick, 2006; Green, 2011; Haozous & Knobf, 2013; Latimer et al., 2012). It is possible that the use of the word 'pain' may also be inappropriate within some Aboriginal communities. For example, Latimer et al. (in press) highlight the fact there is no translatable word for 'pain' within the Mi'kmaq language. This suggests a potential for confusion regarding the intention and purpose of pain tools. Instead, the word 'hurt', which in Mi'kmaq *kesa'si* means 'I am hurting', may be used by Mi'kmaq speaking people when discussing pain.

In addition to the shortcomings of standardized self-reported pain scales, another consideration is the potential for discrepancies between the child's stated pain level and the perceptions of health care providers. Evidence suggests health practitioners often prioritize physical indicators of pain, such as frowning, grimacing, moaning etc., over what a patient reports when determining the presence of pain (Forgeron, et al., 2009; Jain et al., 2012; Rajasagaram, Taylor, Braitberg, Pearsell, & Capp, 2009; Voepel-Lewis, Piscotty, Annis, & Kalisch, 2012). As a result, clinicians tend to discredit the patient's self-report, particularly with ambiguous or absent pain behaviours, high pain scores and/or if the patient's ethnicity differs from their own (Anderson, Green, & Payne, 2009; Forgeron, et al., 2009; Kaseweter, Drwecki, & Prkachin, 2012; Rajasagaram at al., 2009; Voepel-Lewis et al., 2012).

According to Honeyman and Jacobs (1996) Indigenous people suppress pain behaviours and are reluctant to discuss their pain experience with others possibly from the oppression experienced by Aboriginal peoples since colonization (Beers, personal communication 1997 in Fenwick, 2005). Fenwick (2005) notes that pain may be viewed by Indigenous people as a sign of human weakness leading to a tendency to not want to draw attention to their pain experience. In fact, in McGrath's work (2006) with Australian Aboriginal people's views on pain in palliative care, and Latimer's (in press 2014) work clinicians reported that it was more difficult to assess pain and both studies indicated that community members said it was a weakness to show their pain. Despite the high prevalence of painful conditions in Aboriginal children, the absence of conventional and Western-trained expected pain cues and behaviours places children and youth at a significantly higher risk for under-recognized, untreated pain. Though pain experiences are unique to the individual regardless of cultural identity, in an effort to better identify pain in Aboriginal children, it is important to avoid cultural stereotyping while maintaining consideration for how socialized pain expression may vary from Western norms. Cultural variances need to be acknowledged during pain assessment and self-reporting in order to produce meaningful results.

According to the Mi'kmaq Association for Cultural Studies (2013), cultural knowledge and teachings are found only in individuals and their relationships, not in books. For this reason, teachings and traditions are rarely written or translated into print. The best knowledge source regarding Aboriginal culture and traditions are the Aboriginal people and communities themselves. Aboriginal people have a strong oral history; values, beliefs and complex ideas are expressed by way of stories (Sinquin, 2009). In terms of pain, the purpose of the storytelling according to Fixico (2003) is to draw the listener into the experience of the event, allowing them to come to their own conclusions concerning the degree of pain the child is suffering.

Discourse patterns vary across cultures (Fixico, 2003; Chafe, 1980). For example, Mi'kmaq people in pain

do not often use English adjectival or adverbial phrases to quantify pain (Inglis, 2002, 2004). If clinicians pay attention to the details of 'the story of pain causation', in some Mi'kmaq communities, this is where the level of pain is expressed; not through Western ways of using numeric or face scales. In Latimer, Rudderham and colleagues (in press) research one Aboriginal Mi'kmaq Elder shared that 'the more pain, the more story' yet, healthcare encounters are not designed to allow the time to hear stories. Ellis et al (2009) created the Northern Pain Scale to be used in Inuit children to describe their pain and it was shown that it was favoured over typical gold standard measures. Little else has been published about Aboriginal children's pain expression or attempts to describe ways it is expressed and consequently treated. The cultural richness and diversity of Aboriginal peoples combined with the multidimensional approach to communicating pain underlines the central importance of engaging Aboriginal people in the development of relevant pain care; this would help ensure cultural insights, values, and traditions are reflected in the methods used to evaluate pain. The negative outcomes of untreated pain are too high a risk to not pay attention to this issue. These outcomes are further described in the following section.

Impact of Under Treated Pain on Children's Overall Development and Wellbeing

Children with poorly managed pain often experience detrimental and pervasive effects to their overall wellness. Though there is no singular piece of literature that comprehensively summarizes these issues, several overlapping themes have been identified in the works of several authors. Untreated pain has been found to negatively influence (a) future experiences with pain; (b) participation in play and (c) physical activity; (d) academic performance; (e) language development; (f) sleep patterns; (g) growth; (h) behavior; (i) social development; (j) mental health; (k) substance use and (l) risk for future illness (Bidadi et al., 2008; Blanchard et al., 2012; Cooper et al., 2012; FNRHS, 2012; Hammen, Brennan, Keenan-Miller, & Herr, 2008; Jackson et al., 2011; Kennedy, Luhmann, & Zempsky, 2008; Langan et al., 2007; Noel, Chambers, McGrath, Klein & Stewart, 2012; Schroth et al., 2009; Scott & Sullivan, 2012; Zumach, et al., 2010).[2] Further expansion of these outcomes follows with specific discussion regarding academic performance and bio-psychosocial impacts.

Lower educational attainment among Aboriginal people is another area of inequity that we believe may be linked to untreated pain issues. First Nations youth with good overall health have better educational success, better class attendance, higher course completion and enjoyment of school and fewer problems learning in a school setting (FNRHS, 2012). Approximately 34%-50% of Aboriginal people do not complete high school *versus* 15% of non-Aboriginal Canadians (Statistics Canada, 2006). More recently, the First Nations Regional Health Survey (2012) indicated 18% of First Nations children had repeated a grade compared to 3.6% of Canadian children at large. Van der Woerd, Dixon, McDiarmid, Chittenden and Murphy (2005) reported that 45% of 1700 British Columbia youth report missing school and other

[2] Several additional authors have contributed to this body of knowledge, including Baulch, 2010; Bowd, 2005; Casamassimo et al., 2009; Currie & Wang, 2004; Forgeron, Finley, & Arnaout, 2006; Gravel et al., 2006; Grossman, Milligan, & Deyo, 1991; Grunau, Weinberg, & Whitfield, 2004; Huguet, et al., 2010; Jongudomkarn, Aungsupakorn, & Camfield, 2006; Mitchell & Boss, 2002; Lawrence et al., 2009; Mauldin et al., 2004; McWilliams, Cox, & Enns, 2003; Milnes et al., 1993; Mota, Elias, et al., 2012; Ortiz, López-Zarco, & Arreola-Bautista, 2012; Peressini et al., 2004; Ratnayake & Ekanayake, 2005; Rennick, Johnston, Dougherty, Platt & Ritchie, 2002; Shepherd et al., 1999; Spady, et al., 2004; Thorne, 2004; Young, 2005.

activities due to pain. This finding mirrors our own work where 48% of the young people in a Nova Scotian Aboriginal Mi'kmaq community also indicated they regularly miss school due to pain (Latimer et al., in press). Further to the above Canadian findings, Jackson et al. (2011) analyzed school absenteeism related to dental health in non-Aboriginal children. Results indicated that missing school due to dental pain was associated with poor school performance while missing school for routine dental care had no bearing on academic achievement (Jackson et al., 2011). These findings isolate the crucial impact of pain on the educational experience.

In addition, chronic ear infections (otitis media) are up to 40 times more prevalent in some Aboriginal Inuit communities relative to urban dwelling Canadians (Bowd, 2005). The prevalence rates of chronic ear infections among Inuit school-age children range from 3.1-50% (Bowd, 2005). Elevated rates of ear infections with hearing loss were also found in Aboriginal Mi'kmaq children of Nova Scotia, ranging from 10-16% (Langan et al., 2007). According to World Health Organization (WHO) reports (1996; 2004), prevalence rates of chronic otitis media above 4% indicate a substantial public health concern that requires urgent intervention. Considering that rates of ear infections are well beyond the WHO parameters of public health concern in many Aboriginal communities and lower overall levels of treatment (Langan et al., 2007), there are several opportunities to improve the detection of ear pain and prevention of long term concerns, as discussed below. Yet, if health professionals are not culturally safe in their pain assessment knowledge than the infections and accompanying pain will persist with negative outcomes.

Recurrent ear infections can result in hearing loss and subsequent issues related to language, literacy, concentration, behaviour, learning disabilities, socialization and overall academic performance (Bidadi et al., 2008; Bowd, 2005; Langan, et al., 2007; Thorne, 2004; Zumach et al., 2010). Although some research suggests ear infection-related hearing loss is sufficiently transient to resolve by school age, it is important to note that the prevalence, frequency, severity and wide age range of these infections in Aboriginal children far exceeds non-Aboriginal norms (Bidadi et al., 2008; Bowd, 2005; FNRHS, 2012; Gravel et al., 2006; Gunasekera, Morris, Daniels, Couzos, & Craig, 2009a; 2009b; Langan et al., 2007). The 2002-2003 First Nations Regional Health Survey (2005) indicated only 27.4% of First Nations children with chronic ear infections were receiving treatment; equivalent data was not included in the most recent FNRHS (2012). Persistent ear infections often require treatment and earlier detection of painful symptoms has great potential to prevent downstream complications. Thus, untreated ear pain in Aboriginal First Nations children increases their risk for hearing problems and related impacts on learning.

Aboriginal children have higher injury-related mortality rates (26%) when compared to non-Aboriginal Canadian children (6%) (FNRHS, 2012; Saylor, 2004; Spady et al., 2004). These painful incidents can prevent school attendance, normal development and may lead to long-term disability (Spady et al., 2004). Without appropriate treatment, pain and disability may linger into adulthood and interfere with a productive, healthy active life. Being pain free means a child has the potential to be more physically active, and this can contribute to better overall physical and mental health (FNRHS, 2012; Janssen & LeBlanc, 2010).

Bio-psychosocial Impacts

Research in non-Aboriginal populations has shown that infants, children and youth who repeatedly

experience pain react adversely to subsequent pain events (Kennedy et al., 2008; Mitchell & Boss, 2002). Early and untreated experiences of pain, including those in a neonatal intensive care environment, disrupt the development of normal stress and neurological mechanisms (Grunau et al., 2004; Rennick et al., 2002; Young, 2005). In the absence of culturally relevant approaches to pain assessment, Aboriginal children are at higher risk for not having their pain properly assessed and treated which leaves them susceptible to suffering unnecessarily from pain and developing negative pain memories, chronic pain and disability.

Finally, untreated pain threatens an individual's mental health, associated with increased rates of depression, suicide, and substance abuse (Amari, Rehm, Goldner, & Fischer, 2011; Currie & Wang, 2004; FNRHS, 2012; Grossman et al., 1991; Larson et al., 2007; Lynch, 2013; McWilliams et al., 2003; Mota et al., 2012). According to the First Nations Regional Health Survey (2012), youth who were diagnosed with at least one health condition reported alarmingly increased levels of depression (31.6% vs. 20.6%), suicidal ideation (23% vs. 12%) and suicide attempts (8.1% vs. 4.5%) in comparison to those without a health condition (FNRHS, 2012). Equally concerning, 56.7% of Aboriginal youth with the lowest self-reported mental health have never actually accessed mental health services (FNRHS, 2012). Thus, the most vulnerable youth are not likely receiving essential support and at an increased risk for suicide in the presence of physical health conditions. Further, Scott and Sullivan (2012) noted that perceived injustice can modulate the relationship between pain and depression. Consequently, the social and health care inequities previously discussed (Greenwood & de Leeuw, 2012; Stewart et al., 2013) that Aboriginal youth face may increase the chance of developing depressive symptoms in response to persistent pain. Lastly, earlier onset mood disorders have higher rates of relapse in adulthood (FNRHS, 2012; Hammen et al., 2008), emphasizing the preventative importance of assessing and treating pain appropriately in Aboriginal children and youth.

Untreated pain profoundly interferes with a child's ability to achieve developmental milestones, academic success, productivity as a contributing member of society and overall wellness (FNRHS, 2012). Considering the disproportionate burden of illness and pain among Aboriginal children, we must first recognize this as a critical health issue; second, learn how best to assess and manage pain in Aboriginal children; third, create mechanisms to develop and share this knowledge.

Next Steps

It is clear that Aboriginal children experience more pain than their non-Aboriginal counterparts. There are undisputed discrepancies between Aboriginal and non-Aboriginal children for infection, injury, mental health and school achievement rates. Cultural variances in pain expression combined with the use of Western-based assessment tools contribute to the invisibility of Aboriginal children's pain. In the absence of a reliable means to evaluate pain in Aboriginal children, there is an urgent need for culturally relevant approaches to assist Aboriginal children in conveying their pain. Using a *Two-Eyed Seeing* approach, considering both Western and Indigenous knowledge to first validate that there is an issue and then proceed with establishing culturally relevant communication and management strategies, will be necessary to reverse the trends and negative impacts on future pain experiences and children's wellbeing.

The development of culturally safe approaches to pain care does not address the underlying social determinants of health that perpetuate widespread illness and pain in many Aboriginal communities.

However, it is an important first step in resolving health inequities, preventing downstream implications of untreated pain, rebuilding trust with health care providers and giving a voice to Aboriginal perspectives in guiding culturally relevant pain care. When an Aboriginal child presents in a clinical setting, it is imperative that health care providers be adept at culturally safe pain assessment.

In order to move forward, we must recognize the differences in how pain is expressed and partner with Aboriginal communities to learn how pain and hurt can be conveyed. Recent research by Stevens et al. (2012) indicated an excess of 90 different mechanisms to measure pain for infants, children and youth. However, the Indigenous viewpoint has been previously overlooked and has yet to be incorporated into pediatric pain care. Though Aboriginal children and youth will likely benefit from the revitalization of Indigenous knowledge in evaluating pain, there may be elements of this new understanding that also enhance pre-existing Western tools. Our goal is to raise awareness and encourage the creation of new understandings in pediatric pain knowledge, reflecting the best of the *Two-Eyed Seeing* perspective on how to enhance the health care encounter, reduce the hurt and increase the wellbeing of Aboriginal children.

