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Foreword

Joan Glode
Mi'Maq Family and Children's Services of Nova Scotia

In my busy life as a social work administrator, mother, grandmother and board and committee person, I come into daily contact with individuals and groups who represent the broad cross section of our communities and families as well as the agencies we work with and the government groups that fund us. Sharing pictures of my grandson has superceded stories about my dogs but the essential things in life remain the same: working with our staff and with our community to understand and address both the emerging and ongoing needs of our families and children which includes the aboriginal children: Métis, Status and Non Status Indian and Inuit children which the province transfers to my agency, Mi'kmaw Family when they become permanent care and custody. This current issue of the Journal contains a timely cluster of articles which focus on culturally relevant and age appropriate interventions and supports for our youth, many of whom have been involved with child welfare. One article argues that the unique challenges that aboriginal youth face as they make the transition from childhood to adulthood are compounded by the growing evidence that indicates that this population experiences childhood maltreatment and intervention for maltreatment differently than non-Aboriginal youth while another exams the possible links between childhood maltreatment and subsequent alcohol misuse. Other articles describe research or programs that have found respectful and culturally appropriate ways of engaging youth and community members to identify needs and gaps in services and suggest programs and services that could be meaningful to the lives of youth in the community. Many of the articles also document their process for obtaining ethical approval and community consent and provide some guiding principles and practices when conducting research in a First Nation or Aboriginal community. A number of the articles come from my own Mi'kmaq community in Atlantic Canada.

Congratulations and thanks to all of our current contributors, especially the community members who shared their stories.You have provided useful and timely information while suggesting areas that need additional work.

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Guest Editorial

Special Issue: Adolescent development, mental health, and promising research directions for Aboriginal youth

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Introduction to this Special Issue

Like Nature, research is a slow, steady, consistent process of growth. Research involves uncovering what exists. It also involves creating knowledge to understand natural development and testing out whether there is a good explanatory fit. With the issue of child maltreatment broadly, research has shown that there are multiple causes as to why it occurs – it can be an overload of parenting stress, a mismatch in parental personality with child personality, a misunderstanding of child capacity and reasonable expectations, ineffective sanctions for not maltreating and ineffective reward mechanisms for healthful, child-rearing. For Aboriginal populations, the causation web broadens to the level of resources available to the child, family, and community, as well as the mechanism by which such resources are obtainable in a proactive, preventative orientation. With various types of intrusions into the Aboriginal life, the challenges are to create the evidence base to understand the particular issues for Aboriginal youth, the best-fit models to conceptualize the process mechanisms, and the manner in which to intervene in process and show a demonstrated improvement in target outcome, as well as a demonstrated lack of harm. It is in the careful preliminary investigation that the most efficient and ethical models can be conducted. This involves all steps of deciding what to look at, at what stage of development, who the relevant stakeholders are, how to measure the impact of research, what are the necessary safety nets and, ultimately, how to move forward from knowledge gained. The preliminary stages of looking at existing evidence to craft the research question and the pilot phase of a research project are perhaps the most time-consuming, but most cost-beneficial elements of a longer-term vision of individual, family, and community health.

In this special section, we look at the developmental stage of adolescence and the key areas of child maltreatment history, current trauma experiences, and ways of relating. In any relationship, there are at least two interactants. There are a set of behaviours related to the self (e.g., self-harm, capacity for forming positive attachments to significant others, accepting violence towards self). There a set of behaviours related to the other (e.g., others are generally helpful, others are violent, others will listen to opinions). The self and other behaviours are variables to measure, but they are also part of even entering into a research study. One has to believe that one has a contribution to make, and that the research team will faithfully summarize the contributions of the group to show the range of behaviours, as well as the central tendencies. To engage in research is to believe that there is meaningful experience to convey, that others know how to capture these experiences, and that there is a promise of doing something helpful about the new information. Once youth have entered into a research project, ethics demand that the youth is not over-burdened and that

the information is not ignored. Child maltreatment is a harsh experience for the youth to consider, as well as a hard experience for service providers to deal with as its effects reverberate throughout lifespan. Workers in communities are given the task of providing service to maltreated youth in the developmental level that they are at, and in dealing with the developmental tasks that are being addressed, as well as provide a liaison to the community for understanding and valuing youth mental health. If maltreatment occurred earlier in childhood, there may be a tendency to not see a youth's current adjustment difficulties through the lens of traumatization. When the population itself has undergone intrusions and traumatizations, there may be unique interactive or cumulative effects for the traumatized youth. One of the robust lifespan effects of maltreatment is alterations in the ability to keep positive emotions in the forefront and effectively cope and regulate negative emotions. Another consistent effect is in acting out, either sexually or aggressively. A main undercurrent is that maltreatment is fundamentally a relationship disruption and, therefore, involves such features as betrayal, power abuse, silencing, and an orientation towards surviving rather than thriving. All forms of maltreatment involve injury or the failure to protect from injury and so self-injury may become acceptable in terms of under-achieving, under-celebrating accomplishments, self-medication, and self-annihilation. The fight/flight instinct can becomes skewed in relationships that are vulnerable to swings of intensity of involvement and disengagement, attention and rejection, approach and avoidance, disorganization, confusion, and indecision. Functioning in close relationships affect all other spheres, such that a violent dynamic presents a challenge for a youth not unlearn what to do and re-learn or newly learn what not to do. These types of shifts represent significant resource investment to youth at a critical juncture of development, on that bridge between childhood dependence and adulthood independence.

It is a researchable question as to whether youth mental health treatment equals child abuse prevention. If a youth is supported to address their conduct, mood, and personal safety and self-care challenges, will the youth be more likely to select healthful, non-violent partners? Would youth who learn to seek-help and actively address mental health issues be more likely to become actively involved, positive parents and be more likely to seek-help when their parenting begins to falter? Since community standards informs priorities for research, both short-term and long-term learning goals need to be identified. Building the database further helps to refine priorities and sets an agenda for research funding advocacy and community support.

The goal of this special section is to begin to entertain the process and the data for forming youth-relevant research questions. The importance of adolescence is first highlighted. Attending to critical, difficult issues like self-harm, suicidal ideation, and range and level of reported maltreatment is presented in two articles on child protective services populations. These articles set the stage for the context of adolescent development and critical clinical issues to consider. The final two articles are fortunate to have been specifically conducted with First Nations youth and speak to the possible utility of brief intervention for substance use, and the utility of considering mental health alongside resiliency factors. These projects will continue to provide important evidence for action-planning in considering, for example, whether posttraumatic stress disorder symptomatology is a key feature underlying more observable problem behaviours of youth. Such theory-based research serves to direct attention to what would be the most efficient intervention target to yield the greatest level or range of positive outcomes for youth. Finally, we have a commentary by Doreen Stevens who has the unique position of being simultaneously part of the Mi'kmaq reserve community, a youth counselor based in education, a student of research in obtaining a graduate degree, as well as a co-investigator on one of the research projects.

Another addiction, among Aboriginal youth, that is rarely addressed in the literature, is that attributable to smoking. McKennitt's article points outs that the smoking rate among Aboriginal youth in Canada is two times higher than their non-Aboriginal counterparts. His observations indicate that prevention strategies need to be more holistic and adhere to the spiritual, mental, emotional and physical aspects as well as utilize the involvement of Aboriginal health professionals and should include more involved consultation with youth themselves in developing tobacco-use prevention programs.

The last three articles also focus on various social issues impacting Aboriginal youth involving housing, attachment issues and the continued process of assimilation faced by many Aboriginal youth involved

with child welfare. For instance, the issue of youth previously involved with child welfare and housing and homelessness was explored jointly by Brown, Knol, Prevost-Derbecker and Andrushko, who note that Youth who have had child welfare involvement continue to experience the high rates of family poverty and housing challenges faced by their parents, and are often left to struggle with the same issues themselves. Brown, et al. conclude that more resources are needed to expand community-based and community-driven housing for youth who have been involved with child welfare. Neckoway, Brownlee and Castellan's article reflects on whether attachment theories are congruent with Aboriginal parenting and the cross-culturally applicability of attachment models, especially within the context of Aboriginal families. The last article, written by Richardson and Nelson's is a commentary raising concerns about the comparisons between the residential school and child welfare systems. The authors question the appropriateness of foster care for Aboriginal children and further raises the issue of whether foster care, like residential school settings, continues to enforce assimilation on Aboriginal children. While Richardson and Nelson do not assert that individual foster parents possess the intent or the values found within residential schools, they do note that for many Aboriginal children, the outcome have often been the same. They do however, assert that every 'helping' interaction between professions and Aboriginal families needs to be helpful, restorative, educational, curative and build in accountability in our sacred work with children.

Part of research is building the expertise and capacity base that can best represent the research needs, as well as the routes to research utilization. Research can highlight where popular opinion does or does not stack up to the expressed and observed reality. As the main vehicle for science, research is one route to a truth, where it is the repetition of results in different youth populations argues for a common pathway and population-specific findings argue for unique considerations. The end-goal of research is to add to that slow, steady process of knowledge that can be of demonstrable benefit and demonstrable lack of harm.

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Adolescence: A Window of Opportunity for Positive Change in Mental Health

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Abstract

Adolescence is a period of development characterized by risk-taking, sensation-seeking, emotionally-influenced and independence-seeking behaviours. There is a move away from family and towards the social influences of peer groups. Emotionally-driven behaviours may override adolescents' higher cognitive functioning during this time. Especially vulnerable are youth who have been the victim of high-impact trauma or chronic abuse and neglect. Specifically, the posttraumatic stress symptomatology that is often associated with experiences of abuse and neglect may impair the ability of youth to cope during this developmental period. This is where intervention by community workers may be used to support teens with a history of maltreatment, as they develop from children to adolescents and, finally, to adults. Part of such intervention includes violence prevention in families and in teen dating relationships, as well as directly addressing posttraumatic stress disorder symptomatology. This critical developmental period of adolescence presents community workers with an opportunity to intervene and guide the development of these youth, building upon resiliency factors, such as areas of individual mastery and empowerment and participation within the community. Aboriginal youth with a history of maltreatment present a special case for community workers. These youth have been subjected to intense acculturation pressures that do not exist for other adolescent populations, which create unique problems during their transition to adulthood. In order to intervene in the most effective manner, it is necessary to understand the psychological and physiological developmental processes that are unfolding in the adolescent brain. We discuss adolescent development in general and among Aboriginal adolescents, in particular. We present ways to support both groups through these challenging periods that are empirically-based and supported by research.

Introduction

Adolescence is a window of opportunity to effect positive changes in teen psychological and physical health. It represents a period of change wherein the teen has developed the ability to examine past patterns of behaving. The general pattern of psychological development in adolescence is one in which earlier forms of adaptation are carried forward as "options" in behavioural responses. With exposure to and engagement in new developmental challenges, opportunities for shifting stylistic response sets and learning more adaptive, healthful behaviours exist.

This opportunity to develop more adaptive, healthful behaviours is especially important among adolescents with a history of maltreatment. These youth are more likely to engage in risky or unhealthy behaviours as they make the transition from children to adults. Unhealthy patterns of relating to others that were solidified during chronic maltreatment may be carried forward into adult interactions. Considering the psychological and neurological issues that pose a unique challenge to youth with a history of maltreatment versus those without, adolescence can be thought of as a "developmental crossroad" among this population. This crossroad is a period in which effective intervention timed with a natural interest among

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adolescents to learn about relationships, emotions, and ways of processing information or understanding their world can have a significant positive impact on their future development.

While child protective services are not mandated to engage in preventative activities, much of the effort to treat teen mental health, relationship, and vocational issues may contribute to the prevention of child abuse and neglect among the siblings, peers, and future children of these teens. A recent US population-based study found that most psychiatric disorders have their onset in adolescence, but treatment for these disorders is not initiated until 10 years later (Kessler, Demler, Frank, Olfson, Pincus, Walters et. al., 2005). This results in a decade of missed treatment opportunities and unnecessary suffering.

This developmental crossroad is further complicated among Aboriginal youth with a history of maltreatment. Evidence continues to indicate that this population experiences childhood maltreatment and interventions for maltreatment differently than non-Aboriginal youth (e.g., Public Health Agency of Canada – Canadian Incidence Study of Reported Child Abuse and Neglect, 2003). For example, nearly 10% of Aboriginal children in Canada (95.3 per 1000) are estimated to have been investigated in 2003 because of alleged maltreatment, which is more than double the rate for non-Aboriginal children (42.2 per 1000) (First Nations Child & Family Caring Society of Canada - Wen:De Report, 2005). Child welfare reports involving Aboriginal children are more likely to be classified as suspected or substantiated than reports for Caucasian children. Aboriginal children are also twice as likely to be placed in foster care (Trocmé, Knoke, & Blackstock, 2004). In fact, Aboriginal children compose approximately 30-40% of all children in child welfare care in Canada (First Nations Child & Family Caring Society of Canada – Wen:De Report, 2005).

The maltreatment experiences of Aboriginal children also differ from non-Aboriginal children in Canada. For example, Aboriginal children are less likely to be reported to child welfare authorities for physical or sexual violence, but are twice as likely to experience neglect (Blackstock, Trocme, & Bennett, 2004). Unlike abuse, which is usually incident-specific, neglect often involves chronic situations that can significantly impact psychological and physiological development. These differences must be considered when intervening with Aboriginal adolescents. From a behavioural perspective, on-reserve youth are more likely to abuse drugs and alcohol and to suffer from depression, anxiety, and learning disabilities than those youth who live off reserve, as well as non-Aboriginal children (First Nations Child & Family Caring Society of Canada – Wen:De Report, 2005).

Aboriginal youth also face the unique challenge of defining themselves as they make the transition from childhood to adulthood. For example, Inuit adolescents are subjected to intense acculturation pressures that do not exist for other adolescent populations. These pressures create problems for youth in their struggle to establish their own identity (Steenbeek, Tyndall, Rothenberg, & Sheps, 2006). These, and all Aboriginal Canadian youth, are asked to negotiate between their culture-of-origin and the wider Canadian one.

Below we outline several key issues in adolescent development. Each section describes current theory and research being conducted in these areas. The purpose of this review is to present the reader with information on adolescent development in general and the special challenges faced by adolescents with a history of maltreatment. Adolescence is a key period of growth wherein evidence-based intervention can have a lasting positive impact on the psychological and social functioning of the individual. Furthermore,

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Aboriginal adolescents with a history of maltreatment require targeted intervention to address the specific needs of this subpopulation.

Key Issues in Adolescent Development

Relationship Development and Attachment Challenges

According to attachment theory and research, the kind of attachment between parent and child that develops in early childhood will impact relating to others in the future (Bowlby, 1980). This theory suggests that attachment with a parent or caregiver provides the child with an internal concept – a working draft or model of "the self," "the other," and "the self in relationship to the other". Expectations are formed for future relationships, such as "I end up hurt when I get close to others" or "Others tend to ignore me so I have to try harder to get their attention" (Oatley & Jenkins, 2005). In secure attachments, a parent responds consistently to both the positive and negative emotions of a child and builds up the child's confidence in the parent as a reliable and sensitive responder.

Maltreated children tend to struggle when forming an attachment to others because their negative emotions about relationships may dominate over their positive ones. This means that a big part of relationships – enjoying them, feeling satisfied about how you are in them, not over-focusing on yourself or the other person – is a gap in learning. This can make a teen vulnerable when connecting with others over external things such as using drugs or alcohol, delinquent activities or, more positively, sports. Rather than finding that internal connection that may have greater depth and support potential, the youth may be vulnerable to replicate maltreatment-consistent patterns, such as harm to self and harm to others. Research in psychotherapy and resilience has consistently shown that a long-term supportive or mentoring relationship is a key predictor of better outcomes, both at the time of disclosure of the abuse and across development. This mentoring conveys a consistent message to the teen: (1) the teen is an entirely lovable person, although perhaps with some behavioural learning to do yet (i.e., it is crucial to separate the teens' behavior from him or her as a person), (2) the teen is cared for in an every day sense (e.g., going to the dentist, getting up-to-date immunizations, learning leisure activities like playing music, sports, and the arts), and (3) the teen's "big events" are recognized (e.g., birthdays, celebrations, and whatever the teen defines as a big deal). A mentoring relationship is proactive and prevention-oriented, not just consistently supportive in reacting to crises and issues. Teens learn most of what they think about themselves by relating to others. The caseworker is one of those important others that can help define a teen's "psychological family".

Issues of self-confidence, feelings of self-worth, and self-care behaviours may be an especially salient for maltreated Aboriginal adolescents, given the much higher rates of neglect among this population. The youth may carry beliefs of low self-worth stemming from a lack of physical and emotional support and physical care by the abusive parents. Parents or guardians with severe substance use problems may not have been available to provide emotional or physical support for the youth while growing up. Educating the youth about the socioeconomic and historical forces behind instances of substance abuse and neglect in Aboriginal populations is a first step in helping the youth to confront these feelings and beliefs.

Cognitive Development – Negatively Biased Information Processing

Maltreated youth can become cognitively vulnerable by seeing the negative first. This negative bias arises because hypervigilance for threat became an important and helpful component of their psychological repertoire while growing up. One of the potential problems is self-blame. When a negative event occurs, a teen may view it as the result of an internal character trait (i.e., "I'm bad", "If I didn't have bad luck, I'd have no luck at all"), rather than the result of external situational factors. They will see the event as global and likely to happen in all situations, rather than being a temporary "one-off" situation or specific to characteristics of that situation (i.e., "I didn't do well in that test because I didn't study as much as I did before when I did do well").

Furthermore, the maltreated teen may have developed a hostile cognitive appraisals of others' actions and interpret others neutral or ambiguous actions as having hostile intentions (Oatley & Jenkins, 2005). If you think someone intends to harm you, the logical reaction is to attack first with a pre-emptive strike or avoid that person. Either scenario can lead to an initiation of the fight-flight response when the situation has not yet called for that. To counter these pre-emptive responses, the teen may be guided to re-examine

or "walk through" a situation step-by-step, as if a film captured the sequences, to understand their "why thinking" about the other person's behaviour. If there is no clear evidence to support the teen's reaction, then an "ask/check it out" strategy would be most appropriate.

Aboriginal youth may be less likely to experience a negative bias in information processing since they are less likely than non-Aboriginal youth to be reported to child welfare authorities for physical or sexual violence. A negative bias in information-processing is more likely to develop in association with abrupt violent and / or traumatic events most closely associated with physical and / or sexual maltreatment. Eventually, these events lead to alterations in the physiological response of the brain via the stress hormone cortisol and other neurological mechanisms, as discussed below. These alterations in physiology can lead to a hypervigilance for threat and is adaptive for psychological functioning and survival. Future research is required to determine if Aboriginal youth, who are less likely to experience physical and sexual violence, are less likely to experience negatively-biased information processing.

Emotional Development: A Focus on Empathy

Maltreating families can put a focus on survival, yet witnessing sibling abuse and neglect typically brings out tender emotions and care-giving behaviours, especially with younger siblings. These are experiences upon which the teen can build in a developmentally appropriate way, as opposed to "compulsive care giving" or over-worrying about others. Abstract and conceptual thinking increases in adolescence, which presents a window of opportunity for teaching and promoting feelings of empathy and perspective-taking skills. Empathy allows one to function well in relationships and relate well with others. It is the building block for cooperation (Burmack, Flanagan, Sutton, Zygmuntowicz, & Manly, 2006). General strategies like "giving the benefit of the doubt," and developing a better language skill to express concerns are built around empathy (e.g., "When you give me that look, I feel unsure and wonder what you are trying to tell me. If you could say what you want in words, then I could be clearer to you").

Maltreated teens may sometimes get stuck or get into trouble simply because they are not prepared to provide any response. Because they are not ready to respond, they either freeze or rely on well-worn and best-learned responses, which may be aggressive or place themselves in the victim role. For teens, over-learning a standard way of handling a response (When you…I feel… If you …, then I…) may be a helpful starter to better verbal communication skills. Research has shown that teens with better self-control skills, such as the ability to inhibit outbursts of anger and aggression and the ability to use verbal rather than physical means of communication, tend to be more advanced in their social lives. These teens are liked by their peers, have larger circles of friends with whom they are able to discuss their feelings, and are less likely to be involved in physical fights. When these youth do disagree with their friends, it becomes an opportunity for self-reflection, consolidating helpful strategies, and increasing the flexibility and size of the behavioural response repertoire.

Maltreated youth often find it challenging to attain balance in their emotional lives. They tend to be overly fearful of maltreatment-related avoidant emotions such as anxiety and panic, which leads to the avoidance of thoughts or situations that may lead to the experiencing of these emotions. While this may not be perceived as a major issue by some, recent research suggests that approach and avoidant-related emotions are capable of influencing cognitive processing (Gray, 2001). As such, the evasion of maltreatment-related avoidant emotions, which are processed in the right hemisphere of the brain, may impact cognitive functions associated with the right hemisphere, such as making judgments and decisions in ambiguous and real-world situations (Goel, Tierney, Sheesley, Bartolo, Vartanian, & Grafman, submitted). It is often the case that decisions which are highly relevant to an adolescent population, such as those regarding sexual health, social relations and substance use, must be made in the context of uncertain, incomplete, and ambiguous information.

One complication of having a stylistic tendency to want to avoid unpleasant emotions is that ways to self-medicate the emotions may be harmful, yet reinforcing, and therefore likely to be repeated. For example, youth may attempt to keep panic, anxiety, depression, numbness, dissociation, and tension/hypervigilance at bay via substance use, engaging in antisocial behavior, or engaging in self-harm/cutting behaviours. Eventually, the avoidance of certain emotions may become a chronic coping strategy. If

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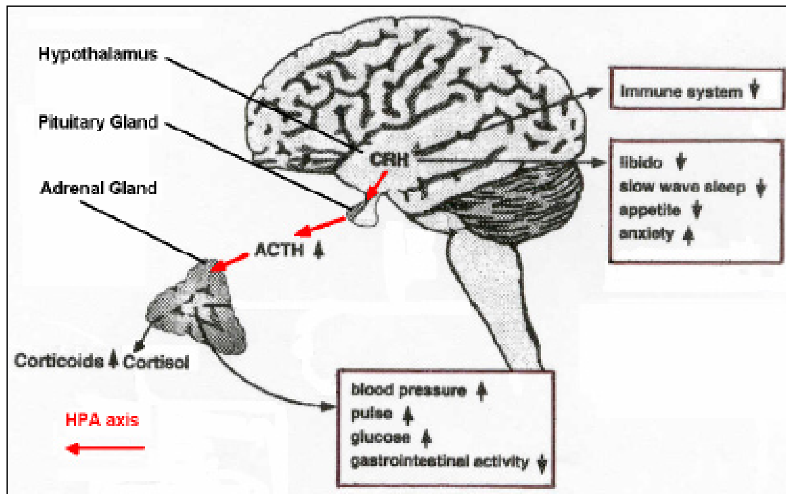

Figure 1. The Hypothalamic-Pituitary-Adrenal Stress-response axis (adapted from a presentation given by Kathy Hegadoren at the Ontario Women's Health Conference).
CRH = Corticotrophin-releasing hormone
ACTH = Adrenocorticotrophic hormone

emotions are avoided, then self-protection may be compromised. For example, one teen indicated that she never felt fear, which is not helpful in avoiding situations in which she may be re-victimized. Finally, if emotions are avoided, teens will not gain practice in talking about emotions and developing their vocabulary for expressing their feelings.

Aboriginal teens may require special assistance with confronting the unpleasant emotions associated with a history of maltreatment. These youth have the added pressure of trying to create a self-identity that incorporates their unique cultural background as well as a Canadian one. This challenge is even greater among Aboriginal youth who continue to live on a reserve, which may contribute to the higher rates of anxiety and depression among this population versus Aboriginals living off a reserve and non-Aboriginals (First Nations Child & Family Caring Society of Canada – Wen:De Report, 2005). While teaching expressive language skills and other self-control strategies can help maltreated youth to confront unpleasant emotions, higher rates of learning disabilities among Aboriginal youth (First Nations Child & Family Caring Society of Canada – Wen:De Report, 2005) can make the teaching of these skills challenging. Finally, high rates of alcohol use among this population can offer a "quick" but temporary solution for numbing unpleasant feelings.

Brain Development and Physiology: Maltreatment and Neuroendocrine Alterations

Youth who experience childhood abuse are more likely to show symptoms of hyper- arousal, associated with Posttraumatic Stress Disorder (PTSD). These symptoms might include hyperactivity, anxiety, impulsivity, reliving the traumatic event, intrusive thoughts of the traumatic event, and sleep problems (Perry, Pollard, Blakely, Baker & Vigilante, 1995). These PTSD symptoms map directly onto the malfunction of particular brain regions. These brain regions are themselves susceptible to environmental programming at the initial phase of life, by means of stress-induced activity and influence of the hormone cortisol (Cicchetti and Walker, 2003; Panksepp, 2004). Below is a figure of the brain to guide the discussion on the neurochemistry associated with maltreatment and PTSD (see figure 1).

Chronic stress or repeated traumas associated with maltreatment can have significant impacts on neurodevelopment during childhood and adolescence. This impact in neurodevelopment can then influence higher cognitive functions associated with the cerebral cortex of the brain (Beers & DeBellis, 2002). Exposure to adverse environments early in life permanently alters the "set point" of the Hypothalamic-Pituitary-Adrenal Stress-response (HPA) axis at the level of the hypothalamus, amygdala, hippocampus, and prefrontal cortex. This altered set point may result in a global net increase in HPA activity and cortisol production. Furthermore, changes in the set point may also influence the functioning of specific brain regions and their corresponding cognitive and regulatory functions (Panksepp, 2004).

