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# Finding Healing and Balance in Learning and Teaching at the First Nations University of Canada

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## Abstract

In this personal memoir of three years teaching at the First Nations University of Canada, the author reflects on what she learned, in applying internally and externally, an Aboriginal model of social work education. As a person of non-Aboriginal ancestry, she explores how her own struggle with the imbalances inherent in academia spurred her search in grounding her teaching in holism, healing, reciprocal relationships, empowerment, liberation, and pleasure, and how the integration of these practices strengthened her relationships with her own spirit, but also with 'all my relations'.

## Locating Myself Within Colonization and Social Work Education

> *We of the empire world are caught at a fateful moment. We are asking, we are learning, digging through time and deep inside, crying, hoping, inventing. And in this process of homecoming, we are becoming fully human (Glendinning, 2002: 172).*

Graveline (1998) asserts that "resurrecting one's own history to find out how it has contributed to the history of the world" (p. 37) is essential to the process of all decolonization work. Imperialism, globalization, patriarchy, fundamentalism, and western rationality have created great imbalance and pain, both on a planetary level and in my personal life. As a forth-generation descendant of Scandinavian immigrants to Saskatchewan, Canada, and as a global citizen, my life work involves re-membering all that has been fractured by centuries of what Eisler (1987) refers to as 'dominator' ideologies and practices. The process of decolonization to me means to re-member and heal, returning to balance and wholeness the severed connections between body and spirit, between men and women, adults and children, between nations, and between human communities and all our nonhuman relations.

My whole life has been lived at the interface between colonizing and Indigenous ways of being in the world. As a child of missionary parents, I grew up in Nepal where the framework for my parents' presence was the belief that they were benefiting the local people with the technologies, systems, values, and Christian religion of the Western industrialized world. Upon my return to Canada, I had neither a sense of my own Indigenous Nordic roots nor the cultures and worldviews of the Indigenous Peoples of this land. From a deep yearning to find and know 'my place in this world', questions of identity and place, privilege and power, language and voice, harm and healing, have been woven throughout both my personal life and academic work.

Despite a few radical classes and educators, my experience of academia was largely of colonization and socialization within the dominant male-Euro-scientific paradigm. In my master's thesis I had critiqued the social work education system in which I had invested, as based on a parochial tradition, which became universalized through a larger project of Western imperialism[1]. While initially drawn to the ideal of 'helping people' (as most social work students are), during the course of my social work training, I became disillusioned with and cynical of the paternalism, moralism, and conservatism endemic in my chosen profession. As much of my life had been lived outside of Canada's borders, I wanted to learn from social work models that were not seeped in the Euro-Western-White tradition that I found so limiting. The ideals of education supporting liberation and enlightenment seemed at odds with the realities of how dominant education systems perpetuate various forms of oppression, imbalance, and domination (of positivist over experiential knowledge; of the cerebral over the spiritual, physical and emotional;

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of male over female, etc). I felt unable to resolve these contradictions within the 'mainstream' academic world.

By my late twenties, upon the completion of two social work degrees and a decade of intense academic, activist, and professional work in the field of social work and international development, I experienced a profound burn-out. The relentless drive that had led to my professional and academic successes had been fuelled by a deep sense of inadequacy; of never doing or being enough, a belief system stemming from childhood trauma, of which at the time I was unaware. Perfectionism, workaholism, and a focus on the intellect at the expense of the other aspects of my being, had left me exhausted and depleted, physically, emotionally, mentally and spiritually. I felt completely overwhelmed by feelings of tension and anxiety, and no longer experienced my former sense of passion and excitement about working toward all I believed in. To continue my professional work, I knew I needed an environment that would nourish my spirit and help me recreate a renewed relationship with education, activism, my profession, and most of all, between my own body, mind and spirit.

Academia was therefore the last place I expected to be able to find healing and wholeness, balance and recovery. And yet, in 2001 when I was offered a job teaching at the First Nations University of Canada[2], I thought, "if there is any space in academia where the spiritual, emotional and physical can be integrated with the intellectual, it would be here", and so I accepted. At the First Nations University of Canada, not only was I given permission, but I was given a mandate that required me to ground all my work in partnership, balance, and spirituality. With a clear agenda of healing all that has been fractured by five hundred years of colonization, First Nations University of Canada, located in three cities in Saskatchewan, is a unique space where students and staff are invited to collectively engage in the project of transforming education from the oppressive and paternalistic 'banking model' described by Paulo Freire (2000), to one of decolonization, indigenization, politicization and liberation.

While for the past hundred years, Indian education has too often meant the education of Indians by non-Indians using non-Indian methods (Hampton, 1995: p.6), today many educational institutions across Canada are actively engaged in indigenizing curriculum and teaching methods. Conceived in the early 1970s, Canada's largest Indigenous university, grounded largely in the knowledge systems, cultures, and languages of the plains and woodlands peoples of Saskatchewan, is today at the cutting edge of the "change from accepting acculturation and cognitive assimilation as final ends to revitalizing and renewing languages and cultural identity and dignity" (Battiste & Barman, 1995: p.xi).

## Learning and unlearning the role of educator

> *We have a responsibility to participate in the struggle against the continuing effects of oppression, because effective teaching practice takes place in relationship with the teacher, student, family, school, community, as well as the broader society, keeping in mind that all of us are situated in, and affected by, the complex historical contexts of culture, race and class (Goulet, 2001,p.80).*

Teaching post-secondary education is a weighty responsibility, intimidating perhaps to any initiate instructor. With the added mandate of integrating First Nations languages, knowledge systems, histories and healing traditions, I felt completely overwhelmed with the task before me. Without a native studies degree, without native ancestry myself, and without any formal preparation for university instruction, I felt completely inadequate and ill prepared for the task before me. I frequently dreamt that I was naked in front of students, for indeed I felt barely clothed by the flimsy credentials a master's degree in social work, and several years of professional work experience. Like most non-Aboriginal people of this land, I had almost no knowledge of the 'Indian country' into which I was now immersed. I knew little of the political systems and structures, cultures, languages, homelands, leaders or visionaries of the First Peoples of Saskatchewan.

During those first agonizing classes, my students and I peered at each other across the divide of differences; myself, the môniyâskwêsis (young European woman) professor, meeting my students, mostly nêhiyânâhk (of Cree language and territory), on average a decade older than me, in the formal setting of the classroom. It was the old story of the teacher coming from white academia and middle class privilege, while most of my students were coming from reserve communities, economic and social marginalization including direct experiences with the oppressions of the residential school system, the justice system, and the child welfare system. In one of my first classes, one of the students remarked aloud, "tânitê êtikwê ê-kî-miskawâcik ôhi okiskinwahamâkêwak" (I wonder where they find these teachers from!?) It's a good thing I didn't understand néhiyawéwin (Cree) at the time, for I might not have been able to go on with the class! Years later he and I would often joke about this first moment of encounter.

As I sought to practice liberation education according to the models of Jean Graveline (1998), bell hooks (1994), Paulo Freire (2000), and Eduard Lindeman (1961). I was alarmed to discover how deeply invested I was in the dominant model of education that I myself had struggled so much within! My own post-secondary learning had been as much about pain (fear, stress, anxiety, intense competition, feeling overwhelmed and personally disconnected), as the

pure pleasure of learning. And while I had already spent considerable time deconstructing social work education as culturally biased in terms of dominant white/western/academic systems of thinking, I continued to discover to my dismay, how much I had internalized and was indeed perpetuating, oppressive belief systems that I intellectually disagreed with! Although as a student I resented being swamped by information, feeling unable to digest it all, I would catch myself, in the name of 'academic rigor', pushing my students' limits of information intake, with beliefs such as "I had to suffer these dry readings so you should too", or the paternalistic "but it is good for you" (the same kind of rationalizations that perpetuates any form of oppression!).

Reflective journaling and conversations with colleagues were indispensable tools for the simultaneous learning and unlearning I was undertaking; of both constructing and deconstructing my role as educator. Through journal writing, I would identify incongruent beliefs and debilitating self-talk patterns based on fear, anxiety, inadequacy, and 'shoulds' derived from inherited notions of 'academic rigor.' I recognized that such fear-based beliefs, though unconscious, increased my sense of stress, thus negatively impacting my ability to engage authentically with students and colleagues. Having identified the fear-based beliefs, I would then create positive affirmations grounded in compassion and self-acceptance, knowing that the inner shifts would affect my outer behaviors.

When I felt overwhelmed with all that I believed I 'should' know and be, I would remind myself that my role as teacher is not so much to be an expert, but rather to learn together with students, and that authentic knowledge comes from integrated experience rather than stuffing heads (mine or theirs) with reams of information. As David Hannis notes in his memoir of teaching in an Aboriginal Albertan community, "An effective teacher is a mentor who acts rather as a midwife, drawing forth the knowledge that lies buried within, in a safe and supportive way" (Hannis, 1993, p.51). My colleagues would remind me about the importance of bringing my whole self to connect with my students as whole people. I would also paraphrase in my mind the words of the apostle Paul, taught to me in my childhood; "even if I have great knowledge, extensive experience, but have not love, these things will profit me (or my students) nothing."

## Exploring tools for transformation

> *Can we, as adult educators, permeate the invisible barriers that keep people of different cultures from "connecting"? Can we somehow move from trepidation to trust, from fear to comfort, from misunderstanding to truth? Are we able to live a philosophy that allows the sharing of our different cultures in such a way that it enhances each of our paths? (Sanderson, 1996, p. 2)*

Knowing I needed all the help I could get, I took every opportunity to nourish myself with the various ceremonies, teachings, and guidance offered by the Elders in our program. Because the practice of teaching 'from head to head' had left me disconnected from my emotions and spirituality, I knew that I needed to create a classroom space in which spirituality is included, learning is collective, and hierarchies between professor and student are minimized, so that the whole being of each person, including myself, was nurtured. Early in my teaching, at the direction of an Elder, I began to practice opening each class with a smudging ceremony, led by one of my students, with the intention of creating space to center, clear, and ground ourselves.

Jean Graveline, author of *Circle Works: Transforming Eurocentric Consciousness*, asserts that the role of teacher is healer, and reminds us that healing means to restore to wholeness. If our dominant education system has suffered from fracturing knowledge into minute areas of specialization, and from separating mind from body, spirit and emotions, liberation education must heal these splits. Both Graveline (1998) and hooks (1994) purport that education as healing practice requires creating a classroom space in which learning is pleasurable, stimulating, and empowering; a place where we connect with our spark, desire and passion. Having structured most of my life according to 'shoulds' and rigorous self-discipline, I found this new conceptualization of excellence both deeply unsettling and exciting. Can I really trust my attractions to lead to excellence? What if I miss important content? What does excellence and 'rigor' mean in the context of Indigenous social work education? As I continued to explore these questions, I was discovering that the more I could release my own need for control, and the more I could 'go with the flow', by teaching from a sense of pleasure and intuition, my teaching was enhanced rather than compromised.

The practice of investing time outside of the classroom in building relationships with students was not only one of the richest and most pleasurable aspects of my job, but also, from my perspective, a key aspect of practicing decolonizing education. Where most universities are nervous about personal contact between staff and students as a problematic 'boundary issue', at our small Saskatoon campus with a student body of only 350, personal contact was institutionally supported and encouraged. Students and staff mixed together freely in the small cafeteria, outside on the 'smoker's deck', in the halls, and at ceremonies. At Round Dances in the winter

months we held hands and danced in spiraling circles until the wee hours of the morning. On weekends, the roles of student and teacher reversed when I attended a Sweat-Lodge ceremony conducted by one of my students, where our most intimate selves were shared, pain released and healing sought. At culture camp, an intensive ten-day course on Saskatchewan's Indigenous cultures held on reserve land, we sat together under the shade of a poplar arbor, listing to the teachings of the Elders, participating in sacred ceremonies, learning traditional crafts and survival skills, and cooking meals together over an outdoor stove.

My students became my teachers in powerful ways. Leading by example, they taught me how to integrate humor and modeled what it means to share deeply from our life stories. In opening their lives to me, they shared their pain; their experiences of various forms of abuse, of the residential schools, of life on reserves, on the streets, of incarceration; as well as their love for their children and grandchildren, their passion for healing, and desire to give back to their communities, the strength of their ceremonial traditions, and what being in the social work program meant to them. Inspired and humbled, I in turn, began to take more risks in sharing from my own life; of coming from a missionary family, of being a survivor of sexual abuse, and of my own cultural identity struggles. In conversations with my students, we were peers, no longer constrained by our institutionally designated roles of teacher and student. As we shared from our personal lives, a deep bond was established, a bond that transcended our differences.

## Conclusion

> *We all have an indigenous mind. No matter where we live now, we all come from ancestors who ... originally saw the world as enchanted ... as a joyful, sentient organism in which all things were alive and capable of connecting with us ... We can find [our indigenous mind] again by discovering and appreciating the surviving indigenous cultures of the world in all their richness, depth, and wisdom (Pearsall, 1996, p.70).*

As one year of teaching folded into two, then three, I came to understand that my own healing and liberation was inextricably woven together with the healing and liberation of my students. I saw that I had come to the First Nations University of Canada as much to learn as to teach; to help as to be helped; to give as to receive; to encourage and empower as to be encouraged and empowered. During my time at the First Nations University of Canada, I have become increasingly aware of how much of my own ancestral tribal knowledge had been lost to me, and I came to realize that the project of decolonization is global and requires all of us, regardless of where we sit on the colonizer/colonized continuum. Through mutual liberation, we are able to find hope for our communities, nations and our planet. My experience of learning and teaching at the First Nations University of Canada helped me to find `my place in this world` among those who are working toward healing and recovery of balance, on a personal, community, regional, national and planetary level, and for this opportunity, I will be forever grateful.

## Endnotes

1. Haug,E. (2001) 'Writings in the Margins: Critical Reflections on the Emerging Discourse of International Social Work'. Masters thesis, Department of Social Work, University of Calgary, Alberta, Canada.

2. Known until 2004 as the "Saskatchewan Indian Federated College."

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# Rethinking Social Work Education for Indigenous Students: Creating Space for Multiple Ways of Knowing and Learning

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## Abstract

McGill University School of Social Work initiated a research project in October 2005 to examine the social work education and ongoing professional needs of the First Nations communities of Kahnawake and Kanehsatake. These communities had previously been served by a 30-credit certificate program. Using qualitative methodology, the project sought to gather data which would eventually assist in the development of a curriculum and pedagogical approach that would reflect the social and cultural reality of these communities as part of the regular BSW program. This paper describes the process, key findings, and potential next steps for the School.

## Introduction

The development of Indigenous social work education in Canada began in the early 1970s. In 1974, Maskwachees Cultural College was formally established by the Four Bands of Hobbema (Alberta). The College created an Aboriginal Social Work Diploma program. Saskatchewan Indian Federated College (SIFC), established in 1976, offered Social Work as one of six programs (in 2003, SIFC changed its name to the First Nations University of Canada School of Indian Social Work). Currently, there are 4 programs offering an adapted Aboriginal Bachelor of Social Work degree across the country (Nicola Valley Institute of Technology in association with Thomson River University, University of Manitoba, First Nations University of Canada – School of Indian Social Work, and Dalhousie University). For the purposes of this study, we have defined social work education as accredited courses and programs offered in academic institutions across the country leading to a recognized professional qualification. In terms of terminology used in this paper, the research team agreed on the interchangeable use of First Nations, Indigenous, and Native to describe the descendents of peoples living in Canada prior to the arrival of the Europeans. This decision on terminology reflects the collaboration

between First Nations researchers and Allied[1] researchers in our study. From its inception, we collaborated as a team in spirit and application.

From 1995-2005, the McGill School of Social Work offered the Certificate in Aboriginal Social Work Practice and the Certificate in Northern Social Work Practice aimed at people currently employed by the social work agencies in the First Nations territories of Kahnawake and Kanehsatake and the Inuit territory of Nunavik. The Certificate was a 30-credit program. Students were able to participate in a range of curriculum modules (10) worth 3 credits each. After completion of the Certificate, students could transfer their certificate credits to the regular BSW program. The course topics were designed collaboratively by Indigenous and allied social workers to address issues relevant to Indigenous communities. The academic year 2005-2006 saw the last cohort of students engage in modules to complete the certificates.

In 2006, the McGill School of Social Work initiated a research study to explore current social work education and ongoing professional development needs in the communities of Kahnawake, Kanehsatake and Nunavik. The Ministère de l'Education, du Sport et du Loisir du Québec funded the study designed to gather information on social work issues facing Indigenous communities traditionally served by McGill School of Social Work. The study was also designed to investigate participants' experience of the certificate program, explore their perceptions of the social issues facing their communities, discuss barriers to involvement in University level programs and gather views on program content and delivery which would prepare students for problem-solving work in their own communities. Interviewees were also asked their views on ways in which the School of Social Work could attract more Indigenous students to the BSW program. The study addressed a persistent gap in knowledge regarding social work education needs in Indigenous communities and the ways in which one could increase the enrollment in social work education by Indigenous students.

This paper is focused on the findings from the interviews of First Nations' participants (from Kahnawake and Kanehsatake). The research team overseeing the study was composed of McGill School of Social Work and Kahnawake community members, meeting First Nations' goals of building capacity and knowledge within Indigenous communities. Researchers interviewed Certificate graduates, community members and other key stakeholders to determine the ways in which the McGill School of Social Work could contribute to social work education and continuing professional development opportunities needs in these communities.

The first section of the paper describes the methods and the study's qualitative approach. The second section presents the findings that illustrate ways in which participants wanted curriculum and program delivery to be adapted to their cultural context. The final section includes a discussion of implications for this adaptation and future plans for the BSW program at the McGill School of Social Work as well as continuing education offered by the School.

## Project Context

In the past 20 years, certain Indigenous communities have been able to assume responsibility for and management of their own community services. For example, in Manitoba child and family services to Indigenous people are provided through three organizations: Métis Child and Family Services Authority, First Nations of Southern Manitoba Child and Family Services Authority and First Nations of Northern Manitoba Child and Family Services Authority.

In the case of Kahnawake, responsibility and management includes the provision of community social services. The Band Council gained control of community services in 1985 and since then has gradually been developing a range of services to the community from family support to youth protection and care of Elders. Historically, non-Native social workers predominated in community services in Native communities because there was a dearth of professionally qualified Native social workers from the community itself. The certificate program operated by McGill until 2005 was able to fill a gap in terms of community workers but, like other certificate or training programs (see Smith & Pace, 1988), the certificate program was not a degree program that offered a professional qualification.

Providing culturally relevant education (in curriculum and program delivery) to members of Native communities is a critical piece in the restoration of autonomy in social service provision in Native communities (O'Brien & Pace, 1990; Weaver, 1999). It is essential to transform educational opportunities for Native students by developing different approaches to learning. Members of Native communities have underscored the need to increase social work education, both degree programs as well as ongoing professional education in ways that are relevant to Indigenous realities (Bruyere, 1998). A reality for the Indigenous communities in Quebec is that there are limited opportunities for participation in social work education. There are myriad challenges to address: logistics, linguistics, cultural distance, racism, and a history of distrust engendered by colonialism (Ryan, 1995). In addition, social work programs have

been regarded as providing only a Western, Eurocentric perspective which does not reflect the political, social or cultural realities of Indigenous communities.

Community input is vital to the emancipatory project in which schools of social work should be involved in order to ensure that social workers operating in Native communities are, first and foremost, members of these communities and, equally importantly, have followed an appropriate professional education. By this, we mean that they have had access to a curriculum which reflects their own cultural and social reality, which uses a range of pedagogical approaches, including traditional ways of learning and knowing, which involves the advice and teaching of community Elders and which, if appropriate is delivered in a community setting. By offering this type of curriculum and pedagogy can schools of social work genuinely participate in a process that will contribute to the decolonizing project of combating structural oppression of Native peoples (Lee, 1992). The research study described in this paper continues the process begun by the Certificate program of the McGill School of Social Work towards such a pedagogy.

Keeping in mind that "the standard for social work education and practice is literature and education based on the worldview, lifeways, and reality" of the dominant mainstream (Sinclair, 2004, p. 53), one of the goals of the project was to explore the types of curriculum and program design that would be culturally relevant in Indigenous communities for Indigenous people. Programs that have an Indigenous perspective have adopted models shaped by the uniqueness of Indigenous world views and traditions, a holistic approach to social welfare as well as the need to address the historical and contemporary impact of colonization on Indigenous consciousness (Morrisette, McKenzie, & Morrisette, 1993; Warner, 2006).

## Methodology

The exploratory nature of the study called for a qualitative approach in order to gain knowledge of individuals' experiences and perceptions rather than "categorizing their experiences out of context" (Omidian, 2000, p. 42). Qualitative methods were chosen to allow interviewees to give voice to their own thoughts, providing insight into program experiences by Certificate participants and graduates as well as perceptions of social work needs in First Nations communities by community members themselves (Lieblich, Tuval-Mashiach, & Zilber, 1998). Additionally, using a qualitative approach could increase the opportunity to have more personal and interactive communication and decrease the typical power relationships found in conventional research.

A Steering Group was formed to comment upon and direct the study in its various stages. The Steering Group was composed of members of the School of Social Work Faculty, instructors from the Certificate programs, Inuit and First Nations BSW and MSW students, practicing social workers with experience in the field of Indigenous social work and the research team. The Steering Group met throughout the study every 6 weeks to guide each step of the methodology.

## Sample

Thirty-six participants were interviewed from the Mohawk communities of Kahnawake and Kanehsatake. There were 28 women and 6 men; 7 were graduates of the McGill Aboriginal Certificate Program and 7 had taken part in some of the certificate courses; and 22 were community members. Purposive and snowball sampling were used in partnership with First Nations community organizations to ensure the distribution of demographic and theoretical variables.

Criteria for participation in the study included having graduated from the Certificate program or having participated in one or more courses, holding a post in the Kahnawake or Kanehsatake community infrastructure with a link to social work, having a key stake in the community as a leader, an Elder or an interested community member. While the first criterion was easy to establish from School of Social Work records, and the second could be established through the community institutions, the two Indigenous researchers were given the freedom to apply the third criterion through their community knowledge.

## Data Sources/Data Collection/Data Analysis

The primary data source was an in-depth, face-to-face, individual interview guided by a semi-structured, open-ended interview schedule with explanatory, interpretative, and evaluative questions. This format allowed for the creation of new categories to emerge from the data (Padgett, 1998). The questionnaire focused on barriers to Indigenous students' success, course content appropriate to Indigenous reality, conceptualizations of social work, and the future of social work education. Interviews, audiotaped with permission, lasted approximately 60 minutes. Background demographic information was also gathered (see Appendices 1 and 2).

The study also aimed to contribute to the research capacity of the First Nations community. Toward this aim, two researchers from the Kahnawake community were hired to conduct all interviews in Kahnawake and Kanesehtake. This arrangement had its advantages since the two were cultural insiders. Although they enjoyed

special epistemic privileges and conducted their work without too much difficulty, we must consider that this is not always the case. Historically, research has been considered "… one of the dirtiest words in the Indigenous world's library" (Tuhiwai-Smith, 1999, p. 1). This point was not lost on the researchers who did their utmost to traverse this delicate terrain in a respectful manner. One of the challenges faced by community researchers was ensuring that a satisfactory reciprocal process was put in place where participants could have the opportunity to view preliminary data results and make suggestions that reflected their views correctly. Indigenous researchers have a dual responsibility of satisfying both the academy and their communities as the "field" is also their home.

The Kahnawake Research Council and the McGill Research Ethics Board approved the study. The project also had to satisfy the ethical standards developed by the communities themselves. This required meeting with and presenting the project to the Kahnawake Community Research Council and to community leaders in Kanehsatake. The Kahnawake Research Council is made up of community members from Kahnawake, Quebec. The Council, which dates back to 2001, was originally developed to attend to numerous external requests to conduct research within the Territory of Kahnawake. The primary role of the Research Council is to safeguard the community from individuals who come with agendas that disadvantages the community. The Council's other task is to ensure the community receive some benefit from the research.

Content analysis was used for analyzing data. Conducting line-by-line analyses of interview transcripts (transcribed verbatim), units of content were gathered, coded, and interpreted descriptively and then assigned to thematic categories that emerged, following the grounded theory approach (Glaser & Strauss, 1967). Members of the McGill/Kahnawake research team met together to discuss interview data and emerging themes, adding to the credibility of the findings.

## Findings

In order to provide feedback to participants as well as the community, a community consultation was held in Kahnawake to present study findings. All study participants were invited as well as other community leaders and people working in the health and social services. The purpose of the consultation was to share the emerging findings of the research with the community and to gather additional views which would supplement the data. The results of the research project and the implementation of the recommendations that flow from the community in terms of developing social work education are crucial in providing social services that are relevant in a local community context (Gray, 2005).

Throughout the interviews, a common thread was the urgent need for professionally educated social work practitioners from Native communities working in Native communities. Underscored was the need to have Native approaches to learning and Native instructors. Although two participants referred specifically to a "Mohawk philosophy" in guiding social work practice, the majority spoke more generally about the necessity of having instructors from diverse First Nations communities, not specifically those that are Mohawk. Participants also felt there was a need for specific Native content in the curriculum. They felt it was critical to offer courses that covered diverse, contemporary First Nations issues and Native approaches to social work practice as well as incorporated Elder wisdom. The curriculum should be grounded in First Nations philosophy, values, and traditions.

Regarding program delivery, some participants wanted the courses conducted in Native communities, while others felt that it was important for students to travel to the McGill campus in Montreal. The majority, however, voiced a preference for a blended version of program delivery, where a portion of the program would be in the community while the remainder of the program would be on McGill's downtown campus.

## Teaching and Learning

Who teaches the courses on Indigenous topics? There was a clear trend throughout the interviews that it was crucial to have Native instructors teaching Native topics. Some participants called attention to the need for non-Native social work students to attend courses on Native topics if they were going to be working in Native communities.

> *If it is somebody who is going to be teaching us and training us, it would have to be a Native person. A Native person knows the community, knows what approaches would have to be given to the community, know our manners of practice in dealing with the outside system, such as the court system. It would almost have to be, if there was specific training that the McGill School of Social Work would like to give, it would have to be something that would be community and culturally oriented and it would have to be given by a person who was a Native person. [Participant 01]*

All participants mentioned the need for Elder involvement in a social work program focused on Native issues. For some participants, Elder involvement consisted of active participation in courses; for others, it

consisted of utilizing Elders' wisdom by integrating it into the curriculum. Subsequent discussion with colleagues in Schools of Social Work offering specializations in Native social work suggests that Elders can be integrated in a variety of ways, such as mentors to the students at specific times during the program, as instructors during a cultural immersion session, as co-instructors for particular courses or just simply to be on hand in the School for consultation. Incorporating Elder wisdom was part of a broader call to bring in traditional values to underscore the uniqueness of a Native approach to social work practice. Participants saw Elder-protected traditional values such as natural helping, consensus building, and healing as foundational to Native social work practice. One participant described social work as

> *looking at our problems coming from a natural way. Our people have always been natural helpers and natural counselors. That is the work we have done and especially looking at the areas within the clan system and each one has their own way of being a counselor, being a teacher, a person who would go and intervene in whatever situation that is happening at the time. [Participant 02]*

The close-knit community of the Certificate program students was something that the participants had valued. Participants often mentioned how participating with other First Nations students had been "empowering" and had bolstered their self esteem.

Participants wanted to see a Native approach to teaching applied to Native issues. Their vision of this was a holistic experience that not only included Native content but a Native approach to learning. One participant described the beginning of a Native program in Ontario:

> *Some of the programs that I know of too in Ontario, like the First Nations Technical Institute, they have Native Social worker programs, it's a Native diploma program, it's a large part of their education is on Indigenous studies and cultural values. So what they do is at the start of it during the first week, the first session, they all work on themselves, like they do talking circles and stuff like that. [Participant 03]*

Aligning a Native pedagogy with Native-focused curriculum content would be an essential piece of a social work program that focused on Native issues. Such an approach would give credibility to the delivery of the content and show a respect for an Indigenous way of being and learning.

## Course Content

Participants recounted numerous social issues facing their communities which they felt social workers needed to address. Some of these issues are also faced by non-Native communities, such as substance abuse, though participants believed that learning about and understanding the Native context was critical to addressing the issues effectively. Participants wanted to see courses or parts of courses devoted to understanding the ways in which the historical trauma experienced by Native peoples plays out in the current social, economic, and political context. Attention needed to be paid to the generational implications of colonialism, specifically residential schools.

Substance abuse was mentioned frequently as a crisis issue participants saw in their communities; addiction involving crystal methamphetamines was explicitly noted by several participants. Child abuse and neglect, including child sexual abuse, was cited by a majority of participants as a central issue tearing apart Native communities. Many specifically mentioned the importance of teaching traditional healing as part of a Native social work program. Participants also felt that Youth Protection needed to be better understood both its role and its history in the community as well as current legal issues important for social workers. One participant felt that without the knowledge of how the system worked, Native people involved in youth protection had a distinct disadvantage:

> *And giving more information on youth protection, that was rarely discussed in the program. Like I said, although we want to work with our own community, we still need to know about the other side and without having that knowledge, then they still have the upper hand on us because we still have to do what they say. We don't want to do that, you know, we don't want to do that. [Participant 04]*

Other issues needing attention in Native communities were bullying, mental and physical health, particularly nutrition-related diseases, and the creation of healthy leaders in First Nations communities who could assist people on the political and social spectrum.

While participants voiced the necessity of having social work curriculum content that focused on Native issues, there was a concurrent feeling that the participation in the program needed to be able to widen the opportunities that Native social workers had. Many participants emphasized the importance of a freedom of choice: they wanted to have the option of working on or off the "rez" with Native or non-Native clients. One participant wanted to gain broad experience in a social work program, noting, "I think your degree has to be able to take you inside and outside of our communities" [Participant 06]. Indeed, the "portability" feature inculcated in a first-class education is not lost on Native people nor is the opportunity it affords them to surmount the effects of historical marginalization and colonization

by allowing full participation as equals in mainstream Canadian society. Another participant highlighted the desire to be able to work with people of diverse backgrounds:

> *If it's geared for the Native, see that's the one thing, if it's geared for us to be dealing with Native people then we would still stay as Natives and all the material would be pertaining to Natives. Whereas if we were given many different Ethnic groups, meaning non-Native or Native or Black people, type of viewpoints on how to work with them, then we could work off the community. [Participant 05]*

Additionally, participants said that it was important to have coursework that would help Native social workers address social work-specific issues such as managing job-related stress and to effectively implement social work practice in one's own community.

## Program Delivery

Participants, who were from Kahnawake and Kanehsatake, also provided input regarding the delivery of a new social work program focused on Native issues offered at McGill. Certificate program participants, most of whom were mature with families, recalled the substantial challenges to involvement in the program, particularly child care, transportation, and working full time. In order for students to succeed, participants felt that it was vital that the program support students in addressing these three issues.

While child care expenses could be supported by financial subsidies, the other two issues could be addressed by program delivery options. Participants described great difficulties in traveling into Montreal. Additionally, some felt that coming to Montreal was as foreign as traveling to another country, and felt that logistical and emotional support would encourage participation in and completion of a BSW degree. To address some of the logistical as well as cultural challenges, there was consensus among participants that the program should be open to offering courses by McGill instructors in Native communities, such as Kahnawake and Kanehsatake. Participants differed in the proportion of courses to be offered in the community, with some wanting more and some wanting fewer courses on the McGill campus. The need to work full time also hindered participation in the program, and participants felt that if the courses were offered in the evenings, on weekends, or in the community, participation would increase. Some participants were interested in online courses and distance learning; however, most felt that face-to-face interaction was an essential part of social work education. One participant stressed the need for interaction among students and instructors:

> *It's good for a group to come together if they're studying together, whether it's video-conferencing or online distance ed. But at some point I think you have to have that human interaction. What my sister said was one of the best things that came out of the McGill certificate program is that almost on a weekly basis there was a lot of lively discussion on the problems or the social issues impacting the communities and it got pretty lively and she says it was the best part of it. She says because it came out and it was open discussion. [Participant 06]*

The preference among the majority of participants was a blended program approach, with courses held on the McGill campus as well as in the community (Kahnawake). Participants also wanted to have some to most of the courses at McGill because they felt it was critical that the program be seen as of the same quality as the regular BSW. One participant noted,

> *It's good to be able to take courses with a Native slant to it, as opposed to mainstream social work. But I think at the same time I think it's necessary for us to be in mainstream programs, to offer the same to everybody, the same quality of training. [Participant 07]*

All participants felt strongly that educated social work practitioners from their communities were needed to address the crisis issues facing their communities. The suggestions for ways to educate members of Native communities for careers in social work ranged from a redeveloped certificate program at McGill that could stand alone or be linked to entrance into a BSW program as well as a BSW program specifically focused on Aboriginal social work. Additionally, based on feedback on academic preparation, the possibility of a qualifying year was also raised. However, the general trend among participants was that a BSW degree, more than a Certificate, would provide greater benefits for Native social workers and wider opportunities for both the social worker and the community in which he or she worked.

## Discussion

Study findings contribute to a growing identification of the need for more professionally qualified Indigenous workers. In Quebec, only the University of Quebec in Temiscamingue offers Indigenous social work students a degree course in English. All schools of social work whose graduates (Native and non-Native) work in or with Native communities have an obligation to offer a curriculum in which Indigenous culture, social reality, and ways of knowing and teaching are reflected. If we accept that social work is a modernist, Western invention which has largely imported Western thinking from Britain and

the United States into diverse cultural contexts around the world (Gray, Coats & Hetherington, 2007), we can use Indigenous ways of knowing, healing and teaching to counter balance the dominant philosophy and pedagogy. A majority of social work graduates will encounter Indigenous people in their future practice. Therefore, it is essential that they fully understand the historical context of the social issues facing Indigenous individuals and communities. During their coursework, they should also learn about the role and contribution of women and Elders in Indigenous communities (e.g., Berman, 2003; Brodribb, 1984; Kulchyski, McCaskill, & Newhouse, 1999; Stiegelbauer, 1996).