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Bullying Behaviour and Victimization Among Aboriginal Students within Northwestern Ontario

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Abstract

This study describes the self-reported bullying experiences and behaviours of Aboriginal students within two schools in a northwestern Ontario community. Different types of bullying and victimization experiences include, but are not limited to: physical, verbal, social, and electronic bullying. These bullying and victimization experiences were assessed among grades 4 through 8 students using the Safe School Survey. The results of the study showed that relative to the entire sample, Aboriginal students reported comparable levels of both victimization and bullying behaviour at school. All students reported verbal bullying behaviours and victimization experiences as the most frequent form of bullying. The results reflected no significant difference between Aboriginal male and female rates of reported bullying and victimization.

Keywords: bullying, victimization, Aboriginal students, cyber bullying, school children

Introduction

Bullying has been shown to be a common problem with serious consequences experienced by children and adolescents (Vaillancourt et al., 2010). Both bullies and victims are reported to be at increased risk of experiencing serious health and psychosocial problems, including somatic difficulties (Schnohr & Niclasen, 2006; Due et al., 2005), depression (Bond, Carlin, Thomas, Rubin, & Patton, 2001; Kaltiala-Heino, Rimpela, Marttunen, Rimpela, & Rantanen, 1999), anxiety (Bond et al., 2001), substance abuse (Alikasifoglu, Erginoz, Ercan, Uysal, & Albayrak-Kaymak, 2007; Alikasifoglu et al., 2004), suicide attempts (Hinduja & Patchin, 2010; Kaltiala-Heino et al., 1999), aggressive behaviours (Alikasifoglu et al., 2004), truancy, and lower grades (Srabstein & Piazza, 2008). Despite the serious and persistent behavioural, psychosocial and health related outcomes associated with bullying and the potential for "bias-based" bullying directed at minority groups (Mishna, 2008), there remains a paucity of research specifically examining the experiences of bullying and victimization amongst Aboriginal Canadians.

Aboriginal Canadians are defined by the Canadian Constitution Act (1982) as comprising First Nations, Métis and Inuit peoples. This study sought to address this issue by exploring bullying behaviours and experiences among Aboriginal children in northwestern Ontario.

The definition of bullying has varied within the literature (Arendt as cited in Sperry and Duffy, 2012); although Olweus' (1993) definition that it involves being "exposed, repeatedly and over time, to negative actions on the part of one or more persons" (p.9) has been widely accepted (Smith et al., 2002). Some researchers have argued that the definition should be expanded to recognize that bullying represents an imbalance of power, with an intent to cause harm and usually includes some form of threat of further aggression (Coloroso, 2003). Thus, most definitions of bullying have generally accepted Olweus' definition with the recognition that it entails the repeated intent to harm a victim based on an imbalance of power between the bully and the victim (Mishna, Pepler, & Wiener, 2006).

Prevalence rates for bullying behaviour and victimization at school vary according to grade level, frequency within a time frame (e.g. over a week or a month), the type of bullying behaviour or victimization reported, and the demographic characteristics of the participants (Public Safety Canada, 2008; PREVNet, 2010). The contribution of these factors to variability in prevalence rates, including international prevalence rates, has not negated the fact that bullying behaviour and victimization reflect a significant social issue amongst school aged children (Ateah & Cohen, 2009; Craig & Peplar, 2007; Kepenekci & Çınkır, 2006; Nansel, et al., 2001; Nguy & Hunt, 2004; Volk, Craig, Boyce, & King, 2006; Wong, Lok, Lo, & Ma, 2008). Canadian data given by UNICEF in 2007 for children aged 11, 13, and 15 show prevalence rates for victimization as high as 36.3% and as high as 37.0% for engaging in bullying behaviour (reported in Vaillancourt et al., 2010).

Bullying can be conceptualized as either an overt or covert behaviour. Overt bullying requires a direct, interpersonal interaction between bully and victim, and typically employs physical and verbal tactics (van der Wal, de Wit, & Hirasing, 2003). By contrast, covert bullying is generally associated with indirect or relational behaviours designed to manipulate, hurt or influence the victim, for instance by social exclusion (Li, 2006; Xie, Swift, Cairns, & Cairns, 2002). Physical bullying usually emphasizes the size of the perpetrator relative to the victim and includes aggressive behaviours such as kicking, pushing, and spitting (Ando, Asakura, & Simons-Morton, 2005; Hinduja & Parchin, 2008; Wong et al., 2008). Verbal bullying, by contrast, does not rely on physical dominance, but rather the use of words to hurt, degrade, dehumanize, or intimidate the victim (Swart & Bredekamp, 2009). Social bullying is similar to verbal bullying, but involves exclusion, ostracism, alienating, gossiping, and making others look foolish (Coloroso, 2003). A recent form of bullying that has emerged along with advances in technology is electronic or cyber bullying (Mishna, Cook, Gadalla, Daciuk, & Solomon, 2010). This form of bullying refers to a deliberate intention to hurt or belittle a victim via any form of electronic communication, such as sending false emails, derogatory comments on instant messaging, blogs, or a website, or forwarding private pictures or information to a cell phone (Keith & Martin, 2005; Patchin & Hinduja, 2006). Two unique aspects of cyber bullying are that the victim may not know the identity of the bully and that it might include the action of a group (Tokunaga, 2010). Each type of bullying is designed to create and sustain a power imbalance; however, the manner in which this power imbalance is imparted will depend on the bullying behaviour.

Gender and Age

Bullying behaviours unfold within developmental and gender specific contexts. The literature has found mixed results in terms of gender differences in prevalence rates of bullying behaviours. Overall, the literature appears to favour the conclusion that boys are more likely to engage in physical bullying and to be victims of physical bullying (Hinduja & Parchin, 2008; Scheithauer, Hayer, Petermann, & Jugert, 2006; Wei, Jonson-Reid & Tsao, 2007; Wong et al., 2008); whereas girls are more likely to be perpetrators and victims of electronic bullying (Hinuja & Patchin, 2008; Li, 2006; Slonje & Smith, 2008). The literature regarding gender differences and verbal bullying is more varied with some studies citing no difference (Wong et al., 2008) and other studies reporting that males are more likely to engage in verbal bullying (Ando et al., 2005; Scheithauer, et al., 2006; Wei et al., 2007). In terms of social bullying, the results are once again mixed with some researchers reporting no gender difference in bullying behaviour (Wong et al., 2008), and others finding females more likely to socially bully their peers (Scheithauster et al., 2006). Similarly, with respect to victimization, research studies have suggested that girls are more likely to be socially bullied (Andreou et al., 2005), while other studies report no gender difference (Monks, Ortega-Ruiz & Rodriguez-Hidalgo, 2008; Scheithauer et al., 2006; Wong et al., 2008). Although the patterns are difficult to discern, enough research suggests possible gender differences in bullying and victimization to warrant continued exploration.

Like gender, age also plays a role in bullying experiences; and again, the research studies have reported varied results. For instance some studies have found that preadolescence is associated with higher rates of victimization that tapers off with increasing age (Monks et al., 2008; Scheithauer et al., 2006; Strabstein & Piazza, 2008). In contrast, other studies have reported that victimization peaks during adolescence (Peskin, Tortolero & Markham, 2006; Srabstein et al., 2006). In terms of bullying behaviour, the results have been more consistent. Researchers have reported that bullying behaviours increase with age and peak for students in early high school (Chapell et al., 2006; Pepler et al., 2006; Rigby, 2004 Solberg, Olweus & Endresen, 2007).

Minority Groups

Bullying behaviour and victimization have often been associated with perceived differences, such as sexual orientation or ethnicity (Kosciw, Greytak, & Diaz, 2009; Mayencourt, Locke, & McMahon, 2003). Research focusing on the different experiences of minority groups based on ethnicities within North America have found no clear pattern of prevalence rates for bullies, victims, and bully-victims among Caucasian, Hispanic, Asian, and African American populations (Holt & Espelage, 2007; Mouttapa, Valente, Gallaher, Rohrback, & Unger, 2004; Sawyer, Bradshaw, & O'Brennan, 2008; Srabstein & Piazza, 2008). Literature suggests instances of bullying behaviours described as ethnoculturally-based, which is when minority groups are more prone or vulnerable to victimization or bullying (Charach, Pepler, & Ziegler, 1995; Dell & Kilty, 2012; Larochette, 2009; Rigby, 2002). Research investigating bullying experiences and group membership suggests that minorities might be bullied due to intolerance related to such factors as gender, race, religion, sexual orientation, ability, and socio-economic status (Mishna, 2008). Some authors (cf. Larochette, Murphy, & Craig, 2010; Rigby, 2004) suggest that bullying itself is a socio-cultural phenomenon because it occurs within a cultural context of historical and social biases that both generate and perpetuate power differentials across social groups. There is a history of disadvantage reflecting disparities between mainstream society and Aboriginal Canadians. Intergenerational trauma,

forced separation from parents through the residential school system, and colonialism have created and sustained a power imbalance (Royal Commission on Aboriginal Peoples, 1996) that might contribute to differences in prevalence rates for bullying experiences among Aboriginal Canadians.

A study conducted in the United States examined the prevalence of bullying among Native Americans (Srabstein & Piazza, 2008) and reported a higher proportion of bully-victims within the Native American population. A Canadian survey of high school students conducted by Eisler and Schissel (2004) also reported that Aboriginal youth experienced a higher rate of bullying victimization than other youth. Similarly, Lemstra, Nielsen, Rogers, Thompson, & Moraros (2011), surveyed 4,197 Grades 5–8 students in Saskatoon and reported that First Nations or Métis students were more likely to be victims of physical bullying. A recent study in Canada by Do (2012) reported a higher involvement of Aboriginal children with bullying behavior and victimization when compared to Caucasian or ethnic minority children. Aboriginal males were reported to be involved with both more physical bullying and victimization, while Aboriginal girls were involved with more social bullying. The above studies suggest that Aboriginal students are at greater risk of being bullied or being involved with bullying; however, there is insufficient research examining bullying experiences among the Aboriginal population.

Further research is needed on how Aboriginal children experience bullying because “the context of mainstream Canadian schools is one in which Aboriginal children may often feel marginalized” (Rawana, et al., 2010, p. 219). Consequently, the current study aims to contribute to the body of literature on bullying by exploring and describing comparative rates in the different types of bullying and victimization among Aboriginal and non-Aboriginal children. In addition, the current study sought to explore the role of gender and age as it pertains to differences between Aboriginal and non-Aboriginal student bullying behaviours.

Method

Participants

The present study was conducted in accordance with ethical standards and was independently reviewed by the appropriate university and school Ethics Review Boards. Data for the present study was drawn from a larger community-based study focusing on bullying and violence in two elementary schools in northwestern Ontario. Surveys were administered to 103 students in grades 4-8. Demographic information including age, gender, ethnicity and grade were collected. The students ranged in age from 9 to 14 years, with a mean age of 11 years. The majority of students were between the ages of 11-12 (46.1%). The gender composition was 49% male and 51% female. Self-identification was used to determine Aboriginal status, which resulted in 36 individuals or 35% of the sample reporting themselves as being Aboriginal Canadians (4 individuals from the sample answered ‘I don’t know’ to the question).

Materials and procedure

The Safe School Survey (SSS) (Totten, Quigley, & Morgan, 2004) is a 47-item questionnaire that assesses perceived safety and frequency of bullying and victimization within a social context. The questions on the SSS used in this survey inquired about the incidence of bullying and victimization over the past four weeks. All items were rated on a 5-point Likert-type scale, ranging from: Never, Once or Twice, Every

Week, Many Times a Week, and Don't Know. This measure also assessed different types of bullying and victimization behaviours including: physical, verbal, social, and electronic. When asked about physical bullying and victimization the students are offered examples on the SSS such as being hit, kicked, pushed, slapped, spat on or hurt by others in any physical way. Questions about verbal bullying included examples such as having said mean things to other students, teased others, called students names, threatened or tried to hurt other students' feelings. Social bullying and victimization included examples such as having left other students out on purpose, refused to play with others, said bad things behind their back, and got other students to not like certain people. For electronic bullying and victimization the SSS suggested examples such as the use of email, phone or cellular phone text messages to threaten other students or make them look bad. Although reliability and validity information for the SSS have not been established, this measure has been recognized by the Canadian Public Health Association as a leading measure of bullying in Canada (Stys, 2004).

Results

Bullying and victimization, frequencies and types

Due to the low frequency rates at the extremes of the 5-point Likert scale for bullying and victimization, the items were collapsed for analysis into two categories: reporting having experienced or not having experienced victimization; or engaged in bullying in the past four weeks. Using this dichotomy, frequency tables are reported below to show how many students reported each of the types of bullying behaviours. Table 1 shows that for the entire sample the rate of victimization at school was high (63.4%). The percentages of victimization reported by the Aboriginal students (54.3%) versus the non-Aboriginal students (69%) at school are also presented in Table 1. The percentage of victimization is comparable between the groups and no significant differences emerged using a chi-square analysis.

Table 1

Victimization experienced at school for non-Aboriginal and Aboriginal students

Victimization	*Aboriginal*		*Non-Aboriginal*		*Total*	
	n	*%*	*n*	*%*	*N*	*%*
Never	16	45.7	18	31	34	36.6
At least once or twice	19	54.3	40	69	59	63.4
Total	35	100	58	100	93	100

To further analyse the different types of victimization, the scores relating to types of bullying behaviour were examined. The frequencies and percentages for different types of victimization are presented in Table 2. A number of students reported experiencing many types of bullying; therefore, when added together the total percentages do not sum to 100%. Table 2 shows that for the total group verbal victimization (57.8%) was reported as the most frequent type of victimization and electronic bullying

(22.2%) was reported as the least frequent. Chi-square analyses of the differences between Aboriginal and non-Aboriginal students for each of the types of bullying behaviours did not indicate any significant differences in the rates of types of victimization reported.

Table 2

Types of victimization reported by the students as having occurred at least once or twice in the past four weeks at school

Victimization	*Aboriginal*		*Non-Aboriginal*		*Total*	
	n	*%*	*n*	*%*	*N*	*%*
Physical	9	29	28	48.3	37	41.6
Verbal	17	51.5	35	61.4	52	57.8
Social	10	31.2	28	51.9	38	44.2
Electronic	8	24.2	12	21.1	20	22.2

Overall a much larger proportion of students reported experiencing victimization compared to students who reported engaging in bullying behaviour. Table 3 shows that some of the students did not answer all questions resulting in a lower response rate of 83 students. Of the students who did respond 28.9% admitted to bullying others at least once or twice over the last four weeks. A cross-tabulation analysis of this number revealed that 32.1% of the Aboriginal students reported bullying and 27.3% of the non-Aboriginal students reported bullying. A chi-square analysis revealed that this difference was not significant.