Recent research has demonstrated that PTSD patients differ from normal controls in terms of HPA axis-related functioning of the 1) Hypothalamus, where there is lower regional activity and poor regulation in arousal and physiological functions, 2) Amygdala, where there is higher regional activity / reactivity and exhibited heightened anxiety to fear-related stimuli, 3) Hippocampus, where there is lower regional activity resulting in poorer memory

consolidation / retrieval and habituation to adverse stimuli, and 4) Prefrontal cortex, where there is lower regional activity resulting in poor impulse control, regulation of mood and attention, and inhibition of distracting thoughts and irrelevant stimuli (Panksepp, 2004; Cicchetti & Walker, 2003). Chronic activation of certain parts of the brain involved in the fear response, such as the amygdala and HPA axis, during episodes of maltreatment and PTSD symptoms (e.g., reliving the event) can "wear out" or impact processing in other parts of the brain that would normally be activated, resulting in an imbalance of functioning (Perry, 2000c). For example, research in non-human primates has found preferential right prefrontal cortex activation in response to elevated stress at the expense of left prefrontal cortex activation (Rilling, Winslow, O'Brien, Gutman, Hoffman, & Kilts, 2001). The observed pattern of brain activation in this study was attributed to alterations in HPA axis sensitivity.

A traumatic stress response, as is often seen among maltreated youth, can lead to enhanced sensitization of the HPA axis (e.g., Yehuda, 2000). As such, adolescents with PTSD symptoms and a history of maltreatment may show differential performance on reasoning, attentionally demanding, and emotionally-laden tasks that load on the right hemisphere, when compared to non-maltreated adolescents. Even small differences in processing of such important activities as reasoning and decision making could have significant consequences for social functioning among maltreated youth. Specifically, the right prefrontal cortex is thought to be important for making judgments and decisions in ambiguous and real-world situations, such as those regarding sexual health, social relations and substance use, which often must be made in the context of uncertain, incomplete, and ambiguous information. As such, it is possible that hemispheric lateralization, in which one side of the brain is preferred or more likely activated than the other, may be crucial in the more complex symptoms of PTSD, such as derealization and depersonalization (Bremner & Marmar, 1998; Shalev, Bonne, & Eth, 1996).

At this time, it is difficult to discuss the effects of HPA-axis, cortisol, and other neuroendocrine alterations associated with maltreatment in Aboriginal populations. Research examining the neurological implications of maltreatment and PTSD symptomatology is in its infancy. Given the differences in rates of types of maltreatment between Aboriginal and non-Aboriginal populations, it is possible that the physiological impact could be different among these groups. Further research is required to answer this question.

Intervention Opportunities for Maltreated Adolescents

Several evidence-based treatment options are available for teens with a history of maltreatment (see Zahradnik et al., this issue for information on Trauma-Focused Cognitive Behavior Therapy, the current gold standard treatment for PTSD). Beyond psychopharmacological and psychological treatments, there is a strong evidence base for implementing exercise as a mental health promotion activity. This research has occurred over the past two decades and has shown significant positive effects of exercise for decreasing and managing symptomatology among individuals with clinical depression. The duration of exercise ranges from 20 min. to 45 min. two to four times per week. Aerobic exercise (17.5 kcal/kg/week) conducted five times per week was more effective in reducing depression than aerobic exercise conducted three times per week or by engaging in flexibility exercises. These treatment options include regiments of daily jogging and brisk walking (aerobic) or stretching, yoga and meditation (flexibility) practice (Stathopoulou, Powers, Berry, Smits, & Otto, 2006).

In some cases of clinical depression or very debilitating anxiety, medication can be an important first step to taking advantage of a more holistic health approach. For example, when depressed, it is hard to find the motivation to enter into a new experience like therapy, whether the depression strikes a teen or adult. It is also difficult to commit to a routine of healthful, consistent eating and exercise, given the fact that depressed individuals fail to find pleasure in normally pleasurable activities. Medications can be used to alleviate the symptoms of depression long enough for teens to become engaged in some of these more holistic and cognitive-behavioral treatments. Exercise is a powerful intervention that is fast to initiate, inexpensive, and is highly effective in depression and anxiety issues. Furthermore, it is effective for chronic and personality-based problems rather than just specific episodes of depression and anxiety. Therapists have taken to walking during their interviews or sessions with clients as a way to introduce and reinforce exercise.

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Research in brain and nervous system physiology demonstrates why adolescents need active guidance and support in improving their mind-body-action connection. This research draws our attention to the vulnerability of the youth who has been a victim of high-impact trauma or chronic abuse and neglect. Specifically, the posttraumatic stress symptomatology that is often associated with experiences of abuse and neglect makes it difficult for youth to cope, and over-emphasizes self-protection via the over-activation of our most basic survival response – fight (confront or attack the danger/threat) or flight (escape from the danger/threat).

This is where intervention by community workers may be used to support teens with a history of maltreatment. We cannot change their past nor magically erase experiences of abuse and neglect from their memories. We can only reinforce the fact that these youth did not ask for and in no way provoked the abuse and/or neglect that he or she experienced. Blame and responsibility for these acts rest solely on the perpetrator. Children and teens are powerless against a determined perpetrator or a caregiver with habitual ways of hurtful parenting. As they grow older and become adolescents, these maltreated children are developmentally propelled to define themselves, chose their peer network and romantic partners, try new behaviours, and are given new responsibilities. As such, teens are in a window of opportunity for separating who they are from what happened to them. Teens are ready developmentally to work on defining who they are, what they are about, what they do and won't do – in effect, what to do and what not to do in order to become the best possible version of themselves. This critical developmental period presents community workers with an opportunity to intervene and guide the development of these youth. In order to intervene in the most effective manner, it is necessary to understand the psychological and physiological developmental processes that are unfolding in the adolescent brain.

Intervention Opportunities for Maltreated Aboriginal Adolescents

The disparities in the experience, prevention, and treatment of childhood maltreatment between Aboriginal and non-Aboriginal youth are only recently coming to light. There is much room for improvement, and more important differences are likely to be discovered. For example, recent research out of the US suggests that African Americans and Native Americans continue to be underrepresented in research samples, highlighting the need for continued expansion in focusing on, reporting, and using ethnicity in research (Miller & Cross, 2006).

The first step in improving the well-being of maltreated Aboriginal youth is to provide them access to resources enjoyed by other Canadians – but in a manner that reflects their distinct identity (First Nations Child & Family Caring Society of Canada – Wen: De Report, 2005). Child welfare officials continue to be misinformed or uninformed about Aboriginal practices, cultural values, and tribal law. As a result, Aboriginal children remain heavily over-represented in the child welfare system. They enter younger, stay longer, and all too often are placed in non-Aboriginal facilities that remove them from their cultural heritage and identity (Evans-Campbell, 2006).

The Four Corners Regional Adolescent Treatment Center, which is owned and operated by Our Youth Our Future Inc., a private company based in Farmington New Mexico, provides an example of what can be accomplished when the cultural needs of the youth is incorporated into the provision of services. The center offers services for American Indian / Alaska Native adolescents. Their cultural-spiritual program provides cultural teachings and activities that foster cultural pride, identity, and values, and enhances the effort for sobriety and recovery. The bicultural treatment model combines cognitive-behavioral and biopsychosocial treatment approaches with an integrated program of culturally relevant practices and activities that compliment the rehabilitative effort of each youth (Stewart-Sabin & Chaffin, 2003). More studies are demonstrating that efforts by Aboriginal groups to preserve and promote their culture are associated with dramatic reductions in rates of youth suicide (Chandler, Lalonde, Sokol, & Hallett, 2003) and other harmful outcomes. The acknowledgement and celebration of Aboriginal adolescents" cultural heritage would seem an important first step in addressing the unique challenges these teens face during the developmental crossroad from childhood to healthy adulthood.

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An Alcohol Abuse Early Intervention Approach with Mi'kmaq Adolescents

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Abstract

This paper describes the development of and pilot results for an alcohol abuse early intervention program targeting at-risk Mi'kmaq youth conducted in partnership with the communities in which these youth live and the schools which they attend. This intervention was based on a previously-established, successful psychoeducational and cognitive-behavioral approach for at-risk adolescent drinkers from the majority culture that focuses on different personality pathways to alcohol abuse in youth (Conrod, Stewart, Comeau, & MacLean, 2006). Through partnership and collaboration with two Mi'kmaq communities, the original intervention was adapted to be culturally appropriate for Mi'kmaq youth. The culturally-adapted intervention included traditional Mi'kmaq knowledge and teachings in order to make the program as meaningful and relevant as possible in the partner communities (Comeau et al., 2005). The pilot results were encouraging. Compared to pre-intervention, students who participated in the intervention drank less, engaged in less binge-drinking episodes (i.e., 5 drinks or more/occasion), had fewer alcohol-related problems, and were more likely to abstain from alcohol use. Moreover, students who participated in the intervention also reduced their marijuana use at four-month post-intervention, even though the intervention was specifically designed to target alcohol misuse. No such significant changes were observed in a non-random control group of eligible students who did not participate in the intervention. Future research should determine if this intervention is effective for at-risk youth in other First Nations communities across Canada, and whether the promising, but preliminary results with marijuana mean that the benefits of the intervention might extend to adolescents' use of substances other than alcohol.

Introduction

The goal of this research partnership was to develop an alcohol intervention for Mi'kmaq adolescents that integrated traditional Mi'kmaq symbols to convey knowledge gained through experience with cognitive behavioral strategies. That is, the intention was to create a truly culturally relevant alcohol intervention for use in schools in Mi'kmaq communities in Nova Scotia. This was achieved by developing a respectful dialogue, and drawing key learnings from the research team – community members (adolescents, Elders, school personnel, RCMP, etc.) partnership. A key foundation was the emphasis on the journey inward toward personal gifts of the Spirit and the power of self-healing. This article describes the development of and pilot outcome data for the "Nemi'simk, Seeing Oneself" intervention program (see Comeau, Stewart, Mushquash, et al., 2005).

In Canada, there are high levels of alcohol abuse and its associated suffering and tragedy among Aboriginal peoples, especially youth (Kirmayer, Brass, & Tait, 2001). The abuse of alcohol is consistently reported as a major problem in Aboriginal communities (Chandler, Lalonde, Sokol, & Hallett 2003; Health

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Canada, 2003). As such, there is a need for culturally-appropriate interventions that target reasons why First Nation youth drink.

This project began as an invitation to Dr. Comeau by the principal of a community high school and the local detachment commander of the RCMP. They wanted to discuss ways of dealing with issues of alcohol and other substance abuse and related issues among the youth in their community. From these early discussions came a partnership with a resolve of working together to create a program that could be meaningful to the lives of the youth in the community. From there, a novel methodology was implemented to first assess quantitatively the relationships between personality and motives for drinking, then to speak to the high-risk youth through qualitative interviews to gain insight into to the teens' understanding of why they drink and, finally, to tailor interventions by basing stories and images in the intervention manuals on these combined multi-method findings (see Comeau et al. 2005; Comeau, Stewart, Loba, & Theakston, 2004, for additional information on this methodology).

The specific pathways to alcohol misuse related to intervention programming in this project have been described in detail elsewhere (e.g., Conrod, Pihl, Stewart, & Dongier, 2000a). Briefly, it has been proposed that individual differences in personality are linked to sensitivity to various reinforcing properties of alcohol (Cooper, Frone, Russell, & Mudar, 1995; Conrod et al., 2000a). For example, one effect of alcohol use is tension reduction. For adolescents who are sensitive to anxiety, it is reinforcing to escape from the unpleasant feeling of tension, which strengthens their likelihood of turning to alcohol when feeling tension. Further, these specific personality factors are related differentially to various motives for alcohol use (i.e., enhancement, coping, social, and conformity (Comeau et al., Comeau, 2004; Conrod, Stewart, Pihl, Côté, Fontaine, & Dongier, 2000b; Mushquash, Stewart, Comeau, & McGrath, 2007; Theakston, Stewart, Dawson, Knowlden, & Lehman, 2004; Stewart, & Devine, 2000; Stewart, Loughlin, & Rhyno, 2001). Essentially, individuals have different personality types and not everyone drinks for the same reason(s). Taking these factors into account at the level of the delivery of the intervention should create a better-matched approach for different teens.

The empirical background for the intervention approach used here classifies adolescents based on their specific personality types and motives for alcohol use in order to target specific programming to address these issues. Targeting these specific personality types and drinking motives has been shown to have positive benefits in terms of changing drinking behaviours among adolescents in the majority culture (Conrod et al., 2006; for more on the cognitive-behavioural techniques used in the intervention see Watt, Stewart, Conrod, & Schmidt, in press). There are at least three distinct personality types related to at-risk alcohol use patterns: anxiety sensitivity (i.e., fear of anxiety symptoms, like sweating, panicky feelings, racing heart), sensation seeking (i.e., preference and searching for novel, intense experiences), and hopelessness/negative thinking (i.e., proneness to feelings of worthlessness and sadness).

Anxiety sensitive individuals show sensitivity to the anxiolytic (anxiety-reducing) effects of alcohol (Conrod, Pihl, & Vassileva, 1998; MacDonald, Baker, Stewart, & Skinner, 2000; MacDonald, Stewart, Hutson, Loughlin, & Rhyno, 2001; Stewart & Pihl, 1994) and are at an increased risk for anxiety disorders, including panic (Maller & Reiss, 1992; Schmidt, Lerew, & Jackson, 1997). Anxiety sensitive persons show increased rates of alcohol consumption (Stewart, Peterson, & Pihl, 1995; Stewart, Zvolensky, & Eifert, 2001), drink to cope with negative emotions (Conrod et al., 1998; Stewart, Karp, Pihl, & Peterson, 1997), and drink to reduce or avoid social criticism (Comeau et al., 2001; Stewart et al., 2001; Stewart, Zvolensky, & Eifert, 2002). Sensation seeking individuals show elevated alcohol use and drink to experience euphoric/intoxicating effects (Comeau et al., 2001; Conrod, Peterson, & Pihl, 1997; Ohannessian & Hesselbrock, 1994; Stewart & Devine, 2000). Finally, hopeless/negative thinking individuals may particularly appreciate the pain-reducing properties of alcohol. Alcohol alleviates pain and hurt (Gray, 1987) and depression is predictive of the eventual development of alcohol problems (Hartka et al., 1991; Helzer & Pryzbeck, 1988).

As predicted by previous findings in the area of personality and drinking motives, the youth in these First Nations communities showed similar relationships between specific personality types (i.e., sensation seeking, anxiety sensitivity, and hopelessness/negative thinking) and risky motives for alcohol use (i.e. enhancement, conformity, and coping). Specifically, those who were identified as sensation seekers tended

toward drinking for enhancement reasons (e.g., to feel high), those who were anxiety sensitive tended to drink for conformity reasons (e.g., to fit in), and those who were hopelessness/negative thinking tended to drink to cope with their negative feelings (e.g., to forget worries; Stewart, English, & Comeau, 2005).

This initial quantitative work was followed by a qualitative phase where youth were interviewed and were asked to describe their diverse experiences with alcohol, as well as the contexts in which they tended to drink. The complexities of their social and personal relationships with others and alcohol, as well as their capacity for healthy ways of dealing with their struggles were key sharing points. Analyses focussed on the identification of themes and sample stories (directly from the voices of the youth) that were used in the intervention manuals (Comeau, Stewart, & Conrod, 2004 a, b, c). This ensured that the situations described were as meaningful as possible to the lives of the youth involved. As well, artwork based on story themes from the qualitative interviews, were included in the intervention manuals. The artwork was contributed by several First Nations youth artists who were living in the participating communities. Working with Elders and other spiritual teachers from the community, the intervention manuals were adapted to include teachings from the Mi'kmaq culture. For example, artists were asked to try and integrate colours into their artwork to represent the Mi'kmaq concepts Mese'k (wholeness), Sa'se'wika'sik (change), and Tetpaqjoqtesk (balance), to convey their spiritual response to the youths' stories and their themes.

An important addition to the cognitive behavioural strategies used within the intervention was the inclusion of traditional sacred Medicine Wheel teachings. The focus of the intervention was on a greater wholeness; the Medicine Wheel helped to convey the aspects of personality we were teaching the youth in the psychoeducational portion of the intervention. The commonalities between certain aspects of the cognitive-behavioural model (i.e. relationships between thoughts, feelings, and behaviours) and the Medicine Wheel, prepared the youth for the cognitive-behavioural exercises which were designed to help keep the various aspects of personality in balance (e.g., balance between thoughts and feelings) – an important teaching shared from the Medicine Wheel. While some additional factors (e.g. history of maltreatment) were not explored (see Zahradnik et al., this volume, for additional information on the role of maltreatment in the alcohol misuse of Aboriginal adolescents), this broader approach was conceptually meaningful to the youth involved in the intervention. This intervention integrated both the cultural and evidence-based science approaches into the programming.

Method

Participants

The sample consisted of adolescents within two Mi'kmaq First Nations communities in Nova Scotia. The age range was 14-18 years (M = 16) and the grade range was from 8-12 (M = 10). The screening sample was comprised of 169 students (87 females, 82 males) and a total of 41 (26 females, 15 males) youth were identified as eligible and willing to participate. Of those, 29 (20 females, 9 males) presented for and received the interventions. The remaining 12 (6 females, 6 males) willing and eligible students were assigned later as controls because they did not participate in the intervention for various reasons (e.g., illness on first day of intervention).

Measures

Various standardized and author-compiled measures were used to gather information related to demographics and personality-risk-type at baseline (pre-intervention), as well as a variety of alcohol outcomes at baseline and four months post-treatment. For selecting kids into the interventions based on personality risk, we used a validated measure of the three personality factors of interest. Specifically, the Substance Use Risk Profile Scale (SURPS; Conrod & Woicik, 2002) is a 23-item assessment tool that measures levels of several specific personality risk factors for alcohol abuse/dependence including Anxiety Sensitivity, Hopelessness, and Sensation Seeking. A demographics questionnaire (Stewart & Devine, 2000) gathered age, gender, and grade level information, as well as asked students to report whether they had consumed alcohol within the last four months. The latter item was used to select students into the interventions (i.e., to select for current drinkers) and was also administered at follow up as one of several outcome measures. Another outcome measure tapped drinking problems. Specifically, the Rutgers Alcohol Problem Index (RAPI; White & Labouvie, 1989) is a 23-item self-report questionnaire that measures adolescent problem drinking symptoms. We also included

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measures of drinking frequency (i.e., "How often do you usually drink?") and of frequency of binge drinking (i.e., "How often do you have six (five if you are female) or more drinks on one occasion?"), both of which were answered on five point scales. Finally, in order to determine if the results were specific to alcohol, we included a measure of recent marijuana use which asked participants to indicate whether or not they had engaged in any use of marijuana in the past 30 days (scored dichotomously as recent use vs. no recent use).

Using primarily published measures allows for the locating of the current findings within the broader literature on teen alcohol/substance use, as many of these will have used the same questionnaires. This strategy also helps to build a knowledge base on First Nations youth, where common points of comparison to non-Aboriginal and other Aboriginal teens are facilitated. Such questionnaires are readily available with access to the published scientific literature.

Procedure

Data was collected during school-wide screenings in 2 sites (4 schools). Eligible students (i.e., Mi'kmaq First Nation teen drinkers who displayed elevations on at least one of the three personality risk factors of the SURPS) were invited to participate in one of three personality-matched brief intervention groups (i.e., one for anxiety sensitive drinkers, a second for sensation seeking drinkers, and a third for negative thinking drinkers). Personality elevations were defined as scoring at least one standard deviation above the screening sample mean, for their gender, on any of the three SURPS subscales of interest. If students showed elevations on more than one of the three SURPS subscales, they were assigned to the personality group where they showed the greatest deviation from the norm (i.e. if they were elevated on both sensation seeking and negative thinking/hopelessness subscales but their elevation was higher relative to their peers on the sensation seeking subscale, they were assigned to the sensation seekers group). Elevations on more than one personality risk factor were common. For example, of the original 41 students, 17 met criteria for significant elevations in negative thinking/hopelessness, 16 met criteria for significant elevations on anxiety sensitivity, and 20 met criteria for significant elevations in sensation seeking. But based on their most significant deviations on the SURPS subscales of interest, of the original 41 students, 14 were classified as anxiety sensitive, 13 as sensation seekers, and 14 as negative thinkers. Of these, 9 anxiety sensitive, 9 sensation seekers, and 11 negative thinkers, completed the interventions, and 5 anxiety sensitive, 4 sensation seekers, and 3 negative thinkers did not complete the interventions.

The intervention was brief; it occurred across 2 x 90-minute sessions, in mixed gender groups with trained facilitators (guidance counselors and police officers) leading the programming. The training on this intervention, using the developed manual, was provided by a licensed clinical psychologist (SS) and a doctoral level researcher with substantial experience in school-based substance abuse prevention programming (NC). Outcome measures were collected at a four-month post-treatment follow-up.

We had originally planned to conduct this pilot as an open trial. An open trial is often the first-step test in the evaluation of an intervention prior to a larger randomized controlled trial (RCT). In an open trial, all participants are assigned to the active intervention and there is no control group. Instead, pre- to post-treatment changes on important outcome measures are examined to determine the change in drinking measures that accompanies this intervention among those who completed the intervention. It is important to note that whether or not the treatment actually causes the observed changes cannot be determined definitively using this method. However, for a variety of reasons (e.g., illness, family issues), several willing and eligible students did not attend school on the days the intervention was offered. These students also completed the pre- and post-treatment outcome measures and thus served as a control group (albeit not a randomized control group), against which we could compare the intervention group effects. We were able to follow up with 25 (experimental and controls combined) of the original 41 (i.e., 61%). Analyses were completer analyses (i.e., only conducted on the data for the adolescents who completed both the pre and post measures), rather than intent-to-treat (i.e., where those not present at follow-up are conservatively assigned the same scores at follow-up that they had at baseline), because there was no reason to assume that those who did not show for the four month follow up benefited less from the intervention than those who appeared for the follow-up (Watt, Stewart, Birch, & Bernier, 2006). In fact, there were many reasons for

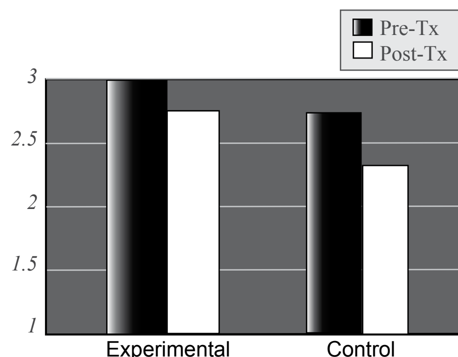

Figure 1: Drinking frequency as a function of group (experimental vs. control) and time (pre-treatment baseline v. four-month post-treatment follow up).

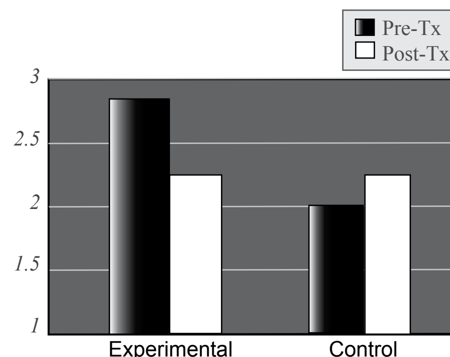

Figure 2: Frequency of Binge Drinking as a function of group (experimental vs. control) and time (pre-treatment baseline v. four-month post-treatment follow up).

students failing to show up on the day of the follow-up assessment including missing school due to illness.

Results

In order to assess the efficacy of this intervention, several outcome indicators were used: frequency of recent alcohol use; frequency of binge drinking; alcohol-related problems as measured by the RAPI; alcohol abstinence; and recent marijuana consumption. Figures 1-5 show results for each of the two groups (experimental and control) on several of the outcome measures at pre-treatment baseline and post-treatment follow-up. Although there were trends for the experimental group to show greater problems on several of the outcome measures at baseline (see Figures 1-3), none of these baseline group differences proved statistically significant. Figure 1 shows the drinking frequency pre- and post- intervention for both the experimental and control groups. A significant decrease in usual drinking frequency was observed for the experimental group ($p < .05$), but not for the control group, from pre- to post-intervention. Figure 2 shows frequency of binge-drinking data for both groups at pre- and post- treatment. The experimental group's binge drinking frequency decreased marginally from pre- to post-treatment ($p < .06$), while the control group's binge drinking frequency did not change over this same interval (Note: Statistical significance is usually taken at a .05 level or less. For $p = .05$, it means that the positive finding is probably true 95% of the time, occurring due to chance or a non-real difference, 5% of the time. Levels just short of $< .05$ [e.g., $p = .06$] are usually considered trends, which are important to report especially when the area of study is new, as in this case).

Figure 3 presents alcohol-related problems outcomes which were quantified as total scores on the RAPI. The experimental group experienced significantly less alcohol-related problems post-treatment compared to their levels pre-treatment ($p < .005$) while the control group showed no change over the same interval. Figure 4 shows that only the experimental group ($p < .005$), but not the control group, showed a significant increase from pre- to post-treatment in the proportion of youth who had abstained from alcohol in the previous four months. Finally, although the target of the intervention was alcohol misuse, it was expected that the intervention might also have effects on misuse of other substances; this possibility was tested with respect to marijuana use. Figure 5 shows that recent marijuana consumption (in the past 30 days) decreased from 55% to 30% in the experimental group from pre- to post-treatment ($p < .05$), while the proportion using marijuana in the control group remained the same at about 50% at both pre- and post-treatment.

Discussion

In the present project, we developed and pilot-tested an early intervention for alcohol misuse among First Nations adolescents from two Mi'kmaq communities in Nova Scotia. This intervention targeted specific at-risk personality types and associated risky drinking motives and is among some promising new developments in prevention and early intervention for alcohol abuse in youth (Stewart et al., 2005). While this type of intervention has been shown to be

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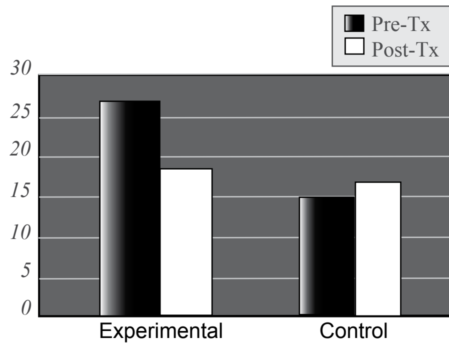

Figure 3: Alcohol related problems on the RAPI as a function of group (experimental vs. control) and time (pre-treatment baseline v. four-month post-treatment follow up).