Indigenous students are underrepresented in undergraduate and graduate social work degree programs. Adapting the social work curriculum and program delivery and infusing general courses with Indigenous content in culturally relevant ways will open opportunities to address social issues in First Nations communities and increase the likelihood of enrollment of Aboriginal students. It is not good enough merely to have a single class on Indigenous issues in a BSW curriculum nor should Native peoples been seen as a monolithic group. It is imperative to foster broad community collaboration in the development of the program so that the knowledge of Elders and other traditional people are reflected in the course content and methods of delivery. Such collaboration should make use of resources that reflect the cultural, social, economic, and political realities of the local Native populations.

Native students face multiple barriers in attending mainstream schools. Study findings revealed that participants, even those who had completed the certificate program, had myriad concerns around their ability to succeed in a mainstream social work program. It is clear that a range of support systems need to be put in place, such as child care, support from family, employers, and the community, help with writing and study skills for mature students returning to full-time education, and the opportunity to support each other and share experiences. In light of that, universities that house schools of social work need to be welcoming in a holistic way. This includes making resources available to support Native students throughout their years of study and creating a university environment conducive to their integration into the student body and to their academic success.

## Suggestions for Future Research and Practice

The McGill School of Social Work has been awarded a grant from the Health Canada Aboriginal Health Human Resources Initiative over the years 2007 – 2010. This project – Indigenous Access McGill - is designed to assist the School and the other health disciplines at McGill to give greater support to First Nations and Inuit students already in programs through ongoing mentoring, tutoring, and summer support programs. An aspect of the project will allow the School to examine the BSW curriculum with a view to adding content and pedagogy that will integrate First Nations and Inuit issues. Three areas have been discussed that would allow a program to develop that is more appropriate to the reality of the increasing numbers of Indigenous students entering social work and that might offer non-Indigenous students an opportunity to make a more in-depth study of Indigenous issues during their BSW program.

The key elements of the project should make the BSW program more attractive to Indigenous students who wish to follow a career in social work both in their own communities and elsewhere and to non-Indigenous students with an interest in Indigenous issues. The project also hopes to create a program in which Indigenous and non-Indigenous students can study together and learn from and support each other. The three elements of the program are discussed briefly below.

### Curriculum Consultation

This methodology has been successfully used in other Schools of Social Work. The School has one First Nations Issues course as an elective and some materials in other courses pertaining to First Nations issues at the discretion of individual instructors. A project of curriculum consultation could begin to examine the required courses on the program and gradually add more Indigenous content and pedagogy where appropriate.

### Summer Support

In 2007, the School of Social Work offered a short summer orientation program for potential social work students. The program proved very successful and was much appreciated by participants. The project offers the opportunity to develop a similar program each year for students who have applied and been accepted to the program. It is anticipated that these students could come together for a program of orientation activities in the summer and just before the beginning of classes.

### Mentoring and Tutoring Support

This part of the project is designed through the establishment of a Resources Room and a two-member team (one of whom is First Nations) to offer ongoing mentoring and support to students on the program. This is a direct result of some of the comments offered during the research study by participants in the Certificate program who greatly appreciated the mutual support generated by the group. Individual and group mentoring, individual

tutoring and all the general resources of the University are available.

The evaluation of this project and the experiences of the students presently studying in the School of Social Work will be a rich resource in terms of future development. There are also a number of future research projects which we hope will grow out of this project, including following graduates of the BSW program into careers in their own communities and elsewhere and explore the impact of the Indigenous Access Project on their practice. The reality is that the majority of First Nations and Inuit BSW graduates will go on to work in organizations or agencies serving children and families. Therefore, another potential study is assessing the impact they will have as Native social workers in their own communities. A potential longitudinal study might examine the impact of Native social workers who use a least restrictive practice approach on the number of Native children in the child welfare system.

## Endnotes

1. For this study, the backgrounds of the two Allied researchers were Scottish, Irish, African American, German, Slovakian, Seminole, Cherokee, and Hungarian.

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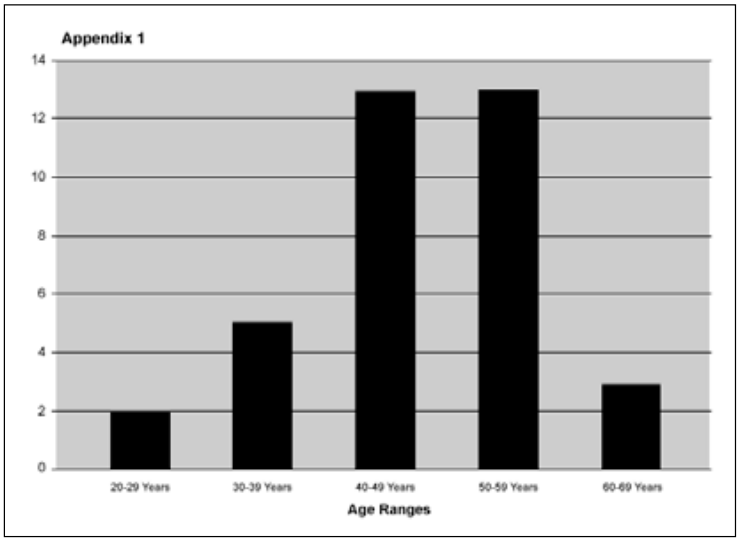
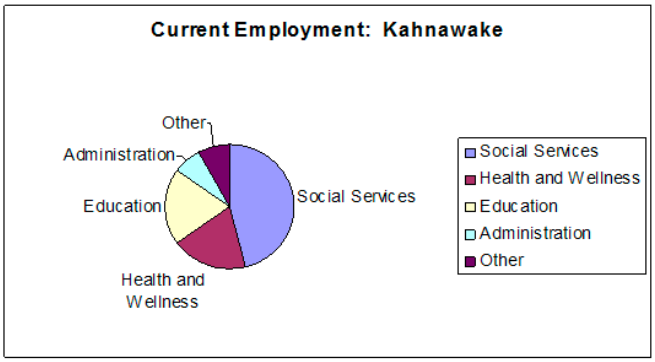
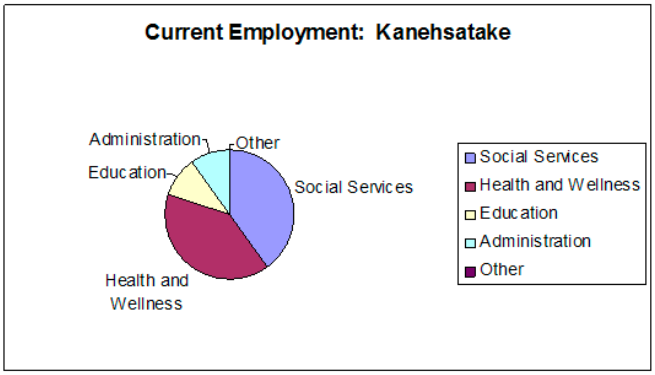



**Appendix 2**



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# Seeking "Mamatowisowin" to Create an Engaging Social Policy Class for Aboriginal Students

Erika Faith

## Abstract

This article recounts the author's personal and professional journey of developing a social policy social work course at the First Nations University of Canada. With no social policy text designed for and about Aboriginal peoples, and very few articles written on social policy issues in Aboriginal communities, the author was challenged to create content, pedagogy, and assignment structures that reflected the cultures of her students who come primarily from the plains and woodlands reserve communities of Saskatchewan. By consulting with Elders, colleagues, and students, as well as by paying attention to her own internal sense of stress or delight, she progressively modified the class over three years, releasing all that was'dry and detached' while building on all that was fun, relevant and exciting. Along the way, the author was introduced to the néhiyawéwin (Cree) word mamatowisowin, which refers to a state of spiritual attunement and divine inspiration. I realized that, perhaps more than head knowledge, it was mamatowisowin that she most needed in order to create a class that optimally served her students and the university's vision of a 'bicultural education' that is equally grounded in both European and Indigenous knowledge systems.

## From Student to Teacher; Entering the Social Policy Domain

> *...by integrating the personal and the political, social work integrates policy and practice, and is inevitably concerned with both (Ife, 1997, p. 166).*

Social policy classes have been the most challenging, rewarding, and transformational of the many social work courses I have both taken and taught over my academic career. When I entered the social work program at the University of Calgary in the mid 1990s, I thought I wanted to be a counselor and help people. Like so many in my cohort, I wasn't particularly interested in politics, economics or political ideology, and in fact found these subjects intimidating, distasteful even. The compulsory class most dreaded, and taught by the most feared instructor, was "Social Policy and Ideology". To my surprise, as I started engaging with the course content, I found myself turned on by an emerging political framework within which to understand the various forms of suffering and oppression that the social work profession seeks to address. I read and re-read Bob Mullaly's *Structural Social Work*, marking the book with comments, questions, and stars. His uncompromising assertion that all aspects of our lives, both personal and professional, must be aligned with socialist values of equality, collectivism, and humanitarianism, resonated deeply for me. His vision of structural social work offered a radical alternative to all that I felt repelled by in the conventional, case-model social work practice I was learning in other classes.

Upon the completion of my Bachelor of Social Work degree, I wanted to expand my analysis of social problems and solutions, to include global structures and policy interconnections. So I enrolled in the international social work concentration of the Master of Social Work program at the University of Calgary. In my thesis I critiqued the dominant social work education system as based on a parochial tradition, which became universalized through a larger project of Western imperialism[1]. I also explored questions of power and privilege, voice and knowledge, inclusion and exclusion, within the discourse of 'international social work'. Although my work explored the interface between colonizing and Indigenous knowledge systems in social work globally (Haug 2001, 2004), I was not grounded in the local context of these dynamics.

Then in 2001 I was offered a teaching position in the School of Indian Social Work at the First Nations University of Canada[2]. Six years after taking my first social policy class, I now found myself assigned to teach the very class that had been so pivotal in my own academic journey. I knew that this class could make

all the difference in whether or not students go on to integrate a political analysis and activism in their social work practice. While I felt excited to share the best of what had been illuminating to me, I also felt immense fear and stress. I was obsessed with the gap between what I believed I should know, and my limitations of knowledge and direct experience in the social policy domain. My idea of a real social policy professor was someone who has read all the social policy texts, has worked extensively in the field of social policy, and knows all the dates and names of the various social policies, as well as relevant statistics. I imagined real social policy professors spend hours poring over the latest government and non-government reports and documents, and scouring mainstream and alternative media so that each lecture is timely, current, and optimally informed.

With the added mandate of integrating First Nations languages, knowledge systems, histories and healing traditions, I felt completely overwhelmed with the task before me. John Taylor states that "non-Native teachers should be responsible for educating themselves about the community, culturally appropriate content, and culturally appropriate teaching methods" (Taylor, 1995, p.241). Without a native studies degree, without native ancestry myself, and without any formal preparation for university instruction, I felt completely inadequate and ill prepared for the task before me. I frequently dreamt that I was naked in front of students, for indeed I felt barely clothed by the flimsy credentials a master's degree in social work, and several years of professional work experience. Like most non-Aboriginal people of this land, I had almost no knowledge of the 'Indian country' into which I was now immersed. I knew little of the political systems and structures, cultures, languages, homelands, leaders or visionaries of the First Peoples of Saskatchewan.

As I began my research for the social policy class, I soon became aware that the information I sought was not to be found neatly packaged in a few succinct books or journal articles. There was no existing social policy text designed for and about Aboriginal peoples. So I began my preparation by taking stacks of the existing social policy texts home from the library. However, I found that just looking at these dry texts triggered tremendous tension within me. With their no-nonsense covers and seriously marching tables of contents, the social policy literature seemed overly cerebral, male and impersonal. Moreover, most did not even mention Aboriginal peoples[3]. While the ideas and analysis they contained had initially sparked my imagination and bourgeoning analysis, I now felt frustrated with the implicit Eurocentrism in these texts, and felt unprepared to link the facts, analysis, history, and information they contained, to the contexts and communities my students were coming from.

A library search of publications on 'First Nations/ Aboriginal/Indian social policy', revealed limited findings. Some publications were out of date, while others were inaccessibly laden with Marxist jargon about the lumpenproletariat within First Nations communities (Wotherspoon & Satzewich, 2000). The historical texts I found chronicling the Canadian government's assimilation policies toward First Nations peoples (policies almost totally excluded from most social policy texts), were helpful as reference materials but inappropriate for a social work textbook. Almost all of the texts I reviewed were written by non-Indigenous male scholars. I realized that to create social policy course readings representative of the voices of both men and women alone would have been a considerable challenge, never mind the additional challenge of equally representing both First Nations and 'mainstream' voices and perspectives!

## Initial Attempts at Indigenizing the Social Policy Class

> *Effective Aboriginal education addresses issues of culture and language, community values and norms, and power relations (Goulet, 2001, p. 70).*

Starting from where I was at, and using the literature that I was familiar with, my first constructions of the social policy class were drawn largely from the information I had acquired through my own studies. I reviewed the history of the welfare state as influenced by dominant western ideologies and political parties (Guest, 1997; Carniol, 2000). I explored how social policy is increasingly influenced by international trade relations and agreements, neo-liberal economics and globalization (Wilson & Whitmore, 2000; Ismael, 1996), and I discussed the model of 'structural social work' for engaging at both the personal and political levels (Mullaly, 1997). The remainder of the class was devoted to current social policy issues in Canada today. I started with Mullaly's (1997) *Structural Social Work; Ideology, Theory and Practice*, and Wotherspoon and Satzewich's (2000) *First Nations: Race, Class, and Gender Relations*, as my primary texts, and invited Elders and indigenous guest speakers to share their knowledge and experiences related to the social policy domain.

In response to my first attempts at teaching, my students were amazingly gracious. Despite my Eurocentrism and obvious knowledge gaps in terms of First Nations social policy and service delivery at the band, regional, and national level, many of my students expressed the same excitement that I had experienced when I first began to frame social work as political practice. Other students, who were perhaps closest to grassroots politics in their communities, gave me

feedback that the class wasn't connecting enough to their communities, political systems and structures, social movements, or macro guiding policies like the Indian Act. Nor was I addressing the most pressing social policy issues in local First Nations communities around the transference of jurisdiction from provincial to band and tribal council service delivery, for how could I teach what I didn't know?

I realized that the structural social work model articulated by Mullaly (1997) had inspired me as a student because I had the academic and cultural framework from which to interpret his ideas. Many of my students were coming from a very different place than I was as a student, in terms of their academic and cultural backgrounds. 'If only I had more relevant experience and knowledge, this would be so much easier' I sighed one day to my colleague Shelley Thomas Prokop as we chatted over Vietnamese noodles. Her response was immediately helpful; "Erika, you're simply coming from the outside in. Whether you come from the outside in or inside out, there is a major process involved in making the connections, no matter where you begin". Oh yeah. I realized that for anyone, it would be a challenge to construct this class according to the ideals of 'bicultural education' as upheld by the Elders who had dreamed our university into existence. And so, I decided to stop berating myself for all I didn't know and to just get on with the task of learning what I needed to know, in order to teach what I needed to teach.

## Seeking Mamatowisowin

> *... while people are mainly in the state of being – the experience of being alive and seeing the goodness in all life as it is experienced – they are also in a state of being-in-becoming – the active seeking of one's purpose (Hart, 2002, p.47).*

Speaking of the knowledge embedded in the néhiyawéwin[4] language, education philosopher Willie Ermine describes how "mamatowisowin is the capacity to connect to the life force that makes anything and everything possible" (Ermine, 1995, p.110). My Cree-English dictionary translates this word as "spiritual power, talent; giftedness" (Wolvengrey, 2001, p. 86). Intrigued by the concept, I asked two traditional néhiyaw (Cree) knowledge holders to further explain it to me. Joseph Naytowhow told me that mamatowisowin relates to "being in tune with the universe, and is a sacred place of the mind." Wes Finday similarly described mamatowisowin as "a state of being spiritually gifted as a result of what we earn through practicing personal integrity." It was mamatowisowin that I realized I needed to develop within myself in order to create a social policy class that optimally served my students.

As part of the Indian Social Work program, I had a responsibility to teach to and from all four domains of the medicine wheel; body, mind, spirit and emotions, upon which the program is based. But how? How to merge the seeming great divide between the political and the spiritual? The education I had received treated spirituality as irrelevant to social policy. Yet Audre Lorde, in her beautiful essay titled Uses of the Erotic, powerfully challenged this division for me;

> *The dichotomy between the spiritual and the political is also false, resulting from an incomplete attention to our erotic knowledge. For the bridge which connects them is formed by the erotic – the sensual - those physical, emotional, and psychic expressions of what is deepest and strongest and richest within each of us, being shared: the passions of love, in its deepest meanings (Lorde, 1984, p.56).*

Did discovering mamatowisowin lead to integrating love, passion and even eros, with politics, economics, history and ideology in the social policy classroom? Now I was really stepping beyond the conventional reach of the social policy text books! If indeed the erotic leads us to our highest standards of excellence, as Lorde asserts, I began to ask myself what a loving, spiritually inspired social policy class might look like?

I began by setting as my goal to create a social policy class that was relevant to my students' personal lives, families, communities, and was fun, pleasurable, humorous, and engaged body, mind, emotions and spirit. To add fun and physical activity to my classes, I began to integrate exercises such as asking groups of students to create 'tableaus' of the different ideologies we were studying, while the rest of the class guessed what ideology the group was portraying. Another method of engaging the body through 'play' was to divide the class in two, and start a sentence on the board such as "social policy is….", and have both teams race to complete the sentence by each student writing only one word.

As I began to focus on creating a class based on pleasure and personal integration, I was shocked to realize how deeply invested I was in the academic model within which I had been socialized. 'What it my duty to teach?' I asked myself. 'Is it possible to ditch what I dislike and focus on what is most 'delicious' without compromising core content?'; 'Is it possible that by doing so I can actually do my job better, or do I indeed have an obligation to force feed dry readings, like a parent making her children eat Brussels sprouts, "for your own good"?' (as the residential school system had done with devastating consequences). Even as I was anxiously trying to catch up myself with all that I thought I should know as the instructor, I found myself trying to 'catch up' my students with what I believed they should know,

and distracted by all they didn't know. While I had begun my teaching with strong ideals of Paulo Freire's liberation education, and social work philosopher Eduard Lindemans' focus on "the primary importance of the learner" (Lindeman, 1961:p.6), I realized that I really didn't know yet how to actually practice these models in the classroom!

When feelings of tension arose around the gap between what I wanted to create and what I had in fact constructed, became overwhelming for me, I would sit down with my journal and I would create positive affirmations for myself such as, "I am able to facilitate an engaging social policy class that is relevant to the lives of my students, and all the supports I need to teach this class optimally, are available to me." I would journal about what an ideal social policy class would look like; action-oriented and inspiring; a class that combined intellectual rigor with nurturing of the emotional and spiritual body.

Increasingly I came to admit to myself the uncomfortable truth that to a large degree, I wasn't enthralled with much of the course content and materials, and that I too felt intimidated and overwhelmed by all the course expectations. Like my students, I would rather be participating in some other class that had more 'attractive' readings and content. Social policy texts were the last thing I felt like reading at home in the evenings or on weekends. I felt like a hypocrite and imposter trying to be enthusiastic about something I didn't even feel enthusiastic about myself! I wanted to inspire students to find and live by their truth and passion, and yet I wasn't being truthful to mine! If I wasn't enjoying the course content, how could I expect my students to? As I was struggling with these questions, I discovered the words of Lakota Wisdomkeeper Noble Red Man, which became a touchstone for me:

> *God made you so you feel good when you do right. Watch when you feel good and follow that good feeling. The good feeling comes from God. When you feel good, God feels good, too. God and you feel good together (Arden, 1994, p.13).*

When I used readings that I really loved and that resonated with the students, and when I was able to create a classroom community that was fun and participatory, I felt good inside. Maybe I didn't have to be and know all I had thought an ideal social policy professor should be and know, in order to provide an excellent policy class after all! It occurred to me that if classes like social policy are left only to the few who love and write social policy texts, the majority of social workers will continue to be politically disengaged, thus continuing the fracture between progressive social policy advocacy and daily social work practice. Slowly I came to see that my own sense of aversion to some of the course content was actually a gift, as it offered me a challenge to create something more rich and holistic.

To not dissociate knowledge from first-hand experience is a fundamental First Nations ethic, as Willie Ermine states, "only through subjectivity may we continue to gain authentic insights into truth. We need to experience the life force from which creativity flows. . ." (Ermine, 1995, p.110). I realized that I couldn't support my students to trust in the authority of their own voice and experiences, if I couldn't do this for myself. My colleague Joan Sanderson told me that she teaches as though life experiences are the primary text and the written texts are supplementary. Such an approach profoundly challenged all my former academic socialization; that the primary role of both the teacher and student is to acquire the knowledge of 'the experts' who write the textbooks! And so, with each passing week, semester, and year, I practiced letting go of privileging the knowledge of those who wrote text books, while exploring more deeply what it means to teach to and from our collective lived experiences. Over three years, I continued to modify the class by releasing all that was 'dry and detached' while building on all that was fun, relevant and exciting.

## Exploring Sharing Circles

> *...learning is a holistic experience that occurs physically, mentally, emotionally, and spiritually. Certainly relevance requires restructuring the approach to social work practice and to teaching practice courses, creating a more holistic model that recognizes, in the case of the former, the importance of kinship ties, and in the latter, that learning holistically involves healing . . (Harris, 2006, p. 132).*

Lecturing, the traditional social policy pedagogical model of choice, just didn't fit for me. Not yet thirty, I was younger than most of my students, and felt ridiculous presenting myself as 'The Knowledge Holder', and they, as 'tabulae rasae.' To practice culturally relevant pedagogy (and to escape the pressure to be in the spotlight at the front of the room), I structured every class in a circle rather than the conventional line by line seating arrangement. Upon consultation with our resident Elders, one of my first steps to indigenize the class was to give tobacco to a male student to lead us in a smudging ceremony each time we met, according to the traditions of the néhiyawak (Cree) people of this territory. For the first class I would also invite an Elder to pray with us. I then began each class with a 'check in'/ sharing circle, giving each student a chance to share thoughts, feelings and ideas about the class materials and the connections to their own lives.

The advantages of the sharing circle format were many. For one, everyone had a chance to speak, and thus, as Jean Graveline (1998) enthuses in her book 'Circle Works,' a sense of classroom community was strengthened, so that students' insights and thoughts were shared collectively. This method also gave me a chance to begin the class by collecting my thoughts and composure while students talked, and helped me to address my comments to theirs.

The circle method also presented certain challenges. My idealistic hope, was that in the circle the course readings would be synthesized, thus doing in many voices and from many perspectives what would otherwise be done only from only my own. I also hoped that the circle method would increase motivation for students to have their readings done for class (my own agenda). The reality however was that many times we would go around the circle and very few would be in a position to comment on the readings. Thus, in our passing of a stone, there would often be broad wanderings from topic, repetition of points, and limited coverage of the ideas and content I intended to focus on that day. In conducting the circle according to the traditional way where each person is given as much time to speak as they desire (Hart, 2002, p.65), just doing a `check-in` and comment on the readings could take a good hour of class time. Some of the students privately expressed to me boredom and frustration with the circle method.

It occurred to me that the ideal of 'shared teaching' requires certain preconditions. In order for students to be optimally engaged with the course materials, they need to have the necessary academic background to integrate the readings, they need to feel a sense of personal relevance of the course content, and they need to feel a sense of confidence in their ability to master the materials. Moreover, in order to be physically and energetically present in the classroom, it is necessary that students' life circumstances outside the classroom, including housing and family relationships, support their classroom learning (Horsman, 1999). In her book *Too Scared to Learn*, Horsman (1999) speaks about how both present and past experiences of violence and trauma deeply affect adult students' ability to learn in the classroom. Similarly, Feehan (1993) notes that there are a number of factors outside of the classroom that disproportionately affect Aboriginal students such as family care-taking and community responsibilities.

"In order to understand your students you must understand the residential schools" one of my students told me during my first year teaching. I thought I did. Just like I thought I understood what liberation education was. It was only by listening, with tears streaming down my cheeks, as students and friends described to me being young children and forcibly taken by the authorities from their parents to attend these schools, that it began to really sink in how deep was the pain, intergenerational trauma, and link between academic learning and violence, disrespect and dispossession. And so I realized that undoing the 'banking model' that Freire describes (in which students are seen as passive repositories into which knowledge is placed to be retrieved at a later date), requires great intra-psychic healing and transformation on the part of all involved in the education project. As Colorado instructs,

> *Western instructors must be able to enter into the reality of Native students. They must feel and express regret for what Westerners have done; they must honestly experience and share the loss of their ancestral European lands, ways, and connections. In the mutuality of this moment, true reconciliation occurs (Colorado, 1993, p. 90).*

I was discovering that ideals of 'liberation education' could not be reduced to a simple formula; 'apply circle and culturally relevant education is achieved.' As I continued to experiment with pedagogical models, my questions deepened; 'What are the various ways that power sharing in the classroom can occur?' 'Is it naïve to expect students to enthusiastically claim ownership and leadership of knowledge creation just because we sit in circle?' 'Is it even fair to ask students to share the instructor's role?' 'Can ideals of 'co-teaching' simply add more burden and expectation to students who are already feeling overwhelmed?' 'In trying to be so culturally sensitive, am I actually abdicating my role as instructor to guide students through the course content?' 'Can the lecture method be used in a non-paternalistic way?'

## Experimenting with Course Readings and Assignments

> *...educators must realize that students learn holistically, which involves watching, listening, and doing, as well as reflecting on these activities; that learning involves healing; that anti-racist practices and policies are paramount in creating a relevant milieu for students; and that the curriculum must provide a context for working holistically with family and community (Harris, 2006, p. 126).*

As I was seeking to integrate culturally relevant pedagogy, I also was seeking accessible class textbooks and readings that contained a minimum of academic jargon, and that were optimally relevant to the communities which students were coming from. Over three years of teaching the class, I experimented with a variety of social work policy text books (including Mullaly, 1997; Swift and Delaney, 2000; Pollak 2000;

Wharf and McKenzie, 1998), as well texts that dealt more indirectly with Canadian social policy (such as Acoose, 1995; Shields, 1994; Wotherspoon and Satzewich 2000). When I discovered Mel Hurtig's (2000) *Pay the Rent or Feed the Kids*, I found that his journalist storytelling style of inquiring into poverty and inequality in Canada, was a wonderful way of accessibly conveying social policy issues. Janet Silman's (1997) *Enough is Enough*, which tells the story of the MicMaq women from New Brunswick whose search for adequate housing ultimately ended with a policy change to the Indian Act, was a perfect complimentary text that my students could really relate to and get enthusiastic about. I also created a supplementary course reading package drawn from edited volumes[5], policy documents[6], and portions of books[7].

To clarify connections between the readings and 'real life' outside the classroom, I developed a variety of action-oriented assignments. The first was a 'letter to the editor' assignment, worth 10%, assigned in the first two weeks of class. This short practical assignment not only gave students the opportunity to learn a potent advocacy tool, but it also gave me an early chance to assess their work. I also created a 'social policy event report' assignment. Drawing from various email list-serves, I provided students with a list of relevant local events that would be happening over the semester, such as local municipal town hall meetings and elections, the Legislative Assemblies of the Federation of Saskatchewan Indian Nations, food security forums and child welfare conferences. Students were to choose an event to attend (preferably in groups), and then write a paper describing the links between the event and the course content.

As well, in order to build student's knowledge of, and connection to, progressive social policy bodies, I developed a 'social policy body' assignment in which students researched and presented a review of a social policy organization such as the First Nations Child and Family Caring Society of Canada, Canadian Council on Social Development, Canadian Center for Policy Alternatives, National Anti-Poverty Organization, and Fraser Institute. I also invited a variety of guest speakers who were involved in social policy development at various levels of First Nations and 'mainstream' Canadian governments to share their experiences with our class.

With a belief that standard term exams don't best reflect student's synthesis of course materials, I experimented with alternative final assignments. At first I assigned term essays, but found that the integrative component of the assignment was too often missed, and students who were fluent First Nations language speakers seemed to be most disadvantaged in this form of expression. I then assigned integrative journals (submitted at mid-term and end of term), which were less academically structured, ensured original work, and gave me an opportunity to learn what students were getting from the class, to hear the voices of those who tended to be quiet, and to learn the connections they were making between the course content and their lives. Many times I was amazed at the depth of insight and synthesis these journals displayed, with students creating linkages that I might not have. As well, though more time-intensive, journal marking was certainly more enjoyable than essay or exam marking.

Still unsatisfied with the limitations of essay and journal assignments in terms of optimally assessing course content 'mastery' and synthesis, at one point I decided to revisit exams. On the day of the scheduled mid-term exam, I informed my students that they would be put in groups of four, and that each group would receive a collective mark. This worked very well, as students were able to talk through difficult questions and learn from one another in a context less stressful than individual exams, and students reported positively on this experience. Yet still I was not totally satisfied, because the knowledge I was mostly `received` rather than `integrative`.

At last I arrived at a 'final integrative assignment' design that best met my goals of equally honoring both Indigenous and Euro knowledge systems, languages and communities. On the assigned exam date, student groups delivered formal presentations on select topics related to social policy. In order for each group to have an audience, each student signed up to be audience members for two other group presentations, and everyone provided positive written and oral feedback to the presenters. The exam day now became a day of interaction, discussion, and inevitably good food as well. The students were evaluated on their presentation skills, displayed knowledge of their topic, and ability to communicate social policy concepts to communities they may work with. Bonus marks were assigned to those groups who gave bilingual presentations in a First Nations language, (thus finally I found a way to privilege rather than disadvantage those who spoke their first languages). In order to assess the bi-lingual presentations, I had to humbly relinquish my role as 'knower,' and specifically invited audience members who possessed the language skills that I did not, to help assess and give feedback on the presentations.

While I would be remiss if I did not acknowledge some inevitable group tensions and struggles occurred, most students reported a positive experience with this collaborative alternative to the standard individualized exam or essay. For me it was a great joy and source of pride to see my students working together by building on each other's strengths and knowledge, while gaining skills for community education. Through these interactive

final assignments, the sense of classroom community and connectedness was deepened, and shared with other members of the campus. In their final evaluations, students offered comments such as, "It is so empowering to have knowledge to be able to look at the whole picture, rather than parts. I have gained confidence to be able to participate in policy and political discussions," and "I feel like my world has opened up so much. I realize how little I knew about policies and politics before I came to this class. I know I will be a better social worker, and a much better person,"

## Conclusions

As instructors we play a significant role in defining the nature and scope of the subjects we teach. I have learned that I have as much academic freedom to experiment with course content, pedagogy and structure, as I choose to claim. Creating a classroom community that engages Aboriginal students required me to deeply question inherited notions of 'academic rigor,' and to consider what it means to engage the body, mind and spirit in the learning process. I learned that providing an excellent social policy class is not so much about what I know, how many social policy or history texts I have read, or even the specifics of my professional work experience. Rather, transformational teaching is primarily about heart, spirit and creativity applied holistically to integrate and synthesize 'textbook knowledge' with the knowledge from lived experiences of everyone involved. I learned that a social policy class need not be about forcing dry formal knowledge on resisting students. Rather, when honored and listened to, expressions of resistance from myself and students, can lead the way to developing a class of greater alignment, joy, and integrity. As an instructor, the more I am connected to the mystery that guides me towards inspiration, creativity, truth, and love, the more I am able to teach from `heart to heart` rather than simply `from head to head`. As I learn to tap into the divine inspiration that guides each one of us, I find myself on the way to discovering mamatowisowin.

## Endnotes

1. Haug,E. (2001) '*Writings in the Margins: Critical Reflections on the Emerging Discourse of International Social Work*'. Masters thesis, Department of Social Work, University of Calgary, Alberta, Canada.

2. Known as the Saskatchewan Indian Federated College until 2004.

3. Wharf & McKenzie's (1998) *Connecting Policy to Practice in the Human Services*, Armitage's (2003) *Social Welfare In Canada*, and most recently Westhues' (2006) *Canadian Social Policy: Issues and Perspectives* (4th ed), are three 'mainstream' texts that have done the most to include First Nations perspectives in their content.

4. The language of those people the Europeans called Plains Cree.

5. Howse & Stalwick, 1990; McKenzie, Seidl, & Bone, 1995; Durst, McDonald & McPhee, 1995.

6. Hanselmann 2001; Assembly of First Nations 1998; Federation of Saskatchewan Indian Nations 1997.

7. Acoose, 1995; Adams, 1989; Hudson & Galaway 1995; Hylton, 1999.

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# A Story of their own: Adolescent Pregnancy and Child Welfare in Aboriginal Communities

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## Abstract

The phenomenon of adolescent pregnancy and its relationship to child welfare in Aboriginal communities provides a useful lens through which to understand fundamental and structural problems with the current child welfare system in Canada. The following paper will examine the relationship between adolescent pregnancy and child welfare, investigate concerns with the current child welfare system, and look to the Convention on the Rights of the Child as a framework for conceptualizing alternative approaches.

## Introduction

Recent reviews of the current discourse on child welfare in Canada have revealed a striking lack of attention to the voices of mothers and children. This silence has been linked to the marked failure of the system to address the systemic drivers of child abuse and neglect (Killington, 2002). Moreover, the absence of personal stories has contributed to a lack of insight into the lives of mothers, into the needs of children, and into the social variables that have led to their encounters with the child welfare system (Killington, 2002). These concerns are particularly relevant in the Aboriginal context, where the effects of the residential school system and assimilationist child welfare policies have led to profound social grief, trauma and dislocation. As one woman explained, her experience reflects an intergenerational cycle; "I never had no parenting skills when I had my kids because I lived in residential school," she recounts, "you never learned anything about how to be a parent so I think I passed that on to my kids [...] Now it's my grandchildren, my great-grandchildren were taken" (Killington, 2002, p. 28).