Table 3

Bullying behaviour reported by the students as having occurred at least once or twice in the past four weeks at school

Bullying	*Aboriginal*		*Non-Aboriginal*		*Total*	
	n	*%*	*n*	*%*	*N*	*%*
Never	19	67.9	40	72.7	59	71.1
At least once or twice	9	32.1	15	27.3	24	28.9
Total	28	100	55	100	83	100

The frequencies and percentages of Aboriginal and non-Aboriginal students reporting different types of bullying behaviour at least once or twice over the past four weeks are presented in Table 4. Verbal bullying

(27.3%) emerged as the most frequent type of bullying behaviour. A similar pattern to the total sample was found, with Aboriginal and non-Aboriginal students reporting similar rates of bullying behaviours. Chi-square analyses revealed no significant differences between Aboriginal and non-Aboriginal students for any of the types of bullying.

Table 4

Types of bullying reported by the students as occurring at least once or twice in the past four weeks at school

Bullying	*Aboriginal*		*Non-Aboriginal*		*Total*	
	n	*%*	*n*	*%*	*N*	*%*
Physical	6	20	7	12.1	13	14.8
Verbal	10	32.3	14	24.6	24	27.3
Social	4	13.8	8	13.8	12	13.8
Electronic	4	12.9	2	3.5	6	6.8

Age. An analysis was conducted of bullying by age grouping using a two-way contingency table and chi-square analysis. To facilitate the analysis, age was collapsed into two categories, 11 to 12 years old and 13 to 15 years old. A chi-square analysis was also performed to examine the distribution of bullying and victimization behaviours for Aboriginal and non-Aboriginal students by age. None of the results emerged as significant. Table 5 shows the victimization rates by age, which revealed that the highest levels of victimization for both the total sample (78.2%) and for Aboriginal students (88.9%) took place between the ages of 11 and 12 years old. No significant differences emerged between the groups. The sample sizes were too small for further statistical analysis.

Table 5

Victimization by age reported for non-Aboriginal and Aboriginal students

Age Categories	*Aboriginal*		*Non-Aboriginal*		*Total*	
	n	*%*	*n*	*%*	*N*	*%*
Ages 10-12	16	88.9	27	73	43	78.2
Ages 13-15	2	11.1	10	27	12	21.8
Total	18	100	37	100	55	100

Gender. To examine any differences in bullying by gender, chi-square analyses were performed using two-

way contingency table analyses to determine whether males or females reported different levels of bullying or victimization behaviour at school. The results revealed no statistically significant differences between the genders for both bullying and victimization either for the total sample or for Aboriginal students.

An examination of whether there were any differences in the four types of bullying behaviour related to gender was also conducted. The only significant difference between males and females that emerged from the results was for victimization in electronic bullying χ^2 (1) = 5.83, $p < .02$. The frequencies and percentages of bullying behaviour of male versus female students, with respect to electronic bullying, are presented in Table 6 as a total sample. The results show that females tend to have a greater proportion of reported electronic victimization (31.2%) compared to males (10.9%). The effect size of this finding, Phi coefficient = .25, is generally regarded as small to a medium (Cohen, 1992), meaning that while the difference is significant it is not a very large difference between the groups. The sample sizes were too small to allow further statistical analysis of the gender differences in specific types of bullying as experienced by Aboriginal or non-Aboriginal students.

Table 6

Victimization experienced by male and female students in the past four weeks

Victimization	*Males*		*Females*		*Total*	
	n	*%*	*n*	*%*	*N*	*%*
Never	41	89.1	33	68.8	74	78.7
At least once or twice	5	10.9	15	31.2	20	21.3
Total	46	100	48	100	93	100

Discussion

The purpose of this study was to explore and describe comparative rates in the different types of bullying and victimization among Aboriginal and non-Aboriginal children. The results of this study indicate that a high number of participants (63.4%) reported being a victim of all forms of bullying behaviours at least once or twice in the four weeks prior to being surveyed. This is much higher than the Canadian data of 36% reported by Vaillancourt et al. (2010). Although it should be noted that considerable differences in prevalence rates of victimization have been reported depending upon the assessment method and definition used (Franks, 2011), it does suggest that the variability in rates within different contexts requires further understanding. An examination of the different types of bullying victimization experienced by all the students showed that: 41.6% experienced physical victimization; 57.8% verbal; 44.2% social; and 22.2% experienced electronic victimization. Lemstra et al. (2011) reported a comparable pattern of victimization, albeit lower prevalence rates, of 23% (physical), 42% (verbal), 31% (social), and 10% (electronic). Thus, the results of this study suggest that children who attend school in northwestern Ontario report similar patterns of bullying, but higher prevalence rates than other areas of Canada. This is

a social condition that requires further understanding, especially considering the deleterious health and social effects of bullying (Franks, Rawana, & Brownlee, 2013).

An analysis of the prevalence rates for victimization among Aboriginal students compared to non-Aboriginal students found that fewer (54.3%) of the Aboriginal students reported being bullied compared to the non-Aboriginal (69%) students. This difference did not emerge as significant and could be regarded as the natural variation between two samples rather than a systematic difference between the groups.

With respect to engaging in the bullying of others, the overall prevalence rate reported by the students (28.9%) was slightly lower, but comparable to the Canadian rate of 37% noted by Vaillancourt et al. (2010). Similar to victimization, the results did not show any significant differences between Aboriginal students and non-Aboriginal students in the rate of bullying others. Upon closer examination of the different types of bullying, the students reported verbal bullying as the most frequent form of bullying behaviours. This finding is consistent with research that shows verbal bullying behaviours as accounting for most of all bullying incidents (Coloroso, 2003). Verbal bullying leaves no visible signs on the victims making it difficult to detect and monitor. For these reasons, it also increases the probability of being a desirable bullying option.

The finding of no significant differences in overall reported rates of victimization or bullying behaviours between Aboriginal and non-Aboriginal students is somewhat surprising given the racism and discrimination Aboriginal peoples have endured and continue to endure (Van der Woerd, 2006). With respect to being bullied, the results of this study differ from the perception that minorities are at an increased risk of victimization and discrimination (c.f. Besag, 1989; Hogarth & Crothers, n.d.; Van Ingen & Halas, 2006). However, the limited research literature has revealed mixed results on this issue. Rigby (2004) has suggested that minorities are at an increased risk for victimization due to the existence of socio-cultural power differential, which is certainly an issue for Aboriginal people within northwestern Ontario (Borg, Brownlee, Delaney, 1995; Brownlee, Neckoway, Delaney, & Durst, 2010). In contrast, Boyce (2004) reported that bullying associated with racial or ethnic differences occurred less frequently than other reasons given for bullying such as sexual orientation. Similarly, a study by Srabstein and Piazza (2008) from the United States suggested that American Indians are not at an increased risk of being bully-victims. The findings of the current study are congruent with this latter research, suggesting that Aboriginal students, at least as reported by the participants in this study, were not at increased risk of being bullied.

Another purpose of the current study was to explore the role of gender and age as it pertains to differences between Aboriginal and non-Aboriginal student bullying behaviours. A comparison between Aboriginal male and females found no significant difference for rates of reported bullying and victimization, indicating that both genders were equally represented across the four forms of bullying. This finding is consistent with the overall literature of mixed results regarding gender differences in the type of bullying and/or victimization (Crapanzano, Frick, Childs, & Terranova, 2011). It differs somewhat from the findings of Do (2012) who reported Aboriginal boys experienced greater involvement with physical bullying and Aboriginal girls greater social bullying. It is possible that differences in sample size or a more specific relationship to social context might account for the variations in patterns of bullying between studies. There were no significant results pertaining to age differences in bullying and victimization. Results nevertheless showed support for the notion that victimization decreases with age (c.f. Carlyle &

Steinman, 2007; Seals & Young, 2003). The current study revealed more instances of victimization for participants in the 10-12 age range than participants in the 13-15 age range.

Limitations and Future Research

One limitation of this study was the moderate sample size. Similar studies have used a larger sample size of 150 students. Future studies could incorporate larger sample sizes that would also permit multivariate statistical analyses. Second, Larochette, Murphy, and Craig (2010) reported that in their study racial victimization tended to vary between schools. This may indicate that if aggregated results were examined from a number of schools a different rate of bullying and victimization would emerge. Again this suggests that future research should incorporate a larger sample involving multiple schools. Third, although the focus of this study was on self-identified perceptions of bullying and victimization, it may be beneficial to use collateral measures of teacher and/or caregiver reports to confirm problems across multiple settings. The inclusion of a measure of bully-victims, rather than the reliance on the dichotomous category of bully or victim would permit the results to be compared against other studies that have used this form of classification. Furthermore, qualitative studies that explore how Aboriginal Canadian children experience bullying behaviours at school and in the community could provide rich insights into our current understanding of these dynamic processes.

Conclusion

The results of this study suggest that bullying is a very prevalent activity among school age youth in northwestern Ontario. The results did not indicate any significant difference between male and female rates of reported bullying and victimization or any significant age differences. Aboriginal students experienced similar bullying and victimization trends as non-Aboriginal students, which is surprising given that the Aboriginal community has experienced high levels of racism and discrimination. As there is a paucity of research exploring bullying within the Aboriginal community, further research is warranted, particularly with larger samples, to explore whether such trends are consistent across similar studies and populations.

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Nitsiyihkâson: The Brain Science Behind Cree Teachings of Early Childhood Attachment

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Abstract

The Nitsiyihkâson project was conceived in order to develop a resource to promote attachment and development in a manner culturally appropriate to the Indigenous (specifically Cree) people of Alberta. Promoting secure attachment between a child and his/her caregivers is crucial to ensuring positive mental health, and improving family well-being. Working collaboratively with the community of Saddle Lake, the process began by launching the project in traditional ceremony. Following this, a talking circle was held with Saddle Lake Elders to share their memories and understanding of child-rearing practices that promote attachment. Using their guidance, we produced the document "awina kiyanaw", which focuses on Cree stories and teachings, for parents to share with their young children. This document will be shared within the community, and agencies interested in promoting a culturally-appropriate approach to parenting. We then examined the cross-cultural applicability of these practices and produced a Resource Manual for service providers, comparing traditional ways-of-knowing with current neurobiological and epigenetic scientific understanding. We believe this helps those working with Indigenous families better understand their culture, and appreciate the wisdom in its teachings. In this paper, we present those findings and their ramifications.

Keywords*: parenting, attachment, early childhood, Indigenous practices*

Introduction

Our goal in the *Nitsiyihkâson* project was to develop a resource to promote childhood attachment within Indigenous (specifically Cree) families, in ways that are culturally appropriate, using their teachings to illustrate principles of early brain development. The project stemmed from the need to develop a resource for CATCH (Collaborative Assessment and Treatment for Children's Health), a multi-agency wraparound

program for infant mental health. Because one of the two pilot sites for CATCH sees only Indigenous children - many of whom live off-reserve, some with foster families not of Indigenous descent – we saw the need to develop a parenting resource to help promote traditional practices that are also supported by neuroscientific evidence.

Translated loosely, *Nitsiyihkâson* means "my name is". However, the term encompasses more than the factual statement – it relates to the kinship connections of the child to the network of social relationships in the community, and indeed the genetic and spiritual connections the child shares with their ancestors. Therefore, it seeks to understand the child's *connection, linkage, and attachment.* The *Nitsiyihkâson* parenting resource, *awina kiyanaw* ("who are we"; in press), was developed to help parents understand the importance of behaviors that promote attachment with their infants and children, and the traditional teachings which support these practices.

Out of respect for the community members who helped produce this work, we are attempting to translate the teachings into western language while being respectful of Indigenous beliefs regarding birth, infancy, and early childhood development.

Methods

The methods used in this community based research (CBR) project were specific to the Indigenous culture at Saddle Lake, and the traditions of their community; we recognize that they may look different than what is commonly seen in journals. However, part of the using a CBR approach requires being respectful of the community, and understanding and incorporating their beliefs and values. The project could not have been successful without such an approach.

While conceived academically, the project was started in ceremony and shaped by the community. It began with a traditional pipe ceremony and feast, led by Elders from Saddle Lake, where the proposed methodology was blessed. It was then shaped via a half-day ethics approval process at the Blue Quills First Nations College, followed by a full day sharing circle in which stories were told relating to attachment and child rearing. These teachings were then transcribed from Cree to English. Themes and important ideas were extracted, and woven into a set of teachings arranged in developmental order. We clarify and expand upon these methodological steps below and discuss how they differ from similar western processes.

Initial Discussion with Elders

Ceremony is an essential part of Indigenous teaching, as ceremony creates connection between self and spirit. In traditional ways of knowing, you must first acknowledge the Creator, and ensure that the research being proposed is fundamentally desirable to, and seen as worthy by, the community.

We met with identified community Elders to share ideas about the project, gather their initial impressions, inviting them to share their thoughts and/or concerns. This meeting began with smudge and prayer to ask for guidance and wisdom from the Creator. We discussed the importance of addressing factors such as the role of oral history in sharing knowledge and beliefs; differing roles of males and females in child rearing; the role of residential schools in creating attachment difficulties in Indigenous families; beliefs about what children bring into the world (i.e., the spiritual component of child rearing);

and maintaining a strength-based focus to the research.

Pipe Ceremony

The initial discussion helped guide us with our next steps, which included a formal pipe ceremony and feast, including the offering of tobacco and cloth. This was done through guidance and support of Elders and pipe holders from the Saddle Lake community. Within that ceremony, we also received the name for the project, *Nitsiyihkâson*.

It is noteworthy that this process was followed prior to obtaining ethics approval; while it is acknowledged within the research community that ethics is an important first step in any research endeavour, we wanted to ensure we practiced Indigenous research protocols, acknowledging the Creator and receiving the blessing of the Elders in the community prior to proceeding. Without their approval, the project could not have advanced.

Ethics Meeting

Our next step was to meet with the Blue Quills College research ethics committee to present the project. The team travelled to St. Paul, Alberta to meet with them. However, seeking to abide by the principles of Ownership, Control, Access and Possession (OCAP), the ethics committee also included elders and interested students, and involved a discussion as to what was best for the community. Thus, the meeting not only explored issues of ethics, it encompassed a teaching opportunity for students and a discussion of community values.