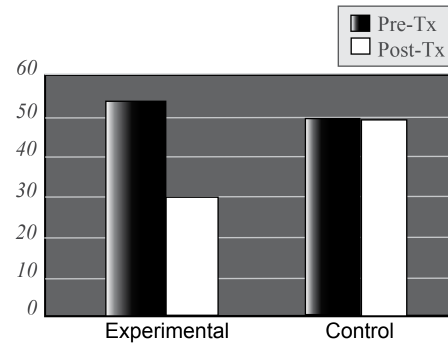

Figure 5: Recent Marijuana Use (% last 30 days) as a function of group (experimental vs. control) and time (pre-treatment baseline v. four-month post-treatment follow up).

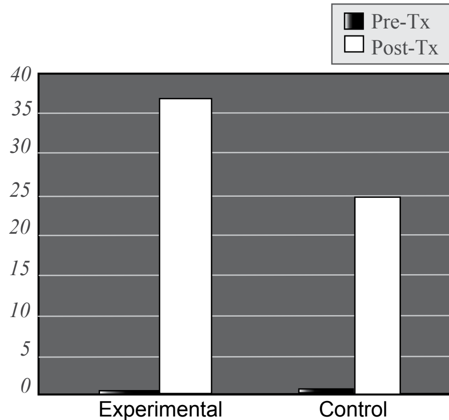

Figure 4: Alcohol abstinence (% last 4 months) as a function of group (experimental vs. control) and time (pre-treatment baseline v. four-month post-treatment follow up).

effective in the majority population (see Conrod et al., 2006), it had not been previously tested with First Nations youth. The present pilot study suggests that this type of intervention is a promising approach for intervening early with First Nations adolescent drinkers, that is worthy of further research.

The intervention was received well in the communities for many reasons. First and foremost, community acceptance of the intervention was in large part due to the communities' identification that alcohol misuse was an issue for their adolescents. Acceptance of the interventions was also enhanced by the collaborative working alliance that was developed between the research team and key members of the community, in all aspects of the project (see Comeau, Stewart, Mushquash, et al., 2005, for additional detail on the community collaboration involved in setting up and implementing this early intervention program). Furthermore, students at the four schools involved were actively engaged in setting up the interventions through such varied types of involvement as participating in the quantitative survey, contributing their own experiences to the qualitative interviews, and/or contributing to the artwork that was used in the manuals.

In sum, these pilot results show that the "Nemi'simk, Seeing Oneself" intervention program is a promising method for reducing drinking behaviour and early signs of drinking problems in adolescent drinkers from this cultural group. Compared to eligible students who did not participate in the intervention program who showed no significant change, intervention completers drank less frequently, engaged in fewer binge-drinking episodes, had lower levels of alcohol-related problems, were more likely to abstain from alcohol use, and reduced their marijuana use at four months following the interventions relative to their levels at pre-treatment baseline.

Due to our small sample size, we were unable to determine whether there were differential responses of the various personality groups to the interventions. This could be important because Conrod et al. (2006) showed, for example, that anxiety sensitive students from the majority culture respond to interventions through increased abstinence rates and decreased RAPI scores, whereas sensation seeking students from the majority culture respond to the interventions through decreased binge drinking. It will be important to conduct a larger-scale study to determine if such personality-specific findings extend to Mi'kmaq

youth. As well, future research should determine if this intervention is effective for at-risk youth in other First Nations communities across Canada by actively collaborating to apply this methodology to be respectful and assure meaningfulness for the youth that comprise Canada's diverse First Nations population. Future studies should also explore whether the reduced rate of marijuana use means that the benefits of the intervention might extend to adolescents' use of other substances, particularly since the personality risk model extends beyond alcohol abuse to the misuse of a variety of addictive substances (e.g., Conrod et al., 2000a). Finally, future research needs to consider factors including gender, exposure to violence, or maltreatment, which might further differentiate those who can benefit maximally from this intervention. Future interventions might be modified to include a focus on dealing with exposure to violence to increase their impact and efficacy (for more on exposure to violence and its relevance to substance misuse in Aboriginal youth, see Zahradnik et al., this volume). Teens in the qualitative interview spontaneously discussed dating violence (Comeau, Stewart, & Collins, 2004) and there is a substantial overlap between various forms of interpersonal violence and substance abuse (Stewart, 1996; Wekerle & Wall, 2002, Brewin, Andrews, & Valentine, 2000). As well, some adolescents scored high on more than one personality risk-factor or motive for alcohol use and thus may use alcohol (and other drugs) for a variety reasons. In our intervention, we addressed only the primary personality risk factor and associated motive for alcohol use. Future research will need to determine whether multiple targets of intervention are any more effective for those youth who are multiply affected.

While the blended approach of combining traditional knowledge with cognitive-behavioural treatment techniques is not necessarily new, what is novel with this particular intervention approach is (a) applying the personality based model to First Nations alcohol misuse and (b) doing this in a culturally-sensitive manner through community-based collaboration that allowed us to capture the meaning of alcohol within the lives of the youth.

With respect to differences between the experimental and control groups in this study, we employed the only analytic approach that is justifiable under these circumstances (i.e., where the assignment to groups was not random): separate pre-post tests in each group. We demonstrated that the intervention group showed reductions in alcohol and marijuana use over the same interval as the control group did not experience these same reductions. The two groups did not differ significantly at baseline on any measures. The control group always appeared to be less (rather than more) severely affected than the intervention group, arguing against the idea that the most severely affected (e.g., those with the most alcohol related problems) are least likely to participate in the interventions.

Finally, because these personality traits have been shown to be risk factors for alcohol misuse and problems associated with misuse, our intervention specifically focused on early intervention with alcohol misuse; however, we recognize that the intervention theoretically has promise for other substances of abuse as well (see Conrod et al., 2000a). Moreover, rarely is alcohol misused in isolation from other substances (Barrett, Gross, Garand, & Pihl, 2005; Barrett, Darredeau & Pihl, 2006). Thus, there are some exciting new directions for this intervention approach. Additionally, the strength and promise of this approach are in its model of partnering research expertise with youth service expertise and traditional cultural health

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expertise with the common goal of improving the health of youth in the community.

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Building a Collaborative Understanding of Pathways to Adolescent Alcohol Misuse in a Mi'kmaq Community: A Process Paper

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Abstract

In April of 2006, a team of researchers consisting of both university and community partners from a Mi'kmaq reserve in Nova Scotia began the data-collection phase of a high school-based research study that had been two years in planning. The study examines the possible relationships between youth-reported childhood maltreatment, posttraumatic stress disorder (PTSD) symptoms, depressive symptoms, alcohol misuse, and resiliency factors. The aim of the research study is to provide information about adolescent alcohol misuse that is of practical benefit to community-based service providers, and capable of making a scholarly contribution to the scientific study of the relations of anxiety/mood symptoms and addictive behaviours. The primary aim of this paper is to present both the context from which the project grew, and the steps involved in conducting research with our school partners and the community service providers. A secondary aim is to present some of the preliminary data from the study, with a specific focus on resiliency.

Introduction

Childhood maltreatment[1] and subsequent alcohol misuse are frequently linked together across cultural groups. They are a concern for most Canadian communities. Although there is very little published literature that either reports on or explores the connection between child maltreatment and alcohol misuse in First Nations' communities, the published research that is available seems to suggest that rates of violence exposure and alcohol use/misuse are high in some communities (Health Canada, 2003). For example, the 1991 Statistics Canada Aboriginal People's Survey revealed that 62% of First Nations respondents reported that alcohol was a problem in their community, while 39% of respondents reported that family violence was a problem in their community (Indian and Northern Affairs Canada, 2004). It is recognized, though, that a complex web of ecological factors support the maltreatment-substance abuse issue. For example, a study by Blackstock, Trocmé, and Bennett (2004) found that Aboriginal families, compared to non-Aboriginal families, face worse socioeconomic conditions, are more often investigated because of neglect, and report higher rates of substance abuse. Poor socioeconomic conditions, substance abuse, and poor parenting skills (e.g., neglect and abuse), to name a few, are problems that are now well understood to be consequences of a history of coloni-

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zation, as pointed out by the Royal Commission on Aboriginal People; a most pernicious manifestation of colonization that has had immeasurable deleterious consequences on Aboriginal health, culture, and identity, is the residential school system (Indian and Northern Affair Canada, 1996).

The residential school system failed miserably in its deplorable goal of attempting to "civilize" Aboriginal children. In its attempt "to transport Aboriginal children through the classroom to the desired assimilative destination," the system more often than not produced individuals who felt marginalized from both their home communities and the communities of their colonizers, leaving many with few constructive alternatives to a life of prostitution and/or alcoholism (Indian and Northern Affairs Canada, 1996). Furthermore, the structure sewed the seeds for generational cycles of family violence because these schools disrupted the transference of parenting skills from one generation to the next, so that many survivors, lacking the necessary parenting skills, came to rely on the lessons they learned at these schools: that adults often maintain power, control, and obedience through abuse (Indian and Northern Affairs Canada, 1996). Because so many cases of sexual and physical abuse went ignored and unhealed, giving rise to numerous unhealthy coping behaviours, including the perpetration of violence, such behaviours often became "normal" and were subsequently passed on to subsequent generations, resulting in intergenerational or multi-generational trauma (Wesley-Esquimaux & Smolewski, 2004).

The authors of this paper recognize the historical and cultural roots to maltreatment-substance misuse problem in some Aboriginal communities, but the present study was not designed to test the contribution of these historical factors. Rather, our research team focused on the current circumstances of exposure to violence, psychological effects of such exposure to violence, and subsequent relations to alcohol misuse among teens living in an Aboriginal community today. Our school-based research study is attempting to not only make a contribution to an area that is presently lacking—the relationship between child maltreatment and alcohol misuse—but to also provide the community service providers with tailored evidence for intervention recommendations. As this study is on-going, the purpose of this paper is not to report on the final research findings, but to provide a brief summary of the research process. This shall include: 1) briefly describing the community; 2) briefly locating the purpose of the research within the community context; 3) briefly locating the purpose of the research within the scientific literature; 4) discussing the process of ethical approval and community consent; 5) discussing the implementation of the study; and 6) sharing some preliminary findings based on the information we have collected thus far.

Community Organization

The Mi'kmaq community is a self-governing First Nations Community. It is one of the largest First Nations communities in Atlantic Canada, and its origins go back to the first half of the 19th century, though it was not until the half way point of the 20th century that the community's population increased dramatically. Shortly thereafter, the community became self-governed by establishing its own Band Council. The community has its own Board of Education, Board of Health, local police, fire department, and ambulance service.

Community Context

In the fall 2002, our research group was invited to the Atlantic Region First Nation community by the principal of the community high school and the detachment commander of the RCMP[2] to discuss ways of dealing with issues of alcohol and other substance abuse among community youth. These discussions lead to further collaboration between members of our research team (led by post-doctoral fellow Dr. M. Nancy Comeau) and school staff (from two schools) and the eventual participation of community youth in the development of a culturally relevant early intervention program for alcohol misuse, entitled "Nemi'simk, Seeing Oneself" (see Mushquash et al., 2007; see also Comeau et al., 2005). The present study evolved from the voices of those adolescents who participated in "Nemi'simk."

From the qualitative data already collected about these adolescents' perceptions of their reasons for alcohol misuse (Comeau, Stewart, & Collins, 2004), it appeared that themes of violence exposure and anger might be important contributing factors. Furthermore, the guidance counselor from one of the community schools, who also became a co-investigator of the present study, in a letter addressed to the Dalhousie Health Sciences Research Ethics Board, underscored the relevance of this project to her community when she noted that both she and her colleagues had observed a recent increase in disclosures and reports of childhood trauma.

Based on some of the findings of the previous work with the schools, and the observations of school guidance counselors and mental health professionals in the community, it was felt that a well-designed study might be able to shed some light on the possible relationship between maltreatment and adolescents' alcohol misuse. Furthermore, given the well-documented relationships between interpersonal violence, post-traumatic stress disorder (PTSD) symptoms, depressive symptoms, and alcohol and other substance misuse in non-Native populations (see reviews by Stewart, 1996, and Stewart & Israeli, 2002), the empirical literature in this area helped ground our conceptualization of the project in a scientific context.

Scientific Context

Interpersonal Violence

Interpersonal violence – witnessing domestic violence, child maltreatment, school bullying, teen dating violence and date rapes – can bring on PTSD symptoms that may become chronic, or remain an "active" risk factor for later onset of post-traumatic stress (Wekerle & Wall, 2002; for a meta-analytic review see Brewin, Andrews, & Valentine, 2000). Trauma researchers suggest that early exposure increases the risk for developing post-traumatic stress beyond the risk associated with other traumatic experiences like motor vehicle accidents, natural catastrophes, and other life stressors (e.g. Kilpatrick, Acierno, Saunders, Resnick, Best, & Schnurr, 2000). It is the interpersonal nature of the violence, especially when a caregiver or attachment figure is involved, that render it a "high impact" event that challenges coping and long-term adaptation.

Post-traumatic Stress Disorder (PTSD) Symptoms

The purpose of the study is not to diagnose students with the psychiatric disorder of PTSD, but instead to show that greater levels of symptom severity might be driving alcohol misuse behaviour, since alcohol may be used as a means of "self-medicating" the unpleasant emotions and memories that result from the trauma. Therefore, although the term 'PTSD symptoms' is used throughout this paper, the results of the study cannot be used to diagnose students with the actual disorder.

PTSD[3] is a complicated disorder that is precipitated by exposure to a traumatic stressor. The Diagnostic and Statistical Manual-IV (APA, 1994) defines a traumatic stressor as any event that is experienced or witnessed that involves actual or threatened death/serious injury, or a threat to the physical integrity of the self or another, and is accompanied by a sense of fear, helplessness, or horror. The disorder is marked by three key symptom clusters that persist for longer than one month: 1) re-experiencing the traumatic event through intrusive thoughts, nightmares and/or flashbacks; 2) emotional numbing and the avoidance of trauma related reminders; and 3) hyper-arousal, including hyper-vigilance (i.e., over-scanning the envi-

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ronment for signals of danger or threat) and increased physiological arousal (e.g., difficulty calming, sleep problems, restlessness). As interpersonal violence can be a risk factor for the development of PTSD, current research indicates that having PTSD symptoms can be a risk factor for alcohol misuse.

Alcohol Misuse and Post-traumatic Stress

Much of the research indicates that PTSD and alcohol and other substance abuse commonly occur together in the same individuals and that this co-occurrence is far more common than can be explained by chance alone (Stewart, 1996; Wekerle & Wall, 2002). For example, in a national probability sample of 3,906 adolescents, Kilpatrick et al. (2003) found that the prevalence rate for having PTSD with a substance abuse disorder (n=50) was almost the same as the base rate for PTSD alone (n=55). Furthermore, from that same study, sexual assault, physical assault, and witnessing violence were all variables that increased the risk for a diagnosis of co-morbid PTSD and substance abuse. Given the co-occurrence of PTSD with alcohol and other substance misuse, researchers have posited several possible causal pathways to explain their relationship.

Pathways Connecting PTSD and Substance Misuse

There are three major hypotheses that attempt to explain the link between PTSD and substance misuse[4]. The high-risk hypothesis suggests that misusing substances elevates the risk of exposure to trauma (and thus of developing PTSD) due to a "dangerous/risky lifestyle.' The susceptibility hypothesis suggests that the misuse of substances can cause physiological and neurochemical changes that make an individual more susceptible to developing PTSD following exposure to a trauma (Brown & Wolfe, 1994). The third and presently best-supported view is the self-medication hypothesis (De Bellis, 2002; Chilcoat & Breslau, 1998; Stewart, 1996).

The self-medication hypothesis reasons that central nervous system depressants like alcohol, cannabis, opioids, and benzodiazepines may help reduce certain fear/startle responses, as well as the intrusive memories that are characteristic of PTSD. People suffering PTSD, having experienced symptom relief with substance(s) use, come to expect that it may relieve suffering, and are then motivated to engage in continued substance use to manage their PTSD symptoms. Although there is substantial empirical support for the self-medication theory as it relates to explaining the relation of PTSD with alcohol abuse, it is currently recognized that the self-medication explanation is overly simplistic (Stewart, 1996). For example, alcohol and other drugs may control certain PTSD symptoms in the short term, but once the effects of the substance have worn off, the PTSD symptoms return. Furthermore, sometimes when symptoms return, they return in even greater severity due the physiological after-effects of substances like alcohol. Particularly, hyper-arousal symptoms can return with even greater severity due to the physiological arousal resulting from substance withdrawal (Jacobsen, Southwick, & Kosten, 2001). It has also been suggested that alcohol can interfere with the body's natural habituation to traumatic memories (De Bellis, 2002). Thus, through a process of mutual maintenance, substance misuse can actually serve to maintain PTSD symptoms in the longer term creating a "vicious cycle" between PTSD symptoms and substance misuse. Although our study does not examine symptom severity across time, and therefore does not allow us to test a mutual maintenance hypothesis, the variables we are collecting data on do allow us to explore a self-medication model as it relates to the misuse of substances in young, potentially traumatized individuals.

Based on both community need and the best available empirical information, we have hypothesized, in accordance with the self-medication hypothesis, that PTSD symptoms will mediate the relationship between childhood maltreatment and substance misuse in a community sample of adolescents. Information has been collected using self-report measures on exposure to violence (Childhood Experience of Violence Questionnaire, CEVQ; Walsch et al., in press) post-traumatic stress symptoms (Child PTSD Symptom Scale, CPSS; Foa et al., 2003), depressive symptoms, (Centre for Epidemiological Studies Depression Scale, CESD; Radloff, 1977), alcohol related problems (Rutgers Alcohol Problem Index, RAPI; White & Labouvie, 1989), and resiliency (Child and Youth Resilience Measure, CYRM; International Resilience Project, Dalhousie University).

The data collection for this study has been administered in groups, but various safeguards have been prearranged so as to ensure that the study is anonymous with respect to data privacy. An active informed consent was sought from the high school

students who chose to participate in this study, while a passive consent process was used with parents. Based on both community relevance and scientific merit, we brought forward our research proposal to the larger body of community stakeholders, so as both to ensure their consent and to give them an opportunity to modify the proposed project in accordance with their needs.

Ethical Approval and Community Consent

Ethical Approval

In the summer of 2005, two variations of the same ethics proposal were submitted to both the Mi'kmaq Ethics Watch at Cape Breton University, and the Dalhousie Health Sciences Research Ethics Board (REB). Approval to conduct research was granted by the Mi'kmaw Ethics Watch in November of 2005 and by the Dalhousie REB in April of 2006. The project proposal that was originally presented to both ethics boards in the summer of 2005 was revised, based on community input (see Community Participation), with respect to what mental health related constructs were being measured, and both ethics boards were informed of and approved these amendments to the project.

As this project is school-based, feedback from the Dalhousie REB that concerned issues around the methodology of the study (e.g., using an active versus passive parental consent) were always first discussed with our school partners from both participating schools. Decisions that came from those discussions were then reported back to the Dalhousie REB both in the form of amendments to the ethics protocol, as well as in the form of letters of approval from the guidance counsellors of both Mi'kmaq high schools and their Director of Education for the community school board.

Community Consent

Although this section of the paper will outline the steps involved in establishing community consent, it is first necessary to specify whom we mean when we employ the term 'community'. When this paper refers to community, it is referring to those agencies or institutions whose service mandate, in one form or another, includes the health and well being of children/adolescents that reside within the administrative jurisdiction of these agencies/institutions. For the purpose of this paper, 'community consent' shall be distinct from 'participant consent', in that the community had to first consent to participating in the collaborative research process as a whole, before participant consent could be sought from potential teen participants. The process of participant consent is described in the section entitled Study Implementation.

Seeing as how this is a school-based study, the primary community partners for this study were the First Nation School Board and the principals and guidance counselors of the community high schools. Furthermore, because this study includes questions that might prove upsetting to some students, and could lead to the disclosure of child maltreatment, our community partnership extended to the community Mental Health and Social Work Services (MH & SWS)[5]. We also gained the consent of other child / adolescent health and welfare related service providers (see below for a list).

Formal community contact began in the fall of 2005, where a joint community-research team was invited to present a research proposal to the community based collaborative and therapeutic team (Case Management) and the Inter-Agency, which jointly consist of representatives from the following service providers/institutions: Native Alcohol and Drug Abuse Counselling Association (NADACA), the Health Centre, Home Care, Mi'kmaq Family and Children's Services, the Regional Hospital's Child and Adolescent Services, the RCMP, as well as three schools under the jurisdiction of the School Board.

Representatives from the various agencies were given the opportunity to become active participants/advisors in shaping the project by asking questions, voicing concerns, and suggesting modifications. Both groups requested updating throughout the various stages of research, and to deliver a full disclosure of the research results and recommendations that the community will be able to utilize in a productive manner. Furthermore, it was agreed that Mental Health & Social Work Services be allowed to use the data from this study to hopefully increase their capacity to secure funding for issues and programming around dealing with the consequences of childhood maltreatment.

Critical to the study was gaining approval at an administrative level by individuals appointed to directorial positions by Chief and Council. The Director of Education was formally contacted in the fall of 2005, and her approval was immediate. The Director

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of Health was also contacted in the fall of 2005, and she invited the lead researcher to present the study proposal to the Board of Health in the spring of 2006. After both the board—a body of 12 appointed community representatives that included 3 elders—and the Director of Health were satisfied that their questions and concerns had been met with appropriate responses, they approved the project. The Director of Health also desired projects updates and a disclosure of the results.

Community Participation

Our school partners have been crucial to the success of this study. Our "internal champion", had both passion for the content area, a job specifically to support teens, and was obtaining a graduate degree that included research (see Commentary, this issue, by Doreen Stevens). As someone born in the community, and a school/mental health professional of the community, she could often answer questions about the project from a position and perspective unavailable to university-based researchers. Such key community partners played a critical role in formulating a process of consent for students and parents that was both practical and ethically sound. While our school partners helped plan and concretize the methodological and ethical issues of the study, representatives from MH & SWS had an influence on the scope of the project as a whole.

Based on the recommendation of the former Case Management Team coordinator who was also a psychologist for Mental Health and Social Work Services (MH & SWS), the project was modified so as to also focus on resiliency. In addition to having information on exposure to violence and its possible consequences (e.g., PTSD symptoms), MH & SWS staff were equally keen to know about those factors—whether they be personal, interpersonal, cultural, or community-based—that might be buffering or shielding certain adolescents from experiencing post-traumatic stress symptoms or depression, or misusing alcohol. This suggested addition to the project has had the further benefit of strengthening and extending the partnership between MH & SWS and the academic community at Dalhousie, as the first author of the resiliency measure adopted for the study, Dr. Michael Unger (www.resilienceproject.org) from the Dalhousie School of Social Work, agreed to come to the community to deliver a workshop on the topic of resiliency. Furthermore, based on the data sharing agreement with MH & SWS, the research team decided to remove two measures that although of academic interest were of less tangible benefit to the community, and to replace them with a measure of depression.

Our rationale for including a measure of depression was based on both community need and empirical literature. The literature on the relationship between exposure to violence and depression, and the literature on substance misuse and co-occurring problems certainly supports enquiry into a mediational relationship between maltreatment, depression, and alcohol misuse within this community. For example, childhood exposure to violence is predictive of both subsequent major depression and PTSD (Kessler et al., 1997; Kendler et al., 2000). Furthermore, Hall and Farrell (1997) report that for those with alcohol problems, the most prevalent cluster of co-occurring disorders, next to anxiety disorders (where PTSD is classified as an anxiety disorder), are mood disorders like depression. Therefore, we reasoned that measuring a pathway from maltreatment through to alcohol misuse that only involves post-traumatic stress symptoms might be casting too small a net, but that if we included a measure of depression, we might be able to provide the community with a more complex view of the roots of adolescent alcohol misuse.

Study Implementation

After receiving both community consent and ethical approval (from the Mi'kmaw Ethics Watch and Dalhousie University REB) the study was implemented in April of 2006. As this is a school-based study, only adolescents attending either of the two high schools in the community were invited to participate. Originally, the study was to use an active parent/guardian consent process in which parents/guardians would be mailed a consent form that they would then have to read, sign, and return (to the school). Only students whose parent/guardian returned the signed form would then be invited to participate in the study, at which point these students would then be eligible to give their own informed consent to participate in the study. However, the Dalhousie University REB was concerned about a possible sample bias, in that students who were being exposed to parental/guardian violence would be less likely to have parental consent to participate in the study; thereby, reducing the value of the information obtained. This concern

was reported back to our community partners, and with their support a passive parent/guardian consent process was proposed to the Dalhousie University REB, which they accepted once it was made clear that school personnel would use school records, school history, and professional judgment to assess whether or not students had the capacity to give informed consent themselves. It was decided that, for those students who were deemed ineligible to give their own informed consent, an informed parent/guardian consent process would be used.

In order not to be in conflict with the Mi'kmaq Ethics Watch provision that all children under the age of 14 need active parent/guardian consent before being invited to participate in research, we ensured that all student participants were at least 14 years of age. As the study uses questionnaires, students requiring the aid of an assistant for reading comprehension were not invited to participate, but an individual fluent in both English and Mi'kmaq was on hand at all times during data collection to assist in translation of key words if necessary.

Community stakeholders were given two weeks notice prior to data collection. At the same time, passive parental/guardian consent forms were distributed to the parents/guardians of all students under the age of majority by the schools. By way of the passive consent letter, parents/guardians were informed about the purpose, tasks, and risks of the study. They were made aware of the collaborative nature of the study, and were encouraged to call university-based researchers or the school staff should they wish to seek more information about the study, and/or to refuse to allow their child to participate in the study. No parents exercised their right to refuse to allow their child to participate in the study. On the day of data collection, the university-based researcher reviewed the consent form with those adolescents that were eligible to participate in the study to provide them the opportunity to ask questions and ensure an informed process. Students who were not interested in participating in the study were free to leave at any time, and some students did choose this option, though records were not kept for how many students choose not to participate. Guidance counsellors and teachers were on hand during the administration of the questionnaires, and students were told that they could talk to their school's guidance staff at any point. Furthermore, MH & SWS were informed well in advance about when data collection would take place, and this agency made arrangements to attend to any students who sought services as a consequence of participating in the study.