In tracing these stories, an alarming statistical trend emerges, linking the issue of adolescent pregnancy to that of child welfare. Adolescent pregnancy in Canada is highest among disadvantaged socio-economic groups, and is a particular health concern for young Aboriginal women. It is four times higher among First Nations adolescents, twelve times higher in Inuit communities, and eighteen times higher on reserves than in the general population (Canadian Institute of Child Health, 2000). Furthermore, adolescents who have been involved in the child welfare system are more likely to become pregnant teenagers (Canadian Institute of Child Health, 2000). At the same time, children of adolescent mothers are at greater risk of abuse and neglect and are more likely to be taken into care (Canadian Institute of Child Health, 2000).

This relationship provides a starting point from which to explore some of the larger structural problems of the Canadian child welfare system. Recently, a human rights complaint by the Assembly of First Nations and the First Nations Child and Family Caring Society of Canada

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(Assembly of First Nations, 2006) signaled the concerning over-representation of Aboriginal children in the child welfare system. It revealed that Aboriginal children - ie. those of Inuit, Métis, or First Nations ancestry - are three times more likely to be under the care of child welfare authorities (p.1). Moreover, Aboriginal children constitute up to 40% of the 76,000 young people placed in foster care in Canada (Blackstock, Trocmé & Bennett, 2004; Blackstock & Trocmé, 2005). These numbers become a socioeconomic rights issue when viewed in light of the fact that the majority of Aboriginal children are removed from their families for reasons of neglect, the form of maltreatment that is most closely linked to poverty (Assembly of First Nations, 2006). While the nature of the human rights complaint focused on discrimination in regard to funding allocated to First Nations child and family service providers, it has highlighted a host of structural and systemic concerns that underpin the overrepresentation of Aboriginal children in the child welfare system. In addition to inequitable funding levels, the current child welfare system raises serious questions as it places a greater focus on the placement of Aboriginal children in foster care, and is limited in its efforts to address the root causes of neglect (Assembly of First Nations, 2006). Aboriginal communities across the country are strongly opposed to the placement of Aboriginal children in non-Aboriginal foster homes, and have underlined the importance of strengthening families and communities to better care for children (First Nations Child & Family Caring Society of Canada, 2005a).

### *Theoretical Starting Points*

Several perspectives offer guidance in approaching these concerns. These approaches - namely, the Aboriginal approach, the child-centred approach, the health promotion approach, and the feminist relational approach - provide a starting point from which to understand the relationship between child welfare and adolescent pregnancy, and from which to explore solutions.

### *An Aboriginal Approach*

Aboriginal values and belief systems, which emphasize holistic approaches and intergenerational responsibility, provide an important perspective through which to assess adolescent pregnancy and child welfare in Aboriginal communities. The saying that "it takes a community to raise a child," (Health Canada, 1997) for example, underlines the idea of childrearing as a communal practice that is done by the extended family and whole community (Health Canada, 1997, p. 5). Furthermore, inter-generational understandings of responsibility provide insight and awareness into the importance of relationships. Narratives reveal that women were viewed as "keepers of the culture;" it is the grandmothers who "held onto what they could of [their] identity as a People," who "kept the fire [from growing] dim," who "ensured that [Aboriginal people] would be able to know who [they were]" (Fiske, 1993). As such, identity and responsibility are understood in relational terms. As one woman explains, "we were taught that the time we are in is only borrowed from future generations – generations yet unborn. Our thoughts, words and actions impact seven generations from now. It is these children held sacred by our Mother Earth for whom we must leave a true fire" (Fiske, 1993).

### *A Child-Centred Approach*

A child-centred approach to the cycle of child welfare and adolescent pregnancy highlights the importance of families and communities in children's social-emotional development, self-esteem building, and identity formation. Carol Phillips, a researcher in early childhood development, has examined a process of socialization identified as "enculturation" (Greenwood, 2003). This process, she explains, whereby the child is integrated into his or her birth community, and whereby "families enable children to know and understand a [culture's] values, attitudes, beliefs and behaviours," (Greenwood, 2003) is critical to children's healthy growth and development (p.2). Moreover, Phillips has noted the need to positively promote Aboriginal children's identity and self-esteem given the history and impact of colonialism (p.5).

Emmy Werner has similarly emphasized the importance of fostering trusting relationships in early childhood. "The ability to trust," she explains, "learned early in a child's life, lays the foundation for resiliency, [...] the ability to bounce back when times get tough" (Greenwood, 2003, p. 2). To this point, H.N. Chang has underlined that "an environment of positive relationships, role models and recognition of a child's family and community enhances the self-esteem of the child" (Greenwood, 2003, p. 7). As a result, disruptions in family and community relationships have been directly linked to negative mental health consequences, and to issues such as adolescent pregnancy and child welfare. For example, in Aboriginal communities, the inter-generational breakdown has been associated with problems of alienation, substance abuse and the early onset of sexual activity (Canadian Institute of Child Health, 2000, p. 30).

### *A Health Promotion Approach*

It is important to note that the intentions of this paper are framed by a focus directed at improving determinants of health. A health promotion approach maintains that "pregnancy and motherhood can be much more positive experiences if the woman is fully developed physically, mentally, emotionally and [if] she has the resources and support [that] she and her child need" (Archibald, 2004,

p. 30). As such, this discussion emphasizes the need to respect young women's choices, while providing them with the support required "to make informed [and] healthy decisions." (Archibald, 2004, p. 30). A health promotion approach thus underlines the importance of "programs that address teen pregnancy prevention in the context of healthy sexuality," and "strategies that use the determinants of healthy development to increase the health and well-being of all children." (Canadian Institute of Child Health, 2000, p. 20).

***A Feminist Relational Approach***

Finally, as Colleen Sheppard explains, a key theme in feminist theory is "the need to situate legal rights within a web of social relationships" (Sheppard, 2004, p. 17). This recognition of interdependence forms the basis of the feminist relational approach, which was first articulated by Carol Gilligan. Gilligan's perspective seeks to challenge the individual self of classical liberalism by "seeing a world comprised of relationships rather than of people standing alone, a world that coheres through human connection rather than through systems of rules" (Gilligan, 1982, p. 29). In formulating her theory centered upon an "ethic of care," Gilligan suggests that women relate more to a moral framework that sees "the actors in the dilemma arrayed not as opponents in a contest of rights, but as members of a network of relationships on whose continuation they all depend" (p. 30). Thus, the focus shifts from separation to sustaining connection, as Gilligan maintains that "in the different voice of women lies the truth of an ethic of care, the tie between relationship and responsibility, and the origins of aggression in the failure of connection" (Gillian, 1982, p. 173).

Building upon this idea, Jennifer Nedelsky suggests a reconceptualization of autonomy that focuses on "the emergence of autonomy through relationship with others" (Nedelsky, 1989, p. 13). This awareness highlights the role of relationships in providing the "support and guidance necessary for the development and experience of autonomy." Looking to the parent-child relationship as a prime example of this reality, Nedelsky posits a perspective that acknowledges "relatedness [as a] literal precondition of autonomy, and interdependence [as] a constant component of autonomy" (p.108).

In the context of adolescent pregnancy and child welfare, the importance of relationship emerges very clearly in light of the intergenerational transmission of disadvantage, and the effects of ruptured relationships upon early childhood development. The role of families and communities in supporting young women's autonomy and decision-making also appears as an important variable in ensuring healthy choices.

These perspectives emphasize the need to empower children, youth, families, and communities for healthier outcomes. They underline the importance of promoting child welfare through prevention strategies that seek to address root causes, such as poverty and social dislocation, rather than simply relying on protection strategies that respond to symptoms as isolated events. Moreover, they highlight the importance of providing support services for young mothers, and the need to strengthen rather than disrupt families. Unfortunately, while child welfare experts and social workers have increasingly supported community-based interventions, changes in the legal discourse around child welfare have been slow to follow (Greenwood, 2003, p. 117). The need to develop a legal framework for change thus presents itself as integral step in promoting real and effective policy solutions.

As such, the phenomenon of adolescent pregnancy and its relationship to child welfare in Aboriginal communities provides a useful lens through which to understand fundamental and structural problems with the current child welfare system in Canada. The following paper examines the relationship between adolescent pregnancy and child welfare, investigates concern with the current child welfare system, and looks to the Convention on the Rights of the Child as a framework for conceptualizing alternative approaches.

## PART I: The Phenomenon of Adolescent Pregnancy and its Relationship to Child Welfare

***A) The Consequences of Adolescent Pregnancy Among Aboriginal Youth for Adolescent Mothers, Children and Society***

As noted above, the rate of adolescent pregnancy among Aboriginal youth, both on and off-reserve, is significantly higher than that among non-Aboriginal youth (Canadian Institute of Child Health, 2000, p. x). In many of these situations, young mothers are able to build "satisfactory lives for themselves and their children" (Canadian Institute of Child Health, 2000, p. ix). Moreover, youth pregnancies may not be stigmatized due to the cultural valuing of all infants that exists in communities. Nevertheless, adolescent pregnancy often involves numerous consequences for adolescent mothers, their children, and society. Studies have indicated that adolescent mothers are "less likely to complete their education, more likely to experience isolation and homelessness, less likely to develop good parenting skills, and more likely to transfer their own history of childhood abuse and neglect to their [children]" (Canadian Institute of Child Health, 2000, p. ix). Similarly, early childbearing

entails health risks for babies; pre-mature birth and low birth weight are common (p. ix), and the infant mortality rate is 60 percent higher (p.8). Children of adolescent mothers face a greater chance of "early childhood injury, acute illness, mental health problems, and eventual involvement in the criminal justice system" (p. ix). The relationship to neglect emerges given that Aboriginal adolescent mothers "are more disposed to substance abuse while pregnant and are less likely to be properly nourished or to breast feed their babies" (Canadian Institute of Child Health, 2000). Finally, the social impact of adolescent pregnancy is evidenced by increased rates of "school drop-out, incarceration, poverty, child abuse, and children taken into care" (Canadian Institute of Child Health, 2000). Notably, many of these effects are interconnected and inter-generational (Canadian Institute of Child Health, 2000).

***B) The Relationship between Adolescent Pregnancy and Child Welfare***

These consequences highlight the complex relationship between adolescent pregnancy and child welfare. Studies indicate that adolescents who have been involved in the child welfare system are more likely to become pregnant teenagers, and that the children of adolescent mothers face a greater risk of being taken into care (Canadian Institute of Child Health, 2000). Why is this? To begin with, adolescent mothers are more likely to suffer from the socioeconomic inequalities which contribute to conditions of neglect, such as poverty and lack of housing (Kirmayer, Brass & Tait, 2000, p. 607). For example, "homelessness is twice as likely by the age of 33 for teenage mothers than for older ones" (Canadian Institute of Child Health, 2000, p. 7). In addition, it has been documented that "the pressures teen parents face predisposes them to child abuse and neglect" (Canadian Institute of Child Health, 2000, p. 7).

The effect of assimilationist policies upon Aboriginal communities further compounds this problem, as the development of parenting skills becomes difficult "within communities in which the extended family has broken down and there is no one to turn to for advice and support" (Canadian Institute of Child Health, 2000, p. 7). As one mother explained, her experiences growing up in foster care led to parenting difficulties; "when you are part of the system yourself you're never given any assistance or any structure on what a mom role is about, especially if you grew up in 10 or 14 different homes. How can you get structure like that as an adult and try to raise your own kids?" (Killington, 2002, p. 15).

Similarly, the lack of enculturation that many Aboriginal children experience due to non-Aboriginal foster placements has been linked to negative self-perceptions among adolescent mothers (Bent, Josephson & Kelly, 2004). The "transition from childhood to adulthood" has been identified as a critical time of "identity formation" (pp. 83-84). Social science research has indicated that "minority group adolescents who reach [a] stage of cultural identity achievement [...] develop a stronger sense of self and a more positive self-concept" (pp. 83-84). Consequently, under the stress of early parenting, adolescent mothers who have developed a negative self-concept due to lack of enculturation exhibit an increased risk of psychosocial problems, which contribute to greater difficulties with child-rearing, and increased rates of child abuse (pp. 83-84).

***C) Mother-Child Narratives and the Transmission of Disadvantages***

The relationship between adolescent pregnancy and child welfare highlights the ways in which narratives of disadvantage are transmitted from mother to child. The cyclical nature of socioeconomic inequality further underlines the importance of empowering young women to shift this narrative. Strengthening relationships between children, mothers, families and communities, through support and services such as counseling, thus becomes critical in ending stories of dislocation.

For example, research has found "that abusive parents are more likely than nonabusive parents to have been abused themselves, that child abuse and family violence are intergenerational in nature, and that women who were sexually abused are much more likely than nonabused women to have children who are physically and sexually abused" (Boyer & Fine, 1992, p. 4). While not all parents replicate abusive pasts, these risk factors merit attention in light of the ongoing relationship between adolescent pregnancy, problematic parenting behaviours, and prior experiences of sexual abuse (Boyer & Fine, 1992). Similarly, mothers recovering from drug and alcohol addictions reported "significantly higher levels of adversive childhood experiences, [negative home environments,] psychological distress, and the use of problemative parenting behaviours" (Harmer, Mertin & Sanderson, 1999, p. 421). Preventive, rather than simply protective, services, thus become critical in preventing abuse before it happens and in addressing larger cycles of disadvantage.

***D) Factors which contribute to adolescent pregnancy***

Many of the causes of adolescent pregnancy are linked to socioeconomic inequalities which contribute to the exclusion, alienation and ill-health of Aboriginal children and youth. Furthermore, increased rates of adolescent pregnancy and single motherhood coincide with the growing feminization of poverty, particularly for young women living off reserve. Recent medical reports have highlighted the connection between health status

and socioeconomic disadvantage, identifying the "young female face of poverty" as a public health concern (Postl, 1997, pp. 1655-1656). As a result, such conditions have given rise to neglect, substance abuse, and the rupture of family relationships. These realities feed into the causes of adolescent pregnancy, which include emotional needs, risk-taking behaviours, and lack of self-esteem.

***Emotional Needs***

In a recent study, adolescent mothers cited feelings of alienation, "the desire to re-create a family," and the need for "love and attention" as motivating factors behind their choice to have a baby (Archibald, 2004). The study concluded that "deficits in family life can contribute to a need for love and belonging that can lead alienated young girls to believe that having a baby of their own will fill the emotional gap and give them a place and purpose in life" (Canadian Institute of Child Health, 2000, p.17).

***Risk-Taking Behaviours***

Studies on risk-taking behaviour have similarly suggested that feelings of alienation increase the risk of pregnancy among young women (Canadian Institute of Child Health, 2000, p. 7). More specifically, findings indicate that "women who spent any time living in foster homes or with relatives other than parents during childhood have an elevated risk of engaging in high-risk sexual behaviours" (Hollander, 2002, p. 55). In addition, adolescents who have experienced sexual abuse, or who have been involved in the child welfare system, are more likely to begin sexual intercourse earlier, less likely to practice contraception (Boyer & Fine, 1992, p. 4) and more likely to engage in substance abuse (Canadian Institute of Child Health, 2000, p. 7; Canadian Institute for Child Health, 2000, p. 17).

***Lack of Self Esteem***

While lack of access to contraception was an issue for some teenage mothers, a larger number of young women expressed an unwillingness to insist upon birth control due to lack of self-esteem (Archibald, 2004, p. 5). These findings are extremely disconcerting, and highlight the important relationship between enculturation, family support and self-esteem formation.

As such, these factors highlight the intergenerational and systemic nature of the relationship between adolescent pregnancy and child welfare. The growing number of Aboriginal children taken into care, alongside the spiraling rates of adolescent pregnancy and poverty in Aboriginal communities, reveal a cycle of harm that extends beyond isolated individuals - that is located in the rupture of family and community-level support systems and relations.

## PART II: The Role of Law in Responding to the Needs of Aboriginal Children and Youth: A Critical Look at the Current Child Welfare System in Canada

Social service providers, Aboriginal communities, and government review bodies have heavily criticized the current child welfare framework in Canada. Concerns have centered around funding and jurisdiction incongruities, the current system's focus on child-removal, and the widespread lack of culturally appropriate services. These issues have resulted in a general perception of the child welfare system as an extension of the residential school system.

***A) Aboriginal Child Welfare in Canada: The Child Welfare Framework***

The complex legislative framework of the child welfare system in Canada has contributed to its problematic history and to a growing disconnect between funding and jurisdiction. Under the constitutional division of powers, funding for child welfare services off reserve is the responsibility of provincial and territorial governments, whereas, due to the Indian Act, funding for child welfare services on reserve to status Indian children remains the responsibility of the federal government (First Nations Child & Family Caring Society of Canada, 2005, p. 107). The system's adversarial relationship with Aboriginal communities was established from the outset, as it organized a mass removal of Aboriginal children from their homes and communities, termed the "60s scoop" (First Nations Child & Family Caring Society of Canada, 2005, p. 107). This traditional focus on removal as the only response to child maltreatment, rather than prevention or family-support services, was heavily criticized and led to the development of First Nations child and family service agencies (First Nations Child & Family Caring Society of Canada, 2005, p. 108).

During the 1990s, restrictions on "the development of Aboriginal child agencies serving on-reserve residents" were lifted by the federal government and a national funding formula, known as Directive 20-1 Chapter 5, was implemented (First Nations Child & Family Caring Society of Canada, 2005). The directive was designed to provide funding for on-reserve child welfare agencies, however, it "requires that First Nations agencies work pursuant to provincial and territorial child welfare statutes." It generally operates across Canada, with the exception of Ontario, which has a separate funding agreement (First Nations Child & Family Caring Society of Canada, 2005, p. 107). As a result of the directive, Aboriginal child and family service agencies that operate under their own child welfare jurisdiction are ineligible for funding (First Nations Child & Family

Caring Society of Canada, 2005a, p. 107). Moreover, the criteria imposed under provincial and territorial child welfare statutes have been identified as problematic, as Aboriginal agencies struggle to reconcile "services that reflect the holistic, interdependent, and communal rights framework of the cultural communities they serve with individual rights-based child welfare statutes" (First Nations Child & Family Caring Society of Canada, 2005a).

***The "Disconnect" between Jurisdiction and Funding***

In 1998, the Auditor General of Canada noted a "disconnect between funding and jurisdiction," reporting an "inequity of services to Status Indian children in Canada" Blackstock, Clarke, Cullen, D'Hondt & Formsma, 2004, p. 160; Auditor General of Canada, 1988, s. 14.76). Under the regime set up by the directive, "funding levels are not linked to the content of provincial and territorial child welfare statutes." Difficulties arise when "provinces and territories change their legislation, [as] there is no concordant review of funding levels to ensure that adequate resources are provided to First Nations child welfare agencies to meet new statutory responsibilities" (Greenwood, 2003, p. 108). Consequently, a 2000 national review of child welfare agencies discovered that "on average, First Nations child and family service agencies receive 22% less funding per child than their provincial equivalents" (Blackstock & Trocmé, 2005; MacDonald & Ladd, 2005). This is especially problematic given the higher level of child welfare needs on-reserve (Blackstock & Trocmé, 2005; MacDonald & Ladd, 2005).

***B) Critiques of the Current Child Welfare System***

More generally, assessments of the current child welfare model have observed failures of the protection paradigm itself, and have recommended an alternative framework based on community wellness (Bellefeuille & Ricks, 2003, p. 23). Such a model, "in contrast to the individual needs-based protection approach, [...] implies a need to broaden traditional child protection policy to respond to the well-being of children generally, not just to those children at immediate "risk"" (Bellefeuill & Ricks, 2003, p. 39). Drawing from the health promotion approach, the community wellness paradigm recognizes the systemic vulnerability of Aboriginal children, understanding "all problems and causes [...] as a problem of larger social structures." As a result, it calls for the "[reconceptualization of] child welfare," and for the development of "empowering health promotion strategies that acknowledge and reinforce the capacity of communities for self-care and change" (Bellefeuill & Ricks, 2003, p. 39).

***Addressing Symptoms Rather than Causes***

The current protection model, for example, has been heavily criticized for its emphasis on child removal rather than preventive services Blackstock & Trocmé, 2005, p. 7). Resources and support are sorely needed in Aboriginal communities, and child welfare agencies are poorly equipped to deal with the systemic drivers of child maltreatment, which include poverty, unemployment, inadequate housing, and intergenerational trauma (Greenwood, 2003; Blackstock & Trocmé, 2005; and Blackstock, Trocmé & Bennett, 2004). This is particularly relevant given that "over half of Aboriginal cases [involve] neglect," the form of maltreatment most closely associated with poverty, "whereas neglect [is] found in only half as many non-Aboriginal cases" (Greenwood, 2003, p. 110).

The problem with addressing symptoms rather than causes becomes abundantly clear in the case of fetal alcohol syndrome (FAS). Given the high incidence of substance abuse on reserves, Aboriginal children face a significantly increased risk of FAS (Marino & Fine, 2003). The legal response to substance abuse among pregnant adolescents has focused on the removal of infants after they have been born with FAS. This is of little help to the children who consequently suffer permanent mental and physical defects (Marino & Fine, 2003). Support services and treatment programs to prevent substance abuse among pregnant adolescents, on the other hand, would promote healthy maternal and infant outcomes, while improving children's long-term well-being (Health Canada, 1997).

Furthermore, the harm that occurs within the child welfare system must not be underestimated. Children are often moved from one foster-placement to another, and "accounts of deprivation in care systems lead to reports from young people that they can no longer trust people in human relationships" (Bagley, 1985, p. 67). The impact of such experiences is severe, as a review in Alberta indicated that nearly a fifth of children in government care had attempted suicide or acts of deliberate self-harm (Bagley, 1985, p. 69). Frequent abuse within the child welfare system has also led to mistrust by the very children it is meant to protect. As one mother who had grown up in foster care expressed, "to them you're either just a pay cheque, a baby-sitter, house-cleaner or play-thing" (Killington, 2002, p.15). While the creation of Aboriginal agencies on reserves has reduced the constant re-placement of Aboriginal children, important gaps in off-reserve services continue to exist.

***The Importance of Culturally Relevant Services***

Concerns have also focused on the lack of culturally appropriate services for Aboriginal families living off-

reserve (First Nations Child & Family Caring Society of Canada, 2005a). Mothers, for example, have "reported experiencing racism and discrimination when dealing with the mainstream government child welfare system, both in a larger structural sense and also in their own personal interactions and involvements with individual workers" (Killington, 2002, p. 28). Culturally relevant services thus play an important role in shaping positive and constructive relationships between the child welfare system, and the children and families it serves.

Similarly, social science research has underlined the importance of enculturation for children's development, recommending that children be "cared for within [the] community whenever possible" (Greenwood, 2003, p. 108). When removal is necessary, the lack of culturally-appropriate placements has been raised as an important issue. While few provinces collect data on cultural placement match, a 1998 report by the Children's Commissioner of BC found that "only 2.5% of Aboriginal children were placed in Aboriginal foster homes despite a statutory requirement to give preference to extended family and culturally based placements" (Blackstock, Clarke, Cullen, D'Hondt, & Formsma, 2004, p. 155). The need for culturally relevant services thus emerges as a critical step in conceptualizing a system which promotes healthy outcomes for children and families (Greenwood, 2003, p. 108).

***Prioritizing the Needs of Children and Families***

Ultimately, these critiques are not new or surprising. In 2000, the First Nations Child and Family Services Joint National Policy Review published a wide range of recommendations. These included "supporting First Nations self-government aspirations in child welfare, [and increasing] levels and flexibility of funding regimes to promote community capacity to care for children, through community development and prevention programming." (First Nations Child & Family Caring Society of Canada, 2005b, p.6). All of these recommendations remain unimplemented (First Nations Child & Family Caring Society of Canada, 2005b, p.6). As the recent Wen: de report expressed, "the urgent needs of children and families are falling through government jurisdictional cracks. Funding formulas and jurisdictional arrangements must put the needs of children and families first" (First Nations Child & Family Caring Society of Canada, 2005a, p. 88). The current legislative framework of the Canadian child welfare system has been assessed - by parties on all sides - as a structural failure in dire need of reform. Legal responses must prioritize the needs of children and families, while recognizing the impact of legislative incongruities on lives and relationships.

***C) The Child Welfare System and its Relationship to Colonialism***

The overrepresentation of Aboriginal children within the child welfare system has further been perceived as a "problem rooted in a pervasive history of discrimination and colonization" (Blackstock & Trocmé, 2005, p.34). To many Aboriginal people, the child welfare system represents a painful history of Aboriginal children being stolen from their homes. As an account by Tikinagan Child and Family Services explains, "our [story] as Native people includes the loss of hundreds of our children from their loving families and communities" (Brubacher, 2006). The report emphasizes the importance of reclaiming the past and "[bringing] lost children back home" (p.9). The struggle thus becomes one in which Aboriginal communities and Aboriginal-based child and family service agencies "reaffirm [their] right to care for [their] own children" (p. 17).

The child welfare system has similarly been perceived as an extension of the assimilationist policies embodied by the residential school system. The legacy of child-removal continues to impact Aboriginal communities on a massive scale. It is estimated that "there are as many as three times more Aboriginal children in the care of child welfare authorities now than there were placed in residential schools at the height of their operation in the 1940s" (Blackstock & Trocmé, 2005, p.1). More disturbingly, between 1995 and 2001, data indicate a "71.5% increase in the number of Status Indian children on reserve being placed in child welfare" (Blackstock, Clarke, Cullen, D'Hondt, & Formsma, 2004, p. 156). These numbers testify to the "past, and current, multi-generational and multi-dimensional impacts of colonization on Indigenous children, youth and families" (Blackstock, Cross, George, Brown, & Formsma, 2006, p. 4). Furthermore, they attest to the ways in which the rupture of families and communities has resulted in dysfunction, separation, "splintered relationships," and an enormous loss in individual and collective identity (Killington, 2002, p. 28; Blackstock, Clarke, Cullen, D'Hondt, & Formsma, 2004, p. 21). As such, the traditional child welfare system as a legal response has contributed to the "multigenerational grief, trauma and displacement" among Aboriginal peoples (Greenwood, 2003, p. 106).

Moreover, current child welfare models continue to reflect colonial patterns, in terms of both the imposition of dominant cultural values and practices in relation to child-rearing, and the consequent devaluation of Aboriginal values and practices (Kline, 1993, p. 306). For example, Marlee Kline maintains that "First Nation women are particularly vulnerable to being constructed

by the courts as 'bad mothers' in child protection proceedings, and to having their children taken away as a result" (p. 340). As such, she argues that the "ideology of motherhood" in child protection cases essentially blames individual women for the difficulties that they encounter in parenting, while ignoring the connection between these difficulties and the history of colonialism (p. 306).

## PART III: The Convention on the Rights of the Child: A Framework for Conceptualizing Alternative Approaches to Child Welfare

In conceptualizing alternative approaches to legal intervention, a human-rights framework offers useful ideas and guidance. In particular, given the relationship between adolescent pregnancy and child welfare, the Convention on the Rights of the Child (CRC) provides an effective starting point for promoting the well-being of children and youth. As a source of international law, the convention envisages children as important participants in society, articulates a set of rights specific to children's needs, and establishes a broad range of state responsibilities (Blackstock, Clarke, Cullen, D'Hondt, & Formsma, 2004, p. 22). Furthermore, the CRC is "the first international treaty body instrument to specifically include protections for indigenous children" (Blackstock, Clarke, Cullen, D'Hondt, & Formsma, 2004, p. 22). The following discussion aims to apply the convention to the current child welfare system in order to outline a legal framework for reform. In doing so, it remains important to approach this analysis with the intention of taking Canada's legal obligations seriously. This is especially relevant in light of the fact that the last residential school did not close until 1996, five years after Canada signed the CRC (Blackstock, Clarke, Cullen, D'Hondt, & Formsma, 2004, p.153).

### *The Best Interests of the Child*

One of the central principles of the convention is articulated in article 3, which establishes that "in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration" (Convention on the Rights of the Child, 1989). Applied to the current child welfare system in Canada, this principle underlines the need to respond to the recommendations of national policy reviews, First Nations child and family service agencies, and social workers. For example, child welfare practitioners have stressed the importance of "community empowerment approaches to child welfare" in ensuring the well-being of children (Walmsley, 2004, p. 63). Critiques of the protection paradigm by those working in the field must be taken seriously and considered in the context of legislative reform. Furthermore, given the overwhelming evidence of the system's structural failures, article 3 demands that immediate steps be taken to promote the best interests of Aboriginal children in Canada.

It is important to note that the best interests principle has not always been interpreted in a culturally neutral way. Aboriginal perspectives maintain that "the notion of the child and her best interests, as separate and distinct from her family, community and culture, is one that has its roots in the individualist orientation of European culture" Richard, 2004, p. 109). Moreover, within Canadian courts, Kline argues that the best interests ideology has "[portrayed] the apprehension and placement of First Nations children away from their families and communities as natural, necessary, and legitimate, rather than coercive and destructive" (Kline, 1992, p. 375). As such, judicial decisions have often minimized the relevance of identity and culture to Aboriginal children's development (Kline, 1992, p. 375). A more relational understanding of the best interests principle suggests the need to support collective approaches that promote children's well-being through belonging and community wellness (Richard, 2004, p. 103).

### *The Right to Non-Discrimination*

The principle of equality is set out in article 2 of the CRC, which declares that "states parties shall respect and ensure the rights set forth in the [Convention] to each child within their jurisdiction without discrimination of any kind" (Convention on the Rights of the Child, 1989, Art. 2(1)). This article underlines the need to address discrimination against Aboriginal children in Canada. The UN Committee on the Rights of the Child has expressed concern at the situation of Canadian Aboriginal children, noting that they continue to face significant and disproportionate levels of risks in areas such as education, youth justice, health and poverty (Committee on the Rights of the Child, 2003). More specifically, in the context of child welfare, article 2 highlights the need to remedy the inadequate funding of child and family service providers on reserves (Blackstock, Clarke, Cullen, D'Hondt, & Formsma, 2004, p. 170). The current situation, where "First Nations child and family service agencies receive 22% less funding per child than their provincial equivalents" (Greenwood, 2003, p. 108), constitutes a clear case of discrimination against Aboriginal children and youth. As indicated earlier a Human Rights Complaint decrying discriminatory funding was jointly launched in 2006 by the Assembly of First Nations and the First Nations Child and Family Caring Society of Canada, a national non-profit organization that advocates, networks and conducts research on behalf of approximately 120+ mandated First

Nations child welfare agencies across Canada (Assembly of First Nations, 2006).

### *The Child's Right to Survival and Development*

Article 6 declares that "States Parties shall ensure to the maximum extent possible the survival and full development of the child" (Convention on the Rights of the Child, 1989, Art. 6(2)). This provision outlines the right of children "to realize their full potential, through a range of strategies from meeting their health, nutrition and education needs, to supporting their personal and social development" (First Nations Child & Family Caring Society of Canada, 2005b, p. 4). As such, it requires that child development theories be taken into account, and that the importance of family, community, continuity of care and culture be recognized in child welfare policies. Nedelsky's idea of supporting autonomy through relationship further emphasizes the importance of human support networks for children's healthy development.

The Native Infant Program on Vancouver Island provides a successful example of an early intervention program for infants and their families. Based upon early childhood development principles, the home-based program targets children from 0 to 4 years of age (Mayfield & Davies, 1984, p. 450). Focusing on "the early correction of departures from good health, and [the] prevention of social problems," the Native Infant Program combines support with education, integrating both "traditional cultural and present child-rearing practices" (Mayfield & Davies, 1984, p. 450). Furthermore, it "provides children with experiences and services which enhance their early development by encouraging and helping parents to develop [the] skills necessary to provide meaningful experiences for their children" (Mayfield & Davies, 1984, p. 450). As such, the Native Infant Program constitutes an essential resource for adolescent mothers, and provides a useful model for child welfare strategies. In supporting parents' abilities to best care for their children, it prioritizes healthy child development during the critical early years, and encourages positive outcomes.

### *The Right of Children to be Heard*

One of the most fundamental principles contained in the convention is the right of children to be heard. Article 12 of the CRC establishes the right of children to "express [their] views freely in all matters affecting [them]," and provides that "the views of the child [shall be] given due weight" (Convention on the Rights of the Child, 1989, Art. 1.2(1)). Furthermore, article 12 explicitly underlines the importance of providing children "with the opportunity to be heard in any judicial or administrative proceeding affecting [them]" (Convention on the Rights of the Child, 1989, Art. 1.2(1)). This provision has been understood to mean "that children are not passive recipients, but actors contributing actively to the decisions that affect their lives" (First Nations Child & Family Caring Society of Canada, 2005b). In the context of child welfare, article 12 highlights the duty to consult children and youth when designing policies and programs that affect them. More particularly, it underlines the need to listen to the voices of children and youth who have come into contact with the child welfare system. The high number of youth suicides while under care (Bagley, 1985, p. 69), the testimonies of abuse within the foster system, and the voices of pregnant adolescents who cite emotional needs as one of the motivating factors behind their choices, speak to the importance of incorporating young people's perspectives. Situating legal responses within the context of young people's experiences is critical to understanding challenges and developing effective strategies for change.

### *The Right to Culture*

The right to culture is articulated in article 30 of the convention, which states that a child "who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practice her or her own religion, or to use his or her own language" (Convention on the Rights of the Child, 1989, Art. 30). This provision reflects the importance of building a child welfare system that focuses on prevention, that adequately funds Aboriginal service providers, and that supports the efforts of families and communities to safely care for their children. Moreover, it emphasizes the need to prioritize cultural placement in order to maintain children's connections with extended family, culture and community (First Nations Child & Family Caring Society of Canada, 2005b).