As per protocol for sharing traditional stories and facilitating a sharing circle, conversation was focused on where and when these stories should be shared. The conversation further evolved with the appropriateness of recording and taping the stories. In this way, the ethics discussion necessarily differed from those often held in western universities, as it required a greater level of openness and flexibility from the team, and served the additional purpose of helping solve logistical issues while addressing concerns regarding community involvement.

Access to Elders

Team members of the research committee that resided in the Saddle Lake First Nation approached the Elders with traditional protocol of tobacco and cloth, and invited them to participate in the Sharing Circle.

Sharing Circle

Community Elders and the research team came together as a group on the Blue Quills College campus, and the day began with prayer and a smudge ceremony. The Sharing Circle involved a full-day of meeting, in which questions were posed to the Elders, and a talking stick (in our case, a microphone used to record the conversation) was passed around the circle clockwise. The group process involved a team member (X.X.) facilitating, providing context and encouraging discussion on the questions. Once each individual had a chance to address a question, the stick was passed around once more to ensure that individuals were able to express any ideas that occurred to them in listening to the others speak. Elders received lunch and small honorarium for their participation.

Importantly, Elders were encouraged to discuss questions in Cree, in an effort to maximize comfort an capture the true sentiments shared amongst the community members. While this somewhat complicated the process (transcription of the full day of conversation had to be done afterward), it was clearly important to the process – in fact, when one question was discussed (regarding residential schools), the tone of the conversation changed markedly and most individuals started speaking English. In discussions afterward, it was posited that this shift reflected their discomfort in reliving the events surrounding colonization.

Thanks Giving and Project Completion

As a final step of the process, another gathering occurred in the community at Blue Quills College. This again was to offer thanks to the Creator, the community, and the Elders that participated and supported the project. At this meeting, preliminary results were discussed, as were ideas about how best to share the information.

Results

Section 1: Prebirth

Maternal-attachment with the unborn child. Cree teachings highlight the need for the mother, and the rest of the family, to connect with the unborn child – this can be through song, such as traditional music, or via storytelling. Modern neuroscience supports the idea that the child is developing sensory capacities pre-birth. For instance, tastebuds first appear 8-12 weeks after conception, and early taste perception can influence taste decisions after birth. Sensitivity to light appears around 16 weeks, with vision continuing to develop after birth. The sense of touch develops between 8-20 weeks, and sense of smell develops around week 28 (Enfamil, 2012; pregnancy.org, n.d.). Infants have been shown to orient to the sound of their parents' voice at as little as 16 weeks of age (What to Expect, n.d.).

Science confirms the nature of the prenatal attachment relationship (between the infant's development in the womb, and the woman's development in becoming a mother) is critical. There has been increased recognition over the past 20 years that the relationship between a mother and child starts before a child is born; in fact, research demonstrates a correlation between prenatal attachment and postnatal attachment (Alhusen, 2008). Furthermore, optimal attachment in early infancy has been identified as an integral component in the future development of a child (Oppenheim, Koren-Karie, and Sagi-Schwartz, 2007).

Prenatal health and nutrition. Some evidence suggests that positive health behaviours (e.g., visiting a doctor regularly for prenatal care; maintaining a healthy diet and exercise routine) are associated with improved maternal bonding while the child is still in the womb (Virtual Medical Centre, 2013). Substance abuse during pregnancy is associated with poor maternal and infant outcomes, as it may make it more difficult for the woman to do the tasks that are important for bonding with her infant.

However, beyond the necessity of maintaining good health during the pregnancy, Indigenous teachings tell us that the issue is broader – it is about the idea of realizing that actions have consequences, not only for the individual but for the generations that follow. In Cree teachings for example, it is said that an event will carry repercussions for 7 generations. It is worthwhile to consider the multi-generational cycles of FASD, spousal abuse, and alcoholism in this context. Interestingly, the idea that events which cause stress

to the parent (whether psychological or physical) directly translate to the child has been borne out by recent evidence. Epigenetics suggests that poor parenting or neglect actually result in changes of the genetic structure of the child. This is because the way in which gene transcription and protein manufacture occurs is actually altered by early stressors (Scott, 2012).

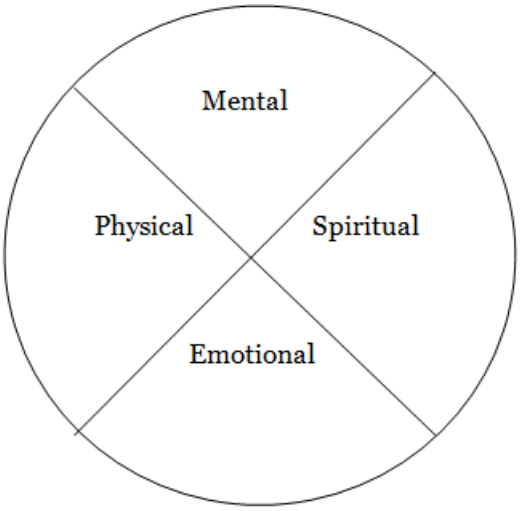

Figure 1
Cree Teaching Circle

Further, their teachings suggest that negative issues are caused by an imbalance in mind, body and spirit (Elders use the word *pāstāhowin* to describe this imbalance); this is one of the lessons behind the Cree circle of life – that there needs to be equilibrium between the mental, emotional, physical and spiritual aspects of the self (see Figure 1, left). The expectant mother in particular needs to try to maintain this balance. Similarly, a role of the parents and family is to assist the newborn in finding this equilibrium, particularly in helping them find a sense of calm alertness, when they are either understimulated or upset. Intriguingly, this is also one of observations of the neurorelational framework (Lillas & Turnbull, 2009).

However, despite the potential for stressors to create imbalance, science also shows that potential damage can, to some extent, be reversed (Perry & Pollard, 1998). It is only in the last couple decades that modern science has accepted the concept of neural plasticity, the idea that brains are changeable and can be altered following long term damage, such as that resulting from abuse or neglect. In fact, Indigenous teachings suggest that it is through traditional practices and ceremony balance can be restored.

That said, science also shows that trying to change behavior or build skills in circuitry that was miswired in the first place takes more work and is less effective. The most effective way to produce resilient behavior is to nurture and protect the developing brain as it evolves (Early Brain & Biological Development, 2010).

Section message. Professionals working with at-risk families likely bring with them their own belief system that may support or conflict with the Indigenous teachings described above. That said, science supports paying attention to the pregnancy, being thoughtful and attempting to be healthy, and making those first initial efforts to bond with the child (e.g., via singing, story-telling, etc.) prebirth. In fact, it may be that if prospective parents are not engaged in the process, they will miss opportunities (or critical periods) for these initial bonding experiences. Nor will they pay attention to healthy habits regarding nutrition and drug use, essential to a healthy baby. Science is only now exploring concepts such as epigenetics and plasticity, but Indigenous teachings have suggested these scientific facts for centuries.

Section 2: Birth

Responsivity. Indigenous teachings place great importance on meeting the newborn child's needs. Their

belief is, the infant "always cries for a reason"; in other words, when a child cries it is because they need something and the parent should tend to them. Rather than following the western custom of feeding a newborn every two hours around the clock, the Cree believe that the child communicates its needs through its cries. Thus, they place great importance on being atuned to the infant, and maintaining a reciprocal relationship with him or her. This reciprocity is now seen as essential to the healthy development of the newborn, a type of "serve and return" back-and-forth communication between the parent and child.

Early sensory experiences. The Elders described early sensory experiences, such as "singing the baby into the world" with a special song (*nikamowin*); as well as early experiences conveyed through smell and touch. These processes lay the fundamental groundwork for how the child experiences the world. In western culture, parents are often left on their own to determine what kind of environment is "best" for their newborn, but new parents may be confused or challenged, and require guidance. The Cree teachings place importance on those early days in connecting to the infant in a physical way.

During the earliest stages of development, the baby's brain is growing and changing extremely rapidly. One of the important activities occurring during early development is synaptic pruning, in which unused brain connections are eliminated. This process begins at birth and extends until adolescence (Iglesias, Eriksson, Grize, Tomassini, and Villa, 2005). Importantly, a major determinant of which connections remain and which are eliminated is use – a principle jokingly referred to as "use it or lose it". This means, however, that the important sensory experiences the child undergoes early on help to determine which pathways will remain and be strengthened, and which will be eliminated. Thus, developing and maintaining these early physical connections with the child is key.

Swing. The swing carries with it many teachings for caring for the newborn. Use of the swing continues to assist the infant with maintaining their spiritual connection. It soothes them and reminds them of the comfort and safety of the womb. However, while being placed in a swing is seen as an important sensory experience, the elders caution against keeping the child in the swing overnight or unattended. According to Cree teachings, this is to ensure that the child remains "grounded" (Gladue, 2002). Thus, the swing is one of the important sensory experiences early on.

Mossbag. As mentioned above, the Elders placed a lot of importance on holding the child, and actual skin-to-skin contact. The belief is that children who are carried in a mossbag tend to have calmer spirits. While western culture understands the importance of restraint systems (e.g., booster seats, car seats, carriers, etc.), the Elders brought attention to the important issue to bonding with the child simply through holding and carrying it. For instance, there are discrete words in Cree that express the concepts of "nurturing and showing affection" to a baby (*ocemōhkatikawiyan*) and "the songs sung while playing with the child" (*nïmihawasowin*). Notably, comparable terms do not exist in English. Scientific research supports the lasting effects of early skin-to-skin contact on an infant's self-regulation, social relatedness and capacity to handle stress and frustration (Feldman, 2011). This author hypothesized that the continuous physical contact soothes the infant and emphasizes the underlying connectedness between members of the cultural group, while in more individualistic societies mothers prefer more active forms of touch. Using hundreds of participants, Anderson, Moore, Hepworth, and Bergman (2004) were able to demonstrate positive effects of early skin-to-skin contact on measures of breastfeeding, maternal touch, and other maternal attachment behaviors.

However, according to the teachings, the mossbag is not simply a carrying device for the child. The broader idea is that the very construction of the bag is meant to mimic the mother's womb – thus aiding the child's transition into the world. For instance, the lacing on the bag can be likened to the mother's ribcage. Essentially, this means that the parent can decide and control how much exposure is appropriate for the child from moment to moment, helping the child build their capacity for self-regulation. The mossbag assists the process of atunement between the parent and child, as to whether the child is ready for exposure to the world or requires the safety of parental contact.

Sleeping. Although for awhile it was seen as dangerous or inappropriate, modern science is beginning to recognize the acceptability of co-sleeping (i.e., sleeping in bed with an infant; Neuroanthropology, 2008). In fact, some research suggests lower rates of SIDS (Sudden Infant Death Syndrome) among infants who co-sleep with their parents. Co-sleeping also results in healthier infants, in that that bedsharing increases rates of breastfeeding while increasing sleep for both mother and baby, potentially reducing infant illness. Thus, according to the authors,

> irrepressible (ancient) neurologically-based infant responses to maternal smells, movements and touch altogether reduce infant crying while positively regulating infant breathing, body temperature, absorption of calories, stress hormone levels, immune status, and oxygenation. In short, and as mentioned above, cosleeping (whether on the same surface or not) facilitates positive clinical changes including more infant sleep and seems to make, well, *babies happy*. (Neuroanthropology, 2008)

As it stands, the authors state that the evidence for co-sleeping remains mixed, with most studies supporting it except for the case of couch co-sleeping, which can result in suffocation. Parents should also be advised not to bedshare if inebriated or otherwise desensitized. Similarly, the relationship of the parents should also be a factor worthy of consideration.

Breastfeeding. Science supports the importance of breastfeeding, both in developing a healthy immune system, as well as in giving opportunity for the mother and child to bond (the Baby Bond, n.d.). Breast milk is a complete, easy-to-digest form of nutrition that contains antibodies, protecting the child from illness. Breastfed babies are better able to fight off infection, and require fewer visits to the doctor. This also gives mother and child an opportunity to connect, often through eye contact, but also through smell and taste, engaging all the child's senses, and bonding mother with child through a multi-sensory process.

Belly button ceremony. The Cree have a practice of making a special ritual of disposing of the newborn's belly button. Rather than throwing it away, they will make a special effort to, for example, bury it in a special place. The belief is that where the belly button is placed helps to define the path the child will take in the world. Burying it helps to keep the child grounded, so that his or her spirit has a home.

Whether or not one might view this as superstitious, it reflects the Indigenous view that it is important to give thought to the child's place and path in the world; that the wishes placed upon the child's future are valuable and require conscious attention.

Naming ceremony. There are names given through ceremony that become a child's spirit name. These names help them connect to their spirit and the spirit world. They have great meaning, and often follow the child throughout his or her lifetime.

However, it is also common for Cree families to grant the child a nickname, informally. This process represents an opportunity for family members to bond with the new baby. This may be via seemingly superficial traits (e.g., "she looks like cousin Shelley; that is how we should refer to her"; "the baby's cry is like the squeak of a mouse!") – but no matter how it is determined, this nickname serves the purpose of outlining a special connection between the child and members of the family. Often, these names are of a teasing, affectionate nature, and kept personal amongst family or community members.

Section message. Indigenous teachings around birth and early infancy focus on the importance of developing bonds with and being responsive to the infant, in both physical (e.g., co-sleeping, breastfeeding, using the moss-bag) and more spiritual ways (e.g., the belly button and naming Ceremonies). In fact, both are fundamental to the development of positive attachment relationships. All these practices will be reflected in the growth and development of the child, helping them move to the next stage of development.

Section 3: Early childhood development

Importance of play and being out in nature. Scientific evidence supports that independent exploration of nature is vital to learning a number of skills and abilities (Janssen & LeBlanc, 2010; p. 40). For instance, research from the Arbor Day Foundation (2013) suggests that outdoor play is fundamental to:

1. Better social and physical development
2. Improved fitness and motor skills
3. Stronger powers of observation, creativity, and imaginative play
4. Improved collaboration, with decreased bullying
5. Reduced stress
6. Feelings of empathy for nature, encouraging environmental stewardship
7. Broad-based development and learning across the curriculum

Just as importantly, the more time spent in physical activity outdoors, the less time spent in sedentary pursuits (i.e., technology; Flett, Moore, Pfeiffer, Belonga, and Navarre, 2010). The physical benefits of being outdoors include lower blood pressure, heart rate and muscle tension. There is also a relationship between the amount of time spent outdoors and child's overall level of physical activity, thereby battling childhood obesity (Munoz, S-A., 2009; p. 9) and type II diabetes. Just as importantly, time spent outdoors is also related to stress reduction and reduced mental fatigue, potentially reducing the odds of mental illness such as depression, anxiety and ADHD (McCurdy, Winterbottom, Mehta, and Roberts, 2010).