The questionnaires were administered in groups (organized by class/grade when possible). Students were informed that in order to increase their privacy, three different versions of the same survey package would be circulated. Due to the variable finishing times of the students who participated in the survey, there was no group debriefing. However, during the process of informed consent, students were made aware that they would have immediate access to the on hand guidance counsellors, and that other community services were ready to assist them on demand. Furthermore, all students received a 'help sheet' that was co-written by the primary investigator, MZ, and the former Case Management co-ordinator. Each help sheet included the name, summary statement, and contact information of support services that are both external (e.g., Kids Help Phone) and internal (e.g., MH & SWS) to the community.

Students were informed that any information that they provided on the survey booklet or answer sheet would be anonymous, providing that they did not share their answers with anyone or write any personally identifying information on either the survey booklet or the answer sheet. They were also made aware that any information they did share with either researchers or the school staff would be kept confidential, unless it pertained to child maltreatment. It was made very clear to the students that if they did share information that pertained to child maltreatment, they would be interviewed in private so as to determine whether or not to report to the RCMP, the agency responsible for child protection. Based on an agreement between researchers and the schools, students were also informed that any information they shared with the researcher that pertained to child maltreatment would be shared with the guidance department of their school.

Given the group/classroom testing context, and the ways in which disclosures were made, verbal disclosures during testing were directed to a private discussion with the school guidance counsellor. Often, maltreated youth use humour to "test the waters" for tolerating personal information and to obtain some sense of mastery over an essentially hurtful and humiliating experience. One student, when reviewing a sexual abuse question, voiced a seemingly flippant remark about an example "like when you wake up

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and someone is on top of you?" The youth was told that that this comment may disturb other students for whom such an experience was true and the youth was subsequently asked to speak in private with the guidance counsellor. As that discussion proceeded, this particular youth disclosed his own maltreatment background. This was the only verbal disclosure of child maltreatment at either school that resulted immediately from the questionnaire completion. As the adolescent was over 15 years old, and the perpetrator was no longer connected to the family, a formal report was not filed. The adolescent did not wish to report the incident, nor did he seek further services from either the guidance counsellor or the community service providers.

There was one other incident that necessitated a follow up. A young adolescent woman had written her name on the survey package and asked for help. The researcher followed up on her request for help by way of a telephone call to her (via the school). The young woman assured him that she was not in any need of help, and that she felt that she could both depend on the school guidance counsellor for any problems that she might have, and that she also knew how to avail herself of the relevant community services. Outside of these two incidents, none of the adolescents who participated in the study demonstrated any signs of distress nor did they communicate any desire for a referral to any of the community service providers.

Preliminary Findings

Based on data we have obtained from 102 adolescent student participants who have completed the measures thus far, we are able to report the following associations between the variables measured in our school-based study. As can be seen in Table 1, the exposure to violence (CEVQ; Walsch et al., in press) total score is associated with post-traumatic stress (CPSS; Foa et al., 2003) symptom clusters, depression (CESD; Radloff, 1979), and problem alcohol use (RAPI; White & Labouvie, 1989; e.g., missing school due to drinking). All measured aspects of maltreatment (emotional abuse, physical abuse, and sexual abuse) were associated with problem alcohol use (r from +.24 to +.37). The exposure to violence total score was most strongly correlated with the following variables: the total PTSD score ($r = +.36$), PTSD-related avoidance ($r = +.35$), and problem alcohol use ($r = +.26$). With respect to problem alcohol use (RAPI), both depression ($r = +.47$), and PTSD symptoms (total score) were related ($r = +.39$). However, PTSD-related hyper-arousal had the strongest association with problem alcohol use ($r = +.54$). This suggests that the more agitated and restless the teen, the more likely they were to report problematic alcohol use.

Our measure of resiliency (CYRM, International Resilience Project, Dalhousie University, 2006), which includes personal, relational, community, and cultural aspects, was not related to any aspect of maltreatment. However, higher resiliency scores were associated with lower depression scores ($r = -.27$), lower total PTSD symptoms ($r = -.30$), and lower PTSD avoidance / emotional numbing in particular ($r = -.41$). These associations are particularly encouraging, especially since the avoidance symptoms of PTSD are most strongly associated with the development (Nemerhoff et al., 2006) and maintenance (Wenzlaff & Wegner, 2000) of PTSD symptoms. In other words, our findings can be interpreted to indicated that resilient adolescents are less likely to suffer depression or PTSD symptoms, and that furthermore, resilient adolescents are less likely to avoid reminders of a trauma (e.g., places where they were abused), which may facilitate their recovery following exposure to a traumatic event. Surprisingly though, higher scores on resiliency were not associated with fewer alcohol related problems. In our planned future analyses, a more thorough exploration of the CYRM's component parts might shed some insight into whether certain aspects of resiliency (e.g., relational) may indeed be protective from problem drinking. Developing resiliency early in childhood may be one prevention strategy for teen mental health, particularly, to the degree that PTSD and depression promote problem alcohol use as suggested here, a focus on enhancing youth resilience may be effective in the longer term in preventing escalation of alcohol use.

Although it is too early to come to any firm conclusions, it is encouraging for our mediational analysis that maltreatment and PTSD symptoms (particularly the hyper-arousal scale) are positively related to problems related to alcohol use, as both of these relationships are necessary precursors to demonstrating statistically that PTSD might be mediating the relationship maltreatment and alcohol misuse. Such a finding would direct practice to target PTSD symptoms as a more direct route for reducing or intervening early with alcohol abuse. These are promising

times for youth intervention, as the one key program – Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) – is available to all practitioners free on a web training site. To date, over 5,000 therapy students and health care professionals have been certified with TF-CBTWeb (see www.musc.edu/tfcbt and, to register for the course, www.musc.edu/tfcbt and click the Register tab). While there is presently no treatment efficacy data on this training program, those that complete the program demonstrate an increase in TF-CBT based knowledge, and prospective studies are being planned for the future.

We remain confident that in addition to providing workshops and training opportunities to community service providers, we will also be able to deliver information from this project that can be used to develop ideas around prevention and intervention that are commensurate with the community's needs and resources. Thus, the community can be ensured that our mutual goal of creating a truly collaborative relationship that has the best interests of the community at heart will be achieved.

Endnotes

1. Childhood maltreatment is defined as experiences that were witnessed or direct victimization in terms of sexual, physical, emotional abuse and neglect. In this study, childhood refers to the teens' lifetime experience of maltreatment, including witnessing domestic violence. The measure used here, however, did not tap neglect.

2. There is no collaboration between the RCMP and the research team with regards to the present school-based study, though the RCMP was made aware of the study through contact with the community Inter-Agency.

3. Although the literature cited for this section typically focuses on PTSD, recent theory on the biological workings of responding to stress have emphasized post-traumatic stress symptoms over the disorder (e.g., DeBellis, 2002). Similarly, our work is consistent with this view in that we are examining post-traumatic stress reactions across a continuum that ranges from lower levels of symptom severity to higher levels of symptom severity, instead of taking a categorical approach where individuals either have the disorder or do not have the disorder.

4. Although our study's emphasis is on alcohol use/misuse and problems that follow from its misuse, the empirical literature suggests that substances other than alcohol (e.g., benzodiazepines, like Ativan or Valium) have a high co-occurrence with PTSD (Jacobsen, Southwick, & Kosten, 2001), and therefore, this section employs the more general term substance misuse.

5. Though the original MH & SWS supporters of the project—the director and psychologist—are no longer with MH & SWS (due to retirement and relocation,

respectively), the new acting director continues to support the study.

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The Effects of Self Harming Behaviours of Youth in Child Welfare Care

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Abstract

This paper considers the clinical issue of self-harming behaviours, defined as intentional self-injury that results in tissue damage. It is distinct from a suicide attempt, as self-harm does not occur within the context of a conscious wish to die. Self-harming behaviours among children and youth is a recent area of research. To date, studies indicate that in community samples, self-harming behaviours occur in as many as 35% of youth who are sampled (Gratz, 2001). Alarmingly, very little is known about self-harming behaviours among children and youth within the child protection system. This study, drawing from data gathered through a government-mandated reporting procedure of all children and youth in care, attempted to explore self-harming behaviours of children and youth in welfare care. While analyses did not focus explicitly on Aboriginal children and youth, it does consider differences in self-harming behaviours among minority and non-minority children and youth in care of the Children's Aid Society of Toronto. Approximately half of all child welfare cases that go through the child protection system in Toronto fall under the responsibility of the Children's Aid Society of Toronto. Although minority status was not significantly related to the number of self-harming attempts or threats, results suggested that minority children and youth in care were less likely to use puncture-type behaviour (cutting, scratching, stabbing) as a means of serious self harm. Results suggest that although self- harm may be a universal phenomenon, culture may affect how children and youth in care engage in self-harming behaviours. Direction of future research should consider between-cultural effects and more importantly, how these culture-specific differences may impact on children and youth's self-harming behaviours.

Introduction

Self-harming behaviours are often linked with adolescence, with frequent media depictions of female-cutting behaviours and reports of copycat suicide attempts. Research, however, is very limited in its knowledge about self-harming behaviours across childhood or amongst vulnerable populations. For instance, children as young as 5-years-of-age can make self-harming gestures, such as pretending to choke themselves or adolescents may scribble across their school notebooks "Better off dead." Adults often say flippantly "just shoot me!" or "I'm going to tear my hair out". For some, self-harming behaviours are frequent events that we know very little about. For the purposes of this study, self-harm is defined as the deliberate destruction or alteration of body tissue without conscious suicidal intent, resulting in injury severe enough for tissue damage. Perhaps what is most shocking is that self-harming behaviours occur frequently in the general population and what is alarming is recent studies have indicated that self harm appears to be increasing (Favazza, 1992; Gratz, 2001; Rodham, Hawton, & Evans, 2004) where between 15%-35% of sampled adolescents self-identify as having engaged in some form of self-harming behaviours (Gratz, 2006; Laye-Gindhu & Schonert-Reichi, 2005). Thus, it would not be surprising that children and youth in the child care welfare sector may also engage in self-harming behaviours.

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To address this concern, the Children's Aid Society of Toronto has closely tracked the number of self-harming incidences of children/youth in care since the year 2000. As a requirement of the Ontario Ministry of Child and Youth Services, all incidences of serious occurrence events must be recorded and documented through the Serious Occurrence Report

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(SOR). An accumulation of data over the years has allowed the Children's Aid Society of Toronto to examine the profile of children and youth in care who engage in self-harming behaviours (Goodman, 2005). However, what remains relatively unclear is whether these patterns are similar across cultures. Given the heterogeneous composition of Toronto's ethno-cultural communities, cross-cultural comparisons are particularly important given the possible intervention implications this information can have. The purpose of this paper is to begin to examine whether cultural differences in self-harming behaviours exist in children and youth in child welfare care. It is suggestive, therefore, of areas of research need, including the importance of considering the context of youth risk behaviours. Specifically, we examined the amount, type and methods of self-harming incidents in children and youth in care who have minority status relative to children and youth in care who do not have minority status.

Culture and its Effects on Suicidal and Self-harming Behaviours

Research in the area of self-harm has been rather limited in that researchers have had difficulties conceptualizing and defining behaviours that are associated with self-harm. Thus, efforts to describe characteristics associated with children and youth who engage in self-harming behaviours have been inconsistent. Similarly, studies examining cultural influence on self-harming behaviours are virtually non-existent, as researchers have focused primarily on suicidal intent and behaviours (Farooqi, 2004). However, given the strong association between suicide and self-harm (Goldston, 2000), similar cross-cultural differences may also emerge with respect to self-harming behaviours.

Drawing from cross-cultural literature on suicide, there are several reasons to suspect that culture may affect self-harming behaviours in different ways. First, research seems to suggest that the rate of suicide may differ across cultures. For instance, cross-cultural comparisons suggest that relative to a Pakistani sample, Americans reported more suicide attempts, multiple suicide precipitants and higher degree of suicide potential (Farooqi, 2004). Similarly, when compared to non-native populations, the suicide rate amongst First Nations peoples is 3-5 times higher (e.g., Kirmayer, 1994). Culture also appears to influence the methods by which individuals engage in suicidal behaviours. For example, when compared to their North American counterparts, Indian immigrant groups report significantly higher rates of suicide by burning (Raleigh & Balarajan, 1992). Taken together, these observations seem to raise the possibility that suicidal behaviours may differ across cultural groups were culture may play an instrumental role in conceptualizing and defining the meaning of suicidal behaviours.

Although self-harm may not necessarily encompass suicidal intent and behaviours, it nevertheless suggests that cultural differences may also exist with respect to self-harming behaviours. Especially since culturally-defined social taboos and religious sanctions conceptualize suicide differently across cultural groups (Farooqi, 2004), these cultural norms may affect how self-harming behaviours are perceived, expressed and understood. To explore this possibility, the goal is to begin to examine the intersection between self-harm and culture through an analysis of self-harming behaviours in minority and non-minority children and youth who are involved with child welfare services. Data from SORs collected during the year 2005 at the Children's Aid Society of Toronto were analysed. Given the exploratory nature of this area, the primary intent is to describe possible group differences between minority and non-minority children and youth in care in the amount, type and method of self-harming behaviours.

First, with respect to the frequency and types of self-harming incidents (i.e., threat to self harm and attempts to self harm), it remains unclear as to whether cultural differences will emerge. Current analyses, therefore, is exploratory in nature. Secondly, given that cultural norms and expectations may in some ways define appropriate behaviours, cultural differences were expected to emerge with respect to the methods used to self-harm.

Preliminary Findings from the Children's Aid Society of Toronto's 2005 Analysis of SOR Data

Methodology

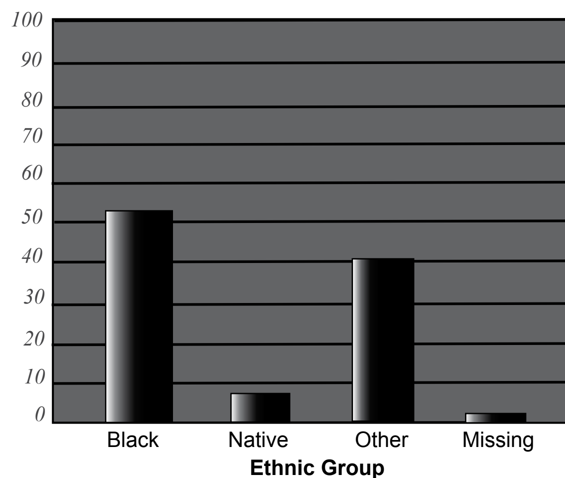
Data from Serious Occurrence Reports (SOR) collected during the year 2005 by the Children's Aid Society of Toronto were analyzed. SORs are completed by the child's worker and submitted to the Ontario Ministry of Child and Youth Services. These reports cover a range of situations with one of them being a self-harming incident or threat to self harm. A total of 72 SORs from children and youth where identified as those with one self-harming incident (including both attempts and threats to self harm). These children and youth represent 75% of the total sample collected by the Children's Aid Society of Toronto during the year 2005. The remaining quarter (excluded from the current analysis) represent children and youth who have engaged in multiple instances of self-harming behaviours. Of the 72 SOR reports used in this study, 38 were from non-minority youth (M age = 15 yrs) and 34 from minority youth (M age = 14 yrs).

Non-minority participants included those who were of European-American heritage. Minority participants included those who were from other ethnic or cultural backgrounds. Of our minority sample, 52% were Black, 6% were Native, 40% were "other" (i.e., Asian, Hispanic, mixed) and 2% whose information was missing (refer to Figure 1). More specifically, a large proportion of minority participants who were categorized as 'other' represent children and youth who are bi-racial with some First Nations ancestry. Minority and non-minority status participants were roughly matched in age and gender.

Results

Data was first explored for cross-cultural differences in the number of self-harming behaviours reported by minority and non-minority youth. Specifically, we examined whether cultural differences existed with respect to the number of self-harming attempts and threats that were reported. A two-way contingency table analysis was conducted to evaluate whether minority and non-minority children and youth in care differed in the number of self-harming attempts or threats. The two variables were minority status with two levels (minority vs. non-minority status) and SOR type with two levels (attempt vs. threat). Minority status and number of attempts, Pearson $\chi2(1, N = 72) = .00, p = .99$ and threats, Pearson $\chi2(1, N = 72) = .00, p = .96$ were not significantly related. This suggested that minority and non-minority children and youth in care did not differ in the number of self-harming attempts or threats that are reported.

Figure 1: Cultural distribution of minority status participants.



We were also interested in whether differences existed in how minority and non-minority youth in care engaged in self-harming behaviours. The specific behaviours examined included number of cutting (including scratching and stabbing), head banging and punching, choking or hanging, overdose (with medicine or poison), jumping (e.g., out of cars or windows) and other types of harm. A two-way contingency table analysis was conducted to examine whether minority status was associated with frequency of self-harming attempts. The two variables were minority status with two levels (minority vs. non-minority) and type of self-harming attempt with six levels (cutting, head banging and punching, choking or hanging, overdose, jumping and other). There was a trend for minority status to be related to attempts of cutting, scratching and stabbing only, Pearson $\chi2(1, N = 72) = 3.30$, p

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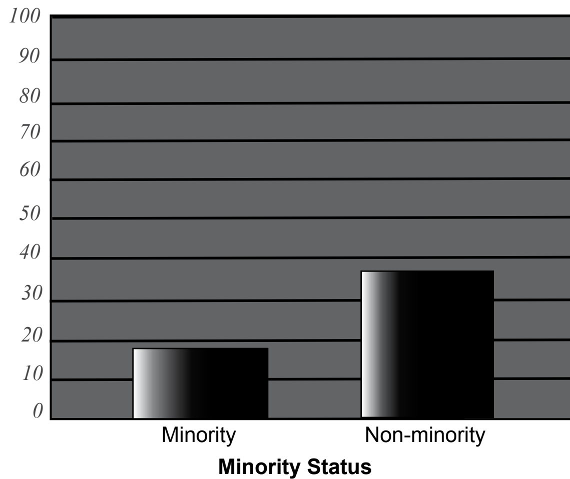
Figure 2: Percentage of minority and non-minority children and youth who engaged in cutting.



= .07. The proportions of minority and non-minority children and youth in care who engaged in cutting behaviours during a self-harming episode were 18% and 37% respectively (refer to Figure 2). Minority status was not significantly related to other types of self-harming attempts. Results suggest that when compared to minority children and youth in care, non-minority children and youth in care were more likely to engage in cutting behaviours when attempting to self harm. No other differences in self-harming attempts are evident.

Finally, we examined whether minority and non-minority children and youth in care differed in the amount of self-harming threats reported. Number of cutting (including scratching and stabbing), head banging and punching, choking or hanging, overdose (with medicine or poison), jumping (e.g., out of cars or windows) and other types of threats were examined. A two-way contingency table analysis was conducted to examine whether minority status was related to frequency of self-harming attempts. The two variables were minority status with two levels (minority vs. non-minority) and type of self-harming threats with six levels (cutting, head banging and punching, choking or hanging, overdose, jumping and other). Across all types of self-harming threats, minority status was not found to be significantly related to any of the behaviours. These results suggest that despite differences in minority status, how children and youth in care threaten to self-harm did not differ.

Implications for Practice and Directions for Future Research

Preliminary evidence presented in this paper suggests that although minority and non-minority children and youth in care did not differ in the number of self-harming incidence for both attempts and threats, culture may affect how children and youth in care engage in self-harming behaviours. That is, when attempting to self harm, non-minority children and youth in care were more likely to cut, scratch or stab themselves when compared to their minority counterparts. There is no evidence to suggest that minority and non-minority children and youth in care differed in other methods of self harm. In the following section, each of these observations will be examined followed by a discussion of how these findings can impact on practice and future research.

Culture and Amount and Type of Self-harming Behaviours

The analysis did not find any evidence to suggest that minority and non-minority youth differ in the amount of self-harming behaviours. That is, the number of self-harming attempts and threats were similar between groups. Perhaps these similarities were seen given the demographics of our sample. For instance Gratz (2003) argues that childhood abuse and neglect is a major contributor to the risk of self-harming behaviours since it may relate to the development of emotion disregulation. Given their involvement with the Children’s Aid Society of Toronto, it is highly probable that a large percentage of our sample experienced some form of abuse or neglect. Thus, despite differences in cultural background and ethnicity, the experience of childhood abuse or neglect may have placed these children at greater risk for self-harm. An interesting avenue for future research would be to examine possible cultural differences in a community sample of youth who self-harm, as well as different cultural communities, including various Aboriginal youth groups. This will help to describe the nature of self-harm in these communities, as well as lay the groundwork for efforts to tease apart the affects of abuse and culture on self-harm.

Culture and the Types of Self-harming Behaviours

Another interesting and important observation that emerged from this analysis is that non-minority and minority children and youth in care appear to dif-

fer in the how they engaged in self-harming behaviours. That is, relative to their minority peers, non-minority children and youth in care were more likely to engage in cutting, scratching or stabbing behaviours. Although statistically this effect was marginally significant, it nevertheless suggests that there may be some preliminary evidence that culture can affect the strategies selected by children and youth in care when engaging in self-harming behaviours.

Perhaps cultural differences seen in cutting behaviours across groups may be related to culturally defined norms and rules. Although it remains unclear as to why these cultural differences were observed, it may be possible that in other cultures, cutting is not conceptualized as self-harming behaviour, nor is it as stigmatized. In some cultures, there is a long history of body cutting and modification that have social significance. For instance, the Bafian tribe of Cameroon hold that being scarred is a way in which tribal members are distinguished from other animals. Alternatively, there may be specific cultural or religious repercussions associated with cutting, scratching or stabbing. For example, as part of the Hinduism doctrine, purposeless mortification of the body is seen as a sign of weakness. Given these cultural differences in how body cutting is conceptualized, minority youth may be more likely to engage in other maladaptive coping behaviours other than cutting during self-harming incidents. Although highly speculative, our observation encourages more research in exploring the cultural meanings associated with different self-harming strategies.

Implications for Practice and Research

Perhaps the most important contribution this paper has to the self-harming literature is the suggestion that self harm may be a universal phenomenon that can be situated along the continuum of risk-taking behaviours common to childhood and adolescence development. Clinically, it would seem of increasing relevance to child protective services populations. Despite differences in cultural background, certain children and youth in care of child protection services appear to engage in some form of self-harming behaviours. Although it remains unclear as to the motives underlying these self-harming episodes, results from the present study underscore the importance of continuing to understand how self-harm is conceptualized by children and youth in care. Most importantly, preliminary results from this study highlight the importance of understanding self-harm within a cultural context. Specifically, more research is required to understand which youth engage in self-harming behaviours, why, and how serious self-harming behaviours are perceived by different cultural community. Lastly, for clinicians working with self-harming individuals, observations presented in this paper shed light into how the profile of self-harm may be different across cultural groups. For instance, depending on cultural norms and values, certain methods of self-harm may be more prevalent in some communities then others. This knowledge can help guide practice and development of effective intervention strategies that are culturally sensitive to the specific needs of these individuals. Although more research is needed to identify the specific needs across cultures, this study emphasizes the importance of this avenue of research.

Given the increasing heterogeneous composition of Toronto's population, examining how culture can affect self-harming behaviours is imperative for clinical practice. However, there are some limitations that must be acknowledged. First, considering that this sample was predominately maltreated children in the care of Children's Aid Society of Toronto, the effects of abuse and culture were confounded. Thus, future research should aim at including a community sample controlling for abuse to examine the specific effects of culture on self-harm. Similarly, we did not distinguish between specific cultural groups in our analysis, due to our limitations in sample size by cultural group. Considering that the effects of culture may impact on self-harm in different ways across groups, future study should also consider comparing the profile of children and youth who engage in self-harming behaviours across different cultures. Nevertheless, this study represents a first step towards identifying the specific needs of various cultural groups of youth with childhood maltreatment histories so that appropriate interventions can be developed to prevent self-harm.

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The Maltreatment and Adolescent Pathways (MAP) Project: Using Adolescent Child Protective Services Population-Based Research to Identify Research Questions

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Abstract

This article introduces readers to the Maltreatment and Adolescent Pathways (MAP) study. The MAP is a longitudinal study that follows active case files of mid-adolescents in a large urban child protective services (CPS) system. The MAP is a unique opportunity to collect information from teens about their physical health (e.g., sleep quality), mental health (e.g., posttraumatic stress disorder) and cognitive style (e.g., attention, memory). The MAP study samples the population of CPS teens on questions that are used in provincial teen surveys, allowing for points of comparison to non-CPS teens. The MAP tracks youth development over 2.5 years. Although the MAP currently has a very small number of Aboriginal teens, the responses of these teens may focus practitioner and researcher attention to priority areas for further research. This includes the investigation of how some research issues, such as maltreatment history, personal safety, relationship to primary CPS worker and suicidal ideation, may be cross-informative. It is known that teen risk behaviours cluster together, but it is important to understand the relationships among these variables. An understanding of these relationships can drive knowledge creation, as well as practice and policy change. Finally, the MAP study has succeeded given a successful collaborative partnership between hospital, university, and CPS partners who both strive to keep the youths' best interests in the forefront.

Introduction

Childhood maltreatment – sexual, physical, emotional abuse and the physical and emotional neglect - is an experience that has been associated with a wide range of challenges across development (see Wekerle, Miller, Wolfe, & Spindel, 2006 for a clinician's resource book). The most severe outcome is suicide, where much is lost, including the opportunity for the health care community to actively intervene and provide the support a youth requires to self-right and craft a life of vitality. Beyond suicide, behaviours such as depression, anxiety, and panic; aggression and delinquency; sexual risk-taking; and substance misuse are among the most common mental health issues.