In addition, the right to culture underlines the importance of ensuring "universal access to culturally-based child welfare services" (Blackstock, Clarke, Cullen, D'Hondt, & Formsma, 2004, p. 170). For example, the Manitoba Aboriginal Justice Inquiry Child Welfare Initiative provides a promising model. The initiative "allows residents of Manitoba to choose [from] four culturally-based child welfare authorities," which include Northern First Nations, Southern First Nations, Métis, and Mainstream. As a result, given that "over 70% of children in care [in Manitoba] are Aboriginal, 86% of families are choosing their culturally based authority" (Blackstock & Trocmé, 2005). The success of this program illustrates the role of cultural sensitivity in shaping positive relationships with the child welfare system and in promoting healthier outcomes.

***The Right of Every Child to an Adequate Standard of Living***

The importance of ensuring children's social and economic rights emerges in article 27 of the convention, which establishes "the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development" (Convention on the Rights of the Child, 1989, Art. 27(1)). The content of this obligation further requires that states "assist parents [and] provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing" (Convention on the Rights of the Child, 1989, Art. 27(3)). This provision underlines the responsibility of governments to implement child welfare strategies that address the systemic drivers of neglect. For Aboriginal children in Canada, article 27 highlights the need for preventive services that respond to widespread issues such as inadequate housing, poverty, and substance abuse.

***The Right to Recovery and Reintegration***

Finally, article 39 maintains that "states parties shall take all appropriate measures to promote physical and psychological recovery and social integration of a child victim of [...] neglect, exploitation, or abuse" (Convention on the Rights of the Child, 1989, Art. 39). The provision specifies that "such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child" (Convention on the Rights of the Child, 1989, Art. 39). This principle speaks directly to the relationship between adolescent pregnancy and child welfare, emphasizing the need to address the intergenerational transmission of disadvantage. It articulates the responsibility of Canada to address the long-term impact of assimilationist policies on Aboriginal communities and children. Moreover, it reflects the need to question colonial patterns that continue to inform current child welfare models and decision-making. A prevention and community wellness-based child welfare framework thus emerges as essential to the recovery and social integration of the youngest generation, and of generations to come.

## Conclusion

The relationship between adolescent pregnancy and child welfare thus provides a vantage point from which to understand some of the larger problems of the current child welfare system in Canada. It tells a story of intergenerational hurt and loss; of disadvantage transmitted from mother to child. Consequently, the voices of young women and their children are critical in conceptualizing a legal - and human - response to the cycle of failed responsibilities that adolescent pregnancy and the over-representation of Aboriginal children in the child welfare system reflect.

Service providers emphasize that "the care of a child does not occur in isolation: an Aboriginal child lives within a family, a community, a Nation, a province, and a country" (Greenwood, 2003, p. 7). In this context, and in light of the fundamental impact of a child's early years and experiences on her development, "it is critical that we 'get it right' as leaders, policy makers, experts and practitioners" (Greenwood, 2003, p. 7).

In a recent report on reconciliation in child welfare, the authors use the analogy of a journey down the river to describe the transformation that is needed. The profession, they claim - from legislators to social workers - must "courageously [reach] within itself to look at what aspects of child welfare [work] for, and against, the well-being of Indigenous children and youth." It must "[explore] the values and beliefs that [have] shaped the path the river has taken before identifying the touchstones necessary to build a foundation for an improved child welfare system" (Blackstock, Cross, George, Brown & Formsma, 2006). Ultimately, the decision that a change in the direction of child welfare is needed "has already been taken" – by the Aboriginal children and youth who have paddled against the current and cried for change. It is they who believe that the life of a child can be different, that the system "can do better" - and it is long past time that we "[joined] them on the journey" (Blackstock, Cross, George, Brown & Formsma, 2006, p. 6).

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# Aboriginal Fathers Support Groups: Bridging the Gap between Displacement and Family Balance*

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* *This paper draws upon ideas and findings from the first research study of Aboriginal fathers' involvement in Canada, conducted by Jessica Ball and an Indigenous research team, in partnership with five Aboriginal community groups in British Columbia (B.C.). The project was funded by the Social Sciences and Humanities Council of Canada and by the B.C. Ministry for Children and Family Development, through the Human Early Learning Partnership.*

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## Abstract

The Aboriginal Fathers Project set out to explore the roles of fathers in British Columbia's Aboriginal families. The project aimed to investigate the ways community programs could support fathers' involvement with their children, and increase their participation in family-centered programs. This article briefly describes the project and outlines a few of the major findings from the research. This article discusses findings from the project which highlight the impact of colonialism and assimilation processes on the roles of Aboriginal fathers. The suggestion to develop father-specific support groups and the use of traditional practices and spirituality in the support groups is discussed.

## Introduction

The well-being of Canada's Aboriginal children depends on the health of their families and their communities (Mussell, Cardiff & White, 2004). To ensure a positive future for Aboriginal children, one must assess family relationships and roles of family in childhood development. Today, hundreds of community programs have been developed to protect Aboriginal children and promote healthy family relationships (Shangreaux & Blackstock, 2004). For many years, fathers have been excluded from this assessment, and the benefits of father involvement have been overlooked as a potential resource for Aboriginal children (Ball & George, 2007). Chief Ed John, the Grand Chief of the First Nations Summit in British Columbia states,

> *Fathers may very well be the greatest untapped resource in the lives of Aboriginal children. If we can support them to get involved and stay connected with their children, that would be a big protective factor for these youngsters as they grow up (Aboriginal Early Childhood Development Leaders Forum, Vancouver, April 27, 2004 quoted in Ball & George, 2007).*

A family-centered approach to Aboriginal child care has been found to be better suited and more culturally

appropriate than simply a child-focused approach (Ball, 2005). The family-centered model is preferred in most Aboriginal communities (Ball, 2005). However, many community programs supporting families and child development in British Columbia noted low father participation in their family-centered services.

The Aboriginal Fathers Project set out to explore the roles of fathers in British Columbia's Aboriginal families. The project aimed to investigate the ways community programs could support fathers' involvement with their children, and increase their participation in family-centered programs. This report will very briefly describe the Aboriginal Fathers Project and outline a few of the major findings from the research. A more in-depth report of the Aboriginal Fathers Project and the findings can be found elsewhere (Ball, 2006). This article specifically discusses the findings from the project which highlight the impact of colonialism and assimilation processes on the roles of Aboriginal fathers. The suggestion to develop father-specific support groups, in partnership with family-centered programs, will also be featured. The use of traditional practices and Aboriginal spirituality in fathers' support groups and community programming will then be discussed. Finally, specific recommendations will be made for community program managers who want to support Aboriginal fathers in their parenting journey, and increase father participation in family-centered programs.

## Aboriginal Fathers Project- Brief Overview

The Aboriginal Fathers Project was conducted as part of a larger Canadian exploratory study on fathers' involvement, the Fathers Involvement Research Alliance (www.fira.org). Community early childhood development programs such as the Little Hands of Friendship Aboriginal Head Start Program, Prince George Aboriginal Head Start Program, and the Lil'Wat Nation Pqusnalhcw Child Care Centre were asked to participate in community-university partnerships with the University of Victoria, School of Child and Youth Care, to facilitate the research. The research team then received further requests from individual fathers and other community programs who wanted to participate. The Aboriginal Fathers Project eventually grew to include two more on-reserve community programs, three off-reserve community programs, and several fathers from various urban communities around British Columbia (Ball & George, 2007).

First Nations and Métis men who self-identified as fathers of at least one child under the age of seven years of age were recruited to participate in the study. The definition of 'father' was left up to self-identification, as the research team quickly learned that many Aboriginal families did not solely depend on the biological father of the child to play the fathering role. The term 'father' came to include biological fathers, step-fathers, partners or former partners of the mothers, grandfathers, and uncles who were the father figures in an Aboriginal child's life. Eighty fathers in various communities across British Columbia participated in a conversational interview, a short survey and a demographic questionnaire. The study included 42 (52.5%) fathers living off-reserve in urban centers, 35 (43.8%) fathers living on-reserve in rural areas, and 3 (3.75%) fathers living off-reserve in rural areas (Ball & George, 2007).

## The Impact of Colonialism and Assimilation Practices on the Aboriginal Father

Several fathers in the study identified the lasting effects of colonialism and assimilation processes on Aboriginal identity and the role of the father. According to the participants, colonialism and assimilation practices have greatly disrupted the role men play in their families and in their communities. Duran and Duran (1995) argue that the effects of colonization on the role the Aboriginal male are especially damaged because traditionally, the male was the protector of the family and the community. The suppression of the man's ability to protect the family and the fragmentation of the traditional community system has lasting, generational traumatic effects on the Aboriginal father (Duran and Duran, 1995). One participant in the Aboriginal Fathers Project explains,

> *...the First Nations male, their job title used to be hunting and gathering, used to have to hunt and if you weren't hunting or fishing you were preparing to go hunting, fishing, gathering food, making shelters and doing all those things…. So, that whole thing with the Europeans coming in and wiping it all out…. First it was the residential school and they took away the language, or tried to take the language away. They took the entire role of the male in the First Nations community away so that left a big empty gap for males. They didn't know what to do, where to go, what to say, when to say it or anything. They had to fit in and woman had to play another role in telling the male what to do, but the women kept their jobs. The women looked after the kids, they did all the food preparations and things like that… that stayed. The women fit in a lot easier than the men I think. It wasn't easy for women, but they had certain jobs that they were able to do, whereas the men they had to go off, they had to go and learn how to build certain kind of houses and they had to relearn how to live in society, how to get a wife and what to do as a husband, as a father and as a member of a community (Anonymous, Lil-Wat Nation).*

The roles of the Aboriginal father are also disrupted by the trauma caused by colonialism and assimilation processes. The trauma of residential schooling has had lasting effects on many fathers' parenting skills, power to communicate and ability to show affection to their children. As one father from the Aboriginal Fathers Project explains,

> *Back then, I didn't have any communication skills like normal fathers had. The affection of a loving father-child relationship, like normal fathers have, like kissing your younger children. I only learned that, years later, that was what it takes to love a child. There was nothing like that when I was growing up in a residential school. Because I was in residential school until I was eighteen years old, I really didn't learn anything. No love and no hugs from the priests or the nuns. I just came out cold (Anonymous, Nanaimo).*

This trauma continues today through the generations. Many Aboriginal people who never set foot into a residential school still experience the 'generational cycle of trauma' (See Figure 1). The effects of generational trauma, such as substance abuse or family violence, have left many men without a positive, father figure in their lives while they were growing up. Many men found themselves having children of their own, without a role model to teach them about parenting skills, how to communicate with their child, how to show affection, or how to deal with stressful parenting situations. Similar findings of Aboriginal men left without positive, male role models are documented in a qualitative research study of Aboriginal men's healing in British Columbia (Mussell, 2005). One participant in the Aboriginal Fathers Project describes memories of his own father,

> *He was abusive. I was only a year old when he left and so I don't know if I ever saw [the violence] or experienced it. He left and then when I was nine, his brother murdered him. He was stabbed in a knife fight. I can remember seeing him and wishing he were more involved. After he died, I had dreams of him and he didn't recognize me. There was a lot of stuff that I had to deal with as I grew up. But, I knew that was not what I wanted for my children. I wanted my children to have a father and to understand the joys and rewards of having both parents in their lives (Earl, Prince George).*

Many fathers described growing up without a positive father figure, and conveyed the difficulties they had as a child, including feelings of emotional abandonment, family dysfunction, family imbalance and neglect. Participants who did not grow up with a father figure explained that they wanted their children to have a positive, male role model in their life because they knew how important it was to have that family balance. Several fathers suggested their motivation to become a good parent stemmed from their own childhood without a father. One father explains,

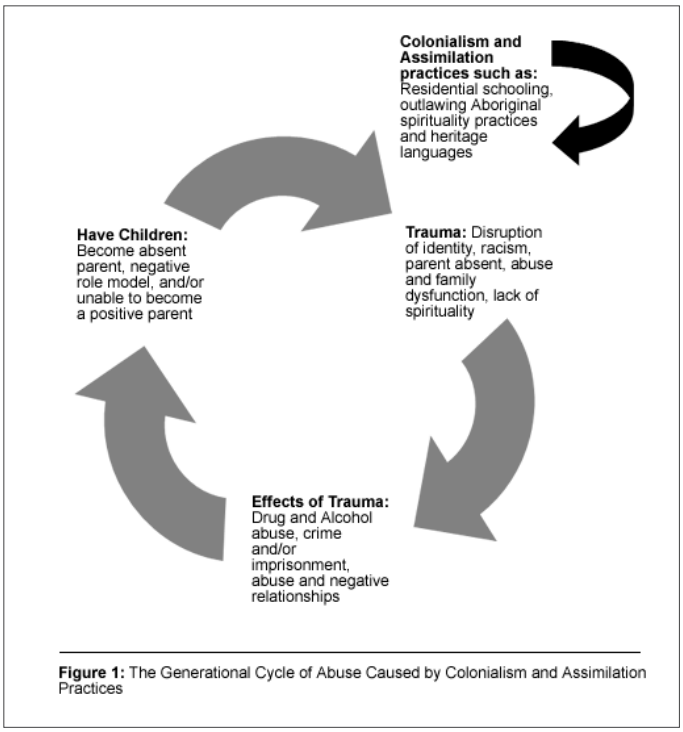


**Figure 1:** The Generational Cycle of Abuse Caused by Colonialism and Assimilation Practices

> *Growing up without a father, without that disciplinary figure in my life… there was just certain things that my mother couldn't do. She raised me well, and she did it all on her own, but I just know that there were some things that she just wasn't able to do. I am a bastard child and I didn't want that for my child…. I did not want my child to be fatherless and lacking that discipline and guidance (Brian, Lheidli-Tenneh First Nation).*

Colonialism and assimilation practices, such as—but not limited to—residential schooling, have had a multi-generational effect on the role of the Aboriginal father in both the family and the community. The participants in the study suggest that their positive involvement with their children gives them the opportunity to break that generational cycle of trauma and give their children what they never had growing up.

## Aboriginal Fathers' Support Group

The fathers in the study were asked about how they prepared for becoming a father. Approximately one

quarter of the men interviewed explained that they had needed to find a positive, male role model in a parenting role. It appears men who want to be positively involved with their children often seek a positive father role model to emulate. For those men who did not have access to a positive father figure or Elder, they often looked to their peers. Nearly one-third of the fathers in the study looked to their community for parenting role models. When the fathers were asked what community programs could do to promote father involvement, several participants suggested the creation of a fathers' support group specifically for Aboriginal men. The fathers suggested that just watching other fathers interact with their children in a positive environment is useful, especially for those who had not grown up with an involved father. Seeing other men, who are similar to themselves interacting with their children in a constructive way, acted as an educational tool and boosted their confidence. In many ways, the role of the support group helped men to redefine what a father is and include other Aboriginal men in that concept. Those participants who had experience as part of a fathers support group reported that their interactions with other fathers acted as both a peer support network and as an affirmation of their fathering role, which enhanced their own beliefs about their ability to be a good father.

The development of a support group specifically for Aboriginal fathers is supported by previous research that suggests the need to develop culture-specific health and family services to support the well-being of Aboriginal people (Kirmayer, Simpson, & Crago, 2003; Stephens, Porter, Nettleton, & Willis, 2006). Many of the men in the current study noted that their insecurities about becoming a father stemmed from disruptions in their own cultural identity. The fathers suggested that the role of the Aboriginal father had been damaged; consequently, Aboriginal fathers face added challenges that Non-Aboriginal fathers may not consider. One father explains,

> *One thing I notice is a lot of Non-Aboriginal fathers going out with their kids, doing stuff with their kids and it is something I don't really see Native guys doing. [Why do you think that is?] I think it has a lot to do with how they were raised and how they grew up in their own family. It was one thing I noticed was that I didn't do those things before, because I was never taught those things, I never did those things with my family. It is kind of hard (Brian, Prince George).*

Participants in the study suggested that an Aboriginal fathers' support group would also give the older or more experienced fathers the opportunity to mentor younger or less experienced Aboriginal fathers. This concept is reinforced by the United Nations Working Group of Indigenous Peoples, which recognizes the importance of empowering younger generations of Indigenous peoples through education and mentorship (Boyer, 2004). This concept is further supported by Canadian research on Indigenous knowledge which suggests that Aboriginal ways of knowing and knowledge must be controlled and driven by Aboriginal people (Hart, 2007). The importance of Aboriginal fathers learning from other fathers is highlighted by one participant from the current project,

> *I think that father's support is big and being able to see how other fathers handle different situations. Because honestly, there are a lot of fathers out there who weren't raised by a father, or were raised by an abusive father, and don't know how to be a father, like me. My father was not around, so you have to learn right from the beginning, when you have a baby sitting right there in front of you and you have to be a dad. I know that John Howard [Society] has that but it is not specifically for Aboriginal fathers. I think that there is a high degree of cultural shame amongst Aboriginal people and I think that if they could identify with other Aboriginal fathers, share their experiences, share their strengths, then maybe they could step out of that and teach their children how to be proud of who they are (Anonymous, Prince George).*

The participants in this study highlight the importance of role models and support networks. Aboriginal fathers' support groups give men the opportunity to share stories, develop social relationships, and watch other men interacting with their children.

## Using Traditional Practice and Aboriginal Spirituality in Aboriginal Fathers' Support Groups and Other Community Programming

Many participants suggested the parenting support groups would further benefit fathers if they included traditional practices and aspects of Aboriginal spirituality. Conceptions of 'traditional practices' and aspects of 'Aboriginal spirituality' differed between individual men and across communities. It is important to recognize the difference between First Nations, Métis and Inuit cultures, just as it is important to recognize the diversity of communities, especially when discussing traditional practices and aspects of Aboriginal spirituality (Adelson, 2005). Due to the cultural diversity of the men in the study, 'traditional practices' and 'Aboriginal spirituality' can not be defined in this paper. The men in the study did refer to the use of traditional drumming, dancing, ceremonies, smudging, sweat lodges, hunting, fishing, berry picking, carving, drum making, healing circles and learning from Elders.

An Aboriginal fathers' support group that promotes the use of traditional practices and spirituality fits the holistic model of wellness. The holistic model of wellness

focuses on the balance of the physical, emotional, mental, and spiritual aspects of a person within their family and community relationships (Adelson, 2005). Traditional practices have been used to reinforce cultural identity, to nourish family relationships and to promote spiritual wellness (Martin Hill, 2003). Promoting and respecting the use of traditional practices and Aboriginal spirituality in fathers' support groups could create an opportunity for men to regenerate their Aboriginal identity.

Several healing programs have found therapeutic benefits using traditional practices and aspects of Aboriginal spirituality (Archibald, 2006; Waldram, 1997). One father in the Aboriginal Fathers Project explains, "The most important thing I did to prepare to become a father was to heal myself" (Anonymous, Lil-Wat Nation). Hunter, Logan, Goulet, and Barton (2006) suggest the process of healing for Aboriginal men includes a 'cultural path', using traditional practices to find spiritual, emotional, mental and physical balance. Healing circles, sweat lodges, smudging, the use of Elders, and the use of other traditional practices have been used by Kishk Anaquot Health Research to reinforce cultural identity and facilitate healing (Archibald, 2006). Many fathers in the current study reported using traditional practices and Aboriginal spirituality to heal themselves and prepare for fatherhood. When Leroy of Lil-Wat First Nation was asked what prepared him for fatherhood, he explained, "Probably the biggest thing was learning to be a grounded, spiritual person. Learning about how my people have dealt with things in terms of children". Getting in touch with their spirituality and becoming confident with their cultural identity helped these fathers in their parenting journey.

Participants in the Aboriginal Fathers Project noted that they could rekindle their cultural identity, embrace their Aboriginal spirituality and nurture their family relationships through the use of traditional practices. A father in Esketemc First Nation learned more about his traditional practices to further nourish his relationship with his daughter. He explains, "I didn't know any of the songs and now that she likes to Native dance, I kind of have to learn the songs so she has something to dance to!" Many fathers suggested that the use of traditional practices has allowed them to escape the generational cycle of trauma caused by colonialism and assimilation processes, and has been key in their preparation for fatherhood. Aboriginal fathers support programs, as well as other community programs meant to facilitate healing, should promote and respect the use of traditional practices and aspects of Aboriginal spirituality.

## Recommendations for Community Programs Who Want to Support Aboriginal Fathers

The 'mainstream' focus on parent-child relationships in community programs does not address the multi-dimensional Aboriginal family system or the impact of colonization on this system (Shangreaux & Blackstock, 2004). The research team quickly learned that many Aboriginal families did not solely depend on the biological father of the child to play the fathering role in a nuclear family setting. The cohesive, multi-generational Aboriginal family is traditionally an arrangement of extended kinships, encompassing responsibilities and roles in raising the children (Shangreaux & Blackstock, 2004; Turner, 1985). As more Aboriginal people move away from their heritage communities into both rural and urban settings, the nuclear family setting has become increasingly popular (Castellano, 2002). Nonetheless, the concept of having extended family directly involved in raising a child is still a powerful ideal held by Aboriginal people (Castellano, 2002). This belief is very apparent in the findings from this project. However, this concept is not reflective of many child and family programs available to Aboriginal families today. The western ideal of the 'nuclear family' has informed the development of programs today, suggesting that these services may need to be reassessed (Bennett & Blackstock, 2002; Red Horse et. al., 2000; Shangreaux & Blackstock, 2004).

Community program development has to be open to the idea that a child may not always belong to the western 'ideal' of a nuclear family. The findings from this study emphasize the need to use a family-centered approach in the development of programs for Aboriginal families, but also emphasize the need to consider the variations that are apparent in families today. Recognizing the roles different family members play in children's lives and how community programs can support them in their parenting roles are imperative to the future of Aboriginal children. Although many community programs have begun to use family-centered models over child-centered service models, recognizing the specific needs of Aboriginal fathers is critical in supporting men in their parenting journey.

## Recommendation:

**Recognize the variations across Aboriginal family systems when development community programs. Ensure that family workers know all of the family members and friends who are involved in parenting the child. Ensure that family workers invite all parents**

**to activities and follow-up with parents who do not attend.**

The study findings suggest that the shift to a family-centered approach is positive, but does not always represent the needs of fathers. Many fathers who tried to participate in family-centered services still felt out of place because they were often one of the only men in the room. Fathers reported feeling uncomfortable as mothers did not include them in the conversations, and childcare providers did not make efforts to include them in activities. One father explains,

> *When I go to things like that, I just do not feel comfortable. I was going to go to the 'Nobody's Perfect' program, but it is nothing but females in there! I would like to go in there and just start advocating for the fathers. I want to go in there and say, This is a good program, but you have to expand it to include the father's point of view, give them a voice.' And when I try to speak up about it, people just brush it off. They say they have 'enough work to do', and 'we only have a certain amount of time to talk about these issues and maybe we'll just talk about it next time.' Nothing happens (Brian, Lheidli-Tenneh First Nation).*

According to the participants in this study, the development of Aboriginal father support groups, within or parallel to family-centered services, would encourage fathers' involvement with their children, and could increase fathers' participation in family-based services. The support group would allow fathers to be heard and create the opportunity for men to support one another, while facilitating the move toward a more family-centered approach. Terrace Child Development Center Dad's Group, which is part of the Terrace Child Development family-centered Park Center Services, suggests community programmers need to give men a safe, inviting environment, and a place where they are respected as parents. Further, the fathers need to be given the opportunity to shape the group, and influence the decisions about the activities that will occur in the group. The importance of having full participation in decision making is well documented in the literature, and is central to the creation of culturally appropriate services (Stephens et. al., 2006).

## Recommendation:

**Ask one of the fathers in your program or a male family worker to help create a father support group alongside the family-centered services. Create a safe, father-friendly environment with several father resource materials available and a relaxed atmosphere. Ensure that the time is consistent and reliable, regardless of the number of attendees. Allow the fathers to create their own discussion topics, while providing a variety of resources.**

Aboriginal fathers' full participation in decision making is especially important to recognize when promoting a holistic approach, with traditional practices and Aboriginal spirituality. Each group will have different needs, traditions and spiritual practices. The cultural diversity of traditional practices must be recognized and appreciated (Martin Hill, 2003). Community programs that use traditional practices and Aboriginal spirituality, stress the importance of developing group-specific healing models (Archibald, 2006; Martin Hill, 2003). Archibald (2006) also suggests that holistic models using traditional practices need to acknowledge the different needs of those Aboriginal people living in urban areas, rural and remote areas, on and off reserve. In the current study, rural community practitioners invited Elders from the community to give advice on their programming and activities. Creating a culturally specific environment can be more difficult in an urban setting, where there is often a culturally-diverse population of men living away from their hereditary lands. In this kind of situation, it is critical that the fathers decide what practices they want to use, without the imposition of a 'pan-Aboriginal' approach. Promoting the use of traditional practices and spirituality, by inviting local Elders and respecting differing perspectives, is the most a programmer can do, the rest needs to be left in the hands of the fathers.

## Recommendation:

**Promote spirituality and traditional practices within your community organization, but do not assume everyone is the same. Invite an Elder to visit your community organization or ask the father support group if they would like an Elder to attend their circle.**

Finally, Aboriginal fathers' support groups hosted by larger organizations or community programs, have specific challenges that need to be addressed. Research suggests that service providers often do not know enough about First Nations, Métis and Inuit culture, historical experiences, generational trauma, traditional practices and/or holistic approaches to health and well-being (Bartlett, 2004). The holistic perspective of well-being held by Aboriginal people does not always "translate" into the "typical bio-medically based" community programs (Adelson, 2005, p.S46). These findings emphasize the need to educate service providers within the larger organization about the cultural and gender differences they may come across while hosting a support group for Aboriginal men. Respect, consistency, and a safe, non-invasive environment are imperative to the success

of a fathers support group; therefore, educating the staff is essential.

## Recommendations:

**Educate all staff, although not all staff may be in direct contact with fathers. Ensure that all staff members are familiar with the importance of fathers involvement, the variation in Aboriginal family systems and cultures, the historical experiences and what that can mean to Aboriginal people today. Expose your staff and program users to resources (such as books, posters or videos) that include and/or promote Aboriginal father involvement.**

## Conclusion

This project highlights the need to consider the role Aboriginal fathers play in the well-being of future generations. The research findings suggest the role of Aboriginal fathers within the family, as well as in family-centered activities, have been displaced through colonialism and assimilation processes. According to the men in this study, developing Aboriginal fathers' support groups within, or parallel to, family-centered services would encourage Aboriginal men in their parenting role, as well as increase participation in family-centered services. These findings are not complimentary to the shift away from child-parent centered ideologies; however, the Aboriginal fathers' support group is a step toward increasing father participation in future family-centered services. Further research will be needed to assess the impact of father-specific support programs alongside family-centered services for Aboriginal people.

The use of traditional practices and Aboriginal spirituality in fathers' support groups and community programming is recommended to promote the holistic model of wellness and healing. Further, the use of traditional practices and aspects of spirituality in Aboriginal fathers' support groups gives men the opportunity to regenerate their Aboriginal identity, create a social support network and develop an opportunity for mentorship. The support group could potentially reinforce the men's cultural identity, their role as a father and, in turn, make them feel more comfortable participating in family-centered services. Further research could target the impact of father-specific support programs and traditional practices on the gender balance in the family roles. Aboriginal fathers' support groups, which encompass a holistic approach using traditional practices, could bridge the gap between the displacement of family-centered activities and today's contemporary family-centered program models.

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# Loss of Trust Among First Nation People: Implications when Implementing Child Protection Treatment Initiatives

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## Abstract

Abstract:
Social workers and other health care providers have been asked to develop and implement innovative and culturally sensitive treatment initiatives in First Nation communities. However, because of traumatization and oppression, many First Nations people face troubling psycho-social issues which have resulted in a diminished capacity to trust. If this loss of trust is not dealt with skillfully, it can impede the ability of social workers to implement initiatives. Through a process of person-centred interviewing, 36 participants identified four levels of trust that have been diminished among many First Nations people. The impact of this phenomenon on the development and implementation of community based initiatives is discussed in this article.

## Introduction

Building on early research (Thibodeau, 2003), this article outlines the results of interviews with social workers and other health care providers. Participants identified four levels of trust that have been diminished or lost by community members living on First Nations reserves. This phenomenon can have an impact on the development and delivery of community based treatment initiatives by health care professionals. Included in this article are broad strategies and recommendations that social workers can employ to allay these concerns.

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## Literature Review

A challenge facing social workers and other health care professionals is designing services that are can provide meaningful assistance to families who are under their purview (Callahan, 1993; Cameron, 2003). Theorists indicate that while practitioners in the field of child welfare focus on child protection and the provision of programs that are reactive, future efforts should move toward community based programs that promote family wellness and provide supports for parents (Callahan, 1993; Collier, 1993; Wharf, 1993). To meet this expectation, social workers need to be more inclusive, flexible, and truly responsive to the immediate needs of families and their communities (Geoffrion & Scarth, 1995). This is particularly true for First Nations communities (Proulx & Perrault, 2000; RCMP, 1996). Regrettably, child welfare systems have not always acted in the best interest of First Nations people and as early as 1985 there were calls to re-evaluate the relationship between child welfare systems and First Nations communities (McKenzie & Hudson, 1985). As a result, innovative community based initiatives

have emerged that focus on strengthening the family by providing such programs as parent support groups and treatment groups for abusive partners (Pecora, 1995). These initiatives have been of demonstrable value (Wharf, 1993). However, social workers must be respectful and informed when implementing such initiatives in First Nations communities. Historically, First Nations people have experienced considerable trauma (Proulx & Perrault, 2000), resulting from well documented accounts of oppression and marginalization (RCAP, 1996). These traumatic experiences have had profoundly negative effects on the psycho-social well-being of entire generations of First Nations people (LaRocque, 1993), and have interfered with their ability to establish trusting relationships (Thibodeau, 2003). Trust has been defined as, "a state of favorable expectation regarding other people's actions and intentions" (Simmel, as quoted in Mollering, 2001 p.403).

Such a diminished ability to trust can have far reaching effects on family functioning, and on community capacity and its ability to endorse community based initiatives (Goodman, R.M. et al. 1998). Fukuyama (1995) who has worked extensively in the area of trust, states, "We often take a minimal level of trust and honesty for granted and forget that they pervade everyday economic life and are critical to its smooth functioning (p.152). Mollering (2001) cautions that, "… without the general trust that people have in each other, society itself would disintegrate" (p. 178) and goes on to clarify that, "Trust's function manifests itself at all levels of society" (p.405). Earlier research has suggested that trust has been diminished at four levels of society in First Nations communities (Thibodeau, 2003). These levels include a lack of trust at a personal level. Matsakis (1998, p.57) describes the connection between traumatization and a loss of trust in oneself:

> *Trauma survivors not only lose trust in some of the basic premises that keep people functioning such as the assumptions of personal invulnerability and that the world is just and fair but they can also lose trust in people, including themselves.*

There can also be loss of family unity, where individuals cannot turn to family members for support in light of maltreatment and victimization within the family (Thibodeau, 2003). The seriousness of this loss becomes clear as First Nations people place a premium on family and clan ties (Crowshoe & Manneschmidt, 2002). Additionally, "First Nations people value family ties and relationships above all else, except their creator" (Supernault 1996, p.97). However, many people have been maltreated and dishonored within the family (LaRocque, 1993) resulting in a diminished level of trust within that domain. Trust has also being diminished at the community level, between family and clan members within the same community (Thibodeau, 2003). This stems in part from extended family quarrels and issues related to abuse between families (Kiyoshk, 1996). Finally there is a lack of trust in government departments and outsiders (Thibodeau, 2003). An outsider is generally viewed as one who is not from the community; this could include a First Nations person from a different community or a non-First Nations person. Supporting literature indicates that there is considerable mistrust and bitterness directed at the Government of Canada (Proulx & Perrault, 200; LaRocque, 1993) as well as with outsiders generally (Lee, 1997). A diminished ability to trust has significant implications for the development and implementation of community based treatment initiates, as trust is a core value when implementing social initiatives (Matsakis, 1998).

## Method

Person centred interviewing and observation was used as a method of ethnographic inquiry, where the interplay of social and personal forces was considered. That is, person centred interviews engage the interviewee as both the informant, a knowledgeable person who can elucidate about culture and behaviour in a particular locale and as the participant, "as an object of systematic study and observation in him or herself" ( Levy & Hollan, 1998 p. 335). Ethical review and approval for this research was provided by facility of Social Science and Law, University of Manchester, UK.

### *Participants*

The sample was comprised of 36 participants employed in one of eight First Nations Reserves in Alberta. A total of 71% of the participants identified themselves as being a First Nations person, while 65% spoke an First Nations language. About half of the participants identified themselves as social workers, while the remaining participants were professional or paraprofessional community workers. Participants were selected using purposive sampling, "[a]sampling procedure that utilizes intentional but not random processes" (Cournoyer & Klein, 2000 p. 261) and that "purposefully select participants … that will best help the researcher understand the problem and the research question" (Creswell, 2003 p. 185). Important characteristics of participants included: (1) they were professional or paraprofessional health care professionals implementing a psycho-social treatment initiative on a First Nations Reserve in Alberta; and (2) they lived and/or worked on a First Nations reserve for at least two years.