However, the teachings go beyond the positive health benefits of play. The exploration of nature is also seen as important to learning survival skills (e.g., which berries are edible; what parts of a slope are most stable), as well as building respect and love for the environment.

Natural consequences and learning to stand up for oneself. The Elders describe the importance of letting the child experience the natural consequences of bad behavior. They believe it is vitally

important for the child to learn difficult lessons themselves, rather than vicariously.

This idea links strongly to neuroscientific principles of memory development; individual experience with and learning of a contingency is more powerful than having that event explained to you, or witnessing someone else go through the event. In fact, procedural memory is by far the strongest type of memory formed (i.e., as compared to declarative, or fact-based, memory), being resistant to experiences such as amnesia (Cavaco, Anderson, Allen, Castro-Caldas, and Damasio, 2004). Interestingly, research has shown that trauma (e.g., post traumatic stress disorder) has the result of shrinking brain structures responsible for forming memories (the hippocampus; Herrmann et al., 2012). One might ask whether building procedural memory – which is less prone to cell loss in those regions (Kolb & Whishaw, 1990; p. 555) – could have a protective effect on children who experience trauma. So, while it is always important to keep children safe, it is just as important to let them experience the negative things that may happen when they are out exploring the world - within limits. This is how the child develops confidence and self-respect.

The Elders also spoke strongly about "not taking the part of the child"; in other words, letting children fight their own battles. The child should be encouraged to find his or her own voice, and to speak up for themselves. This process, known as individuation, is now known to be crucial to child development. In some ways, this belief system stands in stark contrast to many modern practices, in which parents generally, for example, will approach a teacher if they feel their child has been treated unfairly. While modern thinking appears to be that the child needs an "advocate", this issue is really related to the idea of teaching natural consequences; Indigenous teachings place value on learning through direct experience.

The willow teachings. The Cree have a series of teachings referring to the willow stick the child is told to go and find, which represents the object of their discipline. While modern science does not support the use of corporal punishment, it is important to understand that what the child is learning here is that there are consequences for negative behavior, and more importantly, that he or she will be part of the discussion in determining the severity of those consequences. In this way, the willow teachings actually empower the child.

Importance of playing together and building relationships. The Elders put an emphasis on developing good, peaceful peer relationships. One elder describes it as being taught, "*to be able to play and interact with our peers, other children and not to horde our toys but to share it with them.*" This seems like a simple lesson, but nowadays there is a much stronger emphasis on achievement and being first in the class; competition rather than cooperation. There is an importance placed on socialization. As one Elder stated:

> Today our children are being raised by themselves, they don't know each other, they don't understand each other because there are no gathering places for them, even places where they can socialize and talk to each other. The only thing they do is text.

Science has recognized the protective effects of interconnection since Emile Durkheim published his landmark study of suicide in 1897, finding lower rates of suicide among cultures with stronger integration (Suicide [book], n.d.). Modern theories of brain development also place importance on socialization and relationship; children raised in isolation show deficits in areas such as mental health, well-being, and perceived social support (Canetti, Bachar, Galili-Weisstub, De-Nour, and Shalev, 1997). Similarly,

youngsters who report social exclusion are 2-3 times more likely to experience depressive symptoms than their socially-connected peers (Glover, Burns, Butler, and Patton, 1998). Moreover, children of a lower socio-economic status are more likely to report social exclusion (Davies, Davis, Cook, and Waters, 2008). It is also noteworthy that some relationship practices differ in Indigenous communities compared to the western view. For instance, teasing is a common method of bonding amongst community members. It is not done maliciously, rather acknowledging that the individual is part of the group; that he or she belongs - that the child is well known, understood, and most importantly accepted among community members. So, while teasing is a common method of exclusion in western cultures, it carries a different meaning for the Cree.

Moreover, the types of relationships valued by Indigenous communities are much broader than those traditionally considered as part of the western definition of "family". Beyond the parent-child relationship, they encompass extended family, and even the broader community. This is important, because one role of the parents it to help teach the children gender-appropriate behaviors and practices, roles and responsibilities.

However, the Elders also pointed out that the entire Indigenous concept of relationship is different, with the idea being that "you *are* the relationship", as your connections with others both reflect who you are and shape who you are. In other words, there is a focus on interconnectedness. This relates to the Cree concept of *Wahkohtowin*, the idea that "we are all related". In fact, distant relatives are treated like first degree relatives, with cousins treated as siblings, and great aunts/uncles not referred to as such. Relationships among kin are, in some ways, closer and more personal than those experienced in the western culture. In many ways, this point of view reflects the idea that it takes a village to raise a child.

Section message. Indigenous teachings around early development and child rearing focus on teaching the child independence, respect, responsibility, and relationship. The teachings show the value of exploring the world, learning through experience, but also respecting boundaries and showing kindness and charity to others. In so doing, they recognize that cognitive, emotional, and social capacities are interconnected, which is fundamental to brain development as the brain uses some of these functions to enrich others. A main goal behind these teachings to help the child learn roles, expectations, and responsibilities, ultimately preparing them for adulthood, teaching skills to allow children to take their place in the community.

Discussion

This publication documents the scientific merit underlying the practices described in the *Nitsiyihkâson* parenting resource. The parallels between Cree teachings and current scientific thought are striking. There are many dichotomies between western and Indigenous world views. Paradoxically, "new" brain research is now espousing the same parenting practices as Indigenous teachings have been promoting for centuries. It is the conclusion of our study team that, in some ways, science is catching up with traditional practices that have been passed down from generation to generation for hundreds of years. That is, the perspectives of the Indigenous community, their traditional practices and techniques, are now being borne out by modern neuroscience. It is noteworthy that these teachings were practiced pre-contact, and were passed down through oral tradition, ceremony, and relational concepts, but we in the western world are only now starting to appreciate their true value. For this reason, Indigenous thought is both relevant

and prescient in terms of our understanding of attachment and bonding.

In one sense, the fact that the scientific community might be surprised to hear this underscores the issue with colonization: until western science has "proven" a phenomenon to be true, it means little and is taken as curious or hypothetical. In fact, this point of view perpetuates colonialistic attitudes towards Indigenous populations. Moreover, this document suggests that, ironically, our efforts to restrict or destroy these practices in the 20th century actually *set back* child rearing and the promotion of adult-child attachment in Indigenous communities.

As has been elaborated previously, "it is impossible to understand First Nation community health without considering the cultural foundation upon which the community is built" (Keith, 2011). It is our hope that *awina kiyanaw* and the accompanying Resource Manual provide to readers a better understanding of Indigenous practices promoting attachment, and help build a platform to better relate with Indigenous children and families.

The authors would like to dedicate this publication to Community Elder George Bretton, who passed away in 2013. His kindness and wisdom were appreciated and will be remembered.

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Contemporary Practice of Traditional Aboriginal Child Rearing: A Review

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Abstract

There is a dearth of literature available on traditional Aboriginal child rearing. This review paper explores Aboriginal child rearing to determine if traditional practices are still in use, how these may differ from mainstream child rearing and may have been modified by mainstream influences and colonialism. Traditional Aboriginal parenting is discussed in the context of colonialism and historic trauma, with a focus on child autonomy, extended family, fatherhood, attachment, developmental milestones, discipline, language, and ceremony and spirituality. This review was completed using the ancestral method i.e. using the reference list of articles to find other relevant articles and more structured literature searches. In light of the high number of Aboriginal children in foster care, this research may serve to highlight the role that historical issues and misinterpretation of traditional child rearing practices play in the apprehension of Aboriginal children. It may also assist non-Aboriginal professionals when working with Aboriginal children and their families.

Keywords: *Aboriginal, child rearing, residential schools, parenting*

Introduction

The quality of parenting has a significant effect on the physical and emotional health of children throughout their development. When inadequate parenting results in unhealthy family relationships, and deteriorates to the point where it is neglectful or abusive, children in Canada are generally placed into the care of child welfare agencies. The National Household Survey (NHS) of Aboriginal Peoples in Canada found that, in 2011, while Aboriginal people represented 4.3% of the total population of Canada, almost half (48.1%) of the 30,000 children in foster care in Canada were Aboriginal. In 2011, 3.6% of Aboriginal children were in foster care in contrast to 0.3% of non-Aboriginal children. Trocme, Knoke, and Blackstock (2004) noted that Aboriginal families are led by significantly younger parents who have experienced more maltreatment when they themselves were children. These parents' histories of abuse, especially the abuses experienced in residential schools, may have negatively affected their capacity to parent and are likely responsible for overrepresentation of Aboriginal children in the foster care system in Canada (Trocme, Knoke & Blackstock, 2004). Historical trauma and, possibly, significant

misinterpretations of traditional Aboriginal ways of parenting may play a role in these apprehensions.

Cheah and Chirkov (2008) noted that there is little research on Aboriginal parenting and Aboriginal child development. Much of the scant past research on Aboriginal families has focused on the 'deficient', non-mainstream parenting which was practiced by Aboriginal parents (Red Horse, 1997), while espousing a kind of "pan-Aboriginalism" or over- generalizations about Aboriginal people. Loppie (2007) stated that there is no universal Aboriginal paradigm, but does concede that despite geographical, language and social structure differences, there are shared values that are philosophically different from Euro-North American cultural norms. While researchers must thus be careful in making generalizations about Aboriginal child rearing, they should also understand cultural literacy pertaining to Aboriginal practices is essential for professionals who work with Aboriginal families.

Colonialism, historical and intergenerational trauma as inflicted by the residential school system have doubtlessly affected Traditional child rearing techniques. The Truth and Reconciliation Commission Interim report (2012), noted that Residential school survivors specifically asked for support to both regain and teach Traditional parenting values and practices as a means of improving their parenting skills. It would thus be useful to look at how colonialism has affected Aboriginal parenting and to examine any available scholarly information relating to Aboriginal ways of parenting in order to better understand, and potentially remedy, the significant overrepresentation of Aboriginal children in foster care. In this paper, historical factors are examined to provide a background to contemporary Aboriginal child rearing and to highlight how traditional practices may have been altered. Child autonomy, extended family, and Aboriginal fatherhood in particular characterize the parenting of Aboriginal children. In addition, distinct ways of addressing Attachment, developmental milestones, discipline, language and finally spirituality and ceremony will be discussed, as these are facets of Aboriginal parenting that may have been or continue to be misinterpreted by mainstream professionals.

Method

The literature on Aboriginal ways of parenting is relatively scant, but what little exists covers a broad range of Aboriginal cultures, most notably: Australian communities, the Sami, and many nations from the United States and Canada. The existing research is grounded in diverse disciplines including sociology, nursing, anthropology, social work, psychology and occupational therapy. The current literature review was done using both key word searches (e.g. "Aboriginal", "child rearing") in many different scholarly areas and using the ancestral method i.e. using references cited in articles to find relevant articles. The reviewed articles span 19 years from 1993 to 2012.

Historical Factors

Colonialism and its impact on parenting

Aboriginal cultures around the world share a history of colonialism which has likely had a significant effect on parenting practices. In Canada, colonialism, through an insidious assimilation process, has gradually pared away the identity of Aboriginal children and youth who subsequently themselves became parents (Simard & Blight, 2011). Colonialism of the Inuit in Canada, for example, caused profound changes in the former's lives due to language suppression, residential school enrolment, and loss of self-

determinism (McShane, Hastings, Smylie, Prince & The Tungasuvvingat Inuit Resource Centre, 2009).

Critical examination of the effects of colonialism on current Aboriginal child rearing practices is important as colonialism has brought with it dysfunctional behaviors, beliefs and values (Dorion, 2010). Dysfunctional values have come to be part of modern child rearing in many Aboriginal communities both on and off reserve (Dorion, 2010). For example, colonialism may have caused traumatic bonding and/or the inability to express love (Chansonneuve, 2005). Colonialism, residential schools, racism, and poverty have marked family relationships in a multitude of destructive ways that are only beginning to be understood (Neckoway, Brownlee & Castellan, 2007). Thus normative, unidimensional ways of assessing the quality of parenting may be quite inadequate in these contexts, and may need to be replaced by a more multi-dimensional, ecologically oriented approach.

Intergenerational transmission of trauma

The social-historical context created by colonialism includes both acute and chronic stressors, resulting in symptoms related to Post-Traumatic Stress Disorder (PTSD) (Evans-Campbell, 2008). However Evans-Campbell contends that PTSD classification is of limited use to Aboriginal people because it does not address intergenerational trauma, the compounding effect of multiple stressors, only focuses on the individual (and not the family), and its definition does not incorporate the ways historical and present day traumas interact or are interpreted. Historical trauma is collective, compounding, and although the abuses of colonialism were perpetrated over many years and generations, these abuses still continue to impact individuals, families, mental health and cultural identity (Evans-Campbell, 2008).

Aboriginal children have inherited the significant traumas that their ancestors were forced to endure. These traumas were caused by government policies purposefully designed to disrupt cultural practices and family relationships (Sarche & Whitesell, 2012). Brave Heart (1999) has written extensively on historical trauma in the Lakota people in the United States and noted that the impairment of traditional parenting styles was one of the intergenerational effects of this trauma. Wesley-Esquimaux and Smolewski (2004) wrote that historical trauma caused symptoms such as domestic violence because historical trauma corrupts adaptive social and cultural patterns. The maladaptive behaviours, in turn, may be passed on to the next generation as socially learned patterns of conduct which children internalize. It is important for researchers in the areas of child development and parenting to understand these historical effects of trauma, which may directly affect risk for both psychopathology and negative health outcomes (Galliher, Tsethlikai, & Stolle, 2012), and, by extension, parenting. One of the most devastating components of colonialism, and one that caused extensive trauma was the Residential schools system.

Residential Schools

In the late 19th century in Canada, the government instituted Sections 113 to 122 of the Indian Act, which legally took away the rights of Aboriginal parents to their children and instead gave the government control (Chansonneuve, 2005). Taking Aboriginal children away from their families and enrolling them into residential schools was encouraged by the government whose stated purpose was to assimilate Aboriginal children (Lafrance & Collins, 2003). Approximately 130 residential schools were run jointly by Christian churches and the federal government from 1892 to 1996, and 30% of Canadian Aboriginal children spent the majority of their childhoods in those institutions during that period (Chansonneuve,

2005). As just one example of the suffering these children experienced, Fournier and Crey (1997) reported that deaths in Residential schools in the early 1900s ranged from 11% (Alberni School, British Columbia) to 69% (File Hills in Saskatchewan) mostly due to tuberculosis. One-third of Aboriginal children lost the experience of traditional family life, many attained adulthood not having had any model of parenting (Lafrance & Collins, 2003) and many experienced much trauma.