Whenever these behavioural concerns emerge, family violence immediately becomes a clinical hypothesis to consider in assessment. During these assessments, the question about maltreatment needs to be asked directly, and needs to be asked in terms of specific behaviours (e.g., were you hit to the point of

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bruising or leaving marks? Did the individual touch your private parts?), rather than using general terms like "abuse" or "neglect" with a youth. The use of these general terms requires an element of willingness by the youth to self-label as abused or neglected, as well as knowledge of the broader context of normative parenting. It is important to directly inquire about maltreatment as waiting for a disclosure is often not sufficient support to a child or youth who just wants the abuse to stop. The experience of maltreatment suggests that something went wrong in the family, in terms of injury prevention and protection. If the question of maltreatment is not asked, then the opportunity to provide a safety net for a family that has become isolated, insulated, impoverished and impulsive has been lost. This family needs support in (re)learning alternatives to violence.

While the maltreatment may have ended before adolescence, transitioning to genuine maturity and self-care may be challenging. Maltreatment may be felt with each developmental step: finding a best friend, developing supportive social networks, entering dating, having a romantic partner, believing in yourself enough to take on challenging career and educational opportunities, and confronting any mental health issues directly. Given the leveraging that comes with so many changes, including physically and neurodevelopmentally, adolescence is a window of opportunity. To be in the position to set a positive track, it helps to have a map or layout of where the common pitfalls are and what are strong options for health. When roadblocks are encountered, the youth needs to know how to best to go about changing and coping.

One of the goals of directing Aboriginal youth who come to the attention of the child protective service system is to provide a point of cultural contact and facilitate opportunities to foster a positive identity with Aboriginal culture(s), in addition to working on individual youth issues. This article introduces the Maltreatment and Adolescent Pathways (MAP) project, a study that can inform us on teen perceptions of their world. Here, we focus on what teens' are identifying as their individual issues and connect these to research questions that could be considered in the future.

The MAP Study

To date, 218 child protective services teens (54% female), aged 14 to 17 (average age = 15.5 years), have taken part in the MAP study by completing an initial testing. The youth who have participated in the study described their ethnicity as: 38% Caucasian, 33% Blacks, 2% Aboriginal; 13% Other; 14% Bi/Multiracial. Youth were living with foster parent(s) (33%), biological parent(s) (24%), in a group home (30%), or some other arrangement (13%). Teens involved in the MAP study are tested every 6 months for 2.5 years. During these sessions, the youth fill out nearly 100 pages of self-report questionnaires, usually in their homes. These questionnaires ask youth about their socioeconomic status, drug and alcohol use, dating practices, friendships, sexual practices, psychological health, maltreatment history, and resiliency. The MAP has demonstrated a 70% recruitment rate and a 90% retention rate of all youth with active and eligible files within a major urban centre. About 60% of youth in the MAP study report experiencing physical and emotional abuse, 40-50% neglect, and 20-25% sexual abuse. The rates of childhood maltreatment in the MAP exceed what would be expected based only on the profile of new cases at intake in Canadian child protective services as per the Cana-

dian Incidence Studies (CIS-I, CIS-II) of Child Abuse and Neglect. This discrepancy could be explained in terms of the MAP asking about abuse and neglect across the childhood years.

The MAP is not a national study, but attempts to capture the youth population in Toronto, Ontario. In Ontario, the child protective services system is managed by local Children's Aid Societies (CAS) that have geographical catchment areas and, in the case of the city of Toronto, mandates based on identified religion. The MAP study is past the time frame when most of the Aboriginal Toronto-area Children's Aid Society cases in care have been transferred to the local Native Child and Family Services. Present practice dictates that any intake cases with Aboriginal children or family members are directed to their culturally appropriate services (as is the case with identification by religion, specifically, Catholic and Jewish, with all remaining cases going to Children's Aid Society of Toronto). The MAP study is currently involved with 3 agencies in the Toronto area: Catholic Children's Aid Society (CCAS), Children's Aid Society of Toronto (CAST), and Peel Region Children's Aid Society (Peel). The MAP does not have the participation of youth with the Native Child and Family Services in Toronto. The MAP has approached the Toronto smaller agencies about involvement in the study; however, the workload involved in providing liaison members and accommodating the research involvement were not feasible as determined by the agency representatives. Service issues and resources prevent the substantial commitment that the MAP requires in these smaller agencies. Feasibility to participate for the agency is an important decision and is, in and of itself, a research question to clarify parameters for involvement for future research efforts.

A remaining need is how best to support agencies to engage in research, within Canadian funding trends. In the MAP study, honoraria are provided to all agencies on the basis of 10 eligible youth referred for involvement in the study, even if the youth do not consent to participate. CAS agency advisory board members assume this MAP-dedicated time within their CAS workload, given agency administrative approval for the MAP study. At present, direct payment for research involvement by the CAS agencies is not a feasible approach considering the funding caps on Canadian grants. The MAP participating service agencies can expect "reimbursement" for their involvement in the study via access to clinician-scientist expertise and access to systems of research literature and support, such as a literature searches with attached seminal articles on an issue of practice importance. The MAP has a list serve to circulate timely articles and evidence-based practice opportunities, and delivers clinical workshops to CAS agencies in youth service topics areas.

Governing the Research: Partnership for the Youths' Best Interests

The MAP study is guided by a community-researcher partnership. The MAP advisory board represents CAS workers, researchers within the agencies, and university- or hospital-based clinician-scientists and researchers. The academic group is interdisciplinary, with representation from child and family clinical psychology, adult clinical psychology, experimental psychology, pediatrics, child psychiatry, social work, and epidemiology. The advisory group meets regularly - monthly for the first start-up year of the study and bimonthly thereafter. Joint activities include the review of every item and measure included in the MAP study, identifying new research areas to consider, creating and reviewing the testing and clinical follow-up procedures, developing the consent forms for the study (with the help of a CAS lawyer), and providing supporting letters to University Internal Ethics Review Boards to help clarify required or recommended procedures that may be beyond standard ethics practices. This is sometimes necessary given the nature of the population included in the study.

The MAP Advisory Board worked to create practices that maximally supported youth. Researchers wanted to measure youth distress as a function of research participation and, as such, inserted a series of ratings before and after each testing session. Results showed that MAP youth were no more distressed after being in the research than before they started a testing session. CAS workers wanted to ensure research participation had a non-exploitation conceptualization, and was viewed along the lines of a work opportunity. For example, workers were very clear that the best remuneration for study participation would be money, not coupons for music or food items. The youth's time is reimbursed with money and the MAP feasibility study set the longest time a youth needs for testing, and all youth were paid to that level. Traditionally,

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though, ethics boards would see any monetary gift as coercive or potentially damaging (e.g., youth could buy drugs). Feasibility analyses indicated that money was the most often noted reason by youth for participating, but it was not the sole reason endorsed. Other reasons included interest in the research topic and a desire to help others.

Traditionally, ethics boards would also argue that approaching youth to inquire about involvement in the study via CAS workers may foster too close an association with the agency and may be experienced as coercion to the youth. However, all CAS workers used a standard script of a few sentences and were not responsible for answering questions or providing much detail about the MAP study. The caseworker obtained telephone consent for research staff to take on this role where it is clarified several times that services are not affected in any way by a decision to participate or to not participate in the study. It was important to limit initial external contact with the youth by MAP researchers since CAS teens are identified as a population in need of protection. CAS workers were the first individual to contact CAS youth about the study to support a sense of control and limit vulnerability in the population. These examples demonstrate the desire of researchers and CAS agencies to support the best interests of the CAS youth, which meant documenting the rationale for deviating from the norm for university-based research ethics boards. The MAP has been approved by CAS, hospital-based and university-based research ethics boards.

The MAP Study: Research Suggestions from Aboriginal Youth Responses

To date, 5 youth in the MAP study have identified themselves as being Aboriginal. Currently, analyses can not proceed given this small number, and significant findings as compared to non-Aboriginal MAP youth can suggest trends to provide material for further thought about research questions. **Thus, these "results" should not be taken as important in and of themselves, but rather serve as a basis for further discussion of research needs.**

Clinically, it is a truism that productive change will not be maximized if one only targets problem behaviours. Both sides of a behaviour need to be defined – what not to do and what to do - where the positive side is practiced to produce skills at the level of a "ready response." Optimal functioning includes the person's own view of how they are doing, all things considered. It can include approaches to life, such as hopefulness, optimism, forgiveness, and wisdom. It can also include community-based behaviours like "helping out," being responsible, and feeling safe. Often taking a back seat in child welfare practice is "productive leisure," such as exercise, crafts, music, sports, dance and other arts. These activities provide an opportunity for skill-development, mastery, and earning money, in addition to enjoyment, distraction, and relaxation.

There are roles for intentional, planned actions, as well as opportunities for spontaneous engagement. Essentially, youth have to feel engaged in living, have ideas (even vague ones) about a future for themselves, and have supportive relationships. Youth need to understand that they are not alone in their maltreatment and that there are options to prevent other victimizations, be they at school, in dating partnerships, at social events, or with their families and communities. Some youth may need to be "coached" towards accepting help, counteracting thoughts of personal weakness with personal power in taking charge of the issues that are affecting them. Below are three well-being issues that the MAP study considers.

Felt Sense of Safety

Child welfare has always been organized first around child protection. It would seem of interest, then, to understand how protected children and teens feel in their many environments. Even at school, the caregiver plays a key role as advocate in cases of school bullying which can become chronic and has led to maladjustment and, even fatal outcomes. Failures to protect extend beyond the family home to the key environments of school and neighbourhood. Child protection service workers also play a liaison role with schools and communities and can join in family problem-solving on these issues. MAP findings suggest that:

- MAP Aboriginal youth tend to report feeling safe in their neighbourhoods and homes more so than non-Aboriginal MAP teens. Overall, though, 90% of MAP youth feel safe in their neighbourhoods. Further information on the population of high school youth in Ontario (grades 7 to 12) is available from the Ontario Student Drug Use Survey Study at http://www.camh.net/research/osdus.html.
- More MAP Aboriginal youth seemed to feel less safe

in school (25%) than do non-Aboriginal MAP youth (12%). This is substantially higher than the Ontario population of high school youth, where only 6% say that they do not feel safe in school.

Possible questions for future research include:

- What contributes to a youth's felt sense of safety in the environments of their daily lives?
- How does a felt sense of being unsafe in school and in one's neighbourhood impact cognitive functioning, such as the ability to focus attention, move information from short-term memory to long-term memory stores; and "work" or manipulate information for problem-solving?
- How does their maltreatment experiences impact personal safety? Is post-traumatic stress response, including symptoms like hypervigilance and avoidance of trauma-connected cues, maintained in day-to-day life via daily stressors?
- Have youth acquired effective personal safety skills? How does their felt sense of safety influence their style of relating? Do youth feel like they can bring up school safety issues with their workers? Bullying is often related to younger age children, but harassment about sexual orientation and sexual bullying (e.g., giving "up-down" stares or rumors about sexual activity) are prevalent in high school.

Attachment to Care Providers

The stylistic way of relating is still under development in adolescence. It is known that maltreated infants are mostly classified as disorganized in their attachment, meaning that they have low confidence in their caregiver providing a sensitive response and do not have an organized, coherent response to caregivers (see Wekerle et al., 2006 for a review of the literature). It also means that the child is never clear on how best to respond to minimize threat and maximize the ability to stay close to his or her attachment figure. It is important to remember that even if it is insecure or problematic, virtually all children form an attachment bond. Sometimes, the maltreated child avoids the caregiver and pay attention to other things, like T.V., toys, or schoolwork if he can remove himself from the caregiver environment. Sometimes, the maltreated child protests the caregiver's unsatisfactory behaviour, like "getting in their face" or affection attempts that hurt (e.g., giving a too-tight hug). Essentially, the maltreated child has difficulty trusting in relationships since the person they are relating to is so hard to "read." The child may feel that relating is unpredictable, does not often feel good or make them feel good about himself or herself, seems to be outside of any control. Or, the child may overcompensate by trying to become overly controlling, overly compliant, or overly caring in their environment. Mistrust, fear, overly quick engagement and closeness, and easily dropped attachments may come to describe maltreated children's relationships. The primary child protection service worker is one opportunity to provide a context for relationship modeling and learning a new style of relating. Listed below are comments that the MAP teens have made about their workers.

- MAP Aboriginal youth are less likely than non-Aboriginal MAP youth to endorse that they have strong feelings toward their primary worker and feel that the worker is not very important to them. Overall, 27% of MAP youth disagree to some extent with the statement that their worker is important to them. Thus, most youth would seem to feel a positive connection or valuing of their worker, but a substantial number do not.

Possible research questions include:

- How does felt safety and demonstrated support factor into the youth's view of their relationship to their primary worker? Is this influenced by the number of worker changes? Do youth feel that they are empowered to continue their interaction with a worker with whom they feel connected?
- Who are the workers that are valued? Those who convey affection and positive regard for the youth as a whole? Those that celebrate and validate important dates in the youth's life? Those that actively work at inspiring and mentoring youth? Those that actively support the limit-setting and fair behaviour correction practices?
- One research question would be to better understand how there is a successful interplay between worker relationship and relationship investments in strong community-based support?

Thoughts of Suicide

Suicidal thinking does not necessarily reflect a wish to die. However, it is a predictor of suicide attempts and deaths, as well as mental health concerns. The risk of suicide is heightened when there is substance abuse, depression, prior suicide attempts, a plan of action, easy access to suicide means, and fewer obstacles to suicidal actions. All verbal and non-verbal threats of suicide, such as drawing of hanging oneself and writing on school binders of sui-

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cidal thoughts needs to be further followed up in all cases. Below are some findings of suicidal ideation among the MAP youth.

- MAP Aboriginal youth tend to have greater thoughts about ending their life than non-Aboriginal MAP teens. In the MAP overall, 26% experienced suicidal ideation, with 13% thinking of ending their life "quite a bit" or "extremely." As a point of comparison, the OSDUS 2001 study reports that 11% have serious suicide thoughts, substantially lower than MAP teens (see the OSDUS E-Bulletin Report at: http://www.camh.net/Research/Areas_of_research/Population_Life_Course_Studies/eBulletins/eb018_suicide.pdf.) Further, the OSDUS study shows that teens who report thinking about killing themselves also tend to live in a single parent home, have lower parental monitoring, report poorer relationships with their parent, report not feeling as safe at school, have low attachment to school, and are victims of school bullying.

Potential useful follow-up research ideas include:

- What is the context for suicidal thinking and self-harm actions? Are these daily occurrences? Do they match up with "dips" in mood or negative events, such as relationship conflict? Do they occur in the context of substance use? Do friends have these or talk about it?

Research with an Ontario population of adults indicated that the risk of suicidal ideation more than doubles among adult depressed women when they have experienced childhood physical abuse, as compared to those women who have not (McHolm, MacMillan, & Jamieson, 2003). In a population study of teen females in the US, it was found that girls who were "experimenters" (i.e. those that are more likely to have sex, use drugs, or drink alcohol) were 2-3 times more likely to be depressed one year later (Halfors, Waller, Bauer, Ford, & Halpern, 2005). Depression initially did increase the likelihood of moving from an "experimenting" group to a "high risk" group. For boys, binge drinking and frequent marijuana use predicted subsequent depression. Thus, it would seem that for girls, depression prevention may involve sex education regarding intercourse and multiple partners and alternatives to substance use. A gender-specific consideration of the effects of maltreatment is a research area that has been under-considered to date.

Other important research questions related to suicide ideation include what protective factors are in the community to reduce suicidal thinking and risk for action. Further, understanding the youths' reasons for living (family, friends, future, specific plans/goals) versus reasons for dying (escape oneself or others/relationships, feeling hopeless) would seem important to understand from both a motivational set. For youth who repeatedly think about suicide, it would be important to understand what is the nature and sequence of their inner cognitive debate, if there even is a self-dialogue that occurs, or why death seems an attractive option.

Morsette (2006) indicates that Native American humor seems embedded in the culture and in no way depreciates the gravity of situations. As with maltreatment, verbal "testing of the waters" in terms of disclosing suicidal thinking may be relayed in a humorous story. Morsette notes that dealing with an individual issue means being cognizant of the relation of the self to families, elders, and social/local norms. Any statement of suicide needs to be followed up, regardless of a humorous delivery or in the context of a humorous anecdote, and a suicide risk assessment completed (see …). Quite simply, without the youth alive, the maltreatment experience is not fully appreciated and validated, and opportunities to intervene effectively are no longer available. Clinically, when thoughts of suicide lead to a sense of inner calm or has the person smiling, the youth needs support in addressing their affect, and re-engaging and building new positive reinforcing activities.

The day-to-day life of a teen should involve more positive experiences than negative. Otherwise, the job of child protective services is not complete. Child protective services need to be concerned with the daily lives of their youth – how safe they feel, how well they are sleeping and eating, how connected and supportive their relationships are, and whether or not they feel that they are moving toward specific goals and dreams. Some areas of concern have been examined in this paper, but there are many more areas of concern documented by the results of the MAP study. For example, about half of MAP youth tell us that they have difficulty dealing with explosive anger and can't stop thinking about bad things that have happened to them on a weekly basis. The experience of childhood maltreatment forces youth to sometimes find ways of coping in advance of skill development. It challenges their ability to form a "story" of their maltreatment by integrating information from different perspectives and sense-based information, especially when fear is strongly linked to abuse/neglect memories.

It should not be surprising, then, that the MAP youth report that for those teens who are drinkers and smokers, they began their drinking, smoking and use of marijuana before age 13. Nearly half of the MAP youth have had their first “wanted” intercourse by age 14. Among these teens, 5% say that they in fact did not want their first sexual intercourse and 43% say they were unsure about it. Furthermore, about 30% of the MAP youth had intercourse in the past year with someone they did not know well. Thus, while for most MAP teens their maltreatment experiences were in the past, our analyses show that it is related to what they do in the present and how they get through adolescence as a developmental stage. Rather than over-focusing on independence and the providing of information on surface levels (i.e., use pregnancy and disease protection with every intercourse), we may need to return our attention to focusing on guidance at the level of the whole person (i.e., what kind of partner do you want to have?). Simultaneously, it may be important to remain mindful of daily functioning with the knowledge that adolescence is a bridging between childhood and adulthood. Allowing the “child” in the teen to remain active by discouraging the rush toward “adult-like” behavior (i.e., remaining curious, appreciating discovery, and having harmless fun) may be another important way of supporting our teens involved in the child protective services system. In this way, we all hope that the teen will not just survive to adulthood, but thrive.

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A Commentary on Alternative Approaches to the Research Process with Canadian First Nation Communities

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As a co-investigator of one of the research studies in this issue(Building a Collaborative Understanding of Pathways to Adolescent Alcohol Misuse in a Mi'kmaq Community, p. 27), I have had a unique opportunity to work in a multiple capacity roles. In addition to being a community member and a research partner, I am also a graduate student in school psychology. My submission is intended to share my experiences in my capacity role as a First Nation support worker, particularly in research, with the hope of providing some guiding principles and practices when conducting research in a First Nation community. Based on my experience in conducting research on First Nation mental health issues, it seems oftentimes lacking in publications in scholarly journals. This makes it difficult when looking for sources for information. There could be a number of reasons for the deficiency in published information on First Nation issues. In my experience in consultation with community members, their initial reaction is "we have been studied to death", or "researchers from outside the community come in and take information to use for their own benefit", or "what do we get out of it?". While all these responses might be accurate on some level, it leads me to the question as to why it seems so difficult to find information on First Nation issues especially in Canada.

Some possibilities as to why it is difficult to find information on First Nation issues, especially in psychological research, might be that the nature of psychology can conflict with many First Nation sociocultural principles. It has been, at times, challenging to apply many of the principles in psychology in my practice as a guidance counselor working with my Mi'kmaq speaking First Nation community. I often have difficulty in the application of psychological theories and principles as they originate typically from European scientists which often clash at least in part with the Aboriginal worldview. In my practice, more often than not, psychological methods require adaptation to fit the circumstance. Since, the arrival of Europeans and the colonization of the First Peoples of this country, there is a residual sense of distrust of Europeans by many First Nation community members. This sense of skepticism has potential to interfere with the process of conducting a research study such as the one I am co-investigating. As a service provider, the valuable information this study has to offer is recognized as beneficial in developing programs to meet the anticipated needs based on the outcomes and recommendations the study provides. Recognizing the potential benefits of the study and hoping the community will consent to accepting its proposal is an example of the conflict experienced by a researcher from the community.

This study focuses on youth experiences and its effects on their current functioning. This information has possible clinical benefits by self reporting anonymously; this might be the first step to a full disclosure leading to therapeutic intervention. The nature of some items on the questionnaire can be perceived as highly sensitive and, therefore, community members might want to naturally protect the youth from exposure to some of the questions. A lot of time and rapport building is required in working

toward obtaining consent to conduct a study of this nature.

My community is the largest Mi'kmaq community in the Atlantic region in size, population, and in Mi'kmaq speakers. The community is respectively rich in culture, language, and history. For a prospective researcher to go into the community intending to extract information from the community, he/she might be faced with a challenging task - one that requires as much consultation with community members as possible. For this particular study, the process was accelerated via community organizations. This particular community has organized committees whose members represent various stakeholders in the community, such as case management team, interagency committee, and the community health board. (Note: All these committees comprise of community members who meet and collaborate on concerning issues and/or developing interests about the community.) Many committee members are appointed by their supervisors to act on their behalf and report information back to their organization. Not all First Nation communities have active committees or boards; therefore, a researcher might have to meet with representatives individually rather than in groups. The research process may require variation in methodology based on the community and its needs. The planning and preparation is time-consuming, but an essential aspect of the research process. It is helpful when the researcher is able to follow and adapt to the timing of the community schedule. This part of the process may require months or even more depending on the community's reception of the proposed study. Allocation of more time gives the community members time to become familiar with the researcher, time to process the proposed study, time to ask questions, consult and make queries. In making initial contact, it depends upon the nature of the study and the target population. For instance, the target population of this study is the youth; the best access to youth is through the school. Therefore, the initial contact person for consent would be the director of education. If consent is obtained at that level, technically a researcher can then collect data, but may risk obtaining an insignificant number of participant consents and/or parental consents. The next stage is to make presentations to community committees by contacting the chairperson of each committee and consulting with them about how best to present information to that group. Often, it is better when the presentation is less formal, minimizing the length of the presentation and using less jargon where possible. This is also applicable to handouts: less is more. Allowing for more discussion time would likely be helpful in facilitating the process. For optimal results, these stages of consultation are recommended to get as many community members on board even before obtaining parental and participant consents. With our study, prior to data collection, the participating schools made presentations to the teaching staff and students about the proposed study and letters were sent home to parents so that as many individuals are aware about the study. After the data is collected and results are analyzed, as a best practice, the researcher is recommended to return to the community to disseminate the results to the committees and consultants of the community. In an effort to improving the research process in First Nation Communities, allowance for time is definitely recommended and consult, consult, consult.

Taking the time to go through the process as mentioned before could take several months which might lead to difficulties in meeting deadlines with university timetables. Perhaps, cultural awareness presentations could be developed and made available to participating universities interested in conducting research within First Nation communities. Another possibility might be to invite researchers experienced in conducting research in First Nation communities to develop a paper on guiding principles and made available online as a link on university websites. As a frontline worker in my community, I look forward to seeing more scholarly research conducted with Aboriginal people in Canada especially in the mental health field making information about our people relevant, practical, and meaningful.

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A Smoking Prevention Program for Aboriginal Youth

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Abstract

In recent years, policymakers and medical experts have expressed alarm about the growing problem of tobacco related deaths, most specifically from smoking cigarettes. Even more alarming is the rate of tobacco use among Aboriginal people and specifically Aboriginal youth. This paper explores how a holistic approach coupled with Aboriginal healthcare professionals is necessary for an effective smoking prevention program. Moreover, recommendations are provided based on this information to help devise an effective smoking prevention program encompassing all four aspects of health; mental, physical, emotional and spiritual.

Introduction

> *Immediately after taking the puff of smoke, our minds would race, and our whole body would be affected by this smoke since tobacco is a very powerful medicine. It has a specific purpose which must not be abused - Elder Danny Musqua (WUNSKA, 1997, p.92)*

Smoking is the leading cause of preventable illness and death in Canada and is the known or probable cause of many fatal diseases such as lung cancer, heart disease and stroke. Moreover, smoking is responsible for the death of more than 45,000 Canadians each year. What is even more disturbing is the rate of smoking among Aboriginal people in Canada.

In 2001, more than 1.3 million people identified themselves as Aboriginal, representing approximately 4.4% of the total population (Statistics Canada, 2003). Tobacco use among Aboriginal persons is at alarmingly high rates as compared with the general population. Recent data has approximately 60% of First Nations people smoking as compared to 22% in the general population (National Aboriginal Health Organization - First Nations Centre, 2005). Furthermore, First Nations population-adjusted smoking-attributable mortality rates are almost 1.5 times those of the general population and are responsible for almost one in five adult deaths among First Nations people (Wardman & Khan, 2004). Even more worrisome is the smoking rate among Aboriginal youth, which is 2.0 times higher than in their non-Aboriginal counterparts (Reading & Allard, 1999). Consequently, there have been smoking interventions and strategies aimed at reversing high smoking rates among Aboriginal youth (Marriott & Mable, 2002; Ramsden, 2002; Lemchuk-Favel, 2002). These studies unanimously conclude that to maximize effectiveness, Aboriginal youth smoking prevention programs must adopt a holistic approach. Research has also shown that when advised to reduce smoking, adults respond better to healthcare professionals than any other group (Fiore et al., 2000). This paper will discuss relevant areas to consider when developing a smoking prevention program for Aboriginal youth that adopts a holistic approach and centers around healthcare professional utilization.