Table 1: Characteristic of Participants

| Variable | | N | % of sample |
|---|---|---|---|
| **Raised on Reserve** | Yes | 27 | 74.29 |
| | No | 9 | 25.71 |
| **Profession** | Social Worker | 18 | 50.3 |
| | Community Worker | 15 | 41.6 |
| | Other | 3 | 8.2 |
| **Years on Reserve** | 2 to 4 years | 9 | 25.71 |
| | 5 to 10 years | 8 | 22.86 |
| | 11 or more years | 19 | 51.43 |
| **Education** | Some High School | 3 | 5.71 |
| | Completed High School | 5 | 14.29 |
| | Post Secondary | 28 | 80.00 |

### *Data Collection*

In-depth semi-structured interviews, each lasting between one and three hours, were conducted on eight First Nations sites in Alberta between 1999 and 2001. An interview guide with a grand tour question and secondary questions was employed. The grand tour question was: What factors need to be considered when implementing treatment initiatives in your community? The audio-taped interviews were conducted by a co- interviewing team; a First Nations female and a non-First Nations male. Such an 'insider outsider' interviewing team is a recommended interviewing method when working cross culturally (Deutsch, 1981; Labaree, 2002). The research team was aware that sensitive issues, such as family violence and child abuse might arise during the interviewing process (McCosker, Bernard & Gerber, 2001). The team was prepared to address those occurrences by employing an insider outsider team, providing the services of mental health professionals or local elders if required, stressing the importance of confidentiality and anonymity, and emphasizing the voluntary nature of their involvement (Reichardt & Cook, 1992). During the guided interviews, the team explored and identified salient factors when implementing community based treatment initiatives in their communities.

### *Data Analysis*

The purpose of the qualitative analysis was to code data so that thematic categories would be recognized by participants and analyzed behaviours noted (Field & Morse, 1985). The research team used open coding to identifying meaningful statements that led to axial coding and the establishment of categories and themes based on aggregated coded data (Patton, M., 1990; Strauss & Corbin, 1998). The resulting categories were then scrutinized by the research team for redundancy. Analysis of data was supported by the software program NVivo. The interviews were transcribed verbatim by a professional transcriptionist. Five interview transcripts were verified for accuracy by comparing them to the taped interviews. Once the data were summarized these finding were provided to four participants to ensure that comprehensiveness, accuracy and general fit had been achieved. The purpose of this technique, known as a member check (Strauss & Corbin, 1998) was to determine authenticity, that is, if, "the findings of the study make sense? Are they credible to the people we study and to our readers? Do we have an authentic portrait of what we were looking at?" (Miles & Huberman, 1994, p.270). Member checks were not undertaken at four sites given their distance and isolation. Participants' responses were then included in the original data set or used to assist in revising it.

## Findings

Participants indicated that there was a pervasive lack of trust in First Nations communities at every stratum of their communities, but particularly within the family. Participants noted diminished trust at four levels; trust in self, family/clan, community, and governments and outsiders. They also identified five strategies that social workers and other health care providers can employ to mitigate this phenomenon when implementing community based initiatives.

### *Loss of Trust*

As participants discussed implementing treatment initiatives on reserves, the concept of trust and more specifically the loss of trust was a common and recurrent theme. Generally, the absence of trust was a troubling


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issue for many participants. They cited a number of historical and social reasons that have contributed to this phenomenon, including broken treaties with the Government of Canada, the Indian Act, systemic racism and the residential school experience. Many participants emphasized trauma that resulted from residential school experiences where First Nations children learned to 'build walls' and not share information (see Bineziikwe, 2005). Of the 36 participants, thirty (85%) spontaneously identified this theme at least once in their interview. The negative impact that residential schools have had on trust is succinctly expressed by an First Nations social worker:

> *So for me to trust anybody … I did trust! But from the time I was in residential school I knew how to make that wall, to build that wall around me that no one was going to break and hurt me again if I could help it. I was not going to share anything. Everything that ever happened to me I kept secret. (Participant 12)*

An elderly Cree social worker described her ongoing struggle with trust: "My goodness sakes, all my life, for myself this is me, all my life, every time I'd trust I was hurt, especially going back to the mission school [residential school]" (Participant 36). Participants indicated that although First Nations children were no longer attending residential schools, there were second and third generations of people who are experiencing the residual effects of that experience. Participants indicated that children learned from their parents to not trust, to be cautious and to build walls. As a result, individuals, families, clans and entire communities were found lacking the capacity to fully trust themselves and others. A First Nations worker explained this process:

> *People don't trust. I think in [this First Nations] community there's no trust here. They've been … people have been so badly hurt and betrayed and things in their past life, right from childhood and maybe even their parents who learned not to trust, that that's put into the children and you grow up not trusting anybody…. (Participant 8)*

This participant's statement highlights the consequences of this phenomenon on the functioning of family and community. From an early age children experience the pains of diminished trust, which were then echoed by some parents.

The following sections examine the concept of loss of trust at levels that were identified by participants, which include self, family and clan, extended community, and government and outsiders.

### *Trust In Self*

Participants indicated that as a result of personal trauma there has been a pervasive loss of trust among First Nation people at the most primary level, a lack of trust in self. They indicated that trust at this level refers to one's ability to set and respect personal boundaries, to maintain control over one's behavior, to have faith in one's judgment, and to take responsibility for one's actions. This phenomenon and the resulting characteristics are aptly described by a First Nations social planner:

> *Yeah, cause, you know, it's like you're raised in a home where there's so much violence and if they say - 'no kids, you're not going to drink' and they [parents] come home drunk and 'no kids, I'm not going to beat your mom up anymore' and then he's [father] still beating her, pretty soon the kids don't even trust their own parents. And then they're left with a babysitter and maybe there's sexual abuse. They learn not even to trust people, you know, they don't, or there's incest in the family, like trust is something that's so foreign to them and so, I don't know, they don't know how to set personal boundaries, eh? They don't even trust themselves. So I think as they're evolving as individuals that trust, it takes a long time for people to trust someone else and eventually just to trust themselves. (Participant 16)*

Participants indicated that a loss of trust in self appeared to limit how they engaged in daily events and life in general. This diminished level of trust limited the quality and depth of their participation in a range of activities, such as refusing to take personal risks and being absent, just being "… out of the way". It is this lack of trust in self that hinders the development of trust in others, whether they are family, community or outsiders.

> *I am able now to take that risk and to sit here with you guys [research team] and go and talk, but a few years ago [before her treatment] no way, I would have… maybe I would have been sick or something if I knew I had to have an interview. I would have been out of the way … because I wouldn't have trust. If I don't trust me how in hell am I going to trust anyone else? (Participant 12)*

### *Trust In Immediate Family and Clan*

The data indicate that trust has also been lost among immediate family and clan members. As noted earlier, First Nations people value family ties. However, several female First Nations participants reported that many First Nations families were not healthy. They reported that their communities were replete with stories of maltreatment and dishonor by parents, spouses, siblings, cousins and other family members. This in turn has interfered with the normal development of trust within the family. This is not to make the claim that participants did not identify strong and revered families within First Nations communities. Rather, they reported that there are many 'good' families that have embraced their traditional ways which enrich

their communities. But the view of many participants, notably First Nations females, was that some First Nations families have not been bastions of safety and support. The following quote illustrates the level of trust that has been violated and the impact this has had on family functioning.

> *Because -um- well when you look at, you know, the violence in the home, like little children, they learn to not even trust their parents. Cause these people [First Nations People from her community] never trusted people for a long time, some of them. Like you know, this person that you trust, like, your partner or your dad, like, is beating you up, like, so you're not going to trust, like, I'm not going to trust you [non-First Nations social worker] right away. (Participant 14)*

Participants indicated that this phenomenon has impacted the functioning of many First Nations people because they lack a reference point of love, acceptance and safety and as a result have left some feeling apathetic, despondent and hopeless. One woman reflects on the deep sense of hopelessness experienced by many people from her community:

> *I think there's … there's not a feeling like there's going to be a better day. Like there's better days ahead. I don't think people have a sense of that. They just think this is it; it doesn't get any better. … a [sense of] hopelessness (Participant 16)".*

A loss of trust in the immediate family and clan made it difficult for many First Nations people to believe that there will be a better future. Participants argued that it is this pervasive demoralization, this sense of hopelessness precipitated a disinterest in their future, in the family and their community.

### *Trust in Community*

An additional level of diminished trust identified by participants was between families and members of various clans from the same community or reserve. This community-wide discord is illustrated below:

> *… only recently, … just this last fall … there was so much mistrust because you have polarization of families, you know, saying - well, I'm for this side and I'm for that side. And that caused a lot of mistrust…. (Participant 35)*

Another participant commented,

> *"Because it's such a small community. It's 560 people. Everybody's somehow related to somebody. There's a lot of clan wars there. They don't trust anyone." (Participant 13)*

Participants indicated that sometimes community members could not turn to other families or clan members within their community for support or understanding in light of this 'warring' and lack of trust. Conflict at this level fostered the building of walls. Further, community members did not openly accept others from their reserve. As a result, program participants have not always experienced a welcoming and inclusive group experience. Simply put, a community member may not participate in a treatment initiative if a rival clan member is present. An elderly First Nations social worker reported:

> *Within the community here we have groups of people or families and clans, and not all the clans get along. Sometimes it's not so bad, sometimes it's not so good but … there are definite walls there. So trying to do group projects or group counseling doesn't work too well a lot of time … people will not attend if they know someone's going to be there that they don't want to be with; they won't come. And it was that way for a lot of community activities. (Participant 26)*

In addition to affecting the willingness of individuals to participate in treatment initiatives, such fractious and divisive behavior can thwart a cooperative and collaborative working relationship among professions working within the same agency or between agencies.

Based on reports from participants, it appears that a lack of trust at the community level can have significant ramifications. On an individual level it can pit individuals against individuals, making it difficult to recruit and retain participants for specific initiatives. On an agency level, it can hamper collaboration among workers at the same agency or other agencies

### *Trust in Government and Outsiders*

Finally, participants indicated that there is a general lack of trust in government departments and outsiders. An outsider is one who is not from the community; this may be an First Nations person from a different community or a non-First Nations person. Although participants suggested that First Nations people ostensibly have greater trust in outsiders than they do in their own people, several participants indicated that caution must be taken by outsiders so as not to be drawn into a false sense of acceptance.

> *Well, I think, like almost any other First Nations community, when you look at the history of what's gone down in most of those communities, [referring to: residential school, Indian Act, broken treaties and other oppressive government policies] people don't have any reason certainly to trust government or outsiders coming into the community … (Participant 31).*

Granted, outsiders may be seen as offering a degree of anonymity and confidentiality:


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> *Because we, there's so much rumoring and gossiping, you know, when you live in the community. So when you have an outside person, you know that what you say to them, there's less likely the chance that they're going to repeat it amongst other people cause you know that person is going to leave at the end of the day and has their own life and does things and they're not into this meddling and, you know, being the first one to say something. (Participant 16)*

> *However, outsiders must be cautious. Trust must be earned, "So their trust for other people is not there. ... So people [outsiders] have to prove themselves to people [from her community]." (Participant 7)*

## Implications for the Social worker

Participants suggested five broad strategies that may mitigate the impact of diminished or lost trust when implementing treatment initiatives. The following should not be viewed as an exhaustive list but as a point of departure to define and extend actions to be taken to more fully address this issue.

### *Know the Community*

Participants have suggested that social workers should try to 'earn' the trust of families as part of the process of establishing and maintaining treatment initiatives. This can be achieved in a variety of ways, including becoming known and accepted by families in the community.

> *Mm-hmm, I had to tell some of my clients or potential clients who I was and why I'm here and let them know that I talk Cree and, you know, [that] I can feel relaxed and content when I'm sitting in a house, you know and just to get to know them. I did this to build up the trust first and when that happened, it took a long time ... people would come .... (Participant 17)*

Participants cautioned that given a lack of trust, engagement can be a lengthy process that begins by going into the community and meeting people; this may involve visiting dozens of homes and listening to a multitude of stories, opinions, folklore and legends. One participant stated, "Mm - mm Listen to their [community members] stories. Everybody has a story (Participant 13)." By actively listening to their stories, the social worker can develop a greater appreciation for his/her understanding of events, history, difficulties and ideas about intervention, which in turn can be incorporated into the content of the initiative. This process provides community members with a sense of participation in the initiative and ownership of it, which may foster trust between the social worker and the community.

### *Be Known in the Community*

In addition to knowing the community, the community would want to know the social worker. Consequently, community members seek reassurance that the social worker is genuine, trustworthy, and unassuming. In this vein, a participant provided the following advice for social workers:

> *Not acting good, just acting as the way you [social worker] are. And I find that one of the most important areas is just being yourself ... and accepting people for who they are, just the way they are, is another important thing that I found in establishing trust. (Participant 10)*

Participants denoted that First Nations people want reassurance that the social worker will come to their community with an attitude that is informed and insightful. They want a person who will be respectful and knowledgeable about their history, tradition, culture and political situation. A frustrated participant stated:

> *No bullshitting them [community members]. Not putting on the air that you're more knowledgeable than them. Not putting on airs that you have something to teach them because that's what they've had to put up with all of their lives. (Participant 13)*

These characteristics can be demonstrated in a variety of ways. The social worker can actively listening to peoples' opinions and stories, and participate in many of their traditions and rituals. Rituals could include sweats, Sundance ceremonies, traditional feasts, dream quests, funerals and walks to name a few. By participating in these rituals and traditions, the social worker will demonstrate interest and respect for the individual, family and community.

### *Be There During the Ups and Downs*

The social worker can enhance trust by being adaptable and flexible in the design and delivery of service. This could include performing duties that extend beyond the formal mandate of the initiative. A nurse from a northern Alberta community stated:

> *There's a need then for flexibility [among treatment social workers], in terms of dealing with things as they come up, not to be ruled by the schedule, but to be more ruled by the situation as it evolves. (Participant 26)*

As there are few resources in First Nation communities, participants suggested that the social worker must deal with this reality and be prepared to address

the safety and concerns of all family members. This expectation goes far beyond the mandate often faced by social workers working in more mainstream settings. The data suggest that in First Nations communities the social worker must accept this expanded role and 'be there' during the times of need, as suggested in the following statement;

> *... telling them [the entire family unit] that you are here for them, I myself think that's what it is. That is what it takes [to earn the trust of the family and community]. (Participant 4)*

Participants indicated that First Nations people want a promise from the social worker that he or she will make a reasonable commitment to the safety and health of all. A nurse reports on her conclusions:

> *[The child care treatment social workers should] ... also make sure that when you are here that you do everything that you can to try and help, make people know that you are interested and that you want to do anything you can to help them out. If people can pick up on that then you get their trust. (Participant 26)*

The social worker must be prepared to offer a broader range of services to family members, especially when working in communities that have few formal resources.

***Make a Long Term Commitment to the Initiative***

There are other expectations placed on the social worker in order to enhance trust. Participants suggested that in some First Nations communities there is a significant and sudden turnover of professionals. As a result, community members are reticent to make disclosures or to trust in treatment initiatives when there is a possibility that the social worker will not be there for the duration of a project. A predominate message especially among female participants was that despite the slow pace of change and the difficulty with engagement, social workers must be prepared to 'stick it out' for the duration of the initiative. A participant described the persistence required:

> *Like all September, October, November, December, January, like, five months I went every Tuesday and whether they [group participants] showed up or not, like, I still went, ... you open the door and you make coffee and hopefully someone else comes and you can have a meeting. Sometimes there's only two of you. (Participant 8)*

Unmistakably, participants indicated that First Nations people want and deserve the reassurance that the social worker will be committed for the duration of an initiative and 'stay the course'.

> *Well, they [group participants] are looking for someone [group social worker] who is going to definitely be there ... [for the complete length of the program and for the safety needs of the entire family], if you're [group social worker] going to present your ideas and they [group participants] like your ideas, they want to know that you're going to commit to following through on them. Unfortunately, what happens a lot of times in communities is people [care providers] come and go, come and go and come and go ... (Participant 26)*

Participants reported that social workers can instill trust by showing an interest and making a long-term commitment to the community.

***Maintain Confidentiality***

For many participants, trust was closely linked to confidentiality. Confidentiality appeared to be a persistent and menacing concern for many participants. They stated that community members were concerned that the social workers would indiscriminately divulge clinical information to other community members. This was a particularly worrisome concern for participants when the social worker was from their community.

> *I find that when they have community members working in positions of high confidentiality that they don't trust them and they feel that, perhaps, if that person were to go on a drunk or if that person were to fall off the wagon or see them they would judge them or they would tell their brothers, sisters or cousins. (Participant 7)*

> *First Nations communities are often very small, closed and isolated, where almost everyone is related; conditions that cause participants to be concerned about rumors and gossiping. A participant stated: "Because we, there's so much rumoring and gossiping, you know, when you live in the community ... (Participant 16)."*

While another stated:

> *... to recognize that he or she [social worker] is not, like, [going to gossip] everything is confidential. There is not going to be any gossiping. (Participant 7)*

Community members fear that if indiscriminate disclosures were to become public knowledge there would be unrelenting shame for individuals and families. One participant described such a reaction.

> *Shame, embarrassment. .... It's an embarrassment. You don't want family members to know about it. You know -- if I tell you what's going on in my life what are you going do with it? (Participant 34)*

Disclosure of this type of personal information would be a concern in any community, but in First Nations communities the consequences may be more enduring


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because residents do not move significant distances from one locale to another. It is for these reasons that trust and confidentiality are so tightly intertwined.

## Discussion

As a result of their traumatization and resulting loss of trust, some First Nations people have experienced a limited ability to be open, sharing and contributing to self, family, clan and community (Thibodeau, 2003). The data suggest and the literature supports the concept that when people are afflicted by such a loss, they do not participate in family and community activities, and appear passive and unavailable for meaningful social interaction (Mollering, 2001). Matsakis (1998, p.58) advises,

> *Without adequate help, there is a tendency for traumatized [sic] persons to stay "stuck" in the mind-set of extreme distrust that existed at the time of the trauma … [and] do not take into account current reality, they can cause numerous problems both in daily living and relationships.*

A lack of trust can have dramatic consequences for treatment initiatives. The role of immediate family and clan members in First Nations communities is broad and influential (Kiyoshk, 1996). Families are viewed as a place where members learn personal and social skills and to take risks (Nichols & Schwartz, 1995). When a lack of trust limits these social interactions within the family, these core concepts are not conveyed to its members.

The consequences of this phenomenon can adversely affect the implementation of community based treatment initiatives. People who lack trust are less likely to endorse, seek out or support community based initiatives (Goodman et al. 1998). Participants indicated that when community members do attend program initiatives, aspects of engagement, disclosure, personal reflection, confrontation and other essential characteristics of effective group functioning may be compromised because of a guarded stance.

The harsh reality is that this is a phenomenon with no facile or singular solution. Interview participants identified five broad strategies which may begin to allay concerns related to a diminished level of trust, however, considerably more attention and study are required to develop broader and more comprehensive responses.

This study has implications for social workers practicing in First Nations communities. Social workers are busy at the best of times and are now being asked to implement innovative and culturally appropriate treatment initiatives while remaining cognizant and responsive to the issue of lost trust. As a result, workers must prepare themselves, their administrators, funders, tribal council members and supervisors for new standards of clinical practice, such as planning for a protracted engagement phase, providing extensive and ongoing contact with community members and providing a more extensive use of self. Workers must also educate and advocate for new methods of practice, which includes re-writing more reasonable time lines for treatment development and implementation, and redefining appropriate levels of engagement with their clients and community.

In this study the research team solicited the views of only service providers who were working on First Nations communities. The team did not interview clients or family members for their views on this subject nor for their recommendations. This study was limited by a relatively small and homogeneous sample and the involvement of a non-First Nations researcher.

The significance of this concept and its implications for social workers implementing innovative treatment initiatives in First Nations communities cannot be overstated. Thus, the development of new methods of practice that will better serve the unique needs and expectations of First Nations people is warranted.

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# Commentary: "Inside Looking Out, Outside Looking In"

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In the Saturday, October 13, 2007 *Globe and Mail* (A27), Margaret Wente in the ignorance and arrogance of a full member of the colonizing government of Canada, inferred that our culture has no perspective on the suffering of our women and children. Every First Nation Social Worker understands the implications of this perspective. Before I tossed her newspaper commentary *White Guilt, dead children-in the name of political correctness*, in the trash, I suffered personal post traumatic stress effects from seeing in my mind the faces of lost women and young people no longer with us due to violence, suicide and community un-wellness. Early death of clients is a reality that every First Nations community worker painfully accepts as part of the job.

The following paper, *Inside Looking Out, Outside Looking In*, provides a response from a First Nation woman and scholar, Cynthia Wesley-Esquimaux, PhD, and the title becomes a powerful metaphor for social activism in the First Nations cultural revival that Ms. Wente is clearly incapable of understanding. For me, Wente's inability to empathize and support, disqualifies her from having a meaningful role in the movement to heal our populations. Wente represents the unfortunate belligerence that constantly issues forth from political diatribes that maintain the oppression and suffering of our women and youth.

Like many Aboriginal activists, I have spent far too much energy debating with politicians and leaders who seem more interested in maintaining the historical status quo than creating movement towards resolution and reclamation of the immense strengths and resilience that far too often lie dormant and unrecognized in our communities. I have chosen to step out of that what has become an exercise in futility and join First Nation scholars such as Dr. Wesley-Esquimaux who give us a context and perspective to bring hope and change to some of the most vulnerable people on earth. We have decided to submit this commentary as an introduction to her paper on First Peoples alternative health and well-being because there is a need for our people to clarify not only understandings, but offer words of healing and truth of our own.

Having recently read an inspiring book written by Steve Biko (1978) who gave a great deal of thought to the question of white supremacy in South Africa and the quest for true humanity, I have concluded that Ms. Wente's rant is certainly incendiary if not racist. Biko's book, *I Write What I Like,* seeks to address attitudes deeply entrenched in ignorance and arrogance in dominant cultural norms that maintain injustice, suffering and cruelty that "careless" writers such as Ms. Wente perpetuate by blaming victims of historic atrocities for their predicaments. Biko speaks to the notion of

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metaphysical guilt and indifference to the suffering of South Africa blacks and I see a similar denial of complicity in government policies towards Canada's First Peoples. White guilt for him was ownership by white society of the evils of oppression and domination, and, acknowledgement that it is their business to fix things, not the victims. Biko lamented, even in the 50's, the time wasted by white liberals promoting integration and inclusion of the foolish, inferior and trusting oppressed, only to abandon them at a point of actual corrective social change. Biko offers a perspective on racial activism that merits careful examination by First Peoples social workers to enable them to resist mean spirited racially charged attacks such as Ms. Wente's.

First Peoples are generating resistance to the massive damage to their integrity by residual residential school fallout and family devastation all wrought by the spirit and intent of government policies and unscrupulous media. As a society we are not yet fully cognizant of the underlying oppression and genocidal intentions of white Canada openly being promoted in the name of nation building. The destruction of an entire population in the name of progress can only be understood when looked at in the context of total indifference to the planetary devastation of the past 25 years. First Peoples continue to protest Canadian global arrogance. This current government manifests a latent superiority that reveals masked hostility to any disruption of their total domination of Canada. Future generations will pay a huge price for this reckless and indifferent collective capitalistic greed. Ms. Wente rationalizes racism by blaming victims for social problems, much like those who fight against a realistic accounting of privilege and overtly rationalize destruction of the planet.

It is a continuous struggle to bring awareness to social work practice about the truth of historic trauma and the intergenerational legacy that undermines the health and wellbeing of these communities. How do we address "the why" underlying these all too common experiences in our communities? Since 2006, I have brought people into the North whose roles are to do something about violence against women and children in Ontario, and we once attended to a community during the funeral for young man who had committed suicide, and whose death was directly related to dealing crack cocaine and gang activity in Thunder Bay, Ontario. One member of our team had international experience in the world's most complicated conflict zones such as Bosnia and she later informed me that she was angry long after our visit because she had no idea that within Canada's borders these conditions are allowed to exist.

I have endured almost 30 years of having to resist pressures to practice social work from a 'dominant culture' framework. *Inside Looking Out, Outside Looking In* speaks to the stance professionals too often tend to take in their haste to "fix" Indians. I have lost more battles than I have won in my own efforts to bring flexibility to existing service structures. Dr. Wesley- Esquimaux offers insights into the need to alter those approaches by incorporating First Nations healing methods and alternative medical modalities that can also resonate in social work practice if entrenched in our communities.

Margret Wente, by reducing such important debates to "white guilt" and "political correctness" trivializes the trauma First Nations social workers experience when they attempt to assist Aboriginal women and children. For this article, I am sticking to child welfare realities because the real and deeper tragedy of intergenerational family destruction is not yet well understood by the dominant society. Here I can offer some compassion towards Ms. Wente. I cannot dismiss her identity as a (privileged) white woman, but I am saddened by her lack of respect towards the ongoing experience of First Nations women and children. However, together we have a complex interwoven history that requires us to appreciate the realities of our current relationship.

As a community worker, I have had to convince women to give up custody of their children in very difficult situations. One successful intervention was made especially painful when I read months later that this mother, having decided to place her infant in care in hopes of going for treatment, was found dismembered in a Toronto dumpster in Regent Park. My only comfort was that I had followed the guidance of community elders who had pressured me to engage each mother individually and encourage them to make decisions that were empowering and offered hope. This was in opposition to most of the practices of the Catholic Children's Aid, who in the elders opinions, sought mainly to rescue Indian children from their families, and expressed little or no interest in ending the genocidal policies that had evolved from a legacy of residential schools and the sixties adoption scoop.

As a First Nations social worker I have had to establish trust and special kinds of partnerships because when I was not working, I could leave my office, but not my culture behind. Agency indifference to the identity of Aboriginal peoples and their specific roles, as well as the intrinsic cultural motivations we carry requires a great deal of research and discussion. For many of us, it makes it impossible to 'sell out' and it will require monumental paradigm shifts on behalf of child care agencies to acknowledge how differently Aboriginal women are being treated. The ideal is that this would be accomplished without major conflict, because in the end, and in the face of Wente's article, we are mostly left to the conclusion

that it is us who must abandon the notion that we can shift large agencies to examine their antiquated approaches.

A good example was challenging Colin Maloney's refusal to accept changes to the Ontario Child Welfare Act. The suggestion was that First Nations children were Catholic first, thereby making cultural requirements secondary to agency goals and objectives. The ensuing argument to reverse that this assumption was reduced to a debate about my being a trouble maker, and focused on my return accusation that his Jesuit background prevented an earnest discussion on cultural genocide. Neither argument being of any assistance to the issue at hand; amendment of the Act to honour the cultural needs of First Nation children.

I have had to personally launch a major Human Rights case in order to defend the rights of First Nation women to access services and resources that could bring healing and cultural survival in the face of a dominant society that fails to account for its own history of oppression and genocide. I have been left with little patience for liberal non-Natives who claim they are not racist, yet continue to avoid difficult community work, and refuse to contribute to properly training First Nation social workers. The suggestion is that we lack certain forms of 'clinical' expertise, which non-Natives have received from their formal educations. There is no real recognition of the cultural practices that inform our community discourse and relevant healing modalities.

On November 12, 2007, at the University of Toronto, Donald Worme spoke on combating hatred in the 21st century. His paper, entitled *"Hate: What does it look like? What does it feel like?"* raised issues of love and respect. In contrast, in my humblest opinion after almost 30 years of social activism in First Peoples communities, Margret Wente's rant fit every category of hateful ignorance and arrogance that contributes to strained relationships between whites and First Peoples victims of Canadian historical, political and social traumas. This is inexcusable and cannot be justified, especially in the 21st century. The real indignation is that Ms. Wente's article is meant for the majority of Canadians who have a grade four or at best grade six level of education on the actual history of Canada and its relationship with its First Peoples.

Unfortunately, most social workers share the same misinformation and all too frequently blame the "poor Indians" for not being "model" citizens. That Mr. Worme's work gets little media attention or we learn so little about agents of change like Mr. Biko calls for a higher level of education that can create real awareness and sustainable change. First Nation community workers must rise above poisoned messages doled out in media and share resistance and resilience stories for the healing required to re-assert our place on this continent. If we waste our time worrying about mainstream guilt and indifference, we lose the momentum of our ancestor's determination to not be completely destroyed by the evils of colonization and oppression.

There are many stories that articles such as that by Margret Wente illustrate all too well. However, First Peoples today are determined to research, write and teach a different perspective in order to reverse the social and familial decline of our people. Gaining access to the writing of First Nations scholars like Dr. Cynthia Wesley-Esquimaux provides a different context in which to frame the work of a newer generation of social workers. Many of whom feel the urgency of changing the perspective of their own people as well as representative agencies, even while preparing the next generation of social and community workers. To the Margaret Wente's of the world, I end with a request to get ready and to get out of the way!

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# Inside Looking Out, Outside Lookng In

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## Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Judith Herman Chart: Complex Post-Traumatic Stress Disorder**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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# Reflections on Intergenerational Trauma: Healing as a Critical Intervention

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## Abstract

The high numbers of Aboriginal children placed in provincial and territorial care demonstrates the need for effective interventions that directly address the legacy of trauma from colonialization. This paper argues that healing is a critical component of any intervention seeking to help Aboriginal Peoples and their children. Research on healing and recent government initiatives and legislation directed at preserving traditional Aboriginal healing practices are discussed. This article concludes with recommendations for various community members involved in the healing of Aboriginal Peoples.

## Introduction

It has been documented that even before the first treaties were signed, Aboriginal Peoples[1] had the ability and collective will to determine their own path in all aspects of their culture and had control over their own political, economic, religious, familial, and educational institutions (Keeshig-Tobias & McLaren, 1987; Lee, 1992). Years of colonialization have led to the devastation and almost complete genocide of Native culture (Red Horse, 1980; Patterson, 1972; Lee, 1992). Residential schools operated in Canada, opening as early as 1894 (earliest documentation of people being forced to send their children to residential school) with the last remaining residential schools closing in 1984 in British Columbia (Barton, Thommasen, Tallio, Zhang, & Michalos, 2005) and Saskatchewan in 1996 (Department of Indian and Northern Affairs, 2003). Approximately 20-30 percent (approximately 100,000 children) of Aboriginal Peoples attended residential schools (Thomas & Bellefeuille, 2006). Numerous residential school staff across Canada have plead guilty to various types of sexual, physical, psychological, and spiritual abuse towards Aboriginal children placed in their care (Gagne, 1998; Royal Commission on Aboriginal Peoples, 1996). Many children also died from preventable diseases (Milloy, 1999; Trocmé, Knoke, & Blackstock, 2004). Gagne (1998) proposes that most of the family violence, alcoholism, and suicide behaviour among First Nations citizens originated either directly or indirectly from the abuse suffered by residential school students.

Residential schools do not only have effects on the students who attended, but their children, and their children's children (Gagne, 1998). Barton, Thommasen, Tallio, Zhang, & Michalos (2005) examined differences in quality of life between Aboriginal residential school survivors, Aboriginal non-residential school attendees, as well as non-Aboriginal Bella Coola Valley residents. Based on a sample of 687 residents from the Bella Coola Valley area in B.C., Canada, the researchers conducted a retrospective review. Data obtained from 33 questions in the 2001 Determinants of Health and Quality of Life Survey was examined, utilizing a series of descriptive, univariate, and Pearson Chi-square analyses. Aboriginal participants included 47 (27%) residential school survivors and 111 (63%) non-residential school attendees. Ten percent of participants did not answer this question (Barton et al., 2005).

Statistically significant differences emerged between Aboriginals and non-Aboriginals concerning overall quality of life ($p = 0.05$). It is important to note that both

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Aboriginal residential school survivors and Aboriginal non-residential school attendees reported statistically significantly poorer health on most of the outcomes measures, compared with non-Aboriginals. These results demonstrate the intergenerational pervasiveness of the residential school experience. The authors of this study suggest that Aboriginal residential school survivors may have a higher prevalence of Post Traumatic Stress Disorder (PTSD) (Barton et al., 2005). This suggestion is validated by research that has found approximately two-thirds of Aboriginal Peoples have experienced trauma as a direct result of the residential school era (Manson, 1996; 1997; 2000).

Maria Yellow Brave-Heart (2003) identified various effects of PTSD. Possible effects include, but are not limited to, the following: identifying with the dead; depression; psychic numbing; hyper vigilance; fixation to trauma; suicide ideation and gestures; searching and pinning behaviour; somatic symptoms; survivor guilt; loyalty to ancestral suffering and the deceased; low self-esteem; victim identity; anger; distortion and denial of Native genocide; revictimization by people in authority; mental illness; triggers, flashbacks and flooding; fear of authority and intimacy; domestic and lateral violence; inability to assess risk; and re-enactments of abuse in disguised form.

Residential schools and the trauma that was experienced has been described as a "de-feathering process", stripping Native Peoples of their knowledge, spirituality, physical and emotional well-being, and most sadly, has led to the loss of community (Locust, 2000). Native Peoples' connection with the spiritual, emotional, physical, and mental realms has been abruptly and chronically disrupted (Locust, 2000). Gagne (1998) hypothesizes that colonialism is at the root of trauma because it has led to the dependency of Aboriginal Peoples to settlers and then to cultural genocide, racism, and alcoholism.

This trauma is associated with Aboriginal Peoples' loss of culture. Aboriginal Peoples were forced to relinquish something valuable [cultural identity] that is difficult, if not impossible to regain (Ing, 1991). In the residential school system, Aboriginal children were forbidden to speak their own languages, practice their spiritual traditions, or maintain their cultural traditions (Trocmé et al., 2004). Oral transmissions of child-rearing practices and values were also lost, as a result of suppressed language (Ing, 1991; Gagne, 1998). Residential school included parenting models based on punishment, abuse, coercion, and control. Children in residential schools did not experience healthy parental role models and without appropriate parenting models, many Aboriginal parents lacked the necessary knowledge to raise their own children (Grant, 1996; Bennett & Blackstock, 2002).