Boarding schools (as residential schools were called in the United States) separated children from their community's social structures (Fitzgerald & Farrell, 2012) including family. Within the Lakota nation, children who were sent to boarding schools only learned punitive discipline as a means to parent, and were thus put at risk of becoming a generation of uninvolved, non-nurturing parents (Brave Heart, 1999), and learn how to parent primarily in the way that they themselves were parented (Lafrance & Collins, 2003). The Truth and Reconciliation Commission of Canada (2012) reported that clearly, residential school's greatest impact was the breakdown of family relationships because these children were denied parenting knowledge and skill transmission. Lisa, an Aboriginal parent in Canada, who confessed to abusing her children, noted that she "never learned any parenting skills, not at residential school, not with the childhood [she] had" (Fournier & Crey, p.131, 1997). Anecdotal stories from residential schools survivors showed that residential schools impacted generations of their families in very significant ways, resulting in the inability to express love or nurturance, a loss of communication, emotional abuse and traumatic bonding, and having children taken into foster care (Chansonneuve, 2005). It was not just the children who attended residential schools who were affected. Descendants of children raised in boarding schools recounted experiencing childhood neglect and abuse themselves and, when they became parents, had feelings of parental inadequacy and feeling confusion about to how to parent in healthy ways (Lafrance & Collins, 2003). Residential schools interrupted and corrupted traditional child rearing by separating Aboriginal children from their parents, extended family and culture, and by raising them instead within punitive, often abusive institutions.

Traditional Aboriginal Child Rearing: Is it Still Practiced?

Aboriginal child rearing has ostensibly been significantly disrupted by colonialism. One question that arises is why some aspects of traditional Aboriginal parenting are still being practiced while other aspects have disappeared. Few studies have examined this query (Javo, Alapack, Heyerdahl, & Ronning, 2003). Cheah and Chirkov's (2008) research, established that present day Aboriginal mothers still emphasized the importance of family, respect for Elders, and maintained cultural values significantly more than European Canadian mothers. As well, Javo, Ronning, and Heyerdahl's (2004) study showed that Aboriginal Sami child rearing practices differ from the dominant Norwegian culture even following a long period of assimilation. Ryan (2011) asserted that many studies from contemporary Australian Aboriginal urban, regional and remote communities suggest that Aboriginal parents have retained unique traditional child rearing behaviors, expressions of sensitivity, sociability, emotional self-regulation, self-expression and competence. Likewise, van de Sande and Menzies' (2003) evaluation of Ojibway parenting programs proposed that there continues to be significant distinctiveness in ideas on how to raise Ojibway children, in spite of generations of influence by the mainstream culture. Many explanations have been offered as to why so many Aboriginal cultures are still thriving in spite of government policies designed to systematically eradicate them. A spiritual and genetic explanation was provided by Simard and Blight (2011) who maintained that cultural memory is carried inside Aboriginal DNA and has waited to be

awakened to inspire connection to the spirit. Simard and Blight contended that the rich cultural makeup and knowledge systems of Aboriginal peoples in Canada have survived over 500 years of colonialism. Another way that traditional child rearing practices were maintained is that not all Aboriginal children went to Residential schools as some parents resisted this. Although these children stayed with their family, other forms of colonization still likely affected the transmission of child rearing practices. It does appear that traditional child rearing methods, although perhaps altered by colonialism and trauma, are still being widely practised and transmitted by Aboriginal peoples.

Traditional Child Rearing in Contemporary Practice

Child autonomy

Research showed that Aboriginal communities continue to exhibit many distinctive values related to child rearing. One such value is respect for the child. Aboriginal children are openly recognized and respected as persons and are thus encouraged to make their own decisions about how they wish to explore their environment (McPherson & Rabb, 2001 as cited in Neckoway et al., 2007). The concept of *child autonomy* implied allowing children the freedom to make their own decisions which leads to independence (Javo, et al., 2003). This is a quality that the Sami also saw as essential for survival and hardship endurance (Javo et al., 2003). Indeed, in order to encourage independence, Sami parents nurtured exploration and risk taking in their children despite the possibility of danger (Javo et al., 2003). The Sami balanced this independence with emotional responsiveness and affection; it seems that the more Sami parents valued independence and autonomy, the more affectionate and physically close they became with their children (Javo et al., 2003). Further, Javo et al. (2003) found the western value of time organized around a clock was recognized by the Sami, but that they still tried to adhere to their cultural value of allowing their children to eat and sleep, to decide when and what they eat and when, how long and with which family member to sleep according to the child's own rhythm (Javo et al., 2003; Javo et al., 2004). The modern Sami still valued child autonomy although they also recognized and made concessions to western values, such as time.

The concept of autonomy was honoured by Aboriginal people from Canada, Australia and the United States as well. Sheperd (2008) found that Aboriginal parents from Canada more often than Euro-Canadian mothers, allowed their children to decide how much to explore their environment. The Inuit in Canada also viewed autonomy and independence as vital to parent and child interactions and as such, Inuit parents looked for indications from their children to guide their own responses (McShane et al., 2009). Australian Aboriginal children also traditionally self-directed their skill development, including relatively dangerous activities like knife handling and climbing trees (Kruske, Belton, Wardaguga & Narjic, 2012) and this early independence was encouraged for children by setting few limits (Nelson & Allison, 2000). Allowing children to make their own decisions may not, in itself, be an indication of neglect, as often perceived by non-Aboriginal people (Ryan, 2011). Similar to the Sami, in Australian Aboriginal remote communities children were not expected to follow routines and were allowed to eat when hungry and to sleep when tired (Kruske et al., 2012). The Alaskan Yup'ik allowed their children the freedom to move around the home before coming back to the mother to eat the bites of food that were offered (MacDonald-Clark & Boffman, 1995). The Yup'ik had no fixed feeding schedule for their children but instead, fed the children when they were hungry (MacDonald-Clark & Boffman, 1995). Furthermore,

McShane and Hastings (2004) commented that Aboriginal children in the United States are raised in a world that is more adult centred than that of other Americans, and were thus more encouraged to develop adult skills such as showing responsibility for self-care to ensure survival. The prevalent focus on child autonomy was tied in with the Aboriginal preference for non-interference which can be expressed by Aboriginal people through a resistance to giving instruction, correcting, coercing or trying to persuade another to do something (Neckoway, 2010). In many Aboriginal cultures, autonomy is an ideal based on independence (and thus survival) but is counterbalanced by strong affection for the child.

Extended family

Even though risk-taking and independence were encouraged, extended family was traditionally greatly involved with Aboriginal children. Australian Aboriginal children, for example, were highly regarded and valued members of their extended family network (Kruske et al., 2012). Inuit children were also given much affection, attention and tenderness and seen as the centre of attention for their immediate and extended family (McShane et al., 2009). The Navajo culture was both matrilocal and matrilineal and as such, maternal grandmothers and aunts were very involved with young children as are other family members (Hossain et al., 1999). In Anishnaabe (Ojibway) communities, family included the nuclear family, the extended family, the community family (connected by a treaty), a Nationhood family (all Anishnaabe people, regardless of province or country), Clan family (such as deer or turtle clan, a spiritual aspect of family), and a cultural family (linked to Anishnaabe ceremonial practices) (Simard & Blight, 2011). There were many levels of family in Anishnaabe cultures. A fundamental and traditional value of Aboriginal peoples is that of kin, the interconnection of family, non-family community members who were involved in children's socialization (McShane & Hastings, 2004). In the research, Aboriginal extended families were highly valued, interconnected and structured.

Neckoway et al. (2007) noted that bonds between an Aboriginal child and adults (including many caregivers) in these extended families were multi-layered and not dyadic (between two people only). Aboriginal parents from Australia commented that in an Aboriginal family, siblings and extended family members had a designated role in raising the children (Nelson & Allison, 2000). Furthermore, Koorie women from Australia, who were not the biological mother to the child, actively mothered; this concept of allo-mothering set the Koorie apart from mainstream child rearing (Atkinson & Swain, 1999). In many Aboriginal nations in the United States, grandparents have historically played an important role in socializing, providing physical care and training for their grandchildren (Fuller-Thomson, 2005). In this context of allo- mothering, the mother could afford to be less vigilant because she knew that others in her extended family and community were also attending to the child (Neckoway et al., 2007). Extended family can have extensive roles in child rearing in some Aboriginal cultures. This is important to acknowledge when professionals are working with and assessing Aboriginal families. Professionals should ask families which individuals interact and care for the child and never assume that it would only be the mother.

Aboriginal fatherhood

One area that has received very little attention in the literature is traditional Aboriginal fathering. Jaho et al. (2004) studied gender differences in Sami parenting, specifically the similarities in patterns of response in Sami mothers and fathers. In Ryan's (2011) study of urban Nunga and Koorie mothers in

Australia, the researcher observed that men's roles in their children's lives was missing. Similarly to many other Aboriginal communities, because of policies introduced by the State, Koorie men's supportive family roles changed as they were offered only menial and erratic jobs which ultimately resulted in prolonged absences and shortened life spans (Atkinson & Swain, 1999). Ball (2009) remarked that by 2020, if no effective interventions take place, half of the rapidly growing population of Aboriginal children will still be growing up without a father. In Ball's study of Aboriginal fathers from Canada, many men acknowledged that they did not know how many biological children they had, while several admitted that they had at least one child that they were not, nor had not, ever been involved with. This was a familiar pattern for many men who had grown up either without a father, or with an abusive father or father figure, including, in some cases, abusive priests in residential schools. Many men in Ball's study reported that actively parenting their own children brought up painful childhood memories of abuse or family violence, a parent's death, being taken away to residential school or going into foster care. Eighty-six percent of the men in Ball's study talked about their experiences of what Ball themed a disruption in the transmission of intergenerational fathering. Aboriginal fathers may not be involved in parenting because of historical trauma and government policies resulting from colonialism.

Other issues affected research on Aboriginal fathers. Hossain (2001) considered off-reservation Navajo fathers to be a hard to reach sample because they were scattered over the southwest region of the United States and also, because traditionally, Navajo did not encourage outsiders to research their family patterns. Hossain's 2001 study and Hossain et al.'s 1999 study both used western assessment tools which were not validated for use with Aboriginal peoples, and samples that included only Navajo fathers who were not living on reservation. Nonetheless, both studies showed that Navajo men had higher levels of family involvement compared to other cultures, and spent more time with infant caregiving, with fathers spending 60% of the time the mothers did. Aboriginal fathers may also be understudied because of cultural values. Fathering in Aboriginal communities remains an under-researched area with much diversity and numerous interesting questions remaining to be answered.

Attachment

Mainstream Attachment theory posits that how sensitively parents respond to their child when the child is distressed will likely affect the child's expectations for subsequent relationships, world view, and ultimately social emotional health (Ainsworth, Blehar, Waters & Wall, 1978). However, there is diversity in the manifestations of Attachment behaviours across cultures and Aboriginal cultures are no exception. Carriere and Richardson (2009) commented that "connectedness" may be a better description of Aboriginal attachment as it looks more broadly to an individual's total environment and not just to one or two central caregivers. Attachment in Aboriginal cultures may present somewhat differently from the mainstream in the areas of extended family response, secure base and distress response.

When looking at extended family response, Kruske et al. (2012) looked at 15 northern Australian Aboriginal families' experiences with their infants in the first year of life. These researchers found that all participating family members felt an obligation to respond when an infant cried or whimpered and that not to respond and letting a baby cry, was considered cruel and was frowned upon (Kruske et al.). If another family member responded, this might be interpreted, within traditional Attachment theory, as insensitivity by the mother because it might signal that the mother-infant dyad was not synchronous

(Neckoway et al., 2007). The latter commented that, when assessments were conducted with tools based in western Attachment theory, it may appear that Aboriginal mothers were less sensitive and that the child may not have a healthy Attachment to her mother. As well, the dynamic between child and adults may move in both directions. Extended family may respond to an infant but also, the infant or toddler may seek out alternative caregivers (even for breastfeeding) or peers (Ryan, 2011). This dynamic might be misunderstood as an indiscriminate Attachment by western-trained researchers (Ryan, 2011).

Other Attachment concepts such as security may also look different in Aboriginal cultures. Bowlby's concept of secure base in Attachment stated that an infant will use one or two primary caregivers as a safe place to explore from, and retreat to (Waters, Crowell, Elliot, Corcoran & Treboux, 2002). In Aboriginal cultures, the circle of caregivers may go well beyond one or two individuals. In the Central and Western Desert regions of Australia for example, older children were encouraged to look out for other children and siblings (Ryan, 2011). Aboriginal children may seek other caregivers, have other caregivers respond to them, may be routinely cared for by an older sibling or peer and thus, may have many caregivers providing them with a secure base.

One assessment tool that is commonly used to assess parental sensitivity in the parent-child interaction is the Nursing Child Assessment Screening Tests (NCAST) (Barnard, 1986). The Feeding Scale (for birth to 12 months) and the Teaching Scale (for birth to 36 months) of the NCAST both assess the primary caregiver's sensitivity to cues, response to stress, both social-emotional and cognitive growth fostering, the clarity of cues and the infant's responsiveness to the parent (MacDonald-Clarke & Boffman, 1995). The scales have been normed on non-Aboriginal, African American and Hispanic populations. MacDonald-Clarke & Boffman (1995) used the NCAST to study the interaction between mother and infant (93% of the dyads were mother-infant) in Alaskan Yup'ik. Generally, the Yup'ik had similar overall scores on both the Feeding and Teaching Scales as other groups, but some subscale scores differed (MacDonald-Clarke & Boffman). In both the Feeding and Teaching scales (with different aged infants/toddlers), the Yup'ik scored significantly higher than the norm in parental sensitivity to child cues. As a result, 93% of the infants/toddlers in this study did not ever become distressed. It would have been interesting had the researchers also assessed another adult or sibling who also cared for the infant to see if high sensitivity was also shown by other caregivers. Another researcher, Ryan (2011), found that minimization of distress was a cultural norm in Aboriginal peoples from northern Australia who appear to address distress in infants before it happens. One has to wonder then whether a faulty interpretation of minimizing, if not fully understood in its cultural context, may result in inaccurate assessments of Attachment when evaluating a caregiver's response to distress (Ryan 2011).