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Holistic Approach

Aboriginal people tend to take four directions, or four body approaches to health encompassing the physical, mental, emotional and spiritual. Rupert Ross

(1996) says, "… it is important to approach whatever you encounter in life through all four dimensions" (161). In keeping with the need for a holistic approach, each of the following four areas needs to be addressed to ensure the development and delivery of an effective smoking prevention program for Aboriginal youth.

Culturally Appropriate (Spiritual)

There are significant challenges when attempting to design and implement a smoking prevention program for Aboriginal youth; one of these being culture, and in particular, the ethic of non-interference. In Aboriginal culture, people are taught to be independent and deal with issues on their own. The cultural practice of non-interference deems asking for help or offering help as culturally inappropriate. This creates serious barriers to the success of existing smoking prevention programs, most of which utilize group presentations to be effective.

Another shortcoming of existing smoking prevention programs is that they tend to isolate smoking from other related substance abuse and addictive behaviour. Smoking is directly related to alcohol dependence and other addictive behaviour including illicit and prescription drug dependence and problem gambling (Emery, Gilpin, Ake, Farkas & Peirce, 2000; Petry & Oncken, 2002; Rodda, Brown, & Phillips, 2004; Shaffer, Vander Bilt & Hall, 1999; Shiffman & Balabanis, 1995). This fact is particularly important to consider when developing Aboriginal youth smoking prevention programs. Aboriginal youth they are two to six times more likely to have alcohol-related problems than their non-Aboriginal counterparts (Health Canada, 1999). Further, Aboriginal youth are more likely to experience gambling problems as compared to their non-Aboriginal peers; and teenage Aboriginal problem gamblers are also more likely to be smokers than non problem gamblers of the same age (Hewitt & Auger, 1995; Peacock, Day & Peacock, 1999). Thus, Aboriginal youth smoking prevention programs must target these behavioral patterns and taught associations to be effective.

Another major problem with current mainstream smoking cessation programs is the portrayal of tobacco as negative or evil. For Aboriginal people tobacco is a sacred plant used in ceremony and cleansing. Thus, the negative portrayal of tobacco in mainstream smoking cessation programs creates a great deal of tension. When such programs are implemented in Aboriginal communities, Aboriginal youth have a difficult time accepting the portrayal of a sacred plant as a negative, do not give a full effort, and eventually "tune out" of the program. Aboriginal youth need a smoking prevention program that is both effective and culturally relevant.

Understanding the True Role of Tobacco (Mental)

To be effective, Aboriginal youth smoking prevention programs must recognize and acknowledge differences between ceremonial tobacco and commercial tobacco use. To illustrate, prior to the arrival of the first Europeans to Canada, Aboriginal people were using tobacco, though not the in way tobacco is used today. Tobacco was a sacred plant and had many uses. For example, tobacco was used for communication with the spirits as a method of seeking the Creator. Tobacco was also used in important ceremonies such as sweat lodges, pipe ceremonies and smudges. In these ceremonies, tobacco was smoked and used as a cleansing ritual. Tobacco was only permitted for ceremonies, as misuse might jeopardize the effectiveness of tobacco in communicating with spirits (Wardman & Khan, 2005). This understanding is essential in helping Aboriginal youth develop a cultural understanding of tobacco use and the importance of not abusing it.

Targeting Very Young People (Emotional)

Previous studies suggest that two major risk factors for smoking initiation among children and adolescents include accessibility of tobacco products and perceptions that smoking is a common and normative peer and adult behavior (US Department of Health and Human Services, 1994). In many Aboriginal communities, smoking is perceived to be widespread normal adult behavior. Many youth take up smoking in an attempt to appear "grown up". Aboriginal siblings are usually quite close and very influential in each other's decision-making. Compounding the problem, the trauma of residential schools has left many modern Aboriginal parents with inadequate parenting skills. Targeting youth and their parents will help slow down the snowball effect of smoking uptake and nicotine dependence among youth in Aboriginal communities; a problem that is currently rolling out of control.

Recreation (Physical)

It is well known that Aboriginal youth desire to participate in culturally relevant recreational and physical activities such as swimming, camping, dancing and exercise. Unfortunately, in many Aboriginal communities funds for recreation and recreation coordinators are either not available or not utilized, and young people find other activities to occupy their time. In one study, it was clearly demonstrated that involvement in sporting activities contributed to lower smoking rates among young Aboriginal athletes (Yakiwchuk et al., 2005). Thus, physical activity is an important part of helping Aboriginal youth to remain smoke free.

Utilizing Healthcare Professionals

Healthcare professionals play a critical role in reducing tobacco use (US Department of Health and Human Services, 2000). They reach a high percentage of the target population and are in a key position to help smokers change their habits and overcome their difficulties by offering advice and guidance. Additionally, they also have a vital role to play in smoking prevention, especially among youth. The strong, credible voice of health professionals can promote and strengthen the self-confidence and decision-making abilities of youth. Therefore, one strategy to prevent tobacco use is to encourage the involvement of health professionals in tobacco-use prevention programs.

Many Aboriginal healthcare professionals, by the nature of their position, will be required to take leadership positions in Aboriginal health systems, where mainstream approaches will be combined with more traditional health and healing practices (Smylie, 2000). For Aboriginal healthcare professionals, the likelihood of engagement with Aboriginal patients is increased as compared to a non-Aboriginal health care professional (National Aboriginal Health Organization – First Nations Center, 2003). Even more importantly, Aboriginal healthcare professionals are often seen as role models for their communities. As Aboriginal youth commonly lack such role models in their lives, utilizing Aboriginal healthcare professionals as role models within a smoking prevention program is likely to be an effective and even crucial tool in the reduction of Aboriginal youth smoking rates.

Finally, the development and implementation of effective Aboriginal youth smoking prevention programs must involve consultation with Aboriginal youth themselves. Aboriginal youth must be given the opportunity to be the leaders as well as the participants of such initiatives in order for these programs to be effective. Allowing youth a place in the creative process creates a feeling of ownership that reduces drop out rates and increases the overall success of the program. Moreover, the development of a holistic smoking prevention program that utilizes Aboriginal healthcare professionals and includes Aboriginal youth in the creative process is a unique approach that holds promise but has yet to be developed and targeted at Aboriginal youth in Canada.

Bio

Daniel McKennitt comes from the Sandy Bay Ojibway First Nation, just outside of Winnipeg, Manitoba. Daniel recently finished his first of year of medical school at the University of Alberta. Before this, Daniel completed his Bachelor of Science degree at the University of Alberta with a double major in Mathematics and Physical Sciences. Inspired by his mother, a residential school survivor and breast cancer survivor, Daniel became interested in improving the health and success of Aboriginal youth in all aspects of life. Previously working with institutions such as the University of Alberta, Alberta Advanced Education, and Canadian Heritage; Daniel brings a wealth of knowledge in regards to working with Aboriginal youth to achieve their goals. Lastly, Daniel was just named one of twelve National Aboriginal Health Organizations youth role models for the 2006-2007.

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Housing for Aboriginal Youth in the Inner City of Winnipeg

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Abstract

Aboriginal families are highly overrepresented in child welfare caseloads. Major reasons for these high rates of involvement include poverty and housing issues, which contribute to perceptions of child neglect. In Winnipeg, the city with the highest proportion of Aboriginal peoples in Canada, low-cost housing is concentrated in core neighbourhoods. Homeless youth in these neighbourhoods, who are involved or have been involved in child welfare, were asked about their life experiences and the kind of housing that would help them. They talked about the need to be seen as resourceful, contributing members of the community, as well as their continued need of support from others, including friends and family. They wanted more than a place to sleep; they wanted a home that was safe, nurturing and long-term. The youth had school and work aspirations for themselves and wanted to help other youth reach their goals. There is a need for expansion of community-based and community-driven housing with youth who have been involved in the child welfare system.

Introduction

Aboriginal families remain highly overrepresented in Canadian child welfare caseloads. Indeed, "there are more children in the child welfare system and not with their families than there were children in residential schools at their height" (National Children's Alliance, 2005). While in operation between the late 1800's and 1900's residential schools had devastating effects on Aboriginal families and communities; subsequent impacts of the schools have been felt by generations of survivors and their families. Assimilation was pursued through forced attendance of children aged 5-15, legislated by the Indian Act, requiring children to be turned over to the state for "education" (Blackstock & Trocme, 2004). Many affected by the residential schools also had another negative experience of unwanted state intervention, as adults with their own children. Indeed, the 60's scoop, where many adoptions of Aboriginal children into non-Aboriginal homes took place, was yet another attempt by the state to assimilate Aboriginal children, by taking them through force from their families, communities, and cultures (Sinclair, 2007).

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Generations of Aboriginal children who have been removed from their families by the state have not been exposed to role models that assist in the formation of healthy identities as Aboriginal peoples. Opportunities to learn about healthy parenting have also been taken away. "Child protection" for Aboriginal children has typically meant separation, trauma, and disconnection. The intergenerational impacts are multiple, and include problems with illness and relationships, as well as economic hardships, which contribute to the present-day over involvement of Aboriginal children in the child welfare system.

High rates of family poverty and inadequate housing among Aboriginal families have contributed

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to perceptions of child neglect and lead child welfare involvement (Trocme, Knoke, & Blackstock, 2004). Contemporary responses, such as apprehensions and out-of-home placements, have been costly, financially, to the system, as well as socially and emotionally, to families and communities. However, apprehensions and out-of-home placements do not address the fundamental inequities that many Aboriginal families continue to experience. The effects of such ineffective child welfare responses are also passed from generation to generation. Youth who have had child welfare system involvement continue to experience the high rates of family poverty and housing challenges faced by their parents, and are left to struggle themselves with the same issues.

Numerous reports document the challenges faced by Aboriginal youth (MacKay, 2005; Turcotte & Zhao, 2004; Fournier & Crey, 1997; Mussell, Cardiff, & White, 2004), homeless youth (Petrie & McLean, 2005; Klodeawsky, Aubry, & Farrell, 2006; Zamprelli, 2001), and some indicate that rates of child welfare involvement are high among these populations (Fitzgerald, 1995; Serge, Eberle, Goldberg, Sullivan, & Dudding, 2002). However, there is much less available data on the experiences of Aboriginal youth who are homeless and have had child welfare involvement.

Study Setting and Purpose

In urban centers across the Canadian Prairie Provinces, low-income neighborhoods cluster in the inner cities, where Aboriginal populations are also high. In Winnipeg, housing and poverty issues are most visible in the inner city. Winnipeg has the highest proportion of Aboriginal peoples in Canada (Norris & Jantzen, 2003). The population of Aboriginal peoples in Winnipeg cluster in the downtown core (Maxim & Keane, 2003), where low-cost housing is highly concentrated (Distasio, Sylvester, Jaccubucci, Mulligan, & Sargent, 2004). Despite high rates of family poverty and lack of adequate housing for residents, downtown core neighborhoods have a rich history of community involvement and strong social networks. Youth in these neighborhoods face multiple barriers, but also have many strengths and gifts to share. This study focuses on the issues, barriers and solutions to youth homelessness in Winnipeg's core neighborhoods from the perspectives of the youth themselves. Homeless youth who had been involved in child welfare, were asked about their life experiences and the kind of housing that would help youth in their community.

Method

Understanding the "problems" of groups facing multiple barriers has been of interest to researchers for some time. However, these groups have typically had few connections to researchers through which to influence the agenda (Greenwood & Levin, 2000). As a result, participants have experienced little benefit from being researched because the results had no direct application to their realities. We wanted to design a research study that would yield results that could be directly applied toward improving the conditions for youth in the local community.

We used the principles of community-based participatory (CBPR) research to guide this project. CBPR is defined as "a collaborative approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process. The partners contribute unique strengths and shared responsibilities to enhance understanding of a given phenomenon and the social and cultural dynamics of the community, and integrate the knowledge gained

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with action to improve the health and well-being of community members" (Israel, Schulz, Parker, & Becker, 1998, p. 175).

The research team included two agency directors, a university professor, two graduate students, and an undergraduate student, as well as a supervisory staff member within each of the community agencies, two youth who had been previous service recipients and six youth who were local residents. Members were called together to outline the purpose, identify research questions as well as sampling strategy for the study. Our purpose for the study was to identify the range of local issues associated with housing for homeless Aboriginal youth who had involvement with the child welfare system. The questions for this study were drafted by the six youth who were local community residents, and presented to the full research team. These questions are attached as an appendix. It was decided that local residents who were part of the research team would recruit participants through word-of-mouth.

Interviews were conducted in a variety of locations, based on each youth's preference. Locations included coffee shops, public parks, as well as meeting rooms within local agencies. Data were recorded using handwritten notes, since participants were not comfortable with audio-taping. The notes were typed out following the interview.

Data from the 30 interviews were shared with members of the research team in advance of a group meeting where they were to be discussed. The research team members discussed their own reactions to the interview transcripts. A potential data analysis procedure was proposed and discussed. Members agreed that a content analysis of the notes from interviews would be conducted in accordance with Creswell's (2003) procedure, including 1) arrangement of data into types, 2) reading through the data to get a general sense of the meaning, 3) initial coding of the information into chunks and labeling into categories, 4) detailed description about the people, places and events, and generation of codes for use with small number of categories, 5) discussion of each theme and, finally 6) interpretation of the data. This analysis task was undertaken by a graduate student member of the research team in consultation with a university professor. A draft of the results was circulated to members who provided feedback, which was incorporated into a final version. Team members approved the final version before it was made public.

Results

Twenty females and ten males, ages 13 to 21, who were involved in the child welfare system or had been involved in child welfare system, were asked about their experiences and solutions to homelessness. They were asked about their current living situation, their awareness and use of community resources, their present needs and future goals, and what would make a difference to homeless youth and families. The interview guide for these semi-structured interviews is attached in an appendix.

The majority of participants were born in Winnipeg, or in nearby communities. Some were born on Reserves from different regions of Manitoba. Those not born in Manitoba stated that they were born in other Canadian provinces. Three participants were from Nova Scotia, two were from British Columbia, and one was from Saskatchewan.

All of the youth lived in the North End at some point in their lives, or had a family or peer connection living in that area. Many stated that they presently had contact with at least one parent, but suggested that this contact was limited or nonexistent when they were homeless.

The duration of homelessness varied a great deal. Some stated that they had been homeless for only a few hours at a time, while others suggested longer lengths of time, stretching out from days, to weeks, to months. The shortest length of time homeless was a few hours, and the longest time was one year. However, some of the youth stated that they went through periods without a stable home. Several had a family history of homelessness.

> *When I was younger I was homeless along with my brother, sister and mom. I was homeless from the age 6 to around 11 years old. It was devastating to live without a home, we would stay in laundry rooms of apartment blocks, in the foyers of apartments and anywhere we could get warm especially in the winter.*
>
> *My mom was living all over…she lived with her boyfriends but got into arguments so she left.*
>
> *We also stayed at a shelter and with friends because my dad was very abusive to us. When I was 13 years old I left or got kicked*

> *out from my moms and lived on the street, I was never able to sleep properly and never felt safe.*

The youth discussed using and/or relying on several community agencies, as well as adult and youth shelters. They also reported using the services offered by churches, food banks, soup kitchens, and drop-in programs.

Content analysis of interview data revealed six themes. Evidence of these themes appeared consistently across the interviews. These themes included: temporary living, sense of safety, being in control, support networks, future goals, and taking care of others.

Temporary Living

> *I'm in between places right now...got kicked out of a shelter, and don't have an apartment yet...went to check out the one they (welfare) wants me to move into, but it is full of rat shit, and there's no lock on the door, the windows are broken, light switches don't work and it smells...*

Youth described their experiences of multiple short-term living situations.

> *I just went from home to home, from the time I was 16 years old till about 17 and half. I just wandered around. My mom tried to find me but couldn't.*

> *…been bouncing around for five years, between placements and friends.*

> *… we have nowhere to live, staying at a friends place…basically back and forth like.*

To many youth, homelessness meant not having shelter. It also meant being vulnerable to the elements and lacking basic necessities.

> *People that are living on the street, sleeping on benches and in front of stores…that's homelessness.*

> *People having to sleep under bridges, no shelter.*

> *Homelessness is how people have to eat out of garbage cans...have to live in a bus shelter, have to ask for spare change...*

When asked about their present living conditions, the youth talked about how they had shelter, but that it was a limited term arrangement.

> *I am staying at my sisters until Sept.01 until I get my own place. She lives in the North End.*

> *Right now I am homeless. I am staying with my sister in the North End...it's been about one month. It's good in a way but stressful because you don't have your own place.*

Some described the quality of their present living conditions as poor, and that they would gladly move if they could.

> *I have my own place now…it is really bad though…when it rains, it comes inside…it is in the central area, but the landlord is bad… I've been staying at my sister's because my place smells so bad and is falling apart…I called a health inspector and they are kicking everyone out of the place, so I have to find a new place to live in two weeks…*

> *I am on a waiting list for public housing. It would make a difference because it's a house and its decent looking compared to now.*

Sense of Safety

The youth described how they felt about personal safety in their own relationships, both while they were homeless and in their present living situations.

> *I lived with my boyfriend for a while, but he was very abusive...I stayed with friends for a while, and some other family, but that wasn't so great....*

> *My boyfriend was out of control at times and used to break windows and bang on my door making too much noise, so I would get evicted.*

The power held over them by the private landlords in control of their accommodations also threatened their safety.

> *Well, the landlords come and harass us for money for rent…money we don't have…they don't understand that welfare pays for our housing.*

Youth also talked about their concerns about personal safety within the neighbourhood they lived in.

> *…was homeless before…was almost stabbed in the face but blocked with my forearm….*

> *Gangs make it difficult. I was stabbed.*

> *When you are walking around getting jumped out of nowhere…you could get*

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jumped for wrong colors…they could stab you, you could get shot.

The drinking was pretty bad in the area and I worried about the kids around there…I liked having my own place, privacy, my space but the drinking and fighting around there wasn't good.

However, their feelings of safety were also improved, in some ways, because of their social connections and familiarity with resources in the neighborhood.

Everybody (neighbors) know each other, if there is something suspicious happening in the neighborhood they notify someone. Everybody is always looking out for each other.

The neighbors are friendly. They help me out with my kids.

... most people are really nice here, and there are lots of resources around...

I live at a safe house now... I know I have a place to go that is safe and I don't have to worry...most of my friends live with their parents...not scared about anything, myself, in this neighborhood...if you look scared you might be a target, but if you look confident people won't want to fight you...

Being in Control

The youth talked about feeling a lack of control over their lives. They coped with this by taking control of their circumstances in different ways while homeless. Some felt scared and lonely. They worried about finding something to eat, and not knowing what was going to happen next.

I was forced to leave my families house; took everything I could pack.

I was sexually abused by my dad so I don't bother with him anymore. My mom doesn't know about it, so I only see or talk to her every once in awhile.

I got locked out of my mom's place, my aunty didn't want me, and my sister didn't care…I was so scared, I just walked around all night… that was the only time I was homeless…

When I was homeless I felt so unwanted and I wanted to commit suicide at that time.

…it gets lonely when you're homeless…it hurts that your family can't look after you anymore because they've got their own things going on…

Not all of the youth felt accepted into the homes of friends or family. For them, there was a price tag for this help, and some felt they were being taken advantage of.

I didn't like staying with other people because I had to look after all the kids…mine, plus 4 others or more, and they take off and leave you with them…you can't complain because you're staying there, but you also feel taken for granted…

The youth talked about their desire for independence, the benefits as well as responsibilities that came with it, as well as how they made ends meet.

Since I was 16, I've lived on my own…it is good in that you have your own rules to live by and no one telling you what to do.

It was great living on my own because you can do whatever you want…you just have to worry about your bills and food.

Panhandled, stole, shoplifted and sell what I stole, also my boyfriend would jump people and take their money for us.

In terms of money being a problem, it depends on the circumstances. I can get money but its how I get the money. I scam, hustle, and steal…I do whatever I need to do.

The future they wanted involved employment and education. However, the changes needed to reach their goals had to be on their own terms.

Hopefully I'll be working and living on my own this time, next year.

Lots of people could help, but I need to want to help myself.

...you've gotta help yourself...they (agency staff) sure helped me figure out that I needed to make things happen for myself and that no-one was going to do it for me...

Support Networks

The youth described the nature of their support network. They talked about the positive impact of getting emotional support from family members.

…my ex's mom was like a sister to me...she was 31 and could relate because she'd been there, too...

I have sisters in this neighborhood and we

all encourage each other…

My grandparents are around to help me out.

While they all needed help at one point or another, the family supports available changed frequently.

…my boyfriend knows people, has friends and family here…we're staying with his sister right now, and that's going good…

…my mom and sister help me out with food and money…more my sister…

…my uncle helps out…he's got a place on the reserve, but comes into Winnipeg when he gets welfare to help us out with groceries…we share, and look after each other…

The youth talked about the support provided by agencies in the community, as well as professionals who made a difference in their lives and the lives of their children.

the agencies helped me out…they had a bed for me, and they got me to reopen my CFS file…

…there is one place that helps me out a great deal. My son likes it there, too. He goes there early in the morning until 8:30pm. They have a program for young mothers…they take out mom's and baby-sit kids.

...probably the people who helped me the most were some teachers and a probation officer...

They appreciated being close to where their friends, and families lived, as well as the services that were nearby.

I like the neighborhood…it's a nice neighborhood. My sister is near here and there are enough friends around to rely on.

Living in this neighborhood, I'm close to all resources and family.

My sister lives about 5 houses away and my mom and brother live about 4 blocks away...counseling services are close by and the counselors even come to my house. I'm in a program now…I live there, and take classes…they help me a lot with my issues…I knew about the program for a while, but didn't think I needed to be there…my first son's granny worked there, and told me about it…

Future Goals

No matter what their current situations were, the youth had concrete goals in mind for their futures. These goals included centered around education, employment, and longer-term living arrangements.

Next year I want to be graduating high school, then living on my own. I need to stay in school and choose the right friends.

Having my own place, getting a job, having money, putting resumes out there to find a job.

I hope I'll be working, like to go back to school in September, to college to upgrade my high school courses.

I want to finish my high school…have one more year to go, and then done…want to go to college or university after and become a counselor or therapist…

...next year, I'd like to be finished high school and be able to go into child care or youth work...but, I want to take a year off and work, too...

The youth also talked about the services that they needed to help them achieve their goals.

I'd like to better my self as a parent.

Going to programs (drug, parenting) would help me. Also go to an Adult Education program for my grade 12 would help as long as they had a daycare right in the school.

I'd like to go back to university. I was taking Law so I'd like to keep doing that. I would need to get my kids in daycare first though…I would need to get sponsored by my band again so I can have money to live on. I have friends who will help me out and I have myself. I am brave enough to go back to school and that's a start.

Taking Care of Others

The youth discussed what they thought would be useful to help others in similar situations. For immediate help, they noted that more shelters, drop-in programs, safe houses, and community centres were needed. Recommendations were also made to expand existing agencies.

A huge house where anyone could stay...I'd like to buy out all of the staff here, and open my own house, where I made the rules...have TV's and air conditioning in each room...

More places like_____ around here, get kids

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off the streets, places need to be open longer hours and all night.

…someplace where the youth can also go to school, and go on outings…

…need activities for moms and kids separate and together…it would be ideas to have an apartment for kids, like a bachelor apartment, with its own cooking and bathroom stuff…but with adults there, so that you could have someone older to talk to, when you needed it…we also need programs for the young ones because they run away for so many different reasons…they are in desperate need to stop the drugs, but people get in too deep…

…I would like to volunteer and mentor to kids who need someone older to talk to…but you need to make sure that the mentor has been there and done that and has outgrown it, be clean and straight…

Addiction support is needed and education is a big help. The youth need 24-hour programs that they can go to for support

For longer-term assistance, help reconnecting with family and the community, as well as schools was needed. Several mentioned that housing, education, and employment skills training would be helpful.

Employment would help would help youth also reconnecting with family and addiction services could help the youth.

Education is important, kids need a place where they won't be judged, where someone won't call the police or their parents on them. They need counseling but so many teenagers are scared of adults and so many adults are afraid of teenagers…Awareness groups would help people become aware of homeless youth, maybe have people speak to junior highs about homelessness issues… people need to be more understanding of teenagers.

Get these kids to go to school, teach them to help themselves, work experience, to find them a clean home and shower…Put them in drop in centers, so they can feel safe, no worries about violence. Get youth involved in sports, it keeps the violence away.

Housing and employment to get kids off the street and more drop-in centres would help the kids. 24 hours places would help; something for them to do like being able to play basketball at 2 in the morning would also help.

The youth also discussed the need for information. This included counseling services, access to Internet, and access to information about services.

There are lots of places youth can go for food, and shelter.... there's lots out there, people just don't go to these places...maybe they don't know about them...

Didn't turn to anyone, didn't know what was out there, felt like the bad kid.

More publicity is needed on youth homelessness and the services they can contact.

I didn't know anything about any resources, so maybe they should do more advertising about where to go if you're homeless. There should be somewhere that you can call at anytime, and a 24-hour drop in centre with counseling, with a place to sleep for shelter.

Older people who have been homeless talking to homeless youth…if they have been through the same situation they could discuss it.

Discussion

Homeless Aboriginal youth in the inner city are not a homogeneous population. Their experiences and situations are as unique and varied as their future goals and directions. However, the frequency of child welfare involvement among youth who are homeless is a serious concern. The realities of their early family experiences, including poverty and inadequate housing, are also concerning. Interestingly, the youth we spoke to did not dwell on the past, but remained oriented to the present and the future. They spoke about their struggles, but not to complain. Rather, they spoke about their struggles as a way to share their collective abilities to sustain themselves and care for others, despite considerable adversity.

Their realities included multiple moves over short periods of time, from varied arrangements with different family members and friends. They did what they could to keep themselves safe throughout these many transitions, by knowing where they were and deciding who they could trust. They left when they felt unsafe. They did what they had to do to get by with the few income opportunities they had to work with. They wanted security and support, but not at a personal cost that would compromise their inde-

pendence. They wanted to find the right balance for themselves.