The devastating effects of this loss of culture can be seen in the high numbers of Aboriginal children who are removed from their homes and placed in provincial care. The U.N. has stated, "Indigenous children continued to be removed from their families by welfare agencies that equated poverty with neglect" (United Nations, 2003, p. 5). In British Columbia, the number of First Nations children in care increased from a total of 29 children in provincial care in 1955 to 39% of the total number of children in care in 1965 (Kline, 1992). By 1977, 20% (15,500) of children in care across Canada were First Nations (Hepworth, 1980). The highest numbers of First Nations children in care appear in the Western provinces, specifically in British Columbia (39%), Alberta (40%), Saskatchewan (50%), and Manitoba (60%) (Hudson & McKenzie, 1981). In 1981, 85% of children in care in Kenora, Ontario, were First Nations. First Nations only make up 25% of the population in Kenora. In this study, it was determined that status Indian children were placed in care at a rate of 4.5 times than that of other Canadian children (Kline, 1992). By the end of 1999, 68% of children in provincial care were First Nations (both status and non-status) (Farris-Manning and Zandstra, 2003). Unfortunately, Indian children are less likely to be adopted (Kline, 1992; Hudson & McKenzie, 1981). According to the Department of Indian Affairs, over 11,132 children of Indian status were adopted between 1960 and 1990 (Royal Commission on Aboriginal Peoples, 1996). This does not include all other types of non-Status Indian children. It has been documented that as low as 2.5 percent of Aboriginal children are placed in race-matched families (Blackstock & Bennett, 2003).

It is estimated that there are currently over 25,000 Aboriginal children in the child welfare systems across Canada (Blackstock, 2003). This is approximately three times the highest enrolment figures of the residential school in the 1940's (Philp, 2002). Between 2000 and 2002, approximately 76,000 children and youth were placed in provincial/territorial care (Farris-Manning & Zanstra, 2003). Thirty to Forty percent of children in care were Aboriginal, (Blackstock & Bennett, 2003), when less then 5% of total children in Canada are Aboriginal (Human Resources Development/Statistics Canada, 1996). Between 1995 and 2001 the number of Status Indian children entering into care rose 71.5% across Canada (McKenzie, 2002). The U.N. committee on the Rights of the Child specifically raised concerns regarding the disproportionate risks faced by Aboriginal children in Canada and urged the Canadian government to eliminate all forms of inequalities (United Nations, 2003).

Although lengthy, the introduction of this paper has been used to demonstrate how colonization and forced cultural assimilation of Aboriginal Peoples, through the use of residential schools and then child welfare, has taken a substantial toll on Aboriginal communities across Canada. This is evidenced by the overrepresentation of Aboriginal children in care (Blackstock & Trocmé, 2005; Trocmé, MacLaurin, Fallon, Daciuk, Billingsley, Tourigny, Mayer, Wright, Barter, Burford, Hornick, Sullivan, & McKenzie, 2001). The purpose of this article is to demonstrate that healing is an essential component of any intervention aimed at improving the lives of Aboriginal Peoples and their children. As schools of social work in Canada work towards providing interventions that are 'evidence-based,' it is important to consider 'evidence' and 'science' from the perspectives of Aboriginal Peoples. I will begin with a brief discussion of the concept of knowledge and a comparison of Aboriginal and Western scientific practices. Following this discussion, qualitative research regarding the effectiveness of traditional healing practices will be presented. Various legislative impacts on the protection of traditional knowledge will also be discussed. This paper concludes with brief recommendations for the Federal and Provincial governments, professional associations and organizations, academic institutions, and various health care providers.

## Knowledge/ Evidence

Battiste and Youngblood Henderson (2000) define knowledge in the Report on the Protection of Heritage of Indigenous People as "a complete knowledge system with its own epistemology, philosophy, scientific and logical validity… the plurality of indigenous knowledge engages a holistic paradigm that acknowledges the emotional, spiritual, physical, and mental well being" (Battiste & Youngblood Henderson, 2000, p. 41). The authors claim, "traditional ecological knowledge of Indigenous people is scientific; in the sense it is empirical, experimental, and systematic" (Battiste and Youngblood Henderson, 2000, p. 44). Aboriginal perspectives on knowledge differ in two important respects from Western science: 1) it is highly localized (geographically); and 2) it is social. The focus of Aboriginal science is the web of relationships between humans, animals, plants, natural forces, spirits, and landforms in a particular locality, as opposed to the discovery of universal laws (Battiste and Youngblood Henderson, 2000). The following chart notes some important differences between Aboriginal and Western science. There are considerable differences in regards to the purpose of research, methodologies and outcome measures utilized, and issues pertaining to control and ownership of research. While keeping these differences in mind, it is important to remember that the diversity of Indigenous Peoples' cultures, histories, and knowledges should not be a barrier, but used as an opportunity to demonstrate the strength of plural knowledges in contemporary contexts (Martin Hill, 2003).

| ABORIGINAL SCIENCE | WESTERN SCIENCE |
|---|---|
| PURPOSE – to understand WHY or the ultimate causality. | PURPOSE – to describe HOW or the immediate causality. |
| METHODS - talking with Elders, prayer, fasting, and traditional ceremonies. | METHODS – measurement, breaking things down to their smallest parts, analyzing data. |
| OUTCOME MEASURES – balance within and with the Natural World. | OUTCOME MEASURES – a report of findings and data analysis. |
| SUBJECTIVE – the scientist/researcher puts themselves into their study. | OBJECTIVE – the scientist/researcher separates themselves and their feelings from what they study. |
| SPIRITUAL – spirituality is in everything and everything is interconnected. | Separate religion from science. |
| COMMUNITY CONTROL | EXPERT CONTROL |
| | Colorado, 1998 |

Donna Dubie, founder of Healing of the Seven Generations in the Kitchener/Waterloo area, wrote a grant proposal requesting funding for Aboriginal healing programs. The requested document, which she submitted to the Federal Government, had a section for "evidence". The "evidence", from a Western perspective, was likely looking for numbers, data, and a statistical analysis of findings. Ms. Dubie wrote, "I'm sorry it would take me years and years to explain to you how healing works and how we know it works…you will just have to take my word" (Donna Dubie, 2007). This quote represents the complexity of the study of healing and its associated practices. Her proposal was successful and in 1998, the Government of Canada established a 350 million dollar fund that is administered by the Aboriginal Healing Foundation, operated by Aboriginal Peoples (Department of Justice, 2005).

## Healing

Aspects of healing are closely guarded by oral traditions, and specific techniques are received directly from Elder healers, from spirits encountered during vision quests, and as a result of initiation into a secret society. It is believed that to share healing knowledge

indiscriminately will weaken the spiritual power of the medicine (Herrick & Snow, 1995, p. 35). The Aboriginal Healing and Wellness Strategy (AHWS) provides a framework that can be used in developing community-appropriate guidelines for traditional healing programs. The AHWS does not support the recording or documentation of the practices of Healers, the medicines, the ceremonies, and the sacred knowledge for any purpose (Aboriginal Healing and Wellness Strategy, 2002). This is done in order to preserve the integrity of sacred knowledge and out of respect for the practitioners who hold this wisdom.

Community members have stated that healing work needs to be intimately aligned to relationships with Elders and other cultural leaders, as well as ceremonies and protocols designed for personal development (Lane, Bopp, Bopp, & Norris, 2002, pp. 2-3). Western/European interventions of mental health have been identified as generally ineffective in responding to the needs of Aboriginal Peoples (Warry, 1998; McCormick, 1997; O'Neil, 1993). It is also well documented that Aboriginal people avoid using mainstream mental health services (McCormick, 1997) and have unusually high dropout rates when such services are utilized (Sue, 1981). Healing is an essential component in addressing the fact that both the Federal and Provincial governments have inflicted Aboriginal Peoples with many various forms of systematic abuse and discrimination, over several generations, in an attempt to assimilate Aboriginal Peoples into the dominant society through education, religion, law, and theft of land (Morrissette, McKenzie & Morrissette, 1993; Waldram, 1990).

Aboriginal Peoples argue that supporting and enhancing Aboriginal culture is a prerequisite for positive coping (Peters, 1996). This process of regaining our cultural heritage is essential for survival. Our ancestors have prescribed interventions for many generations and these teachings need to be revived and integrated into current practices. It is essential that we are able to get in touch with our Indigenous identities and ways of being in the world. Until traditional Indigenous therapies are implemented and considered legitimate, there will remain the struggle and suffering of a historical legacy, and ongoing trauma will continue (Duran, Duran, Yellow Horse Brave Heart & Yellow Horse-Davis, 1998). The Aboriginal Healing Foundation (2007) believes that culture is the best medicine.

## Research on Healing

The best available evidence for Aboriginal Healing is derived from qualitative studies. Thomas and Bellefeuille (2006) conducted a formative qualitative study exploring a Canadian cross-cultural Aboriginal mental health program in Winnipeg, Canada. A recruitment notice was circulated among Aboriginal organizations inviting people, who had prior residential school experience, within the city to participate. Methods utilized were conversational-style interviews (non-scheduled format) and a focus circle/group. Traditional Aboriginal healing circles and 'focusing' (a psychotherapy technique comprised of self-awareness and empowerment practices), were the interventions being evaluated.

Traditional healing circles refer to the coming together of Aboriginal Peoples for the purpose of sharing their healing experiences and to further their healing journey (Heilbron & Guttman, 2000; Latimer & Cassey, 2004). Focusing refers to a body-based, awareness technique that involves turning one's attention to the various sensations of the body. It allows people the opportunity to be safe observers of their bodily experiences of trauma and to experience this sensation at their own pace (Gendlin, 1996).

Results demonstrate that the traditional healing circle created a safe environment for the participants, emphasized the sacredness of each story shared, and gave the opportunity, to each of its members, to share without being interrupted. Story telling, teaching, and sharing within healing circles promoted a spirit of equality in the counselling relationship, empowered the participants, and eliminated hierarchy. Focusing was found to be effective in helping people to overcome self-criticism, overcome feelings of being stuck in life, deal with unsure feelings, get what they are seeking from within themselves, better handle emotions, shift out of old routines, and deal with past traumatic events. It was suggested that focusing could be appropriate for Aboriginal Peoples, as it is a humanistic, person-centered approach to healing, which reflects the core values of respect and non-interference (Thomas & Bellefeuille, 2006).

Kishk Anaquot Health Research collected data from participants of various healing projects funded by the Aboriginal Healing Foundation from Sept 2002 to May 2003. They utilized a National survey, individual questionnaires, and focus groups. Participation requests were sent out to active grants projects and 826 participants from 90 different healing programs across Canada responded. Challenges affecting more than half of the participants in this study were: denial; grief; history of abuse as a victim; poverty; and addictions (Aboriginal Healing Foundation, 2003).

Western interventions identified as helpful were: individual, group, couples, and family therapy; art therapy; narrative therapy; attachment theory; and genograms. Traditional interventions included sharing circles, sweats, ceremonies, fasting, Métis wailers, and traditional teachings. Alternative interventions were

also noted, such as energy release work, breath work, acupuncture (Aboriginal Healing Foundation, 2003, p. 68). It was stressed that these various approaches were balanced and/or used simultaneously (Aboriginal Healing Foundation, 2003, p. 95). This literature suggests that a choice of intervention approaches be offered, with the flexibility to meet special needs.

The participants of this in-depth study identified individual therapy sessions as helpful to improving their self-esteem and finding personal strengths. Individuals found healing programs helpful in the following ways: ability to handle difficult issues (71%, n= 726); ability to resolve past trauma (75%, n= 726); ability to prepare for and handle future trauma (78%, n = 731); ability to secure family supports (64%, n = 675) (Aboriginal Healing Foundation, 2003).

The most helpful aspects of healing programs were: Legacy education, opportunities for learning (specifically relationship skills and processing intense emotions), bonding or connecting with other participants, and cultural celebration. Legacy education refers to information regarding residential schools and has been noted for its particular usefulness as it "explains that the reactions to the residential school experience are normal and predictable consequences of institutional trauma and not an individual character flaw or weakness" (Aboriginal Healing Foundation, 2003, p. 76).

The focus group participants also identified several key characteristics of a healer: a good track record of ethical conduct supported by references; humble; honest; gentle; has worked through their anger; are recognized by others as a healer; listens intently; hears clearly; has reconciled with mother earth; absolute self acceptance; respected in the community; fearless; free from the need to control; understands professional limitations and makes referrals; and is spiritually grounded (Aboriginal Healing Foundation, 2003).

Duran & Duran (2000) conducted a study using a combination of culturally based dream interpretation & Western psychotherapy techniques. First Peoples found these techniques to be helpful in treating PTSD symptoms with a focus on how they are transmitted across generations. The most promising aspect found was reconnecting clients with their Native identity, which improved self-esteem and sense of identity, which in turn, was correlated with healthy functioning (Duran & Duran, 2000, p. 89). Within counseling, client's are helped to reconnect with their culture, as well as to understand and cope within the dominant white environment, while still maintaining their cultural sense of identity (Duran & Duran, 2000).

Chandler and Lalonde (1998) examined cultural continuity as a protective factor against suicide among First Nations Peoples. Six factors of cultural continuity were examined: evidence of self-government; evidence that bands had tried to secure Aboriginal title to their traditional lands; majority of students attend a band-run school; band-controlled police and fire services; band-controlled health services; and established cultural facilities. Data for the study was taken from suicide information (both Aboriginal and non-Aboriginal) and was gathered from several sources: Statistics Canada, The British Columbia Ministry of Health, Health Welfare Canada, The Canadian Centre for Health Information, Indian Registry, and Band Governance Database from Indian and Northern Affairs Canada. They hypothesized that when communities have a strong sense of their own historical continuity and identity, vulnerable youth have access to resources in the community that act as a buffer in times of despair. Therefore, in communities where cultural transmission has been disrupted, vulnerable youth may be at increased risk of suicide due to the lack of such buffers (Chandler & Lalonde, 1998).

The researchers found that the rate of suicide was strongly associated with the level of these factors. They discovered lower suicide rates where efforts were being made within the community to preserve and rebuild their culture. Communities with all of the cultural continuity factors had no suicides, while those with none had significantly higher suicide rates (p= .002). They note that there is no clear reason to label a death as suicide, and therefore, deaths are typically recorded as accidental (Chandler & Lalonde, 1998). Accidental death rates are substantially higher within First Nations populations. This suggests a massive underestimation of true suicide rates.

Brave Heart-Jordan (1995) conducted a group intervention among the Lakota, with the primary purpose of grief resolution and healing. Key features of this intervention are congruent with treatment for Holocaust survivors and descendants. Catharsis, abreaction, group sharing, testimony, opportunities for expression of traditional culture and language, and ritual and communal sharing were included in the intervention model.

Results demonstrate that 100% of participants found the intervention helpful in the area of grief resolution and felt better about themselves after the intervention. Ninety-seven percent of participants were able to make constructive commitments to memories of their ancestors following the intervention. Seventy-three percent of participants rated the intervention as very helpful (Brave Heart-Jordan, 1995).

It has been found that healers help clients overcome their fear of change, help to clarify their vision, and

strengthen their motivation. It was also found that no specific healing technique was better than another, but rather appeared to be a vehicle for giving clients the power to access something they already possess (Carlson & Shield, 1990).

Davis-Berman & Berman (1989) conducted an evaluation of wilderness camps and found participation in the camps to: foster a strong sense of cultural pride; renewed sense of belonging; and increased trust in relationships. Wilderness Camps address physical, spiritual, emotional, and mental aspects of the lives of the youths attended. These camps were found to foster increased self-esteem in participants because these programs are flexible and diverse, allowing every participant to find a different activity in their area of strength (Davis-Berman & Berman, 1989).

Fuchs and Brashshur (1975) found that Native Peoples believe that Western medical care treats the symptoms of disease, but does not deal with the cause (p. 918). Two hundred and seventy-seven families were interviewed and completed the survey and 170 families (33%) who completed the survey were not interviewed, due to a variety of factors. Results demonstrate that 1/3 Native families (in US-random sample) used traditional Native medicine in combination with the use of modern Western medicine

A strong relationship between the use of traditional medicine and returning to the reserve was found and it was suggested that this association reflects an unmet need for traditional Aboriginal medicines in urban areas (Fuchs & Brashshur, 1975). Suggestions are made for urban centers to preserve Native culture and promote the availability of traditional health treatments (Fuchs and Brashshur, 1975, p. 925).

Traditional healing practices have also been found to have profound effects on individuals who have sexually offended in the community. For example, counselors taking part in traditional healing practices with Aboriginal men reported an increased openness to treatment, an enhanced level of self-disclosure, and a greater sense of grounding or stability. “Having attended sweats, I do know that during the ceremony people are able to talk about their own victimization because of the safe and secure nature of the Sweat” - the quote is an expression from a therapist (Solicitor General Canada, 1998, p. 76).

There is a diverse range of traditional healing practices that have roots in Indigenous values and cultures. Some core values of healing practices (holism, balance and connection to family and the environment) are common to Aboriginal worldviews across cultures, while others are clearly rooted in local customs and traditions. For Indigenous peoples, the concept of holism extends beyond the mental, physical, emotional, and spiritual aspects of individual lives and includes relationships with families, communities, the physical environment, and the spiritual realm. These values are seen in traditional interventions in Greenland, Australia, and the United States of America (Archibald, 2006, pp. 39-53). Over time, some of these practices have grown to incorporate Western values and practices. It has been well documented that a cross-cultural approach will allow for both traditional Western clinical practices and Aboriginal healing practices (Culley, 1991; Graveline, 1998; McGovern, 1998; Thomas & Bellefeuille, 2006).

The Aboriginal Healing Foundation published a report of the history of Aboriginal Peoples in Canada in order to enable a future in which Aboriginal people have fully addressed the legacy of historic trauma suffered in the residential school system (Aboriginal Healing Foundation, 2006). The Foundation states that healing is a long-term process that occurs in stages. They project that it takes an average of ten years of sustained work, for a community to reach out to individuals and create a trusting and safe environment, while disengaging denials of the past, and engaging participants in direct therapeutic healing. Healing goals are best achieved through services provided by Aboriginal practitioners and long-term involvement in a therapeutic setting. Participants of services provided by the Aboriginal Healing Foundation rated Elders, healing and talking circles, and traditional ceremonies and practices as most effective. During a discussion with the commissioners of the Royal Commission on Aboriginal Peoples, Harold Orten elucidated the relationship between culture and healing with this quote

> *“Recovering our identity will contribute to healing ourselves. Our healing will require us to rediscover who we are. We cannot look outside for self-image; we need to rededicate ourselves to understanding our traditional ways. In our songs, ceremony, language and relationships lie the instructions and directions for recovery” (Peters, 1996, p. 320).*

For many Aboriginal Peoples, healing means addressing approaches to wellness that draw on culture for inspiration and means of expression (Thomas & Bellefeuille, 2006).

The Aboriginal Healing Foundation provides detailed information on best healing practices and state that healing and reconciliation are central to First Peoples’ ability to address other pressing social issues and to move to better relationships (Aboriginal Healing Foundation, 2007). Traditional healing practices have demonstrated effectiveness and should be incorporated in all possible interventions involving First Peoples and their children.

These practices should be evident in both professional practice and in the development of social policies.

## Legislation: Aboriginal Culture and Research

*Protection and Promotion of Existing Knowledge*

In January 1998, as part of its response to the report of the Royal Commission on Aboriginal Peoples, the Government of Canada issued a Statement of Reconciliation. This document acknowledged the contributions made by Canada's Aboriginal Peoples to the development of Canada. It also recognized the impact of actions that suppressed Aboriginal language, culture and spiritual practices, which resulted in the erosion of the political, economic, and social systems of Aboriginal Peoples. It acknowledged the role that the Government of Canada played in the development and administration of residential schools and stated that we need to work together on a healing strategy to preserve and enhances the collective identities of Aboriginal communities. This statement is important because offering an apology and acknowledgement of the wrongs of the past is an important first step to building the foundation for a new relationship with Canada's Aboriginal Peoples, one founded on trust and respect (Department of Justice, 2005).

The Canadian Medical Association has called on it's members to show "openness and respect for traditional medicine and traditional healing practices, such as sweat lodges and healing circles" (Indian and Northern Affairs Canada, 1996). This is in line with the Royal Commission on Aboriginal Peoples, which promotes "openness and respect for traditional medicine and traditional healing practices" (Royal Commission on Aboriginal Peoples, 1996).

The Canadian Association of Social Workers (2004) state that the institutions responsible for providing mental health services to Aboriginal Peoples are embedded in 'westernized' models. They argue that these models do not correspond with the realities of First Peoples and call upon Canadian schools of social work to support the development of culturally appropriate social work education and models of practice.

***Recent Government Initiatives***

The Government of Canada has made a five year commitment of 125 million dollars in order to sustain critical work of healing the legacy of abuse suffered in Canada's Indian residential school system. Although this is cause for hope and celebration, this funding will only sustain current programming for up to three years and does not allow for funding any new projects. This greatly appreciated financial gift barely touches the tip of the iceberg. The Aboriginal Healing Foundation projects that it will take 600 million dollars, over the next 30 years, to fully address the effects of abuse resulting from the residential school system (Aboriginal Healing Foundation, 2005).

***Aboriginal Research***

Aboriginal research is comprised of research committees, a research ethics board (REB), and a code of research ethics. James Bay Cree Health and Social Services Commission and the Assembly of Manitoba Chiefs have research committees that review proposals to ensure that they are acceptable to their member communities. All funding agencies in Canada require approval from an REB before they will grant funds for research. For research involving First Nations, an REB has to consult with a First Nations expert, or with people from the First Nations communities concerned. This is important because the REB and First Nations may have different ideas about what constitutes harm, benefits, and confidentiality (First Nations Centre, 2003a).

The development of ethical guidelines is critical to prevent further exploitation of Aboriginal communities and to protect their knowledge. First Nations Centre at the National Aboriginal Health Organization provides extensive information and tool kits about understanding research, ethics in health research, privacy, and OCAP: ownership, control, access and possession. The OCAP principles can be applied to all research initiatives involving First Nations (First Nations Centre, 2007). Codes of ethics developed by First Peoples' communities are also very clear about issues of community rights.

***Community Rights***

It is of the utmost importance that the community being researched also benefits from the research and its findings. Community consent must be obtained from representatives of the people concerned (such as a Band Council or a regional First Nations organization). Oral consent and gift giving is very traditional and acceptable for First Peoples. Community control over the research process and how the results are used are very important to First Peoples. There is often an agreement on the sharing of results; the originating community has the right to know the research results. At a minimum, this means that research results should be returned to the community or the participants in a format that they can understand, such as plain-language flyers, radio broadcasts, or public presentations. Ideally, the people involved in the research should be the first to see the results. Community ownership refers to the shared ownership of information collected from a community. The information should remain collectively owned by the community from which

it was taken (First Nations Centre, 2007). This is critical in developing strong relationships & rebuilding trust.

Mainstream research organizations consider it good practice, but not mandatory, to involve communities in interpreting research results, whereas, the codes of ethics developed by some First Nations communities, state explicitly that if outside researchers are involved, the research results must be jointly interpreted by the community and outside researchers, governments and universities. In the case of a disagreement over the interpretation of the results, the researcher can go ahead and publish, but the community has the right to include a description of why they disagree and how they interpret the findings. The idea is that the public will be able to read both interpretations and decide which one they agree with (First Nations Centre, 2003b).

After reviewing the research regarding the effectiveness of healing and discussing current legislative and government initiatives concerning research involving First Peoples, brief and non-exhaustive recommendations are made in the aspiration of increasing awareness on issues regarding First Peoples' culture, traditions, values, and best healing practices.

## Recommendations: Government

1. Provide funds to allow for the development of traditional healing awareness, healing programs, and further research in best healing practices.
2. Continue to fund healing programs and services such as the Aboriginal Healing Foundation, created April 1, 1998 to assist First Peoples communities as they work to heal the legacy of the physical and sexual abuse of the residential school system, including intergenerational impacts. The Foundation provides funding and supports holistic and community-based healing initiatives and projects that incorporate traditional healing methods and other culturally appropriate approaches (Aboriginal Healing Foundation, 1999-2007).
3. Provide incentives for other funding organizations to commit a certain percentage of funding to promoting research on Aboriginal issues.
4. Increase awareness with government-initiated awareness campaigns regarding the demographics of Aboriginal Peoples, the disruptive impact of colonization, and governmental obligations and policies regarding health (Society of Obstetricians and Gynecologists of Canada, 2000).

## Recommendations: Professional Associations and Organizations

1. Set aside time at annual conferences to provide professional education regarding the legacy of residential school and its impacts on First Peoples today.
2. Hold periodic regional and national sharing and networking conferences across associations and organizations. There is a need for information sharing and development of relationships among healers and Elders, in conjunction with western-trained health professionals. For example, the Society of Obstetricians and Gynaecologists of Canada (SOGC), has an Aboriginal Health Issues Committee which is a multidisciplinary committee with Aboriginal and non-Aboriginal members, with representation from several Aboriginal organizations and backgrounds including First Nations, Inuit, and Métis (SOGC, 2000).
3. Offer training to health care providers in culturally appropriate practices and interventions for First Peoples.
4. Encourage employees to increase their own self-awareness regarding their own stereotypes and biases that may affect treatment.
5. Develop specific best practice principles and guidelines to assist in working with First Peoples clients. This should be done in collaboration with First Peoples.
6. Provide culturally sound interventions when working with First Peoples and their children that incorporate Legacy education, cultural identity, and opportunities for healing.

## Recommendations: Academic Institutions

1. Educate social work and other health care professional students with regards to the legacy of residential schools and the ongoing effects of colonialization on Aboriginal Peoples today.
2. Provide social work and other health care professional students with a critical appreciation of the centrality of Aboriginal culture in the healing process and an understanding of the diversity of First Peoples expression of culture. The ways in which this diversity affects one's sense of identity and approaches to social work practice should be incorporated into the curriculum (Thomas & Bellefeuille, 2006, p. 11).
3. Mandate courses in cultural competency in Canadian schools of social work. For example, Wilfred Laurier University offers courses on different paradigms (Aboriginal and Western models), as well as compulsory courses on multicultural counselling or cultural competency. Wilfred Laurier University offers a one year MSW program in the Aboriginal

field of study (Wilfred Laurier University, 2007). In this program, students are taught: holistic healing practices from Elders; Indigenous identity, knowledge, and theory; and Indigenous research methodologies. There is also a cultural camp, which includes a five day program in a camp setting in the presence of Elders, where participants learn about traditional songs, dances, teachings, and values.

4. Encourage and support further research in collaboration with First Peoples, for First Peoples, utilizing a combination of Western and First Peoples' methodologies.

## Endnotes

1. Throughout this article, the terms Aboriginal Peoples and/or First Peoples is used to collectively encompass First Nation, Inuit, and Métis people in Canada. The term Indigenous is used when discussing Aboriginal Peoples internationally. Other terms, such as Native, Indian, Status Indian, and non-status Indian are used in order to maintain the original language of the specific literature being referred to.

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# Exploring the Experiences of an Elder, a Psychologist and a Psychiatrist: How can Traditional Practices and Healers Complement Existing Practices in Mental Health?

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## Abstract

This qualitative research study asked the question: how can traditional practices and healers complement existing practices in mental health? Three interviews were conducted with the intention to explore the experiences of people who have expertise in the areas of traditional healing and mental health. Interviews were held with an Elder, a Psychologist and a Psychiatrist. Analysis of the interviews highlighted the different perspectives of each worldview, which is thoroughly discussed in the literature. In addition common themes to practice were identified and this is an area that is not often highlighted in the literature. The interviews revealed each perspective is strongly grounded in a desire and intention to help people and is then built upon via training. To move forward it is essential to begin from commonalties in how each perspective works to help people, in addition to a solid understanding of the two perspectives and the causes for the current health and mental health of First Nations and Métis.

## Introduction

Health outcomes for Aboriginal people in Canada have been highlighted in the literature as a significant concern. Mackinnon (2005) notes Aboriginal peoples experience a lower life expectancy than non-aboriginal peoples by at least eight years. She states "it is well documented that the health of First Nations lags behind that of the non-aboriginal population" (2005, p.2). The need for improvements to the health of Aboriginal people is reflected in current public policy. In 2005 Aboriginal healthcare was brought forward via the Blueprint on Aboriginal Health. This document was drafted by federal, provincial and territorial governments and representatives of Aboriginal peoples in every region of Canada. The stated intent of the Blueprint is to make significant progress in closing the gap in health outcomes between the general Canadian population and Aboriginal peoples. In the Blueprint it states, "All parties will support holistic approaches including traditional practices and participation of traditional practitioners in the health team" (2005, p.5). Although this policy was not carried forward after the last Federal election, the process and content of the policy remains relevant, particularly in the review of current practices regarding First Nations in health. The work that needs to be done to include the participation of traditional practitioners in the health team is vast and covers a diverse range of health sectors and issues.

This research will focus on the inclusion of traditional healing in the area of mental health and asks the question, "How can traditional practices and healers complement existing practices in mental health?" To answer this question interviews were conducted with an Elder, a Psychologist and a Psychiatrist. The research question immediately draws on the obvious point that First Nations traditional healing and mental health operate from two fundamentally different worldviews (Dee Letendre, 2002). In addition to these fundamental differences,

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issues of efficacy and evaluation of traditional healing are often raised and are controversial (Waldram, 1997). The experiences of First Nations and Métis people as they encounter mental health systems are often viewed in relation to a history of oppression and current social conditions. It is related in the literature that mental health issues for Aboriginal people cannot be separated from the broader historical issues, though they often are, and this is discussed as persistent sociopolitical marginalization (Smye & Browne, 2002).

The terminology used in this paper includes the use of "Aboriginal, "First Nations", and "Western" and will appear as it was in the text of the author cited and capitalization may as a result vary.

## Literature Review

Most of the literature on Aboriginal peoples and mental health discusses differences in First Nation and Western worldviews. Coates, Gray and Hetherington (2006) state that traditional healing practices are embedded in a spiritual sense of interconnectedness which is fundamentally different from the dominant Western paradigm. The Western worldview removes individuals from their context while traditional practices reflect on the interconnectedness of social, physical, and spiritual environments. Traditional healing practices are very embedded in Aboriginal culture and cannot be simply defined. Dee Letendre (2002) states "A reciprocal relationship can be shown to exist between traditional medicine and Aboriginal culture" (p.79). The fundamental differences between Western and Aboriginal approaches fall into three categories. According to Dee Letendre these include "philosophical approaches to health; the structural components of health care delivery, and; the guiding principles of each knowledge system" (p. 82). Martin-Hill (2003) discusses several challenges in defining traditional medicine. She offers that we must remember that the term "traditional" is a British colonial concept and was introduced to individuals by scholars.

Other areas of the literature look directly at mental health systems with regard to First Nations and Métis people and discuss services and access. A project involving the development and evaluation of a cultural consultation service in mental health found that access to mental health varied by linguistic and cultural background and that racism diminished access to mental health care or undermined the relevance and reception of conventional care. In addition, it was found there was insufficient development and integration of cultural training in most professional programs. The researchers stated the findings indicated significant unmet need for mental health services for Aboriginal peoples.

Nine recommendations were given by these authors, and included the need for bringing together clinical expertise and cultural knowledge in service provision. Overall the recommendations outline effective means for responding to the needs identified in the report by developing additional services and through ongoing training and support to organizations and staff. The authors introduce the concept of "cultural brokers" and state,

> *"There is a need to support community services and improve liaison with professional mental health care to develop the role of cultural brokers who can work closely with clinicians to mediate during clinical encounters and identify appropriate resources to assist with the social care of patients" (Kirkmayer, Rousseau, Rosenberg, Clarke, Saucier, Sterlin, Jimenez, &Latimer, p.2, 2001).*

In a similar study, Kirkmayer, Brass and Tait (2000) focus on the mental health of Aboriginal peoples, and note that Aboriginal people have experienced a rapid culture change and absorption into the global economy with little regard for their autonomy. The authors note that most mental health services in urban centers have not been adapted to the needs of Aboriginal clients and this is reflected in the low rates of utilization.

In reviewing the issues related to the development of plans to improve the effectiveness of mental health services to urban First Nations people, Peters and Demerais (1997) discuss the medicine wheel, a holistic model, confronting the fragmented system of Western mental health services. The interconnected areas of physical, mental, emotional and spiritual, are contrasted to a western concept of mental health in isolation to other aspects of wellness. While stating the differences, they note "integrated health care is catching up to traditional native views on the need to address the whole person in context" (p.30). This article was written ten years ago. While it may be viewed as outdated, it becomes relevant from a viewpoint of current system analysis. They state "evidence has accumulated to show that many of the most important health and mental health concerns of the First Nations community are, in large part, poverty problems" (p.30). To address these problems the authors suggest a need for advocacy directed at the determinants of health within mental health systems, for mental health to not only focus on managing symptoms but also on addressing root causes. The researchers suggest mental health systems collect information that documents the quality of life of mental health consumers by ethnic origin and bring this information to the attention of groups that can effect the needed changes.

Schmidt (2000) notes there is a significant amount of research regarding mental health and Aboriginal peoples. He relates that as early as the 1970s cultural anthropologists began research in this area. Since then aspects of intervention, prevention, service provision and ways traditional healing can be applied in mental health have been researched. However, mental health services to Aboriginal peoples with severe and persistent mental illnesses have not been well documented (p.75).

Smye and Browne (2002) suggest that rather than thinking about many "mental health problems as medically defined disorders, Aboriginal caregivers and policy analysts feel it is more appropriate to focus on mental health issues which are posing the most serious threat to the survival and health of Aboriginal communities" (p. 48). Like other researchers, Smye and Browne go on to say that many mental health disorders are a by-product of the colonial past with ongoing assaults on culture and identities. They also say,

> *"this does not mean that aboriginal people live without schizophrenia, bipolar disorder and other affective disorders and that these are of no concern to their communities, but that these disorders are considered less problematic in relation to community survival" (p.49).*

Schmidt (2006) echoes this assertion and discusses that in the context of massive community challenges "the needs of First Nation people with serious and persistent mental illness are often subsumed by broader concerns" (p.84).