Another cultural norm for select Australian Aboriginal peoples is the discouragement of negative emotion as the latter may be seen as disrespectful of Elders (Ryan, 2011). Ryan noted that this squelching of negative emotion could be construed by non-Aboriginals as promoting avoidant Attachment, i.e., resulting in the child's not being responsive to the mother when the mother is present, and not showing distress when the mother leaves and a stranger is present (Berk & Roberts, 2009). The child may be repressing distress signals because this is what they have been taught and if this occurred during an assessment such as the NCAST, the results might be confusing.

Aboriginal connectedness may thus differ from mainstream Attachment manifestations in the areas of extended family response, the notion of secure base and distress. Mainstream Attachment theory may

thus not fully reflect an Aboriginal infant's socialization experience, which is embedded in the parenting practices shared by many Aboriginal communities (Neckoway et al., 2007).

Developmental milestones

Aboriginal cultures may understand developmental milestones differently than other groups. For instance, the Inuit looked at each child individually and then tailored their approach to developing autonomy and respecting the distinct ability of that child instead of assuming identical levels of development for all children of the same age (McShane et al., 2009). In Kruske et al.'s (2012) study, Aboriginal parents from Australia did not attribute as much importance to the age of their infants as mainstream Australian families did. These researchers inferred that because there are differences in exposure to skill development and parental cues and encouragement, that children from remote Aboriginal communities may meet developmental milestones at different ages than mainstream children. Within Inuit and Aboriginal families from Australia, children were not compared to other children the same age; rather, they were allowed to have their own path for development of milestones. When western assessment tools are used to assess Aboriginal children, these children may appear to be delayed in their skill development because the yardstick used to measure Aboriginal child development is mainstream western child development and thus, Aboriginal children are deemed to fall short. This in turn may be a contributing factor when children are placed in foster care.

Discipline

Discipline was another family value that has been studied in the context of Aboriginal versus mainstream parenting. In many Aboriginal communities it appeared that parents did not readily use physical punishment with their children. In a study of Aboriginal children from two southern California counties, Dionne, Davis, Sheeber and Madrigal (2009) found that the disciplining of children was used cautiously with aforethought and patience. Strict discipline was seen as very strong "medicine", whereas positive play, affection and praise, or "good medicine" might be used more frequently so as to strengthen the child (Dionne et al.). In Cheah and Sheperd's (2011) study, Aboriginal mothers were less likely than European Canadian mothers to force the child to behave appropriately, threaten with negative consequences or use punishment when responding to proactive aggression in their children. The Aboriginal mothers in that study were more likely to respond to aggression in their children with goals that teach values, societal rules or important life lessons which could benefit the child (Cheah & Sheperd, 2011). One Aboriginal culture that reported the use of physical discipline was the Sami, where mothers described more slapping and use of threats than mainstream Norwegian mothers (Jaho et al., 2004). Sami mothers also used more threatening with supernatural beings, tricking and teasing of the child than did mainstream families (Jaho et al., 2004). Interestingly, the Inuit used interpersonal games (which may be perceived by outsiders as teasing) but this type of "teasing" was used to provide practice for the children in how to use appropriate emotions in specific interpersonal situations (McShane et al, 2009). Thus Aboriginal parents seemed to focus more on each child's individual abilities and to generally use much less physical discipline.

Language

How children are spoken to and expected to speak may be another feature of parenting that differs from Aboriginal to mainstream culture. There are prevailing misconceptions about culture and language differences among Aboriginal peoples that can at times be perceived to be deficits in both communication and parenting (Ball, 2009). Adolescent Aboriginal mothers who identified with their Aboriginal culture were found to have low verbal initiation, low responsiveness and low spontaneous conversations with their children (McDonald Culp & McCarthick, 1997). In a study of Alaskan Yup'ik, it was found that Yup'ik parents scored lowest on engaging in social play and praising the child or making positive comments about the child (MacDonald-Clark & Boffman, 1995). These researchers did note that the communication between Yup'ik mother and child depended largely on nonverbal cues which the mother-child dyad handled very well. Although Aboriginal adults may speak less to their children, there is evidence that there is more unspoken body language being used between child and adults.

Crago, Annahatak and Ingiurwik's (1993) study of Inuit language socialization was a two year long ethnographic study which looked at the language patterns of two older Inuit mothers (who had been born in igloos, never gone to school and only spoke Inuktitut) and two younger Inuit mothers (who had only ever lived in houses) and also interviews with another 20 Inuit women (both older and younger) in northern Quebec. What these researchers found were three cultural language practices called "aqausiit" (traditionally sung or chanted rhythmical verses sung in a parent-child dyad with each dyad having a unique song), "nilliujuusiq" (a form of affectionate talk that the women used with their children which sometimes included a string of nonsense syllables) and "piaruujuusiit" (a specialized, consistent across households, vocabulary of "baby words" which have phonologically simpler roots used both to and by the children). Aqausiit, at the time of the study, was only used by a few of the younger and older women while nilliujuusiq seemed to be used more extensively. The majority of older women in one of the communities commented they knew a child had learned language not by the child's speaking ability, but rather, by the child's understanding of directives. The study also revealed that an Inuit child's ability to understand and to follow directions is a culturally valued behaviour. One major difference between the older and younger Inuit women is how they valued silence in children. The younger Inuit women did speak more to their children and tried to elicit language from them and explained that they did this because this was valued by non-Aboriginal people and in schools. On the other hand, the older Inuit women commented that the younger women did not seem to know how to eat silently with their children. Traditionally, children were often ignored when they asked questions because Inuit children were not encouraged to have conversations with adults. This study gives the kind of background cultural information on parenting values that allows professionals and non-Aboriginal people to understand why language may be less central in the interactions between Aboriginal children and their parents. The latter study also shows how traditional values are changing and what may be causing these changes. Having an understanding that more non-verbal language may be used and also understanding different cultural values (e.g. not encouraging questioning from children) need to be understood by professionals who may view the lack of verbal language as a deficit in Aboriginal parents.

Spirituality and ceremony

There is mention of Aboriginal spirituality and its connection to child rearing in the literature although it

is somewhat sparse. Red Horse (1997) noted that Naming ceremonies organized kinship obligations in terms of meeting the child's physical and emotional needs. As the children got older, there were more ceremonies which increased their spiritual and community responsibilities (Red Horse). Simard and Blight (2011) noted that Spirit is the foundation from which all other developmental areas (spiritual, mental, emotional and physical realms) stemmed, providing the child's cultural identity. The fact that in Aboriginal theories of child development, such importance is attributed to the Spirit is another difference between Aboriginal and non-Aboriginal approaches to child rearing.

Discussion

While Aboriginal child rearing practices may have been modified because of historical events such as colonialism, residential schools and foster care, and traditional parenting may have been corrupted by this history, many aspects of traditional Aboriginal child rearing continue to be apparent in the ways in which Aboriginal families organize their family life. It is thus important to consider the cultural, social and historical realms of Aboriginal communities when assessing Aboriginal children, especially in the context of child protection, as identifiable differences may exist between the parenting norms in Aboriginal communities and those of mainstream groups. A better understanding of these differences is hampered by the dearth of research on Aboriginal child rearing, especially when considering the diversity of Aboriginal cultures. It is thus imperative that more comprehensive examinations of parenting and child development in diverse Aboriginal cultures be undertaken, so as to more usefully inform decisions made by professionals in the areas of child welfare and child and family mental health. When professionals have a better understanding of the cultural differences in child rearing that can be occurring in Aboriginal families, they will be better equipped to make decisions to ensure the safety and well being of the child, and to tend to the cultural needs of not only the youth, but their families and communities.

Limitations

One of the main limitations of this review is the lack of nation specific research. Another research gap exists around Aboriginal fatherhood and extended family. A future research consideration would be to look at whether differences exist when assessing Attachment with Aboriginal mothers and then with the infant's other caregivers. Other future research endeavors could be to begin documenting traditional Aboriginal child rearing practices from Elders and Grandmothers.

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From the House of Commons Resolution to *Pictou Landing Band Council and Maurina Beadle v. Canada*: An Update on the Implementation of Jordan's Principle

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Jordan's Story

Jordan River Anderson was a child from Norway House Cree Nation in Manitoba. He was born with a rare neuromuscular disease in 1999 (Lavallee, 2005). Because his complex medical needs could not be treated on-reserve, Jordan was transferred to a hospital in Winnipeg, far from his community and family home (MacDonald & Attaran, 2007). In 2001, a hospital-based team decided that Jordan's needs would best be met in a specialized foster home closer to his home community. However, federal and provincial governments disagreed regarding financial responsibility for Jordan's proposed in-home care (Blackstock, 2008). Jordan remained in hospital while conflicts between the federal and provincial governments continued for more than two years. The disputes ranged from disagreements over funding for foster care to conflicts over payment for smaller items such as a showerhead (MacDonald & Attaran, 2007). In 2005, Jordan died in hospital, at the age of five, never having had the opportunity to live in a family home (King, 2012).

For Jordan, tragic delays in services resulted from a jurisdictional dispute which emerged because provincial and federal government departments disagreed on who should bear financial responsibility for necessary home care services, which were normally available to off-reserve children (Blackstock, Prakash, Loxley, & Wien, 2005). Status First Nations individuals are particularly vulnerable to jurisdictional disputes due to their unique status under Canadian law and policy (Blackstock et al., 2005; Nathanson, 2010). The federal government generally finances provincially/territorially regulated health and social services on-reserve, while provincial/territorial governments have sole responsibility for health and social

services to non-Status or off-reserve individuals.[1] There is increasing evidence of factors which could potentially contribute to jurisdictional disputes between governments or government departments over funding of services for children living on-reserve. These factors include: the systematic underfunding of on-reserve services by the federal government (Auditor General of Canada, 2008; McDonald & Ladd, 2000), federally/provincially recognized disparities in the services normally available to children on- and off-reserve (Auditor General of Canada, 2008; Terms of Reference Officials Working Group, 2009), and ambiguities in the delineation of federally and provincially funded on-reserve services (Federation of Saskatchewan Indian Nations, 2008).

Jordan's Principle is a child-first principle named in memory of Jordan River Anderson. The goal of Jordan's Principle is to ensure that Status First Nations children are not subjected to delay, denial, or disruption of needed services due to disputes between governments or government departments. It is intended to ensure equitable treatment of First Nations children, in accordance with Canada's national and international obligations (First Nations Child and Family Caring Society [the Caring Society], 2011). Jordan's Principle was unanimously endorsed by the Canadian House of Commons (Private Member's Motion M-296, 2007) and the federal government began implementing a response to Jordan's Principle in 2008. Federal and provincial efforts to translate this policy endorsement into law are detailed below.

This article draws from a comprehensive review of Jordan's Principle-related government documents, non-governmental agency reports, and academic articles (see Blumenthal & Sinha, 2014) to describe the steps that the federal government has taken to implement an administrative response to Jordan's Principle, and to outline some of the major limitations in the scope of that response. It also provides an overview of a legal case which centers on Jordan's Principle and raises troubling questions about the extent to which Canada has implemented Jordan's Principle (*Pictou Landing Band Council and Maurina Beadle v. the Attorney General of Canada [PLBC v. Canada]*, 2013). The Federal Court decision in this case has been appealed by the federal government, and the goal of this article is to provide readers with the background required to understand the context and importance of the upcoming appeal hearing.

The Implementation of Jordan's Principle

Working with advocates from across the nation and around the world, the First Nations Child and Family Caring Society (the Caring Society) has spearheaded Jordan's Principle advocacy since 2005. Jordan's Principle was first articulated in a series of extensive research reports that examined First Nations child welfare service funding (known as the *Wen:de* reports; for details see MacDonald & Walman, 2005). A motion (M-296) stating that "the government should immediately adopt a child first principle, based on Jordan's Principle, to resolve jurisdictional disputes involving the care of First Nations children" was passed unanimously in the House of Commons on December 12, 2007. Debate on the principle considered its applicability to all First Nations children. Member of Parliament (MP) Steven Blaney expressed the government's support of Jordan's Principle this way:

> In other words, when a problem arises in a community regarding a child, we must ensure that

1 While some have stated that the federal government is obligated through the Constitution Act (1982) to finance services for First Nations individuals (Boyer 2003), the federal government has argued that their funding of on-reserve services (particularly health services) is a matter of policy, not legal obligation (Boyer, 2004; Romanow, 2002).

> the necessary services are provided and only afterwards should we worry about who will foot the bill. Thus, the first government or department to receive a bill for services is responsible for paying, without disruption or delay. That government or department can then submit the matter for review to an independent organization, once the appropriate care has been given, in order to have the bill paid. I support this motion, as does the government. (Blaney, 2007)

MP Blaney's paraphrasing of Jordan's Principle corresponds to the position of the Caring Society, which defines Jordan's Principle as applicable in situations where "a jurisdictional dispute arises between two government parties (provincial/territorial or federal) or between two departments or ministries of the same government" (the Caring Society, n.d.). As of May 2014, more than 8,000 individuals and organizations have signed on as supporters of Jordan's Principle through the Caring Society's website, including: the Assembly of First Nations (AFN), the Canadian Nurses Association, the Canadian Paediatric Society (CPS), the Canadian Association of Paediatric Health Centres (CAPHC), the Canadian Medical Association Journal, and UNICEF Canada (the Caring Society, n.d.).

The endorsement of Jordan's Principle by the House of Commons in 2007 provided the mandate for a child-first principle. Subsequently, several provincial and national level legislative efforts attempted to specify the measures needed for effective implementation. Legislative efforts to codify Jordan's Principle were undertaken in the Canadian House of Commons in 2008 (Bills C-563 and C-249), the Yukon in 2006 (Motion 700), and Manitoba in 2008 and 2009 (Bills 203, 233 and 214; see also Bourassa, 2010; Lett, 2008a, 2008b; Nathanson, 2010). These bills attempted to define: what qualified as a jurisdictional dispute, how payment mechanisms would be implemented, and who would preside over dispute resolution processes. None of the bills proceeded beyond first reading.