The problems the youth had with private market and public housing reflected the same challenges their parents and other families faced. They had difficulty finding decent, local, affordable housing. Multiple challenges such as absentee landlords, dirty conditions, shady deals for rent, and unsafe buildings, were reported. However, these were the only places that they could afford. For many youth, the local community did offer support in terms of people and organizations they had good relationships with. The challenge was finding a decent place to live, with the right amount of stability and support. The youth also wanted educational upgrading or training and work experience that lead to a living wage job, close by.

The challenges faced by local youth who have been involved in child welfare affect only the youth, but their families and the greater community. However, the lack of local housing, educational and employment opportunities for youth when they turn 18, create huge barriers obtaining the personal, educational and work skills they need to achieve the level of independence they want. The youth themselves have identified the need for housing models that help them find the right balance of skills and experience, in a setting where they receive the social support they need, within the community where their friends and family live, in a city where they are seen as assets for the future.

Local community-based agencies are providing much-needed and effective services to Aboriginal youth in the inner city. These organizations, based local leadership and the strengths of residents, are well placed to deliver the needed services within the community. What is needed is the commitment of government resources to the expansion into more housing for youth.

Conclusion

Homeless youth who were involved in the child welfare system have many strengths, including self-control, resourcefulness, friendship, sharing, protecting, looking to the future, and as well as a desire to take care of others. The youth are actively involved, and interested in continuing to be involved in the development of local resources for their friends and families in their local community.

The solutions, from the perspective of youth themselves, lie in valuing their contributions, allowing them to grow as individuals and parents by providing gentle guidance from well-intentioned others within their community. Punitive responses have not, and will not work. The need for a safe place to live, where there is the right amount of support nearby, and resources for re-entry into school or a job.

A significant gap is the absence of supportive housing for youth after they reach the age of 18. Inner city communities have the expertise, but a greater commitment of government resources to address root causes of homelessness among youth their families, namely less poverty and more affordable housing, are needed. The funding and development of second stage housing models, based on local community-identified priorities, are needed to ensure that youth leaving the child welfare system do not become homeless.

Bios

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Is Attachment Theory Consistent with Aboriginal Parenting Realities?

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Abstract

Attachment theory has become one of the most influential models guiding parent-child relationships in programs of prevention, treatment, and education, including programs for Aboriginal parents. However, whether the model can be reliably applied when working with Aboriginal peoples has not yet been established. Studies on attachment security conducted with different cultural groups provide a means of comparing naturally occurring differences in parenting practices and socio-emotional environments of children. These studies report inconsistencies of attachment security across cultures and suggest that consideration should be given to cultural differences when applying attachment theory across cultures. In this article, we analyse the correspondence between attachment theory and descriptions of Aboriginal parenting and question the relevance of attachment theory to Aboriginal parents who do not adhere to the mother-infant dyad as the sole contributor to the child's sense of security.

Introduction

Attachment theory has become one of the most important conceptual schemes for understanding the early socio-emotional development of children (Cassidy & Shaver, 1999; Crittenden & Claussen, 2000). It has also become one of the most influential models guiding parent-child relationships in key areas such as daycare, child welfare, head start programs, hospitals, schools, and parenting programs. Equally, attachment theory has a central role as a model that informs social work practice with Aboriginal parents even though the applicability of the model for working with Aboriginal peoples has not been established. This raises the question of whether Aboriginal parenting practices are congruent with attachment theory.

Since attachment theory is believed to have a central role in child development, it has been widely incorporated into programs dealing with parent-child relationships. The role of attachment theory in guiding programming for parents is evident in the many references to the theory given in the rationale and design of the programs (Aboriginal Head Start, 2006; McCain & Mustard, 1999; Rycus & Hughes, 1998).

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Despite this widespread adoption of attachment theory, research on the applicability of the model with different cultural groups has been limited. By looking at cultures that do not follow Western child rearing practices, an opportunity emerges to examine naturally occurring differences in parenting and socio-emotional environments of children that can clarify the implications of these differences for attachment behaviours. The research that has been conducted, which will be reviewed below, has suggested that parenting practices which differ from Western norms lead to inconsistent results in infant security. This suggests that attachment security as a guiding concept for Aboriginal parents requires further analysis.

In this paper we first provide a brief description of the core ideas in attachment theory. Then, we examine studies that have explored the consistencies of attachment security across cultures, which have raised questions about the cross-cultural applicability

of the model. Next, we analyse the apparent consistencies or inconsistencies between attachment theory and descriptions of Aboriginal parenting. Finally, we offer some suggestions for applying the model with Aboriginal parents.

Attachment

Attachment theory has long been recognized as an important model for understanding individual development. Attachment is regarded as significant in shaping our capacity for interpersonal relationships, as well as, in the formulation of our view of the world and of others around us. John Bowlby (1969, 1973, 1980), a British psychoanalyst, is credited with developing attachment theory. Bowlby argued that attachment is biologically based and represents a child's instinctual need for a reliable, ongoing relationship with a primary caregiver and that if this attachment was interrupted, lacking or lost, lasting emotional damage could occur (Karen, 1994). Bowlby focused on the distress that infants tend to show when separated from their mother or the person with whom they are emotionally bonded. Through his research, he identified a series of infant attachment behaviours, including crying, clinging, following and smiling, that he argued serve to keep the caregiver close at hand to ensure the child's safety and survival. He observed that these attachment behaviours were invoked when the distance from the mother (or attachment figure) exceeded a certain threshold in time and/or space and the infant sought to regain proximity.

Bowlby argued that the responsive action or inaction of the primary caretaker to these expressed attachment needs formed the foundation of what he termed the infant's 'internal working model' – a mental representation or belief about the ability and willingness of others around them to provide comfort and care (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969). Thus, he proposed that attachment figures who were able to promptly and consistently provide comfort and reassurance to an infant experiencing distress laid the foundation for an optimal internal working model that enabled the infant to view the world as trusting and responsive and ultimately in terms of a sense of security. Conversely, caregivers who were slow or unable to respond to an infant's expressed needs contributed a foundation for an internal working model that persuaded the infant to view the world through a lens clouded with mistrust and uncertainty (Bowlby, 1973; Bretherton, 1985; Main & Hesse, 1992). The internal working model is seen as a relatively fixed and lasting schema of the accessibility and quality of the relationship with the attachment figure (Bowlby, 1973). It has further been described as an unconscious blueprint of emotional development that has the potential to impact future relationships (Morton & Browne, 1998).

Working from Bowlby's premise that initial primary relationships between infant and caregiver could provide insight into relational development, Mary Ainsworth and her colleagues (Ainsworth et al., 1978) laid the groundwork that extended the concept of attachment into a phenomenon open to empirical examination. In an attempt to further analyze and understand the intimate bonding exchange between mother and infant, Ainsworth began strategically observing maternal responsiveness and sensitivity to infant need, proposing that this was the crucial link in the development of infant attachment. In a pivotal study, Ainsworth, Bell and Stayton (1974) demonstrated that mothers' responses to their children varied widely, which in turn could be clearly shown to be linked with the infants' level of secure attachment.

The Strange Situation Procedure

In her ongoing exploration of the fundamental components of attachment theory, Mary Ainsworth et al. (1978) devised the strange situation procedure (SSP) to test and observe individual differences in infant attachment behaviour. During this procedure, which optimally occurred with infants between twelve to twenty-four months of age, mothers and babies were viewed in an unfamiliar but pleasant environment that invited exploration and play. Through a series of brief episodic encounters, infant behaviour was closely observed under varied conditions of stress: (a) when the mother was separated from the child (leaves the room) after a stranger has entered and begun to interact with the child and (b) when the child was left alone (mother has left the room) whereupon the stranger enters the room and interacts with the child. The infant's responses to the reunion, upon the mother's return on the two occasions of the procedure, were carefully assessed and soon became one of the focal points of the study of attachment behaviour. Based on the systematic observations of Ainsworth and her colleagues (1978), three categories of infant attachment behaviours were proposed.

Infant responses were labelled as Insecure – Anxious/Avoidant (Type A), Secure (Type B), or Insecure – Anxious-Resistant or Ambivalent (Type C) infants.

Secure – (Type B) infants displayed an optimal level of exploration and caregiver affiliation during the pre-separation phase of the procedure, mild to moderate wariness when the mother left the room and were easily comforted upon her return. It was noted that this group of infants protested or cried when separated from their mothers, but when their mother returned secure infants tended to greet her with pleasure, often reaching out their arms to be picked up and were relatively easily consoled (Karen, 1990).

Anxious-Avoidant – (Type A) infants were observed to be seemingly confident and independent, displayed a relative lack of distress when separated from their mother and avoidance behaviour upon her return. Avoidant infants seemed to be independent. These infants would explore the new environment without seeming to rely on their mothers as a base, and they did not engage in repeated checking on their mother's presence like the infants labelled secure. When the mother left the room, anxious-avoidant infants did not show any marked reaction and when she returned they snubbed or avoided her (Karen, 1990).

Anxious-Resistant or Ambivalent – (Type C) infants showed little interest in exploring their environment; they became highly distressed when left alone or when in the presence of an unfamiliar adult and could not be easily comforted by their mothers. Infants classified as ambivalent were mostly clingy from the beginning of the procedure and seemed fearful about exploring the room on their own. These infants showed a high level of agitation and became very tearful when separated from their caregiver. When the mother returned to the room ambivalent infants sought contact with their mother, but also arched away appearing to be angry and resisted efforts at being soothed (Karen, 1990).

A Disorganized/Disoriented – (Type D) category was suggested by Main and Solomon (1986) to describe another group of infants who seemed to lack any coherence in their responses to the SSP. These children were later found to be in abusive or traumatizing mother-infant relationships that caused a mixture of fearful and uncertain reactions that appeared disorganized and inconsistent (Bretherton, 1985; Main & Solomon, 1990).

The classifications of infants' secure and insecure attachment behaviours emerged as significant when Ainsworth linked them to in home observations of the mother-infant pairs. From these initial observations specific associations could be made between a mother's style of parenting and the infant's attachment behaviour (Karen, 1990). The infants that had received a classification as securely attached had mothers that responded readily to their infant's communication such as when they cried or otherwise expressed discomfort. These caregivers also reciprocated infants' smiles with an affectionate response. These observations regarding secure attachment confirmed Ainsworth's central premise that a responsive or sensitive mother provides a secure base from which her infant can explore the environment (Ainsworth et al., 1978; Ainsworth & Marvin, 1994)

In contrast, the mothers of infants labelled as insecurely attached – avoidant (Type A) were found to be insensitive to their infant's expressions of discomfort. These mothers also seemed to display a dislike for physical contact and showed little emotional responsiveness towards their infant (Ainsworth et al., 1978; Bretherton & Waters, 1985). The mothers of infants labelled as insecurely attached – resistant or ambivalent (Type C), on the other hand, demonstrated a clear inconsistency in responding to their children's needs (Bretherton & Waters, 1985). Infants labelled as Disorganized (Type D), however, would appear to have experienced both inconsistent and abusive primary relationships characterized by caregiver intrusiveness and maltreatment, including physical abuse and psychological unavailability (Carlson, 1998; Sroufe, Egeland, Carlson, & Collins, 2005).

The patterns established by these attachment relationships are thought to become internalized by the infant as an internal working model or set of beliefs about what to expect of relationships and this internal model is regarded as stable and resistant to change (Cassidy & Shaver, 1999). Bowlby (1973) surmised that the beliefs associated with the internal working model persist throughout life. He hypothesized that early attachment success provided a foundation for healthy functioning in future relationships, whereas failure to attach could hinder an individual's ability to form satisfactory relationships later in life and potentially lead to a variety of behavioural and emotional difficulties. Much research has focused on this hypothesis that attachment security predicts

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subsequent behaviour and has tended to confirm an association between attachment types and behaviours during infancy and early childhood, such as play and exploration, autonomy and competence, peer relationships and psychopathology (Sroufe, Fox, & Pancake, 1983).

The idea that the internal working model is stable and has an enduring effect arising from an individual's secure or insecure level of attachment is a concept with far reaching implications. Thus, attachment patterns are measured by using the SSP and interpreted as secure or insecure. Lasting and stable internal working models are by definition a function of early parenting behaviours, with sensitive parenting leading to the preferred outcome of the secure child. But what if the parenting does not follow attachment theory's ideal pattern, not because the mother or caregiver is insensitive, but because the cultural context in which the child is raised promotes parenting practices that are contrary, or at least, not consistent with the attachment theory ideal.

A number of researchers have pointed out that attachment theory makes assumptions, based on Western ideologies, regarding ideal dyadic relationships and preferred developmental outcomes based on the mother-infant bond (Harwood, Miller, & Irizarry, 1995; McShane & Hastings, 2004; Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000). For instance, not all cultures expect mothers to be the sole caregiver (Bournstein et al., 1992) nor do all cultures interpret the child's needs in the same way (Sagi, 1990) or have the same reactions to emotional expression, such as the meaning of an infant's cry (Harwood et al., 1995). What must surely come into question then, is the universal applicability of attachment theory (van IJzendoorn, 1990). Although there are relatively few studies that have examined the consistency of attachment theory and attachment security across cultures (van IJzendoorn & Sagi, 1999), there have been studies that have allowed for comparisons between cultures. In the next section we review studies that have examined the pattern of attachment security using the SSP with parents and children from cultures where parenting practices differ from the normative sample from the USA.

Thematic Analysis of Attachment

Although there are numerous cultural differences in parenting that could be explored, there are three core patterns that are identifiable which have a bearing on attachment theory. First, parenting that is very involved and intensive in meeting infant needs or what we have called 'hypersensitive parenting.' Second, parenting that is less intensive in meeting infant's and what we have called 'selective parenting.' Third, the involvement of multiple caregivers in a significant role in caring for the infant or what we have called 'shared parenting.' We will review studies that have examined the association between these patterns of parenting in different cultures and attachment security.

Hypersensitive Parenting

In Western culture the expectation is that a parent will respond sensitively to a child's needs as a reaction to explicit signals from the child. In Japanese culture the expectation is different, a parent is expected to engage in a high level of emotional closeness and to anticipate a child's needs rather than wait for a signal from the child (Rothbaum et al., 2000). The Japanese mother is encouraged to view the child as an extension of herself (Bournstein et al., 1992), with close physical contact between the dyad, whereas American mothers "prefer more distal modes of interaction with their baby" (Vereijken, Riksen-Walraven, & Kondo-Ikemura, 1997, p. 36). The aim in Japanese culture is to promote interdependence while in Western culture the aim is to promote independence of the child (Rothbaum et al., 2000). Thus, Japanese parenting contrasts with what attachment theorists have described as sensitive responding (Ainsworth et al., 1974). Japanese mothers, according to the theory, could be labelled hypersensitive (Gibson, Ungerer, McMahon, Leslie, & Saunders, 2000). According to attachment theorists this type of interaction could lead to insecurely attached infants, specifically anxious-resistant infants.

Takahashi (1986) conducted a study with Japanese mothers and their infants using the SSP that allowed this assumption to be examined. Takahashi reported that 68% of the infants were assessed as having a secure attachment with their mother while 32% were reported as having an anxious-resistant attachment. However, when Takahashi decided to classify the infants on a modified SSP, where only the first five episodes were used and the infant was not left alone in the room, the results were drastically altered. She found that 83% of infants were rated securely attached and 17% were classified as having an anx-

ious-resistant attachment. Durett et al. (1984) studied 39 intact middle class families living in Tokyo with one-year-old infants and reported an attachment distribution of 13% anxious-avoidant, 61% secure, 18% anxious-resistant and 8% unclassifiable (cited by van IJzendoorn & Sagi, 1999). Durett et al's distribution of infant classifications is more consistent with global averages. What is noteworthy from the research with Japanese infants is the variety of attachment classification distributions within the culture, the fact that none of the studies reported high levels of anxious-avoidant attachment, and that all of the studies reported average or above average levels of securely attached infants.

Selective Parenting

Ahnert and colleagues (Ahnert & Lamb, 2000, 2001; Ahnert, Lamb, & Seltenheim, 2000) have conducted a series of studies with German infants and parents which offered a unique opportunity to study cultural differences. These researchers were able to study parent child relationships before, during, and after the reunification of East and West Germany. East Germany was known for its rigid child rearing practices and valued child independence at an early age (Uhlendorff, 2004), which included children's introduction to socially run daycare facilities. West Germany, in contrast, fostered a more nurturing and sensitive role on the part of mothers, with maternity leave being granted from employment for up to three years to care for their children. Yet when the pattern of attachment security between East and West German infants was compared, the rates of secure attachment were virtually identical at 49% and 50% respectively (Ahnert & Lamb, 2001). Another result of interest was the high rate of infants identified within the avoidant category from East Germany during all three time periods (before, during and after reunification), whereas the West German infants assessed before and after reunification showed a higher than average classification in the disorganized category. The results from the studies of post reunified Germany suggest that the culture is associated with a higher than average level of infants classified with avoidant attachment (Ahnert & Lamb, 2001). Given that anxious-avoidant attachment has typically been regarded as a rare form of attachment (True, Pisani, & Oumar, 2001) and that German culture would appear to emphasize nurturing parenting with a Western orientation, questions inevitably surface about the reliability of the attachment concept across cultures.

Shared Parenting

The central focus of attachment theory has been on the dyadic relationship between the infant and the mother or primary caregiver. But since many cultures involve other family members or even community members in significant parenting roles, these cultures offer an opportunity to explore the implications of shared parenting for attachment security.

The kibbutzim in Israel were collective farms founded upon socialist principles of an equal sharing of responsibilities and rewards among community members with no individual having greater hierarchal (social or economic) importance. These communities are unique in that they are the only cultural group that has adopted an arrangement where children sleep in a separate location from their parents while being tended at night by non-family members (van IJzendoorn & Sagi, 1999). The intention of this arrangement was to socialize children for communal life and to create a sense of group cohesion and, thus, people who could socially and emotionally function within the community. This would mean that if a secure attachment was formed it would have been secondary to the core goal of the community.

Sagi, van IJzendoorn, Aviezer, Donnell, & Mayseless (1994) conducted a study that compared 25 family-based sleeping infants with 23 communal-based sleeping infants from a kibbutz. These authors concluded that home-based infants had a higher rate of secure attachment. The distribution of attachment security among the home-based infants was 0% anxious-avoidant, 60% secure, 8% anxious-resistant, and 32% disorganized, whereas among the communal infants it was 0% anxious-avoidant, 26% secure, and 30% anxious-resistant, and 44% disorganized. Furthermore, the average rate of disorganized attachment was 37%, almost reaching the rate of secure attachment of 44% with the kibbutz. These findings coincide with Sagi et al's earlier study in 1985 concluding that "41% of kibbutz infants were insecurely attached to their mothers" (Oppenheim, 1998, p. 80). Thus, the form of shared parenting adopted by the kibbutzim appeared to be associated with an overrepresentation of infants classified as anxious-resistant and an under representation of infants in the anxious-avoidant category (van IJzendoorn & Sagi, 1999).

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African cultures such as the Dogon, Efe, and Gusii also rely on multiple caregivers to maintain and ensure child subsistence, although the degree and role of the caregiver is diverse among each culture. The African cultures are known for feeding infants on demand, and keeping infants in close proximity. True's (1994) study on the Dogon of Mali showed a high percentage of disorganized infants (23%), a high rate of secure infant attachment (69%), an absence of the anxious-avoidant classification, and an under-representation of infants in the anxious-resistant category (8%)(cited by van IJzendoorn & Sage, 1999). These results were supported by another study conducted by True et al. (2001) with a sample of 42 infants in which they found the attachment distribution to be 67% secure, 8% anxious-resistant, 25% disorganized and again an absent of the anxious-avoidant category. Similarly, Kermoian & Leiderman (1986) studied 26 Gusii infants ranging from 8 to 27 months in age, and reported 61% of the infants being classified as securely attached. Unfortunately these authors did not identify the type of insecure attachment these infant possess. Thus, when the SSP is used to assess attachment security among children in these cultures, the category distribution has similar outcomes, having an over representation in one of the insecure groups despite the fact that the cultures pride themselves on sensitive parenting and instant responses to infant cues.

In summary, attachment theory argues that sensitive caregiving leads to securely attached children. Yet in the above cross-cultural studies, where maternal sensitivity is thought to be high and the caregiving is nurturing, the rate of security is inconsistent with the sensitivity hypothesis.

Aboriginal Parenting

Many descriptions and assertions of Aboriginal parenting exists in the literature (RCAP, 1996; Report of the Aboriginal Committee, 1992; Report of the First Nation's Child and Family Task Force, 1993), however, there has been relatively little research that has been conducted with Aboriginal Peoples analyzing parenting practices (Gfellner, 1990) and even less research related to attachment theory (Christensen & Manson, 2001; McShane & Hastings, 2004). The authors could find no research that has examined the pattern of attachment security using the SSP with parents and children from Aboriginal communities. Therefore, in this section we will review some of the descriptions of Aboriginal parenting that have appeared in the literature and which may have a bearing on attachment theory.

Aboriginal cultures in Canada are similar to other cultures in that they cannot be viewed as homogeneous (Isajiw, 1999), rather they have characteristics specific to their geographic locations and social networks (Preston, 2002). Although there are differences between Aboriginal Peoples and differences within each People group in terms of culture, there are nevertheless some consistently reported generalizations, based upon observations and shared experience, that suggest Aboriginal parenting is often characterized by shared parenting (Red Horse, Lewis, Feit, & Decker, 1978) and selective parenting.

Aboriginal families do not adhere to the linear sequence of the mother as the sole contributor to the child's physical and emotional well-being (Weaver & White, 1997). There is no pressure put on the sole relationship between mother and infant in most Aboriginal cultures (Report of the Aboriginal Committee, 1992). The 'nuclear' family of mother, father, and children is considered a household within the family (Red Horse, 1980). Aboriginal concepts of the family range from the extended family concept, where lineage and bloodlines are important, to the wider view where clans, kin, and totems can include elders, leaders, and communities (Okpik, 2005; Red Horse, 1980). Hallowell (1955) observed this centripetal tendency of Saulteaux (Ojibwe) kinship structure where people were continually included as part of the family, regardless of bloodline. These members all share a collective responsibility for the caring and nurturing of the child (McShane & Hastings, 2004) and keep a watchful eye on young children in the community (Lame Deer & Erdoes, 1994). The bond between the child and the parent and other caregivers in Aboriginal culture, therefore, is multi-layered rather than dyadic. The effect of these diverse, overlapping bonds is to create a dense network of relationships within which sharing and obligations of mutual aid ensure that an effective safety net is in place (Brendtro & Brokenleg, 1993). Attachment theory, in contrast, concentrates on the linear relationship between the mother and the infant and does not include in the theory wider social relationships except to suggest that the mother infant relationship becomes a template for all future relationships (Lewis, 2005). Attachment

theory, therefore, does not fully reflect the reality of an Aboriginal infant's life and socialization experiences. Additionally, the qualities that emerge from the mother-infant relationship do not necessarily transfer to other relationships because the roles others play in the child's life take on a different meaning.

Children hold a special place in Aboriginal cultures. According to many Aboriginal traditions, children are gifts from the Creator (RCAP, 1996). This is a spiritually based view of the world and contains a belief that everything will work out in the end, that momentary struggles are no more than a temporary tribulation or lessons in life that need to be learned. As a result, parents take a long term view of the child, which includes a sense of destiny, and which means that the parent's role is not to shape and create behaviour but to provide a context for its expression. This can also be seen in Aboriginal parents preferring non-verbal teaching and learning styles where they observe their children's behaviours rather than intervene (Letourneau, Hungler, & Fisher, 2005). Children are allowed to make many decisions because they are considered a person and free to explore their own environment (McPherson & Rabb, 2001). In comparison to Canadian mainstream parenting practices, Aboriginal values and parenting practices would be interpreted as passive, permissive, and lacking control of children's behaviour (Hamilton & Sinclair, 1991).

Kelso & Attneave (1981), for instance, commented on the role of emotional restraint in the parenting practices of Aboriginal parents, which was considered a traditional parenting style associated with the demands of a nomadic life. Even though the traditional context has disappeared, the child rearing practice has persisted. Hallowell's (1955) experiences with living with the Saulteaux on the east side of Lake Winnipeg bear out this common practice. Dr. Claire Brant (1990), a Mohawk psychiatrist, observed in his experiences with the Cree of James Bay, that the practice of inhibiting aggression was a prevalent parenting strategy. The behaviour has been misinterpreted as psychopathology and/or conflict suppression by clinicians unaware of the cultural values that have shaped this behaviour.

One of the cornerstones of attachment theory is the emphasis on the mother's ability to be sensitive to her infant's signals or cues and responsive to the infants needs. In a context of multiple caregivers living in the same household, the mother can afford to be less vigilant and can have an expectation that someone will be available to attend to the infant's signals and needs. The implication in terms of attachment theory is that such practices by a mother would be considered insensitive and when assessed in the SSP it is possible that the child would reflect an anxious-avoidant pattern, when in fact the child's behaviour would be consistent with his or her social context.

Summary and Conclusion

The ability to capture an infant's quality of relationship to a caregiver using the SSP has been challenging because of the variety of contexts in which families live and the roles adults play within a child's life. The SSP has been modified to compensate over-stressed infants and those whose proximity seeking behaviours were not normally activated by the procedure. This raises the question of the extent to which the SSP can be modified before it is unable to measure what was originally intended.

van IJzendoorn (1993) acknowledges that infants in multiple caregiving cultures can establish a network of attachment relationships but the primary relationship is still with their mothers. Questions arise as to what the distribution of attachment types should look like when the measure is applied to many family contexts across numerous cultural groups. The larger issue is whether attachment classification matters if the family in question sees the infant developing along culturally expected goals. If families follow culturally congruent approaches to parenting, these may not be in accord with what attachment theory suggests. For instance, in cultures with shared parenting practices, such as Aboriginal families, it is less clear who should be included in parenting skills training. Therefore, the relevancy of attachment theory may apply only to those parents who are intent on developing certain characteristics within their children.