Added to the community challenges, it is notable to mention that while many people in society and in the literature recognize the loss of culture to Aboriginal people, it is often not recognized in terms of cultural genocide. To this date Canada has never formally acknowledged that genocide occurred to Aboriginal peoples in Canada. This is reflected in the literature and the term genocide is not often used, instead "loss of culture" is discussed. Martin-Hill (2007) compares this to the experiences of the Jewish holocaust survivors and the ongoing community pain that is endured when the wrongs that have been done are not acknowledged.

How we tell our history impacts our identity and how we see ourselves. Paul (2006) discusses how the history of North American First Nations has not been told and how this adds to the ongoing present conditions for First Nations and Métis people. For example, in research conducted with residential school survivors it has been found that from 1919-1950 little or no academic education existed, only a life of hard work bordering on slavery (Hansen & Rucklos Hampton, 2000). Martin-Hill (2007) echoes these findings and shares in her research she has found the same results including an absence of school curriculum comparable to the current provincial curriculum of that time. She indicates that by all existing evidence residential schools during this period were a form of child slavery. While child slavery appears evident this is not how the history is told. First Nations and Métis history is not clearly taught to our society. History and traditions are closely related; as such it is difficult to relate the extent of the diversity to the understandings and meaning of traditional healing.

Chaimowitz (2000) poses an interesting question, "are we able to think outside of the traditional views of psychology and psychiatry and look at another perspective?" (p. 605). He poses this question after discussing the low profile of Aboriginal psychiatry and Aboriginal mental health issues. He shares the history and contributions from Dr. Clare Brant, the formation of the Native Mental Health Association of Canada, and more recent contributions by Dr. Cornelia Wieman. Reasons for the low profile are attributed to lack of articles, low numbers of Aboriginal clinicians, the history of Aboriginal peoples' treatment by government, organizations and individuals. He states, "it may perhaps be simpler and more intrinsically comfortable to try to right the wrongs and help the victims of dominant and oppressive cultures when they exist in lands foreign to our own" (p. 606).

After discussing the history and context in which First Nations' poor health outcomes are derived, Chaimowitz states that many of the mental health issues remain framed in terms of western cultural and political discourse. For example, Schmidt's research posed that psychiatric rehabilitation programs originated in urban centers, and as such there are assumptions regarding housing, employment and community services that do not apply for northern and remote First Nation communities.

In further considering the reasons for the low profile of Aboriginal psychiatry and mental health issues. Chaimowitz adds that the mental health community sees itself as kind and tolerant and offers that the literature presented on First Nations and mental health could raise discomfort. He suggests it is difficult to connect to phrases such as "cultural genocide", "condescending, paternalistic attitude" and "organized efforts to destroy Aboriginal culture," the phrases that native people and researchers use to describe the history. The author makes a compelling point however, this writer suggests that the rationale given by Chaimowitz could subtly silence Indigenous people by dissuading Indigenous practitioners to speak their truths to avoid mainstream mental health practitioners feeling discomfort.

Chaimowitz suggests that we begin the process of learning by strengthening local resources and demonstrating a willingness to build long-term partnerships, he states

"delivery of care is as much something we do with someone as it is something we do for someone" (p.606). In discussing partnerships Peters and Demerais (1997) state the most successful partnerships develop informally from the bottom up, initiated by line workers who have recognized the need to solve a shared problem. This type of partnership ensures that the goals of the programs and the needs of the clientele are put foremost. While at first glance it may seem that partnerships and the work to be accomplished are readily attainable, there are evidently no clear solutions in the literature.

Chaimowitz cautions that

> *To conceptualize aboriginal mental health as an area in which we deliver culturally sensitive service to disadvantaged populations would be simplistic and wrong; the potential for falling into the trap of a more modern version of paternalistic intervention is high" (p. 606).*

First Nations, Métis and non-Aboriginal alike may visualize a utopian service provision model where traditional healers and mainstream health practitioners collaborate. However, as Waldram stated in 1997, "I have yet to see an example of true collaboration between traditional medicine and biomedicine" (p. 96). Given the existing literature, it is possible that ten years later his assertion holds true.

It seems apparent that collaboration is not easily accomplished. Wieman (2000) discusses in an overview of Six Nations Mental Health Services that both westernized and traditional viewpoints exist among First Nations. Of particular interest she shares the difficulties the organization she worked at had in establishing collaborative working relationships with traditional healers in the community, stating "there is ongoing consideration given to balancing the 'medical model' with traditional, holistic approaches" (p. 8). The service that she is writing about is delivered by First Nations mental health practitioners to First Nations people on Canada's largest First Nation – Six Nations in Southern Ontario. Wieman is Canada's first female First Nations psychiatrist.

Cautionary elements, also drawn from the literature, suggest that sometimes focusing on the needs for research and support in a given area inadvertently highlights problems as being Indigenous specific. This is the case with Fetal Alcohol Spectrum Disorder (FASD) as discussed by Tait (2000). Tait relates that FASD in Canada is understood mainly as a wellness concern of Aboriginal people and that Aboriginal groups are concerned that FASD has become a blanket term to medicalize social problems, poverty, lack of education, structural racism and violence against Aboriginal peoples. This also has implications for main stream mental health as they are not challenged to view FASD as a broader social concern… therefore, often questions about alcohol and drug use do not get asked of main stream populations.

First Nations themselves have prioritized health issues related to substance abuse and this has lead to research and funding. To highlight how research and support can inadvertently send the wrong message Tait shares the example of Saskatchewan in 1998 when twenty FASD community development initiatives focused on First Nations almost exclusively. Of the twenty projects funded, sixteen were on reserves and four were urban or prison focused with either Aboriginal organizations or a strong Aboriginal component.

In addition Tait highlights contradictory public messages given regarding FASD. Media campaigns often state that FASD is 100% preventable; however, they do not relate the systemic barriers that stop pregnant women from entering treatment. Together these implied messages do not work towards improving health outcomes for First Nations or building long-term partnerships. Careful consideration must be given by everyone to ensure that research and support does not aid in the further stigmatization of First Nations and Métis people.

Formal assimilation policies are considered to be a part of the past and the modern era has introduced multicultural policies that support traditionalism. Policies that support traditionalism pose an interesting challenge via the potential for the creation of systems that institutionalize traditional healing and approaches. It has only been since the 1970s that traditional healing ceremonies have been held without fear of repercussion, or in some jurisdictions held legally. In this short time First Nations now find themselves at a point where it is necessary to protect traditional medicine from exploitation and appropriation, and give strong consideration to intellectual property rights including knowledge and medicine (Martin-Hill, 2003). Informal assimilation is a concern for the present and future of First Nations.

In sharp contrast to the need to protect traditional knowledge and medicine is the aspect of the efficacy and evaluation of traditional healing, particularly when related to mental health. Mental Health is often discussed in the literature as being a part of western medicine or paradigms (Struthers, 2003; Hanson & Hampton, 2000; Coates, Grey & Hetherington, 2006). As such it is built upon practices that are referred to as evidence based or empirically supported (Garfield, 1998; Jensen, Weeersing, Hoagwood & Goldman, 2005; Borkovec & Castonguay, 1998).

What do the terms "evidence based" and "empirically supported" mean? In 1995 the American Psychological Association presented the basis and background for empirically validated therapies. Briefly stated, empirically supported therapies are defined as clearly specified psychological treatments shown to be efficacious

in controlled research with a delineated population (Chambless & Hollen, 1998). "The process and philosophy of evidence based practice as described by its originators is a new educational and practice paradigm for closing the gaps between research and practice to maximize opportunities to help clients avoid harm" (Gambrill, 2006, p.339).

The effort to find practices that has lead to the question of mental health practices and traditional healing practices coming together and being evaluated via an existing Western systemic way of looking for evidence. In the inquiry into the efficacy and evaluation of traditional healing, it has been found that scientific studies of traditional healing have yielded ambiguous results and from this the following questions are raised:

> *Is this because the healing itself is ineffective? Is it possible that science currently lacks the tools (and the inclination) to see "traditional healing"? How do healers view the issue of efficacy? What are their goals when they undertake healing and what measures (if any) do they employ to determine success? Is efficacy, as science understands it even an issue for traditional healers? Is the whole idea of questioning efficacy and developing evaluation programs even necessary? Is it possible that to undertake these we are violating the basic principles of the healing itself? Can traditional healing ever be understood by the dominant biomedical system? (Waldram, 1997, p.93)*

These questions perhaps best summarize the exploration of efficacy and traditional medicine. There are no clear answers, and it is clearly controversial inspiring deep emotions within each perspective. Waldram concludes with the following:

> *"It is essential that healers be able to determine their own understandings of the problem and definitions of efficacy. They should not have to prove to biomedicine that what they are doing is equivalent to biomedical understanding" (p. 96).*

The literature reviewed provides an overview of the differences in worldviews, the historical reasons for the current state of Aboriginal mental health, a discussion of the existing services, barriers in services, and potential solutions such as partnerships. Each of these elements need to be clearly understood and articulated when considering how traditional practices and healers can compliment existing practices in mental health.

In considering the literature, it may be relevant to state that there is a lot to be learned and understood in the area of mental health with regard to traditional healing. This appears to be largely due to the fundamental differences in each perspective, however, while each is fundamentally different there are some common elements regarding the aspects of helping people and a desire to explore working together. What appears to be a problematic point is the fact that we live in a society that operates from a western worldview and ideology. Due to this it is easy to overlook other worldviews and the systemic barriers that will stop us from working in truly collaborative means.

## Methodology

Recent years have seen a growing body of work dedicated to Aboriginal research, methodologies and ethics. Larson and Brown (1997) discuss the challenges for Canadian social work educators in teaching research methods to undergraduate Aboriginal students in ways that respect cultural context, are anti-racist and empowering. They state that in teaching research to Aboriginal students the students "must become knowledgeable and competent consumers, practitioners and participants of research" (p. 206) and this is the way they will be liberated from the reality of oppression.

Aside to understanding mainstream research and methodology, "Aboriginal communities, political organizations and scholars are insisting that the integrity and validity of research cannot be assured by western methodologies alone" (Castellano, 2004, p. 106). Aboriginal methodologies are often a mix of existing methodological approaches and Aboriginal practices (Tuhiwai Smith, 1999). Kovach (2005) states, "gaining control of the research process has been pivotal for Indigenous peoples in decolonization" (p.23). Indigenous research exceeds beyond the parameters of the researcher being Indigenous, or merely placing the word "Indigenous" in front of research. Epistemology plays a large factor in identifying how we know our world. An Indigenous epistemology suggests an Indigenous way of functioning in the world and includes meaningful aspects of living specific to an Indigenous group (Kovach, 2005).

## Ethics

Further to Aboriginal methodologies, ethics in Aboriginal research are also of significant concern. Section 6 of the Tri-Council Policy Statement is entitled "Research Involving Aboriginal Peoples". This section discusses agreed upon requirements for research involving Aboriginal communities. Specifically nine points are cited as good practices. To the fullest extent possible this research followed the practices at all points of the research.

To respect the culture, traditional and knowledge of the Aboriginal group, and to consult members of the group who have expertise the researcher met with an Elder's helper, an Oskapios. This was done prior to meeting with the Elder. Specifically the conversation focused on the work and research, with regard to overall

appropriateness and respect. Further to consulting with experts the researcher also met with an experienced researcher who has completed research with Aboriginal groups to discuss the formation of this research. A meeting with an Aboriginal consultant in the area of mental health and addictions was also held.

## Data Collection

***Interviews***. This is a qualitative research study. Semi-standardized interviews were conducted with an Elder, a psychologist and a psychiatrist. The semistandardized interview was chosen for its flexibility. As stated by Berg the semistandardized interview is somewhere between the extremes of completely standardized and unstandardized interviews (p.95, 2007). The standardized interview schedule may have been suitable for interviewing a psychiatrist; however, it would not be a suitable approach for an Elder. A semistandardized interview allowed room for an Elder to use a narrative or storytelling style. The transmission of history and culture by First Nations people was by the oral tradition of story telling (Hanson & Rucklos Hampton, 2000).

It was important to find a method of interviewing that allowed each participant the opportunity to share their experience in a comfortable yet comparable manner. Participants chose where the interview would be conducted. The interviews lasted 45 minutes to 90 minutes in length.

***Participants***. The participants were selected by a convenience sample of people close at hand who work in the respective areas. At the time the interviews were conducted the researcher worked in mental health and utilized special knowledge of the group of individuals sought. Kirby et al. (2006) refers to this as purposive sampling. Purposive sampling can not be generalized to other populations (Struthers, 2003).

The interviewer was mindful to be respectful to all their experiences and value each given area and knowledge in a similar manner. The author listened respectfully to the participants as they related their experiences and added prompting questions only when needed to draw focus on and highlight their experiences, or when asked for. Two participants were male and one was female. All participants have extensive backgrounds in their respective areas of mental health or traditional healing. The interviews consisted of the following questions:

***Psychiatrist/ Psychologist Interview***

1. Can you tell me how you became a psychiatrist/ psychologist?
2. What guides you in your work as a psychiatrist/ psychologist?
3. Can you tell me about the field of MH in your understanding and experience?
4. What is your understanding of First Nations traditional healing?
5. How do you see First Nations traditional healing complementing existing mental health practices?
6. What has your experience with traditional healing and mental health been?

***Elder Interview***

1. Can you tell me how you became an Elder?
2. What guides you in your work as an Elder?
3. Can you tell me about First Nations traditional healing in your understanding and experience?
4. What is your understanding of Mental Health?
5. How do you see First Nations traditional healing complementing existing mental health practices?
6. What has your experience with traditional healing and mental health been?

***Data Analysis***

During the data analysis and after transcribing each interview I separated each interview and reviewed it selecting themes specific to only that interview. This step allowed me to truly hear and see the essence of each interview on its own, capturing the individual experiences of each participant (Kirby, 2006). In the second analysis I looked at each question across the three interviews and drew out commonalties and differences specific to each question. In a third review I gave consideration to the themes captured in the literature review and cross-referenced some of this back to the interviews. In this forum and length the author felt it was not possible to do an exhaustive comparison of the interviews to the literature, however, some of the correlations are discussed.

The two broad themes to be discussed look at the commonalties and differences across the three interviews. Commonalties included three areas:

- A desire to help people, and
- Being humble, and gifting.

As a First Nations individual I have often heard our people talk about traditional healers as being “gifted”. In discussing the work traditional healers do Struthers (2003) refers to the bestowed gift of healing. The concepts of “gifted” and “gift” are not static and healers and Elders share their gifts with the people and this can be described as “gifting”.

Differences in the interviews were revealed in:

- Practice perspectives and worldview;
- Current issues and existing service provision (barriers); and
- Solutions.

The differences found are not surprising and these differences are well supported in the literature. While the common elements found across the interviews are not unusually profound, the researcher found the similarities to be practical and relevant to this research and work at hand. The interviews were refreshing in bringing focus back to the essential elements of the work we all strive to accomplish.

## Results

The areas discussed in the interviews overlap with the literature and entail many different aspects of mental health and traditional healing. Overall the interviews were very diverse and we must remember that as one participant stated in relation to mental health, "gosh it's a big field." The same assertion holds true for traditional healing. While some aspects of the interviews are discussed herein it was not possible to capture the depth of content of this work, nor was it the intention. The intention was to capture their experiences and look at how traditional healing and healers can complement existing mental health practice.

## Differences

***Practice Perspectives, and Worldviews***. The methods of traditional healers are discussed in the literature as being different from those of western medicine because of dissimilar worldviews related to health and illness (Struthers, 2003). This dissimilarity came out in the interviews and was apparent in several areas beginning from the time each person started to consider becoming an Elder, a Psychologist or a Psychiatrist.

The Elder shared, "the way I became an Elder I was selected by leadership in my community, there were four of us. I was about fifty-eight, fifty-nine years old. They invited us to a band council meeting and I remember the chief saying to us the old, old people are old and we have to understand it is time for them to retire. This way he said we depend on them and we have them running around and around doing things, we are going to do more harm to them, so therefore he said those 75 and over let them take life easy, enjoy life, they don't have to be worrying about anything."

The Elder shared the four people invited that day were all given tobacco, there was a pipe ceremony, a feast and all their families came. The Elder shared they were not forced, and they were asked in a positive way with a lot of honor. After they accepted the tobacco they spent time talking about being Elders, and learning from the old Elders and others for some time. This included a immense amount of learning and training in the areas of spiritual, physical, mental and emotional. The Elder had already worked in the community for a number of years prior to being asked.

The Psychiatrist shared "when I went to medical school I had no idea to become a psychiatrist." The Psychiatrist related the process of medical training, being exposed to different specialties and shared the following,

> *To be honest I hated psychiatry when I was a medical student mostly because I didn't know what they did, the experience I had was not that good, I didn't find it was helpful in how I could help people.*

The Psychiatrist went on to tell more about medical school, and shared that on psychiatry rotation there was a psychiatrist who made an impact about the field of psychiatry. From this new experience an interest developed and the decision was made to become a psychiatrist. The Psychiatrist shared in total it was approximately 12 years of training.

The Psychologist shared a similar path of development via first of all the interest and then subsequent formal university training leading up to a doctorate. It is not surprising that right from the beginning each person in their given area started out in a different way. There are many factors in the interviews that highlight differences. Underlying the differences are the fundamental differences that are discussed in the literature review regarding philosophical approach and guiding principles (Dee Letendre, 2002).

The guiding principle related by the Elder was, "the most important or essential one is prayer, the spiritual part of an Elder." The Psychiatrist shared that the training and schooling guided the work. "Based on medication, medical school, and the literature of what works." The Psychiatrist also shared that the training is medical and that makes it a different outlook. The Psychologist shared that the guiding factor in work is "success working with others" and, "the work is always interesting." A story was also shared regarding the development of a given field in mental health. That field developed from people in the community and then developed to exploration in psychology, development of literature and examination of what works best. The Psychologist was interested in how this area went through transitions of coming to best practice but did not "start in the lab."

***Current Issues and Existing Service Provision (barriers).*** The Elder spoke about children, "traditionally we say when a child is conceived it is a spiritual human being and we treat them that way. In our way we never

talk baby talk to children, we talk to them like this (motioned to indicate how we were talking), show them respect, and when a child grows up they have a greater understanding of it." The Elder discussed current ways of interacting with children, how sometimes parents call children "rugrats" and how this can take on a negative meaning to how the children grow to see themselves.

Related to this the Elder spoke about current mental health practices and labels that occur such as "schizophrenia." The Elder said, "in our traditional way we never label anybody." The reasons were linked via the story of calling a child a rugrat, the formation of identity and self image and the subsequent harm that comes from negative identity development and image.

The Psychologist talked about the formation of mental health and how history changes some of this. In discussion the Psychologist stated, "one hundred years ago and someone had depression, is that different than it is now? I don't think there were some kinds of mental health problems that there are now." In further conversation the Psychologist gave examples such as anxiety disorders or alcohol and drug related issues. This is discussed in the literature via Tait's work with FASD and the current concern that FASD unintentionally gets noted to society as an Aboriginal specific problem. In talking about mental health the Elder discussed how FASD is something that we do to ourselves and there are parts of our mental health that we create.

The Psychiatrist shared the following when considering how to work with traditional healing, " I guess to be honest, the way things work now, say I am working with a client I probably wouldn't go out of my way to say 'there is this person.' I am not sure that would be my role and I don't know people [healers] well enough." The Psychiatrist shared that when patients have sought traditional ways and found them helpful the Psychiatrist is supportive but could neither recommend nor not recommend due to lack of information and resources.

There were two particular instances where the Psychiatrist related there would be aspects for caution. One being when a traditional healer may require a person to ingest a medicine, the Psychiatrist would recommend the person check with a pharmacist to see if it would interact with anything the Psychiatrist is prescribing for ingestion. The second area relates to severe and persistent mental illness. The literature review related that this is an area that is not well documented or studied with First Nations and Métis (Schmidt, 2006). The Psychiatrist shared concern for patients that clearly have a psychotic illness and are delusional or hallucinating and if this is a suitable time for traditional healing approaches. This concern is understandable considering the need for mental health professional to ensure the care of clients. Each profession in mental health has ethics and standards of practice that must be met and these are directed and enforced by professional associations.

This is a special area for further consideration. In traditional healing, people familiar with the work of Neihardt, Black Elk Speaks will have some familiarity with the significance of visions in traditional ways of knowing. The book was originally published in 1932 and shares the experience Neihardt had with Black Elk, a Lakota medicine man. From a current mental health perspective it is important that clinicians become aware of the differences between visions and hallucinations. This is an area that could be of significant importance in individual clinical sessions. In his book *Revenge of the Windigo The Construction of the Mind and Mental Health of North American Aboriginal Peoples*, Waldram discusses this via a culture-general model (2004).

In relation to conveying knowledge about traditional healing the Elder shared "I sit as the Elder, I go to hospitals and speak to managers, I speak to different departments about our traditional ways and sometimes I come out of there feeling they don't care. But I can't blame them because they weren't raised up [this way], you have to believe it in order to practice it and know what it's all about."

***Solutions***. Further in the above discourse the Elder discussed how we currently as First Nations people and Elders, try to bring non-First Nations managers and others to sweat lodge ceremonies as a solution or part of learning about traditional healing. The Elder said, "I don't believe in that, you never force your sacred way on anybody, give them the freedom. They could come but sit on the outside and pray. The ones, the believers, the First Nations, don't say and tell a manager 'oh you have to come into a sweat', that's not the way." The Elder talked about partnerships as a way of working together. The literature also discussed the same aspect of partnerships as a part of the solution to working together (Chaimowitz, Peters & Demerais).

The Psychiatrist spoke about solutions in the way practice is currently set up. He considered how it might work if at Intake at a mental health clinic, the workers added an assessment piece to determine if traditional healing methods could be utilized. The Psychiatrist also discussed a "need to have somebody that has knowledge of both systems, and talking about how it would work." Kirkmayer et al, (2001) also referenced this and referred to such people as "cultural brokers." The Psychiatrist relayed an interest in mental health and traditional healing working together and related it to current practice and collaborating with other professions e.g. social work, psychology and psychiatry.

The Psychologist related that the overall sense currently is "people would like it to be successful. Some areas seem to make more sense to involve traditional

healing and other areas will require more thought and attention." This was similar to the areas discussed by the Psychiatrist. The Psychologist was thoughtful in the course of this discussion and said, "we all try to live together how do we accommodate these different things." The Psychologist gave acknowledgement to understanding the history of First Nations, as related in the literature, and brought this back to the changes in mental health over the past one hundred years, and said, "mental health changes over time and across cultures so at times there are problems and other times not."

In regard to evidence based practices the Psychologist related a program discussed previously that did not, "begin in the lab." The psychologist shared the following, "guidelines of working in clinical work, quite clearly on one hand [are the] experiences of evidence based practice, the other is to understand the client and the context of their lives. How to put those things together, how it works best or why not? Find out what they say in evidence based practice if it is useful then [consider] how this can be applied. Then, humorously, the Psychologist added "According to theory this is supposed to make you feel better and if you aren't better you must not be a good client, you haven't tried hard enough, right?" As discussed in the literature review the point of evidence, efficacy and traditional healing can be controversial (Waldram, 1997, 2004).

The Psychologist responded to the issue of evidence based practice in a clear manner giving voice to the areas that exist when considering how we work with people and what works best. The Psychologist also utilized the element of humor and this is referred to in the literature as an important feature of Native American culture (Dean, 2003). In review the author found it skillful and sensitive of the Psychologist to use humor in this way given that this is a controversial area. It also introduced another element to evidence based practice which acknowledges there are practices proven to be significantly effective, however, they are not 100% successful.

Solutions to the evaluation and efficacy of traditional healing are not in sight, the only suggestion is what was offered from Waldram, in considering evaluation of traditional healing it is important that it be from the healers direction. While it could be stated that the evaluation of traditional healing is an area creating discomfort, it may be necessary to explore it. Chaimowitz cautioned, "to conceptualize aboriginal mental health as an area in which we deliver culturally sensitive service to a disadvantaged population would be simplistic and wrong; the potential for falling into the trap of a more modern version of paternalistic intervention is high" (p. 606). This could be particularly true if mental health services that adhere to offering evidence-based practice also begin to offer some forms of traditional healing.

## Commonalties

***A Desire to Help People.*** Across the three interviews it was found the development of each individual's beginnings in the area of mental health or traditional healing began with a desire to help people. Each person had his or her own way of conveying this information. Their words did not capture the full essence of this, the observations of the author added to the words relayed a strong desire to help people in a sincere and meaningful way.

While this may be a simplistic observation it is very pivotal towards developing long-term partnerships. Obvious differences between mental health and traditional healing exist, with this said the researcher found coming back to the essential formations of the intention and desire to help people was grounding. Part of the work at hand will require that we work towards developing common space and understandings. The author postulates that "the desire to help people" will be the first building block to the work and partnerships.

***Being Humble.*** Within traditional teachings Elders talk about the importance of being humble. In the interview the Elder stated the word "humble" a number of times. The Elder related that "to live a humble way of life is to always walk with forgiveness." Being humble was also discussed as putting away all the negative parts of life, jealousy, and anger, to have pity for everything around and always the spiritual part coming first. This is also discussed as putting others before the self.

During the review of the interviews it became evident that the Psychiatrist and Psychologist also displayed elements of being humble. The Psychiatrist discussed how psychiatry is often seen as the top of mental health, and stated "My piece in mental health is pretty tiny." The Psychiatrist then went on to convey the important role of the other professions and the work that is directly done with families as being either more significant or at least equally significant. The Psychologist showed great care to attention of respect for the two perspectives and always to the care of others as guiding in practice. Further exploration into this might reveal that people who choose to work with people have the underlying characteristics that are complementary to living a humble way of life.

***Gifting***. Kirby (2006) shares that an oral history analysis reviews the words an Elder uses to gift the story. As previously discussed gifting involves the passing on of the gifts a healer or Elder has. In the interviews the Elder gifted the story by sharing traditional teachings. Gifting was also done by using single words with significant meaning, such as "sacred", "prayers", "humble", "grandfathers", "spirits" etc., as well as stories. The Elder shared the teachings of the drum, and sacred words in

Dakota related to mental health. The Elder shared, "nasu, or the brain the old people talk about something called Hamacki, the inner brain inside the brain.., they say that's more powerful than our brain.., 'nasu' means something very spiritual and 'na' it's something like the creation of God and then 'su' is a seed, in our language, so when we put the two together "nasu" to us it means the seed of our being, the whole body, even the feeling the seeing, everything."

The Elder shared teachings that gifted the story and the author also captured elements of the experience of "gifting" from the Psychiatrist and the Psychologist. This is not offered to downplay the significance or the meaning of the gifts shared by the Elder. It is offered as the experience of the author and as such is relayed in the words and added nuances of the experience.

The Psychologist spent one half-hour with the author talking about how to be helpful in this process, the question was directly asked to the author, "What can I do to be most helpful? What do you need to know from me?" This was not asked for or necessary, though it captured the essence behind "gifting." One aspect of the teachings and stories from Elders is to share of the self, and pass on knowledge. The Psychologist displayed a true intention to share experiences, pass on knowledge, to put "self" outside of the experience. In this manner the author felt the same intention and experience of receiving "gifts".

The Psychiatrist gave time for the interview with very short notice, one week. The author relates that within mental health psychiatrists' time is in great demand and there are long wait lists to see psychiatry. Despite the fact that the Psychiatrist gave free time the aspect of feeling rushed, short of time, or distracted by waiting work (a client literally outside the door at one point) was never conveyed. The Psychiatrist showed deep thought in the questions and responses. Genuine interest was also conveyed into aspects of traditional healing and a query into how the Elder had responded to some of the same questions. In this manner the author again related the significance of this genuine giving of time in a similar capacity to the Elder's teachings, a feeling within the author of graciousness and thankfulness for others giving, for the "gifts" of the three participants.

## Discussion

### *The Need to "Know" Each Other*

Across the three interviews each person inadvertently came to highlight the need to know the other perspective in a more meaningful way. In regard to not believing managers in a medical setting were listening, the Elder stated "they were not raised up this way", similarly the Psychiatrist indicated in relation to Elders, "I do not know people [healers] well enough." The Psychologist stated, "mental health changes across time and across cultures so at times there are problems and other times not." For systems to come to work together a facilitated meeting of these people could be foundational to change. Given the opportunity to talk and listen to one another, or to discuss the statement put forward by the Psychologist could facilitate each perspective getting to know each other.

The literature review presented the overall presence of the enquiry into traditional healing and mental health practice. Aside to the enquiry that exists at an academic level are a variety of First Nation and Métis community initiatives' and practices. The real challenge is bringing these together in a meaningful way. The interviews highlight a need to bring together Elders, Psychiatrists, Psychologists and other pertinent mental health professionals to begin a dialogue on working together. There are a variety of ways that this could be accomplished. The researcher suggests beginning with identifying key Elders and mental health professional and starting with a series of directed talking circles, lead by a facilitator or cultural broker who has experience with both mental heath and traditional practices.

To revisit the cautionary note from Chaimowitz regarding aboriginal mental health as a culturally sensitive service, "the potential for falling into the trap of a more modern version of paternalistic intervention is high." It is evident that to avoid further paternalism and oppression every clinician working with an Aboriginal population in mental health must clearly examine what we are doing and what needs to be done. The barrier taking Aboriginal mental health beyond offering culturally sensitive services is the current reality that each perspective does not know one another in a practical and meaningful way.

### *Elder's Interview*

There were several rich aspects of the Elder's interview that could not be related to the experiences of the Psychiatrist or Psychologist. In particular there were significant themes in becoming an Elder. The author refers to this not to dismiss the formal education that the Psychiatrist and Psychologist have experienced, but to develop further understanding of traditional healing perspectives. Because it can not be related to the experiences of the other two it was not included in the analysis. The literature revealed that many mental health issues remain framed in western cultural and political discourse (Chaimowitz).

Most people who review this work will have had the experience of attending university, however, most will not have had the experience of hearing how someone became an Elder and what is involved. While it would be the norm for the author to use segments of the interview and

discuss, the entire dialogue of the Elder will be used. This is done for benefit of the reader and for the words to not be tainted by potential misrepresentation or analysis. It is also done as a method to pass on the gift that the author received.

The Elder shared the following in relation to becoming an Elder:

> *"I was one of the first ones to say okay I accept, being an Elder we were kind of like making like jokes too, I said maybe we were "Elders in training", things like that. But it got down to the serious part of it that we needed to become Elders from that day on I carried on as an Elder. During that time you know I myself personally went through healing ceremonies, traditional prayer ceremonies. I went to the states for a doctoring ceremony and the reason why I did that was the community was so small and you know I didn't feel right going to one of my own medicine men, or healers, so I went to a traditional medicine man in the states. I did go into a ceremony in the ceremony there were many things they told me how I was to was supposed to conduct myself as an Elder today I follow those teachings that I got from the ceremony like that. One of them things I always remember is they told me to walk in a humble way of life I have to get rid of all the negative ways I was carrying, and I was always remember I thought I was good, what negative ways, I didn't realize what they meant by that was the gossip they told me not to repeat what I am hear cause half the time you don't even know if it is true. One of the other things was to live a humble way of life is always to walk with forgiveness, if somebody maligns you or says something to hurt you even if they hurt you so bad and they make you feel angry, you have to be strong enough to say I forgive you and I pray for you, and you know when you do that its true what they say to you or what they do to you it doesn't seem as bad. You're out there with that forgiving part of what comes at you. So that's what I learned from there I had to put away many of my mental and emotional feeling I walk with feelings, sometimes like I say for example jealousy, when someone walks up to you, you kind of get that jealous feeling you push that away, you live like that until you are fifty some year old but when you pray and make that spiritual connections to the grandfathers it helps a lot and today that's the way I, you know try to walk that way of life a humble way of life have pity for everything around and always the spiritual aspect of myself comes first. When I am going to do something I pray the night before and everyday I come here two days a week I do my spiritual prayer and offer to my relatives in the spiritual world, so it makes stronger, do more positive than negative ways. So that's how I became an Elder, it was hard at first but after I went through the ceremony and understanding I have to change my way of life, um it was hard because you know when you are 58, 59 you too you want to, like I was employed at the band office at the time and sometimes you know there was a Christmas party and it was held in a place where there was alcohol and meal you know, but a lot of times I have to sacrifice not to go because I was taught an Elder is to be a role model and .., many thing I do I try in my life I think an Elder should be one who lives according to their own teaching your telling the group not to do these things, yet you're doing it and I found out also an Elder who is not living in a humble way of life or a positive way of life they try to counsel the youth., the child is sick, so when you speak to a child and you yourself are full of all this negative way of life, maybe you're still drinking maybe you're still doing things in a negative way and you try to counsel a youth I have been told it doesn't work. Somehow, some way in our traditional ways .., we're not living a good way of life, so you have to be very careful of that as Elders. I see a lot of that happening today, even doing ceremonies and after its over they're back to the old bad ways, the way they talk, the way they think, you know sometimes I wonder if even their prayers are heard, and to bestow that onto a innocent child I think does a lot of harm to them. So those are things we have to watch for."*

At the end of the Elder interview and off tape the Elder asked the author if the author believed in medicine, and gave a knowing smile. The concept of medicine as related in the literature has a duality (Waldram) and different meanings can be meant by the term "medicine." In simple form Garrett, Garrett and Brotherton (2001) share the following about medicine, "Medicine is in every tree, plant, rock, animal and person. It is the light, the soil, the water, and the wind. Medicine is something that happened ten years ago and still makes you smile when you think about it ... There is medicine in watching a small child play. Medicine is the reassuring smile of an Elder.., And there can be powerful medicine in painful or hurtful experiences as well" (p. 23).

Chaimowitz (2000) posed an interesting question, "are we able to think outside of the traditional views of psychology and psychiatry and look at another perspective?" (p. 605). The interviews would suggest that it is possible to think and look outside of the traditional views of psychology and psychiatry and look at the perspective of traditional healing.