While politicians and advocates were pursuing legislative approaches to Jordan's Principle implementation, the federal government began to discuss non-legislative agreements with provincial and territorial governments. Bi-partite agreements were reached in Manitoba, Saskatchewan, and British Columbia. Tripartite agreements (agreements between federal and provincial governments and First Nations) were reached in Nova Scotia and in New Brunswick, where the latter's legislative assembly mandated the government to pursue a tripartite agreement in 2010 with Motion 68 (Canadian Paediatric Society, 2012; Government of British Columbia & Government of Canada, 2011; Government of Canada, 2010; Indian and Northern Affairs Canada [INAC][2] & Federal Interlocutor for Métis and Non-Status Indians, 2010). By 2012, the federal government stated that all provinces "have been engaged in discussions [about Jordan's Principle] and have put joint processes in place" (Government of Canada, 2012, p. 17).

While information about the actual administrative response flowing from Jordan's Principle agreements is limited, the federal government has indicated that it focuses on cases which meet the following five criteria:

1. A First Nations child who has status or is eligible to have status is involved;

[2] Aboriginal Affairs and Northern Development Canada (AANDC) was formerly known as Indian and Northern Affairs Canada (INAC) and, before that, as the Department of Indian Affairs and Northern Development (DIAND). We have used these names in accordance with the source documents from which we drew information.

2. The child is ordinarily a resident on-reserve;
3. The child has been assessed by health and social service professionals and has been found to have multiple disabilities requiring services from multiple providers;
4. The dispute is between the federal and provincial government, and
5. The assessment is made based on normative standards of care provided to similar children in a similar geographic location (Aboriginal Affairs and Northern Development Canada [AANDC], 2013).

Thus, the administrative response has a much more limited focus than Jordan's Principle itself, which was intended to apply to all Status First Nations children in need of health, social, educational, or other services normally available to non-Aboriginal children (MacDonald & Walman, 2005). Neither the text of M-296 nor MP Blaney's comments on behalf of the government indicate that Jordan's Principle would apply only to children with multiple disabilities requiring services from multiple providers. The narrow focus of the administrative response limits the potential benefits of child-first protections and, in denying these protections to others, potentially introduces new disparities in the services available to different groups of Status First Nations children.

Building on non-legislative agreements, federal and provincial governments have developed dispute resolution mechanisms for addressing cases that fit their administrative response criteria. However, the available evidence suggests that these mechanisms essentially formalize the case conferencing process which led to tragic delays in services for Jordan River Anderson. In a 2009 appearance before the Standing Committee on Aboriginal Affairs and Northern Development, a senior INAC official highlighted the case-by-case approach, stating:

> In terms of what we're doing on Jordan's Principle, we do have a group we work with at Health Canada where, if we are made aware of a case, we have identified focal points in both departments in our regional offices. When these cases are brought to our attention, we then branch out and look at what program is implicated in our particular department. We look to see if we can resolve the case through that approach and do the case conferencing. But what's important is our need to be made aware of these cases. (Johnson, 2009)

"Focal points" are federal employees designated by the government to "help navigate cases within the existing range of health and social services based on the normative standards of care provided to children off-reserve in similar geographic locations" (INAC, 2010, p. 54). Focal points are charged with facilitating case conferencing, assessing the existence of jurisdictional disputes, and determining remedy for the jurisdictional disputes (Robinson, 2011). Our review found that little additional information is publicly available about focal points and details regarding the dispute resolution process are difficult to access. AANDC's description of its administrative response to Jordan's Principle notes that, "the current service provider that is caring for the child will continue to pay for necessary services until there is a resolution"

(AANDC, 2013).[3] However, the mechanisms for timely enforcement of this policy, for ensuring payment in cases of requests for new services, and for repayment of funds expended during the case conferencing process are unclear.

Concerns about the administrative response to Jordan's Principle have been noted in a series of independent reviews. UNICEF Canada (2012) found that "there are missing elements that contribute to confusion among stakeholders" and highlighted "concerns that the implementation is construed in a far more limited scope than Parliament intended" (p. 4). In their 2012 status report on Canadian public policy and child and youth health, the Canadian Paediatric Society (CPS) provided ratings of the implementation of Jordan's Principle in all provinces and territories. Eight provinces/territories were rated as "poor," meaning that the jurisdiction had not adopted a child-first policy. Four provinces were rated as "fair," meaning that a child-first policy was adopted but not implemented. Nova Scotia, the only jurisdiction which CPS rated as "good," is also the site of a Jordan's Principle related legal challenge that is discussed in detail below (CPS, 2012).

Legal Appeal Based on Jordan's Principle

Background

Maurina Beadle, a resident of Pictou Landing First Nation, is a single mother and the primary caregiver for her son, Jeremy Meawasige. Jeremy has been diagnosed with hydrocephalus, cerebral palsy, spinal curvature, and autism; he has high care needs, and can be self-abusive at times (Champ & Associates, 2011). In May, 2010, Ms. Beadle suffered a stroke and was hospitalized. She subsequently required assistance with her own care and could no longer care for Jeremy at the level that he required. The Pictou Landing Band Council (PLBC) began funding 24-hour in-home care to assist both Ms. Beadle and Jeremy. Ms. Beadle's condition improved; however, an October 2010 assessment by the Pictou Landing Health Centre recommended that the Beadle family continue to receive in-home care services to meet Jeremy's needs (Champ & Associates, 2011).

By February of 2011, Jeremy's care costs were $8,200 per month, which was approximately 80% of the monthly home care services budget that PLBC Health Service received from the federal government. The PLBC Health Director was aware of Jordan's Principle and contacted the Health Canada Regional Director (the focal point in this case) to discuss Jeremy's case and to request case conferencing regarding payment for his care. In subsequent case conferences, the provincial representative explained that, in the case of an off-reserve child requiring similar care, the province would allocate a maximum of $2,200 per month for in-home respite services (*PLBC v. Canada*, 2013).

At the same time that case conferencing was occurring in Jeremy's case, the Nova Scotia Supreme Court was deciding on a case which challenged the legality of the $2,200 per month cap on in-home respite services (*Nova Scotia Community Services v. Boudreau* [*NSCS v. Boudreau*], 2011). The Boudreau

[3] Where details were available in bi/tripartite agreements, the party responsible for payment for needed services, the child's "current service provider," was defined as the agency, ministry, or department that is providing services to a child, or the agency/government of first contact for services (Blumenthal & Sinha, 2014).

family claimed that the cap violated a legislative provision allowing for in-home care funding exceeding the standard maximum in "exceptional circumstances." On March 29, 2011, the Nova Scotia Supreme Court ruled that Nova Scotia Community Services was obligated to provide in-home care exceeding $2,200 in cases involving "exceptional circumstances," which included (among other), situations where "a single care giver [sic] has sole responsibility for supporting the family member with a disability" or "an individual has extraordinary support needs to the extent that they are reliant on others for all aspects of their support" (*NSCS v. Boudreau*, 2011, p. 7). The court also ruled that provision of home care fell under the requirement to "furnish assistance to all persons in need" mandated by the 1989 Nova Scotia *Social Assistance Act*. Importantly, the ruling noted that departmental discretionary regulations and policies do not take precedence over legislation.

The PLBC Health Director attached a copy of the *NSCS v. Boudreau* court ruling to a formal request that federal authorities provide additional funding for Jeremy's in-home care. AANDC officials responded, reiterating that Jordan's Principle did not apply in this case because there was no jurisdictional dispute; provincial and federal government agencies were in agreement that services provided to Jeremy should not exceed $2,200 per month (*PLBC v. Canada*, 2013). They further noted that Jeremy did, however, meet the criteria for placement in institutional care (*PLBC v. Canada*, 2013). The cost of the institutional care was estimated to be approximately $10,500 per month, an amount which was nearly 30% more than the cost of Jeremy's in-home care (Robinson, 2011).

Pictou Landing Band Council and Maurina Beadle v. Canada

In June 2011, PLBC and Marina Beadle filed an application for judicial review in Federal Court, claiming the AANDC decision was a violation of the Nova Scotia *Social Assistance Act*, Jordan's Principle and the *Charter of Rights and Freedoms* (hereafter the *Charter*; 1982). The applicants argued that Jordan's Principle is an essential mechanism for ensuring protection from discrimination on the basis of race, national/ethnic origin, or colour that is guaranteed by section 15 (1) of the *Charter*, and that the AANDC decision constituted a violation of section 15 (1) (Champ & Associates, 2011).

The respondent, the Attorney General of Canada, argued that Jordan's Principle did not apply in this case. They suggested that because the province and federal government agreed, there was no jurisdictional dispute, and Jordan's Principle did not apply. They further argued that, because the province had not yet enacted policy changes to comply with the *NSCS v. Boudreau* ruling, the $2,200 per month limit remained the normative provincial standard (Attorney General of Canada, 2012). Finally, the government argued that PLBC was not entitled to reimbursement for the cost of Jeremy's care. They stated:

> While the applicants have a right to seek judicial review regarding the [focal point/AANDC representative's] decision that Jordan's Principle was not engaged here, if they are unhappy with the amounts they receive under their funding agreements, then their course is to ask Canada to renegotiate and amend those agreements. (Attorney General of Canada, 2012, p. 672)

Accordingly, Canada argued the decision did not violate the *Charter*, and that Jeremy was treated no differently than any other Nova Scotian with similar needs.

Federal court ruling

On April 4, 2013, the Federal Court ruled in favour of Maurina Beadle and the Pictou Landing First Nation, finding that Jordan's Principle is binding on the Government of Canada and ordering AANDC to reimburse Pictou Landing for costs associated with Jeremy's care (*PLBC v. Canada*, 2013). The court found that, in assigning Jordan's Principle focal points, the federal government accepted the task of implementing Jordan's Principle and incurred a responsibility to do so. Moreover, the court found that Jordan's Principle applied in Jeremy's case and that, accordingly, it did not need to consider the question of whether AANDC's decision violated Jeremy's *Charter* rights.

The court rejected Canada's arguments that the "exceptional case" clause in existing regulation did not apply and that a jurisdictional dispute did not exist. On the issue of the applicability of the exceptional case clause, the court stated:

> The Nova Scotia Court held an off reserve person with multiple handicaps is entitled to receive home care services according to his needs. His needs were exceptional and the *SAA* [*Social Assistance Act]* and its *Regulations* provide for exceptional cases. Yet a severely handicapped teenager on a First Nation reserve is not eligible, under express provincial policy, to be considered despite being in similar dire straits. This, in my view, engages consideration under Jordan's Principle which exists precisely to address situations such as Jeremy's. (*PLBC v. Canada*, 2013, p. 31)

In regard to the existence of a jurisdictional dispute, the Court stated:

> I do not think the principle in a Jordan's Principle case is to be read narrowly. The absence of a monetary dispute cannot be determinative where officials of both levels of government maintain an erroneous position on what is available to persons in need of such services in the province and both then assert there is no jurisdictional dispute. (*PLBC v. Canada*, 2013, p. 28)

The ruling stated that "the PLBC was delivering program and services as required by AANDC and Health Canada in accordance with provincial legislative standards." It further highlighted the cost of Jeremy's in-home care, noting that it was equal to 80% of the PLBC personal/home care service budget, and concluding that, "this is not a cost that the PLBC can sustain" (*PLBC v. Canada*, 2013, p. 34). Accordingly, the court ruled that Jeremy did qualify for in-home care funding greater than $2,200 per month, quashed the AANDC decision, and directed the federal government to reimburse the PLBC for Jeremy's in-home care without delay (*PLBC v. Canada*, 2013). This ruling can be read as setting a precedent that a jurisdictional dispute exists if program standards and/or provincial legislation require on-reserve services that are not funded by the federal government.

Appeal

On May 6, 2013, the Attorney General of Canada appealed the decision in *PLBC v. Canada* to the Federal Court of Appeal (Department of Justice, 2013). The Notice of Appeal filed by Canada argues that: the Court erred in the interpretation and application of Jordan's Principle; the decision was unreasonable; that the remedy granted to the respondents was wrong; and other grounds to be determined (Department of Justice, 2013). On January 29, 2014, both Amnesty International and the Caring Society were granted intervener status in the *PLBC v. Canada* legal appeal; the Assembly of Manitoba Chiefs was granted

intervener status on February 20, 2014 (Federal Court of Appeal, 2014a, 2014b). Interveners in a case may only present arguments that the applicants (PLBC and Maurina Beadle) will not present. Amnesty International will present arguments that focus on the AANDC manager's decision (the focal point) to deny services to Jeremy in light of Canada's international human rights obligations, while the Caring Society will present arguments focusing on the meaning and spirit of Jordan's Principle as a child-first principle (Hensel Barristers, 2014; Stockwoods LLP Barristers, 2014). The hearing of the appeal is scheduled for September 8, 2014 (Blackstock, 2014).

Conclusion

Jeremy Meawisige's case, in many ways, exemplifies the type of situation that the federal government's administrative response to Jordan's Principle claims to address. This administrative response is limited in scope, yet Jeremy fits within the narrow parameters defined by AANDC. He is Status First Nations, ordinarily resident on-reserve, and has "been assessed by health and social service professionals and [...] been found to have multiple disabilities requiring services from multiple providers" (AANDC, 2013). Additionally, he resides in Nova Scotia, the only jurisdiction in which Jordan's Principle implementation has been rated "good" by the Canadian Paediatric Society (CPS, 2012). Moreover, the *NSCS v. Boudreaux* (2011) ruling provided a clear and explicit description of the "normative standards of care provided to similar children in a similar geographic location" (AANDC, 2013).

That Jordan's Principle was not honored under these circumstances raises troubling questions about the extent to which Canada is implementing Jordan's Principle, even within the narrow parameters it has outlined. Although the *PLBC v. Canada* ruling did not explicitly challenge this narrowing, the court strongly endorsed the federal obligation to implement Jordan's Principle as a child-first principle that ensures Status First Nations children with multiple disabilities and service providers are not subject to delay, denial, or disruption of services because of federal government failure to fund services that are in keeping with provincial legislation and standards. Thus, the ruling in *PLBC v. Canada* is an important step towards ensuring timely and equitable services for some of the most vulnerable First Nations children. It remains to be seen, however, whether the ruling's indictment of the federal government's administrative response to Jordan's Principle will withstand appeal. In addition, it remains to be seen whether action will be taken to extend child-first protections to the wider population of Status First Nations children who are not currently addressed by the administrative response to Jordan's Principle.

For more information about Jordan's Principle and for updates on the government's appeal to PLBC v. Canada, visit: www.jordansprinciple.ca.

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