The larger social and historical context of Aboriginal realities in Canada, such as colonization, residential schools and their lingering affects, racism, poverty, high rates of suicide, high rate of child welfare involvement, school dropout rates, etc. renders concerns about maternal sensitivity as potentially trivial. Many of these social-historical forces have destroyed relationships that many Aboriginal families have tried to develop with their children. In these situations, it is important that attachment theory does not get over-extended in application by addressing mater-

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nal-infant relationships while ignoring social forces acting upon the family. Waters, Corcoran, & Anafarta (2005) acknowledges the limited domain which attachment theory addresses, that is, the secure base facet of specific relationships, usually the mother. Therefore, a broader context of attachment theory as it relates to different contexts is not only desirable but clearly necessary in order to promote understanding and avoid misperceptions.

Instead of continuing the focus of research on universality, which some researchers consider moot (Bretherton & Waters, 1985), others consider it unresolved (LeVine & Miller, 1990), and yet others consider it inaccessible (Grossmann & Grossmann, 1990), researchers are now considering the issue of conditional strategies in parenting (Main, 1990). Recognizing that the selection of parenting strategies reflects cultural norms, conditional strategies are considered to be those parenting strategies that are most useful given the mores and expectations of a society. Accordingly, Bretherton (1995) has noted that to better explore cultural variations in attachment organization, attachment researchers need to develop ecologically valid, theory driven observational and interview measures that are tailored to specific cultures and based on deeper knowledge of parents' and children's culture-specific folk theories about family relationships and attachment. In Aboriginal cultures this would imply exploring extended family connections, clans and kinship systems and their influence and role in parenting.

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A Change of Residence: Government Schools and Foster Homes as Sites of Forced Aboriginal Assimilation – A paper Designed to Provoke Thought and Systemic Change

Cathy Richardson and Bill Nelson

Introduction

Richard Cardinal is a Metis boy from Fort Chipewyan. He now resides in the spirit world, along with many other Aboriginal children, after hanging himself from a birch tree in Alberta in the backyard of his sixteenth foster home. Richard is not forgotten, but reminds advocates for Metis children, Aboriginal children, all children, that we are in the midst of an ongoing crisis when it comes to caring for "removed" children. Not unlike many children in the care of the state today, Richard had been removed from his parents, removed from his home community, and finally separated from his siblings without his consent. He was placed in twenty eight different living situations: these included sixteen foster homes, twelve group homes and locked facilities, as well as time spent on the street while trying to escape from abusive foster parents. He died at age seventeen. It was a Metis organization that brought Richard's plight into the public eye. The abuse, degradation, and inhumanity endured by this Metis child was exposed. However, in spite of his suffering, he was ostracized in the system for being difficult, while he became more and more suicidal.

By the age of nine, Richard was in his eleventh foster home. After being separated from his siblings, no one bothered to let them know his whereabouts. In his suicide he wrote:

> *I'm skipping the rest of the years because it continues to be the same.*
>
> *I want to say to people involved in my life, don't take this personally –*
>
> *I just can't take it anymore.*

Tragically, we still hear of similar situations today.

The authors of this paper both experienced a particular resonance with the life of Richard Cardinal. Richard came from the same community as Cathy's mother, Fort Chipewyan; Bill worked at a northern Alberta Child and Family serving agency that was held partly responsible for letting Richard fall through the cracks. Both the authors felt moved to influence child welfare practice in ways that respect the integrity of family and Aboriginal communities. However, the colonial structures of the child welfare machinery are geared to facilitate the removal of children from family through practice, policy and Canadian law. Attempts to honour and empower extended family systems to care for their own young ones continue to be met with systemic obstacles, as well as to go against the historical grain. As we move from interning children in the prisons called Residential Schools to foster homes, are we merely changing the residence of Aboriginal assimilation in Canada? And will child welfare be the last site of forced assimilation while many Canadians aspire to de-colonize and renegotiate the social contract between non-Aboriginal and Aboriginal peoples? This paper will address some of the similarities of these two residential structures that have housed hundreds of thousands of Aboriginal children when they are removed from their people.

From Residential Facility to Residential Facility

In the 1960s, the Canadian government extended its assimilation from education into the realm known as child welfare. Through changes in the Indian Act, social workers received a legal mandate for a foray into Native reserves to remove Aboriginal children from their parents. In response to these changes, Patrick Johnson (1983) coined the term “The Sixties Scoop” to describe the mass redirection of Aboriginal children into European-Canadian residences and communities, as well as into adoptive homes abroad. The authors of this paper are startled by the unsettling qualitative similarities between the residential school and the present day foster residences, from a systemic perspective related to processes of cultural assimilation. We do not assert that individual foster parents possess the general intent or values found in the Canadian residential schools. Foster caregivers are often nurturing and loving individuals who aspire to provide quality care to their wards. However, the systemic practice of moving children through the world of foster houses and group homes can leave Canadian youth scathed and traumatized.

The research has shown that Aboriginal children in foster or adoptive families tend to experience greater wellness and offset mental/emotional/physical and spiritual illness when they remain connected to their natural families (Carriere, 2006; 2005a, 2005b). Carriere’s (2005) doctoral research in Alberta showed that “all 18 participants described that their need to know their birth family stemmed from longing to know who they are and where they came from” (p. 547). This connection to family has been recognized as integral for child wellness that is it recognized in the United Nations Convention on the Rights of the Child:

1. All children have the right to a legally registered name, the right to nationality and the right to know and, as far as possible, to be cared for by their parents.

2. Governments should respect children’s rights to a name, a nationality and family ties.

3. Children should not be separated from their parents unless it is for their own good, for example if a parent is mistreating or neglecting a child. Children whose parents have separated have the right to stay in contact with both parents, unless this might hurt the child. http://www.anationalvoice.org/rights/rotch./2.htm

The Royal Commission on Aboriginal Peoples Gathering Strength (1996) states the following about extra cultural fostering and adoption:

> The removal of Aboriginal children from their communities through cross-cultural foster placement and adoption is a second major cause of family disruption. Children removed from their families are severed from their roots and grow up not knowing what it is to be Inuit, Metis or a First Nation member. Yet they are set apart from their families and communities by visible difference and often made to feel ashamed of their origins. At the same time, their home communities and extended families are robbed of part of the next generation (www.ainc.gc.ca/sh/recap/rpt/gs_e.html)

A recent study in British Columbia (Morley & Kendall, 2006) found that children in the child welfare system in B.C. are far more likely to suffer serious physical and mental health problems. Youth in care are 4.5 times more likely to die preventable deaths than those not in care. They are also more likely to suffer respiratory problems, to get pregnant, and to abuse alcohol and drugs. Sixty-five percent of children in care have been diagnosed with a mental disorder, compared to only 17% of children in the general population.

The research indicates that youth in the child welfare system tend to move back to their birth family as soon as they are cut loose from the child welfare authorities – that is if their familial connections were not completely severed by social work practice. Babb, L.A. (1996) in “Statistics on U.S. Adoption: The Decree” by the American Adoption Congress, reported that 72% of adopted adolescents wanted to know why they were adopted and 65% wanted to meet their birth parents. Courtney and Piliavin (1998) reviewing Wisconsin youths who were emancipated from foster care found that many had contact with natural families after discharge and that one-third were living with their families. Cook (1991) reported that the population of emancipated youth leave the system

with considerable issues: 2/3 had not completed high school, 61% had no job experience, 38% had been diagnosed as emotionally disturbed, 17% had a drug abuse problem and 17% of the females were pregnant. In a follow-up study conducted 2.5 – 4 years after leaving foster care only 50% had completed high school, less than half had jobs, 60% of the females had given birth and fewer than 20% were completely self-supporting.

Working for an Aboriginal child and family social services agency, the authors have witnessed various approaches to child welfare. Although some approaches could be called more 'humanistic' than others, it is rare that fostering arrangements are put in place which honour the child's familial and cultural relationships. There are two crucial issues related to such broken connections. Firstly, many fostering arrangements involve the ongoing movement of peoples who have been assimilated into European-Canadian families, thus depleting Aboriginal nations of citizens and loved ones. Aboriginal agencies are allotted minimal budgets to do the "mopping up" of the state decisions, to relieve the suffering of individuals and families in the wake of a multitude of losses. Keeping focused on "problem-solving" redirects energy from tasks of visioning and advancing Aboriginal sovereignty through treaty negotiating and nation building.

Secondly, while there are always rational explanations about why familial connections cannot be maintained, these ruptured relationships are often stated to be severed "in the best interest" of the child. Sometimes, these 'attenuated' relationships involve practice compromise where workers have not exercised the full range of possibilities to keep family members in contact with each other in alignment with a more collectivist worldview, where limited work time and resources undermine best practice standards and Aboriginal cultural consultants are not engaged in most cases involving Aboriginal children. Relationships with the natural/birth family are attenuated in order to create a new bond with what is called "The Forever Family" (http://www.mcf.gov.bc.ca/minister/archived/speeches/adoption.htm).

However, perhaps most relevant to this point is that the severing of family attachments seems to be perceived as a means of facilitating adoption, and adoption, i.e. permanency, is considered by many to be in the best interests of the child (Carriere, 2005; Yellowhead Tribal Council, 2000). So, it is not an issue that severing the child's family relationships per se is in the best interests of the child but instead that the outcome of severing these relationships allows for less encumbered adoptions in mainstream adoption practice (e.g. for non "custom care" adoption, Yellowhead Tribal Council, 2000). For example, in British Columbia parents may request an "Access" order in the case of adoption, but child protection workers tend to oppose these orders on the assumption that it will make it more difficult to find adoptive parents, a belief that is yet not proven in the research (Seaborn, 2007, personal communication). Given that Aboriginal families are disadvantaged by the structure of state-perpetuated power relations and shrinking social net, they have little recourse to contest such impositions.

A Brief Look at Residential School Internment

When the Canadian government, through its department of Indian affairs, established an internment system known as "residential school" in advance what Indian Affairs Superintendent Duncan Campbell Scott called "the final solution of our Indian problem," (RCAP film "No Turning Back", 1996; Cameron, Davis, Nixon & Ruemke, 2006, p. 3) these educational responsibilities were contracted out to religious organizations such as the Anglican and Roman Catholic churches. Under a policy known as "aggressive civilization" (Wade, 1995, p. 171) Campbell Scott was first noted using the words "the final solution" when deciding to remain inactive to the high levels of deaths in the schools due to the spread of tuberculosis (Annett, 2002). Of the approximately 100,000 children who were interned, researcher and writer Kevin Annett (2002) estimates that 50% of the interned children died as a result of the various forms of abuse and disease.

The removal of Aboriginal children was one arm of the colonial attack on Aboriginal communities: the destabilization caused by the forced removal of children (reminiscent of earlier introductions to alcohol in the context of ongoing imperial takeover)

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facilitated the transfer of Aboriginal lands and resources into the hands of the Crown and mining and land companies. Residential Schools were operated for over a hundred years, providing intensive and systemic resocialization and cultural deprogramming for Aboriginal children while inflicting endless grief onto Aboriginal communities. While most residential institutions had closed by 1980, the last D.I.A. funded school remained open up to 1990 (Cameron, Davis, Nixon & Ruemke, 2006, p. 3).

Today, many parents of children who come to the attention of the child protection system are described with the same colonial discourse used to justify publicly the forced internment of children. They are described as lacking the skills, resources, and expertise needed to parent their children. Aboriginal families are subjected to policies based on the colonial foundations that structure many of the White-Aboriginal relationships and government services. Wade (1995) identifies "a very close and mutually supportive relationship between colonialism and the so-called "helping professions". This colonial code of relationship is outlined as follows (Wade, 1994, p. 45):

1) You are deficient/I am proficient;

2) Therefore, I have the right (duty, privilege, responsibility) to perform prescribed operations upon you, with or without your consent;

3) These operations are undertaken for your own good.

In his work as social work supervisor at an Aboriginal child welfare agency, Bill Nelson has observed the dynamics and practices that facilitate the child removal process in regards to Aboriginal families. After removal, these children tend to be assigned to a European-Canadian residence. Nelson has outlined "The Seven Steps To Child Removal" which constitute part of the machinery that prevent Aboriginal families and advocates from challenging successfully the loss of parental rights (except in the few cases where parents have managed to cultivate the good opinion of their worker). These steps are as follows, and are often enacted after a mother has approached the Ministry for help with poverty or substance use related to grief or spousal violence and the child is taken into temporary care:

1) the Aboriginal child is said to be "special needs"

2) the mother/parent is assigned a diagnosis in accordance with the DSM IV

3) an "expert" (psychologist) is called in to develop a report, often out of any cultural or ecological context

4) the report confirms that because the child is "special needs" s/he requires a caregiver with specific expertise; because the parent has a diagnosis they clearly are not the one to raise the child

5) the mother/parents' visits are deemed to cause grief for the child and are thus "attenuated"; the relationship with the new caregivers becomes the focus

6) the diminished connection between the parent and child is then blamed on the mother

7) the child is taken into permanent care of the Ministry and placed in a foster residence while adoption is considered; parental rights are terminated.

Healing From Residential Internment

There are differing perspectives about the success and nature of these DIA- administered institutions. While Aboriginal people across Canada continue to query about who it was exactly that gave the Canadian government the mandate for Indian education, and how that could have been done without the express permission of Aboriginal people, the Canadian government is now acknowledging that the schools were a mistake. However, there is a lot at stake related to Aboriginal healing and the responsibility of the state for acts of apology and restoration. While George Erasmus has said, many Aboriginal people feel they have not had the definitive opportunity to tell their story of their history from their perspective;

the Canadian public remains largely unaware of the state-imposed violence and genocide towards Aboriginal people. Unlike Australia, we have had no National Sorry Day (Kinnear, 2002) and Aboriginal people have not been witnessed collectively for the injustices enacted towards them. Blackstock et al identify a non-linear process involving Truth Telling, Acknowledging, Restoring and Relating" as key aspects of Aboriginal related, also related to a larger renegotiation of the social contract between non-Aboriginal and Aboriginal peoples (Blackstock et al 2005). However the Canadian government still refuses to grant universal compensation or to grant an apology to the school's victims, nor to initiate a movement towards restitution and reconciliation.

The Elimination of Aboriginal Culture

In this section the acronym "LRS" will be used in parentheses to say "Like Residential Schools". For example, the authors have noted that mainstream Canadian foster families do not speak Aboriginal languages (LRS). Many foster families are Christians (LRS). Many foster families do not teach about Native spirituality, attend ceremonies and encourage foster children to honour their ancestors, spirit guides and the four directions (LRS).

In many mainstream Canadian foster homes children are loved and nurtured. They are taught values from some moral code and are encouraged to "work". In the past, children's work was of a productive nature: children often did chores and helped gain income. In residential schools Aboriginal children were the housekeepers: they washed floors, sewed and mended clothing and textiles, prepared food, cleaned toilets, dusted, polished and acted as handmaidens/servants for priests and nuns. Today, a child's job is to "play". So, in many foster homes children are kept busy with child's play, which often seems to be watching videos, playing videogames, in a bedroom. Children are kept on a busy schedule – a schedule that could not be maintained or supported financially by the birth family. This schedule often involves more child work, such as swimming lessons, dancing, piano, scouts, softball, soccer, etc. Most profoundly, children in residential school were largely denied access to their families. Today, Aboriginal children who have been removed from their birth families are "weaned" away from their family in order to bond with a new foster family or prospective adoptive parents.

Child protection and adoptions and guardianship workers for the B.C. child welfare ministry (Ministry for Children and Family Development) gradually deny families access to their removed children, a process referred to as "attenuation." There are programs such as Family Group Conferencing and ROOTS that assist in finding family members who could care for their young ones. While current child protection practice often involves time constraints that inhibit workers from going out into communities, building relationships and knowing families, these processes could be supported fiscally for the benefit of Aboriginal children. In cases where adoption is necessary, both children and young mothers could be "adopted" in ways that do not separate families and cause lifelong grief and disruption. This will be discussed further in the section on recommendations.

The New Missionaries

Aboriginal children are often fostered in white Christian homes. The Christian religions are often monotheistic and do not encourage the worshipping of any gods other than their own. While Aboriginal children may be encouraged to accept Jesus into their hearts, is there also room for the spirit of the mask?, spirit guides?, nature spirits? Do the religious values in the mainstream foster home facilitate the ongoing development of a Native spirituality which may be consider "pagan"? Developmentally speaking, can children maintain the openness of a both/and, rather than either/or, mentality when it comes to honouring the beliefs of their birth family and a new foster family? And without this kind of openness, can Aboriginal children thrive into adulthood avoiding a major crisis of identity leaving him/her with no foundation and becoming vulnerable to the typical trappings of people lost on Canadian streets such as East Hastings.

In the fostercare system this situation is exacerbated by the temporal limitations placed upon the provision of care. Today, a youth in care remains in care only until their age of majority (19). At that time they are passed over to the "welfare" system. Natural families

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maintain contact and connections with their children throughout their lives, providing a natural extended support system which is functionally denied the child in care when they reach the arbitrary age of nineteen. So, not only does the present system create an artificial environment, removing present familial supports but it also perpetuates this by cutting the child in care adrift without the benefit of future supports (other than the pittance of welfare). In addition to being overrepresented in child welfare, Aboriginal people often end up overrepresented in the prison system, moving from one institutional residence to another.

So What Do Aboriginal Families Say?

Many Aboriginal parents who have had their children removed are startled by the way they are held up against mainstream Canadian foster families who chauffeur children around from appointment to recreational activity to respite care to the psychologist's appointment. Cross-culturally, Aboriginal family life may appear inactive by the relative dearth of extracurricular, recreational activity. In fact, playing outside with other children on the block is often seen as dangerous or neglectful by mainstream standards. Also in fact, many Aboriginal families (not just parents, but entire families) have their children removed permanently because they cannot relate to the European-Canadian standards of parenting, and normal aspects of worldview and behaviour are labelled dangerous or neglectful (fishing, carving, walking home from school, playing outside, having younger children supervised by older children, being discriminated against in medical appointments for racial and linguistic reasons [thus being unable to advocate for children's health needs], missing school to attend big house ceremonies, not having a big house or a separate room for each child, etc). An example of this myopic view occurred during an investigation on a reserve in northern Alberta. The children had been coming to school unwashed and in dirty clothes.

The child protection worker assigned to the investigation was quite concerned about the hygiene of these children and wanted to place them in care. It was recommended to the social worker that she needed to conduct a home visit. During this visit the social worker discovered that the family relied on a creek for their water supply. The quarter mile walk to the creek in –50 weather, having to chop the ice and then having to carry the water to the cabin explained why bathing and washing clothes was a weekly, not daily routine.

We Are Not Resilient! – We Are Fed Up

We often hear that "it is amazing how resilient children are!" Yet, do we say that the ones who don't make it aren't resilient, or that in their state of vulnerability, they were overpowered by violence and cruelty in a system that did not attend to their needs adequately? Perhaps the biggest difference between the mainstream Canadian foster system and the residential school system is that many Aboriginal children attended only one residential school. The average Aboriginal child in foster care may experience between three and thirteen families before the age of nineteen. Then, according to the research, they go home to their birth family if they can still find it. Many children forget who they are, but they do maintain the urge to find out who they are when they are cut loose by the system upon reaching the age of majority. At the same time, they become experts in the area of heartbreak from broken attachments. Love becomes something elusive while children become experts at emotionally distancing themselves from each new set of temporary caregivers. This ambivalence was documented in a poem by Richard Cardinal while in the care of the state:

> *Love can be gentle as a lamb, or ferocious as a lion*
>
> *It is something to be welcomed: it is something to be afraid of*
>
> *It is good and bad*
>
> *Yet people live, fight, die for this*
>
> *Somehow people can't cope with it*
>
> *I don't know – I think I would not be happy with it*
>
> *Yet I am depressed and sad without it*
>
> *Love is very strange*

The authors of this paper are startled by the unsettling qualitative similarities between the residential school and the present day foster home, from a systemic perspective. That is, we do not assert that individual foster parents possess the general intent or values found in the Canadian residential schools; nonetheless the outcome is often the same. It's nothing personal, it's just that the kids can't take it anymore. We are fed up – they are giving up.

Recommendations

When we look deeply, we see that we are at a crisis point in the way we are living on the Earth. Most critically, we need to move from a culture of problem solving to one of visioning and creating the world we want. In terms of our practice, every 'helping' interaction between professions and Aboriginal families needs to be helpful, restorative, educational and curative. The work of Richardson and Wade (2007) shows that practice must be grounded in an understanding of the importance of human dignity and psychological safety, including a person's need for sovereignty, autonomy in decision making, and respect. Too often, families are judged from outside their cultural frame and are deemed to be deficient. Psychological tools, developed through the period of empire, are used continuously against Aboriginal and other marginalized people and to assess not capacity but deficiency.

These assessment tools are used by child protection professionals to amplify weakness and dysfunction while ignoring "responsivity" (an individual's many forms of response to challenge and blessings), while ignoring strength and while ignoring the social context and the blatant power imbalances between workers and families. Therefore, in order to interventions to be curative, thorough steps must be taken to attend to client dignity and to equalize power imbalances. Under such conditions, the real work can begin.

Along with individual and familial capacity, helping interventions can also build community capacity, which is necessary if things are to be different for Aboriginal children. Through "cleaning up" our practice and working in ways that actually preserve and strengthen extended families and communities, we help families to help themselves. With increased wellness and improved White/Aboriginal relations (free of racism, Euro-centrism and economic marginalization) true collaborations may emerge. Under improved conditions, all individuals will begin to care for the young ones, as well as the Earth, in a loving and thoughtful way. On a spiritual level , separation is the cause of much of our planetary grief; solutions will not come from continuing to separate children from their families, from their community and from their lands, traditions and spiritual practice.

That being said, as a society we can re-arrange fostering arrangements so that they are temporary and include parents and children rather than just children. We can advocate for housing that will support parent mentoring and multi-family cooperation, as in times past. We can ask that those who foster children receive regular clinical supervision for their own ongoing support and education, for the benefit of the children. We can support grandparents financially to care for children with support and alter our views about paying strangers and not family members to look after the young ones. We can legislate cultural plans and connective agreements between caregivers and Aboriginal communities, to maximize a child's possibility of cultural education.

Finally, we need to develop appropriate strategies to assist mothers in cases of paternal violence. Mothers who are victims of violence and abuse are typically held accountable for "failing to protect" their children from violence, even though they are all victims of the same perpetrator (Strega, 2006). As well, research by Coates and Wade (2004) has shown that professional language is used to obscure responsibility for violence, to cover up evidence such as client resistance to violence, and to blame the victims. Professionals can become much more clear in their positioning and handling of cases of spousal violence in order to work appropriately and effectively with cases of child protection. Community and social responses that enhance safety for victims and (e.g. mothers, fathers who are victims of spousal violence that is not self-defence, and children) hold perpetrators accountable for violence and healing are essential. However, both practice change and practice continuity sit within the "colonial container." Canada cannot continue to destabilize families through the ongoing disregard for Aboriginal treaty rights related to fishing, hunting, and community provision and

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wonder at the high levels of familial breakdown. If, as an arm of the state, child protection workers make Aboriginal parents redundant while wondering why these parents don't' "step up to the plate" and "just get over" the multiple losses inflicted upon them and look after their children. Meanwhile, we have to address issues of sub-standard housing, poverty, and unequal access to the law, to safety, to nutritious food and to medical care. When holistic principles of social justice (e.g. anti-racism & authentic restoration for genocidal violence) are advanced, including the end of corporate pressure on Aboriginal lands and minerals, things will improve for Aboriginal children in all forms of care in Canada. Until then, Canada will continue to perpetuate assimilation for easier access for corporations to what we are standing on (land, minerals, oil, etc).

Today, Richard's former home of Fort Chipewyan sits on the shore of toxic waters from industry and people are getting sick at alarming levels (Brethour, 2006). Now more than ever, children's preservation is linked to environmental preservation and we are called to be even more thoughtful and holistic in the task of child protection. The memory of Richard Cardinal calls us to accountability in our sacred work with children.

Endnotes

1. At the time of Richard's passing (1984) Aboriginal people comprised 3.5% of Alberta's population, and 37.5% of the children who were wards of the state. Today (2003) in British Columbia, the figures are …

2. More information about Richard's life can be found in the National Film Board video "Richard Cardinal: Cry From A Diary of a Metis Child, directed by Alanis Obomsawin

3. In 1919, the Governor-in-Council amended the law to lease reserve lands to mining companies without band approval. In the 1920s, laws ensured that "squatters" on reserve lands (e.g. Aboriginal people who went there to fish) were jailed. In 1936, responsibility for 'Indian Affairs' was transferred from the Department of the Interior to the Department of Lands, Mines & Resources (RCAP, 1996, p. 285)

4. Not only as having special needs, but as being "special needs" in a vernacular, totalizing description of self.

5. The DSM 4 is the diagnostic manual of the American Association of Psychologists. Often these diagnoses are given by people who do not have the credentials to assign diagnoses. Once a particular diagnosis is entered upon a file, it is rarely removed and continues to influence future decisions.

6. The attack on the safety net has meant that funding for services such as supervised visits has been erratic. In some cases, parent/child visits are denied because supervised visitation programs have not been funded. Then, in court, the absence of these visits is sometimes used against the parent in their efforts to retain custody of their children.

7. And, in cases of paternal violence, mothers are often held responsible for the violence under "failure to protect" laws. This means that children are removed from mothers who are the victims of violence while society does not move to assist victims. The misuse of "failure to protect" legislation has been documented by Sue Strega (2005) at the University of Victoria School of Social Work.

8. Kinnear (200) tells, "As we were walking something quite extraordinary happened. We looked upwards and saw the word "SORRY" being written in the sky. It was simply overwhelming!"

Bios:

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Bill Nelson has recently retired from an urban Metis child and family services organization on Vancouver Island. He has worked both in Alberta and British Columbia and

has 32 years experience working in and on the periphery of the child welfare and mental health systems. He has spent his career as a social worker, a family therapist and a child welfare advocate. Bill is married, a grandfather and is currently working part time as a family therapist.

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