This project highlights that while it is evident that differences in worldview and practice perspective of mental health and traditional healing exist there are also some common elements that the two share. The work completed offers a starting point to develop understandings between mainstream mental health practitioners in the development and inclusion of complementary traditional healing practices. The author presents that while it is important to understand these differences and the causes for the current health and mental health of First Nations and Métis it is perhaps more relevant to bring attention to the commonalties. Only from here can both perspectives come together and make decisions regarding the establishment of long-term partnerships.

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# Intercultural Communications and Conductive Hearing Loss

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## Abstract

Widespread conductive hearing loss among Aboriginal peoples in first world nations has a significant, although largely invisible impact on intercultural communication. Poor acoustics and cultural differences in communication styles compound the effect of widespread hearing loss among Aboriginal peoples. This article considers Australian research that has investigated how conductive hearing loss can impact on intercultural communication in schools and in the criminal justice system, as well as communication processes within Aboriginal families. An understanding of these issues can facilitate the development of innovative interventions that can help address Aboriginal disadvantage, especially within mainstream institutions.

## Introduction

Cultural and linguistic differences are critical factors to consider in intercultural communication. However, the widespread hearing loss that is known to exist in Aboriginal communities can also have a significant and adverse impact on communication, especially intercultural communication. Children who grow up in poverty, who live in crowded housing, and who experience poor nutrition and inadequate health care, are prone to repeated severe episodes of middle ear disease (otitis media). These episodes can often cause conductive hearing loss (Bowd, 2005; Couzos, Metcalf & Murray, 2001).

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In Canada, otitis media is endemic among Inuit, First Nation and Métis children in northern Canada, with prevalence rates as high as 40 times that found in the urban south. Conductive hearing loss among children may affect as many as two-thirds of Aboriginal children in northern Canada (Bowd, 2005). In Australia, as many as 80 per cent of the Aboriginal children in remote communities have some degree of conductive hearing loss (Couzos, Metcalf & Murray, 2001).

## Different types of hearing loss

When thinking about hearing loss people generally think of those who are 'deaf', that is those who have severe to profound levels of permanent hearing loss. However, there are a far greater number of people who have less severe and sometimes fluctuating levels of often unidentified hearing loss. This is especially true amongst children.

People who are pre-lingually deaf (that is, profoundly deaf before developing oral language) are noticeable because of their manner of speech and/or because they rely on sign language and lip reading for communication. In contrast, people with slight, mild and moderate hearing

loss are less noticeable. They use spoken language as their primary means of communication and their ability to listen and hear may be adversely affected in only some situations. Nevertheless, mild to moderate levels of hearing loss can still have significant social, educational and occupational implications.

## Conductive hearing loss, otitis media and 'listening problems'

'Conductive hearing loss' is hearing loss caused by problems that affect the transmission of sound impulses before they enter the inner ear. The term refers to the way sound is transmitted by mechanical conduction through the vibration of the eardrum (tympanic membrane), along the small bones in the middle ear, and then through the pressurised air in the middle ear. Conductive hearing loss among children is most often the result of infection in the middle ear – otitis media.

The infection causes a build up of fluid in the middle ear. The pressure exerted by this fluid can build up to the point where the eardrum bursts, or perforates. The fluid build up and eardrum perforations inhibit the transmission or conduction of sound through the ear. In most developed communities otitis media is a common but short-term childhood illness that is resolved by the time children begin school (Bluestone, 1998). However, in communities where children grow up in overcrowded housing, have poor nutrition and limited access to health care, middle ear disease is more prevalent and more severe (Couzos, Metcalf & Murray, 2001). Children from these communities often experience mild to moderate fluctuating conductive hearing loss during their school years.

Aboriginal Australians, Canadians and Americans (WHO, 1996), and Pacific Island and Maori children in New Zealand (Greville, 2001) have a known higher prevalence of middle ear disease and associated conductive hearing loss than other population groups in those countries. It has been estimated that Aboriginal children in Australia experience middle ear disease and related hearing loss throughout their childhood for an average of two and a half years, while the average for children in the mainstream Australian community is just three months (Couzos, Metcalf & Murray, 2001).

Childhood middle ear disease also contributes to a secondary condition - problems with the processing of auditory information. The persistent partial sensory deprivation that results from the conductive hearing loss associated with middle ear disease can inhibit the development of the neurological abilities needed to process sounds (Hogan & Moore, 2003). This can lead to an ongoing auditory processing problem, which is sometimes referred to as a central auditory processing disorder. While about 10 per cent of people in the general community are affected by auditory processing problems, one Australian study found that 38 per cent of a group of Aboriginal secondary students showed signs of auditory processing problems (Yonovitz & Yonovitz, 2000).

'Listening problems' are especially evident in noisy situations and are related to a combination of conductive hearing loss and auditory processing problems, both of which are caused by past or current middle ear disease. For the sake of descriptive simplicity in this article, this combination of problems is termed 'conductive hearing loss' or 'hearing loss'.

Conductive hearing loss is widespread among Aboriginal adults as well as among Aboriginal children. While intermittent conductive hearing loss is most common among children, many Aboriginal adults have some degree of ongoing conductive hearing loss as a result of significant uncorrected damage to the middle ear caused by repeated infections during childhood. In Canada it is estimated that 44 percent of Inuit, and 39 percent of First Nations adults living in reserves or settlements have hearing loss (Bowd, 2005). For remote Australian communities, studies have found 50 percent of Indigenous tertiary students (Lay, 1990) and 60 per cent of a group of Aboriginal workers have some degree of hearing loss (Howard, 2007a).

In developed Western countries with Aboriginal minorities (Canada, Australia, New Zealand) research in the area has mostly been restricted to studies of the health aspects of ear disease among Aboriginal peoples (Bowd, 2005; Couzos, Metcalf & Murray, 2001). However, in Australia there is also a small body of research on the effect of conductive hearing loss on educational and social outcomes of ear disease among Aboriginal people. This is described in the following sections.

## Intercultural Communications in Classrooms

> *'All of the kids with that ear problem, they're fighting or bullying the other kids [at school].'*
> *(Australian Aboriginal Health Worker)*

In intercultural classroom settings[1] Australian Aboriginal students with conductive hearing loss have been found to participate less than other students in the highly verbal Australian teaching processes. Studies have showed that they contribute little to class discussions and are less likely to answer questions. Often they are also the students who are most disruptive in class (Howard, 2004); and they tend to be less academically successful at school (Yonovitz & Yonovitz, 2000). In part, this is because persistent conductive hearing loss makes it more difficult for the affected Aboriginal children to acquire language skills, especially when learning English as a second or

third language (Jacobs, 1988; Yonovitz & Yonovitz, 2000; Howard, 2007a). However, their classroom and language based learning difficulties are also related to aspects of the classroom environment.

Classroom based research in Australia points to a number of mediating factors that influence the extent to which adverse communication and social outcomes result from conductive hearing loss among Aboriginal children (Howard, 2004; Howard, 2006a). These factors are:

- The cultural context of the classroom;
- The teachers' perceptions of, and responses to the behaviour of Aboriginal children with conductive hearing loss; and
- The levels of background noise in schools.

## Classroom cultural context and hearing loss

In Australia, most Aboriginal children are taught in standard Australian English by a non-Aboriginal teacher. In this setting certain factors appear to compound the difficulties associated with hearing loss for Aboriginal children (Howard, 2006a).

- They face culturally unfamiliar and highly verbal teaching styles that require students to learn from listening to teachers and peers in an artificial classroom environment;
- Their classrooms are often noisy and seldom have adequate acoustics for Aboriginal children with hearing loss.

The standard classroom approach to teaching and learning differs markedly from the traditional styles of education found in many Aboriginal cultures, where learning occurs in small groups or 'one-to-one' and in real life contexts (Harris, 1980; Erickson & Mohatt, 1981). These more informal styles of education have many advantages for children with mild to moderate hearing loss.

- Firstly, real life contexts provide children with multi-sensory learning cues - they can observe tasks as they are demonstrated, so they do not have to rely on mainly spoken explanations;
- Secondly, the levels of background noise in one-to-one or small group instruction in real life settings are often lower than they are in classrooms.

Moreover, it is easier for children to understand someone who is known, speaking a familiar language, and who is able to talk about topics within the context of a familiar cultural framework. These 'familiar' supports for communication and learning become critical when conductive hearing loss reduces the information that is otherwise available from listening.

The evidence from Australia suggests that if Aboriginal students are taught in the language with which they are most familiar, in a wholly Aboriginal class group, by a teacher from the same cultural group, the risk of the adverse communication and social outcomes for the children with conductive hearing loss appears to be minimized (Lowell, 1994; Massie, 1999; Howard 2004). When teachers are from their own culture, children can learn within a framework of cultural and linguistic 'familiarity' that makes it easier for them to understand what is said. 'Familiarity' with the person, language and culture helps children to 'fill in the gaps' that result from diminished auditory input. Without such non-auditory supports and aids to understanding, Aboriginal people with hearing loss (adults as well as children) can find speech difficult to comprehend. When they do this can in turn lead to fear of being 'shamed' - because they have not understood - and the resulting anxiety can compound the difficulties with understanding. The problem becomes a cyclical and negatively reinforcing one, and one that, for Aboriginal children with conductive hearing loss, can limit their ability to learn and to develop essential understandings of culturally unfamiliar 'world views'.

## Conductive Hearing Loss and 'Worldviews'

A shared 'worldview' is important for successful inter-cultural communication. Shared 'worldviews' develop as the result of a series of successful cross-cultural negotiations over time (Lowell et al., 2004). However, people with conductive hearing loss and who come from minority cultures are less likely to be able to successfully participate in the interchanges and negotiations that are needed to arrive at a shared 'worldview' (Howard, 2006b).

Firstly, when people with conductive hearing loss do engage in intercultural communication, they are often unable to do so as successfully as those who can hear well. They may misunderstand what is said. They are often slower to learn concepts. They may distract a group with 'off topic' interjections, or they may just maintain a perplexed silence (Howard, 2006a). Secondly, Aboriginal people with conductive hearing loss often seek to cope with their communication difficulties by avoiding or minimizing their involvement in intercultural communication. In the case of Aboriginal children with conductive hearing loss in Australia, they are absent from school more often than others (NACCHO, 2003). When they are at school they are more likely to try to avoid engagement with their teachers and involvement in many classroom activities (Howard, 1994, 2004).

Many Aboriginal adults with hearing loss employ the same tactics – absence or avoidance.

*"I try to have little to do with white people"*
*(Aboriginal Health Worker with hearing loss).*

By avoiding or minimizing their involvement in intercultural communication, Aboriginal people with hearing loss are dealing with the anxiety they may otherwise experience during intercultural communication, where successful communication depends on levels of auditory/verbal skill they do not have. However, if they are familiar with the people and social processes involved, this can help to minimize their anxiety, notwithstanding any hearing loss. Conversely, communication with unfamiliar people in the context of unfamiliar social processes compounds the communication difficulties that result from hearing loss. For example, school children with hearing loss often have more difficulty when dealing with a temporary teacher (an unfamiliar person) and exhibit more significant behaviour problems when they are participating in school excursions (involves unfamiliar social process).

Over time, their adverse experiences and negative response patterns have a cumulative result. To begin with, they experience basic communication difficulties. They have difficulty hearing-what-is-said, because of their hearing loss. This, in turn, can lead to difficulty with understanding-what-is-heard, because they have not acquired the familiarity with Western 'worldviews' that would help them to understand-what-is-said. The problem compounds first in childhood and then into adulthood; many people with conductive hearing loss seek to avoid or minimize the risks of intercultural communication – anxiety, communicative failure and 'shame'. As a result, those with conductive hearing loss develop less familiarity with Western ways of doing things than do other members of their group.

The effects of this disengagement can be seen in the comment from a teacher when told which of the Aboriginal children in her class had been identified as having conductive hearing loss. She said that she had thought her difficulties in communicating with and relating to these students had arisen because they were "more Aboriginal" than other students. This comment is indicative of the way in which hearing loss can obstruct the development of shared 'worldviews'. It also serves to show how a focus on 'cultural differences,' as an explanation for intercultural communication difficulties, can obscure recognition of the contribution that conductive hearing loss often makes to these difficulties.

## Relationships with Teachers

The way teachers view children's classroom behaviours (which may be related to a hearing loss) and the way teachers respond to these behaviours are mediating factors in the disadvantage experienced by Aboriginal children with conductive hearing loss.

For Aboriginal students, their relationships with their teachers are a key factor in their success at school (Malin, 1990). Some students with conductive hearing loss actively avoid engagement with teachers, misunderstand what is said, fail to complete work, are disruptive in class and tease their peers. The teachers often see these types of classroom behaviour as a function of poor motivation, limited ability or overt defiance. In one study, the Aboriginal students that non-Aboriginal teachers said they had most difficulty relating to were the ones who were found to have conductive hearing loss (Howard, 2006a). However, when teachers know which children have conductive hearing loss and understand how certain classroom responses are shaped by conductive hearing loss, as well as how to communicate better with these students, then the students' engagement in learning as well as their relationships with their teachers improves. At the same time, the amount of antisocial behavior decreases (Howard, 2006a; Hookey, 2007).

## Background noise

Background noise can significantly increase communication difficulties for people with conductive hearing loss. Although people with mild to moderate hearing loss may cope when listening in a quiet environment, they experience difficulties as the background noise level rises (Whitlock & Dodd, 2003; Finitzo-Hieber & Tillman, 1978). School environments are often noisy because of the activity and talk among groups of children congregated in confined and often acoustically poor classrooms (Wilson et al., 2002). In these situations, Aboriginal children with conductive hearing loss experience learning difficulties and display lower levels of achievement (Yonovitz & Yonovitz, 2000; Howard, 2004) as well as poor social and emotional outcomes and higher levels of antisocial behaviour (Zubrick et al, 2004; Howard, 2004).

Thus, the evidence from research in schools, from an Australian perspective, serves to confirm that the consequences of schooling for Aboriginal children with conductive hearing loss are significantly mediated by cultural context, non-Aboriginal teachers' perceptions of and responses to student behaviour, and noise levels in classrooms. These factors interact synergistically with conductive hearing loss to determine the level of disadvantage that can be associated with conductive hearing loss. The same factors also influence outcomes when Aboriginal people become involved with the criminal justice system.

## The criminal justice system

In Australia and New Zealand, there is evidence that a higher proportion of Aboriginal prison inmates have

some degree of hearing loss when compared with the general incidence of conductive hearing loss in the total Aboriginal population (Bowers, 1986; Murray & La Page, 2004). This suggests that:

> *Involvement in the criminal justice system may be the end product of a cumulative link, whereby hearing-related social problems contribute to low educational standards, unemployment, alcohol and substance abuse, these being the more obvious antecedents of contact with the criminal justice system (Howard et al., 1991, p 9).*

And here, as in schools, difficulties with intercultural communication processes, the perceptions and responses of non-Aboriginal staff and background noise levels, in combination with conductive hearing loss, can and do lead to significant communication problems.

Linguistic and cultural differences are frequently presumed to be the reason why an Aboriginal witness may misinterpret a question, give an inexplicable answer, remain silent in response to a question or ask for a question to be repeated. The potential contribution of conductive hearing loss to a break down of communication is generally not considered. However, it is probable that the distinctive demeanor of many Australian Aboriginal people in court is related to their hearing loss. Where this is the case there is a very real danger that the court-room demeanour of Aboriginal people (not answering questions, avoiding eye contact, turning away from people who try to communicate with them) may be being interpreted as indicative of guilt, defiance or contempt (Howard, 2006c).

Court processes are largely an artifact of 'Western' culture. The social processes are structured and highly formal and the language used is often obscure, even to native English speakers. Yet Aboriginal people can be disadvantaged if they do not participate fully in court processes that involve archaic examples of 'Western' social etiquette and a specialized English vocabulary. An anthropologist made the following comment after observing Aboriginal defendants in court proceedings:

> *(The) most frequent response is to withdraw from the situation, mentally, emotionally and visually. One magistrate in a country town complained to me that "Aborigines in the dock are always gazing out of the window, or looking down and either ignoring questions or mumbling inaudible answers"(Howard et al., 1991, p 10).*

Also, as is the case between a student and his/her teacher, conductive hearing loss can jeopardise the building of rapport and quality communication between a client and his/her legal counsel. Yet a good relationship between them is critical to effective representation within the criminal justice system.

> *One Aboriginal man with hearing loss related that, years earlier, feeling confused and embarrassed about his hearing-related communication difficulties, he pleaded guilty to a charge of which he believed he was innocent. He thought it would be easier to plead guilty than to try to explain (through his lawyer) his innocence in court. He subsequently spent six months in prison (Howard et al., 1991, p 11).*

The following anecdotes are indicative of ways in which communication elsewhere in the criminal justice system can also be adversely affected by conductive hearing loss, with perverse consequences.

> *A defendant with hearing loss was crash tackled when being transported from court when he did not obey a verbal order to stop, that he did not hear.*
>
> *After sentencing, a defendant with hearing loss was placed in an unfamiliar room to be told what his sentence meant. His usual lawyer was not available because of other commitments, so another unfamiliar lawyer tried to explain the sentence. However, the man became wild and 'trashed' the room when the new lawyer tried to explain the court outcome. He only calmed down when familiar staff from the detention centre arrived.*
>
> *A long term feud developed between a hearing impaired prisoner and another prisoner after a hearing related misunderstanding during a game of cricket in prison (Howard, 2006c, p 9).*

In the criminal justice system, background noise also plays an important role in communication problems for people with conductive hearing loss. A group of prison staff linked the places and times when it was noisiest with the incidence of most arguments between inmates. They also noted that the number of fights reduced when the public phones used by inmates were enclosed to better sound proof them, because people using the phones experienced less frustration as a result of noise intrusion (Personal communication, 2006).

There is also evidence that hearing loss can inhibit not only intercultural communication but also communication between Aboriginal people.

## Family life

Research into the influence of conductive hearing loss within families indicates that conductive hearing loss can have an impact on communication between people from the same cultural background. One small qualitative study (Howard & Hampton, 2006) supports the view that conductive hearing loss can have a negative effect on family life.

> *Half the kids get floggings [beatings] because they [the family] think they're [the children] ignoring them. I see parents giving kids with hearing loss a flogging when they [the children] have not understood - I see that all the time, everywhere.'*
>
> *They are cheeky…you see a kid [who has middle ear disease] throwing rocks at Mum and swearing and demanding something, and usually most times they will give it to them to shut them up (Aboriginal Health Workers -Howard & Hampton, 2006, p2).*

There is also evidence of the adverse effects that a child with conductive hearing loss can have on other family members.

> *I felt depressed and frustrated because I didn't know what was going on. I was blaming myself. I thought it was my fault and I was a bad mother. I felt like I was letting her down. I was trying to figure out what to do. The behaviour problem came at school. They never suggested anything and it was depressing not knowing what to do… but it was getting me down and it was the stress levels. I was growling her and yelling. I was pushing her away because I didn't know how to deal with it. It made us grow apart. I did not want to be around her. I didn't want to deal with it. I didn't know how to deal with it. It really stresses me. Other people [people in the family] scatter coz I am going off my head yelling at her (Mother of child with conductive hearing loss - Howard & Hampton, 2006, p3).*

In homes, just as in schools, antisocial behavior associated with conductive hearing loss can be mediated by background noise. Disputes and arguments involving people with hearing loss typically arise in noisy social gatherings, especially when alcohol is involved. Sometimes other family members experience frustration and anger because of their family member's hearing related communication difficulties. The following short case studies describe how this can happen and how dire the consequences can be for a family.

> *One woman with hearing loss accused her husband of 'mumbling' when she could not understand him at a time when there was lots of noise at home because of many visitors staying. She got angry with him and threw something at him, he responded by hitting her, which led to his arrest and jail (Howard, 2007b, p1).*
>
> *A young husband with hearing loss described how the birth of a new baby made it harder for him to hear. Communication demands on him were greater because his wife wanted more support from him to look after their new baby, but she got angry when he had trouble understanding her above the baby's crying.*
>
> *On one occasion he had to go to hospital after she became angry and hit him. She had asked him to get something from the shop but he had misunderstood what she said and bought the wrong thing with the last of their money (Howard, 2007b, p1).*

There is also some evidence, from studies of non-Aboriginal children, that conductive hearing loss can influence family life in other important ways. Children with conductive hearing loss may instigate familial interactions less often than children who can hear well, and may also be less responsive to their parents (Roberts, Burchinal & Clarke-Klein, 1995). This results in a diminished quantity and quality of social interaction between affected children and caregivers (Hoff-Ginsberg, 1990; Vibbert & Bornstein, 1989). Mothers with a child who had experienced chronic middle ear disease were more likely to be depressed and to feel that they were less adequate as parents than other mothers (Forgays, Hasazi & Wasserman, 1992). Some non-Aboriginal Australian mothers also reported that they found it more difficult to feel close to a child with conductive hearing loss (Dorothy Moore, personal communication, 1992).

Other studies among non-Aboriginal children have been less supportive of the long-term effects of early conductive hearing loss (Bowd, 2005). However, it should be remembered that these studies were carried out in non-Aboriginal communities where less severe middle ear disease affects far fewer children, and fewer adults have permanent hearing problems. These non-Aboriginal communities also face far fewer other types of social disadvantage than is often the case in Aboriginal communities, and they do not face the challenges involved in being a cultural minority. As a result, the adverse consequences of conductive hearing loss are likely to be more muted than they are in Aboriginal communities (Nienhuys, 1992; Howard, 2006b). This means research outcomes involving non-Aboriginal groups should not be used as a basis for policy and practices applied in Aboriginal communities.

## The Implications for Welfare Agencies

There has been no formal research into hearing loss among Aboriginal welfare clients. This is despite there being both disproportionate numbers of Aboriginal people who have hearing loss (Bowd, 2005, Couzos, Metcalf, & Murray, 2001) as well as an over representation of Aboriginal people involved with welfare services (Wien et al, 2007, Trewin & Madden, 2005). There are also clear links between hearing loss and issues associated with involvement with welfare services. We have seen earlier how widespread hearing loss can influence Aboriginal family life (Howard & Hampton, 2006). There are also

indications that Australian Aboriginal children with a history of ear disease are more likely to be involved in substance abuse (Lowell, 1994). We know too that non Aboriginal children with hearing loss are more likely to experience sexual abuse than non Aboriginal children (Sullivan, Brookhouser, & Scanlan, 2000).

Informed speculation would suggest that many, if not most, of Aboriginal welfare clients in Australia, Canada and New Zealand have some degree of hearing loss as a consequence of endemic childhood ear disease. As outlined earlier most of the Australian Aboriginal children who have behaviour problems at school have hearing loss, as do the majority Aboriginal adults who become prison inmates in Australia. Many of these children and adults will be involved with welfare agencies at some point.

Widespread Aboriginal hearing loss has a number of practical implications for welfare agencies. These include the importance of determining if Aboriginal clients have hearing loss, plus ensuring caseworkers and, as much as is possible, family, carers and educators know and use effective communication strategies with welfare clients who have hearing loss. These clients also need to have access to health services to treat any active ear disease or have surgery to repair damage to ear drums, if this is needed. Further, formal research of this significant issue among Aboriginal welfare clients is urgently needed

These matters are not easily addressed as the information and/or infrastructure needed to do so is mostly not readily available. For example, Aboriginal children on reserves in Canada and in remote communities in Australia have the worst ear health in their respective nations, as well as very limited access to health services. A Canadian reviewer of this article pointed out that many children living on reserves can only access adequate ear health services when they are taken into care (Shangreaux and Blackstock, 2004). Nevertheless, the awareness that conductive hearing loss has important communication and social outcomes for many Aboriginal people who are involved with welfare agencies is an important first step on what will be a long journey.

## Discussion

Drawing on research carried out in Australia, this article has outlined the significance of conductive hearing loss in both intercultural and also potentially in same-culture communication. Attempts to address the health aspects of middle ear disease in Australia over the last thirty years have had limited success (Bowd, 2005; Morris et al., 2007). In isolation, however, and without consideration of the social and educational consequences of conductive hearing loss for Aboriginal children and adults, such health initiatives are likely to have a limited effect on the cycle of poverty and the way it can unfold for Aboriginal people affected by conductive hearing loss and its consequences; poverty contributes to a higher incidence of middle ear disease among children, which results in conductive hearing loss, which leads on to poor social, educational and employment outcomes, which perpetuate poverty.

Middle ear disease is an important health issue, but there is also a need for a greater focus on the communicative and social consequences of Aboriginal hearing loss. It is a problem whose impact is seldom fully appreciated or addressed.

Widespread Aboriginal hearing loss acts as a direct barrier to communication. It also contributes indirectly to the linguistic and cultural barriers that constrain intercultural communication. These barriers can have a negative impact on social and emotional wellbeing, educational opportunity and access to almost all services where access depends on effective communication. Many of the problems that arise are not caused solely as a result of conductive hearing loss. They arise because communication is impeded by the interaction of noisy environments and culturally unfamiliar communication processes with widespread hearing loss. From what we presently know, to successfully overcome these barriers, three things are important; knowing which people do have conductive hearing loss, improving environmental acoustics by limiting background noise levels, and adopting more effective communication processes, including culturally based communication strategies.

## What does this mean in practical terms?

1. Access to audiological services for hearing tests is often problematic, especially in remote areas, but ‘easy-to-use’ hearing screening strategies can help to identify probable hearing loss (Howard, 1993).
2. There are a number of ways to acoustically improve an environment. In schools sound field amplification where the teachers voice is amplified to the whole class is beneficial as is adapting buildings to prevent noise intrusion and limit reverberation (echo) in rooms (Wilson et al., 2002). One inexpensive intervention is simply to minimize background noise levels during communication. All too often, non-Aboriginal professionals with good hearing decide whether or not an acoustic environment is adequate for communication with Aboriginal people who have conductive hearing loss that the professional does not know or think about. Communication outcomes can be significantly improved if people are aware that they may be talking with people who quite possibly have conductive hearing loss, and if they take steps to

minimise background noise levels (Howard, 2006a).

3. Communication problems that arise because of unfamiliar cultural communication strategies and differing 'world views' can be addressed through the involvement of Aboriginal staff in service provision and as communication brokers, as well as training all staff[2] in effective communication strategies for people with hearing loss (Howard, 2007a). These strategies include using visual cues during verbal explanations, selectively using amplification devices, spending more time on 'communication' and being careful not to make inappropriate judgments about capacity or motivation on the basis of people's communication difficulties (see www.eartroubles.com for more information).

This is not to suggest that we already know enough about these issues to be certain about how best to address them. There is a need for more research into the consequences of widespread conductive hearing loss among Aboriginal people - children and adults, and ways of addressing this problem. In the field of education, there have been a few in depth studies. In the criminal justice and the welfare sectors, as well as in other contexts, there is much more work to be done. Without a fuller understanding of the long term and 'life cycle' consequences of conductive hearing loss, in interaction with other environmental and cultural factors, it will be difficult to fully assess and effectively address the problems arising from childhood middle ear disease. Nevertheless, the results of the work in Australia do point to steps that can be taken now to minimize some of the consequences of conductive hearing loss for individuals, their families and their communities.

There is a parallel in the disadvantage faced by the Aboriginal peoples of Canada, Australia, New Zealand, because of the role that conductive hearing loss plays in the perpetuation of the cycle of poverty that affects Aboriginal minorities in first world nations. Further, it has been estimated that a third of the populations in developing countries experience hearing loss because of childhood ear disease that is related to poverty (Berman, 1995). This means there are at least a billion people world wide who can be assisted by a better understanding of these issues.

## Endnotes

1. Classes of Aboriginal students taught by a non-Aboriginal teacher who speaks standard Australian English.

2. While Aboriginal people can often communicate effectively with Aboriginal people with hearing loss, they are often unaware of their own or others' hearing loss. When they become aware of these issues they can use their communication skills even more effectively.

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# The Informal Caregivers of Aboriginal Seniors: Perspectives and Issues

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## Abstract

Over 1 million Canadians aged 45-64 provide care to seniors with disabilities or physical limitations, and 70% are also employed – many full-time. Yet often policy assumes that all communities face the same eldercare challenges despite regional and cultural distinctions. This paper highlights what little is known about Aboriginal informal eldercare providers. Trends in health, employment and migration continue to raise concerns about the availability of caregivers, particularly in isolated communities. Difficulties accessing services increases the burdens of caregivers both locally and at a distance. More information about the context of Aboriginal eldercare is sorely needed.

## Introduction

It has been well documented that Canada's population is aging. Propelled by low fertility rates and longer life expectancy, the number of seniors aged 65 and older has increased by 68% over the last two decades (Turcotte & Schellenberg, 2007). In a medium-growth scenario it is estimated that by 2056 seniors will represent over 27% of the total population (Statistics Canada, 2006). While government policy has begun to address some of the issues that older people and their families are facing with respect to policy shifts in healthcare, the economy and social support, the challenges associated with receiving and providing unpaid family care continues to be a concern.

Some 1.7 million Canadians aged 45-64 provide care to an elderly person with long-term disabilities or physical limitations, and 7 out of 10 of these caregivers are also employed – most of them full-time (Stobert & Cranswick, 2004; Habtu & Popovic, 2006; Lero & Joseph, 2007). This is the current scope of the policy challenge and it is growing. Yet Keefe (1997) and others emphasize that national policies that are based upon the assumption that all communities face the same caregiving challenges fail

to recognize important regional economic, social and cultural distinctions (Bedard, 2004; Sutherns, 2004). Inuit, Metis and First Nations seniors and their family caregivers know this all too well.

The fact that all Indigenous communities are not the same but are diverse in geography, language and social structure is important to emphasize. There are more than 50 individual languages belonging to 11 Aboriginal language families in Canada, reflecting a rich tapestry of distinctive history, culture, family and community identity, land and traditional knowledge (Norris, 2007). Therefore it is easy to see how the needs and solutions to problems may differ significantly between groups. Yet, this fact is often overlooked in policy development (Loppie, 2007).

Taken together, the three distinct groups of First Nations, Inuit and Metis make up approximately 1.3 million people (Statistics Canada, 2005b). Although Aboriginal populations tend to be younger than those in non-Aboriginal communities, there are nearly 40,000 Canadian Aboriginal people 65 years and older (Turcotte & Schellenberg, 2007). The number of these seniors is expected to rise significantly by 2017, although it is predicted that each group (Inuit, Metis and First Nations) will experience different rates of growth (Statistics Canada, 2005b; Turcotte & Schellenberg, 2007). This means that like non-Aboriginal people, the number of seniors in the Aboriginal population will represent a much higher percentage of their total population in less than 20 years (Lemchuck-Favel & Jock, 2004).

For Aboriginal Canadians in general, and particularly for those who provide care to family members, housing shortages, high rates of unemployment and lack of access to health services are factors that affect both life expectancy and quality of life (Lafontaine, 2006). Given the distinctive cultural, linguistic, socio-economic and demographic characteristics of Canadian Aboriginal peoples then, it is not only likely that some aspects of the experience of aging in these communities will be unique compared to that of the non-Aboriginal majority, but also that the experience of being a family care provider to an Aboriginal senior will also be equally unique.

This paper brings together what little is known about family caregivers of Aboriginal seniors as a spark for discussions around aging, services and policy reform. While a few studies have explored issues associated with caring for seniors, and have included elderly Aboriginal Canadians with other seniors in their samples, very few studies have focused exclusively on the topic of caregivers and seniors in Aboriginal cultures. Building on a review of what is known about the context of Aboriginal seniors, this paper's main focus is on what is known about those who provide care to Aboriginal seniors. Teasing out what is buried within multi-cultural studies and re-framing this knowledge within a focused discussion on the caregivers of Aboriginal seniors provides practitioners with a more easily accessible resource upon which to build a case for change. Moreover, and importantly, it also assists in illuminating what is not yet known – exposing those gaps in understanding that if explored further might assist in the development of more appropriate policy interventions. In short, the paper addresses the following questions:

1. What is the context within which Aboriginal families provide care to seniors?
2. What are some of the challenges that caregivers of seniors in Aboriginal communities face?
3. What aspects of their experiences and needs are yet to be explored?

## Setting the Stage – The Context of Aging in Aboriginal Communities

A discussion about the issues that impact upon family caregivers of Aboriginal seniors is incomplete without first considering the context of their care recipients. This is important because the health of the aging population, access that seniors have to services and supports, the information available to them and the resources that they choose to use or reject – and why - directly impacts upon the type, level and amount of care that seniors will need from their families and/or friends.

For most non-Aboriginal Canadians, the meaning of the word 'elder' and 'senior' is interchangeable and is defined by the dictionary as being "a person of advanced years" (Merriam-Webster, 2006). However, to be called an "Elder" in an Aboriginal community means much more than this. In many Aboriginal communities, age is not defined by chronology (Kramer, 1991). In fact, the concept of date-specific birthdays and life stage celebrations were only introduced there fairly recently in historical terms (Kramer, 1991). Not all elderly Aboriginal people are "Elders" and, in fact, not all "Elders" are elderly (Dumont-Smith, 2002). Nevertheless, it is important to emphasize the high esteem with which seniors are traditionally held in Aboriginal communities. It is particularly interesting to note that U.S. studies show that the role of elders in American Indian communities is possibly equated with lower incidences of self-destructive behaviours including alcoholism and suicide - which are not uncommon among some younger Aboriginal populations (Kramer, 1991).

Of the over 40,000 Aboriginal seniors in Canada, Ontario has the highest number of any province or territory (Statistics Canada, 2003). However, Manitoba and Saskatchewan have the largest proportion of

Aboriginal seniors in their senior populations (Turcotte & Schellenberg, 2007). Fifty-three percent of Canadian First Nation seniors lived on reserves in 2001, and of those that did not live on a reserve, most lived in rural as opposed to urban areas. In the far north, three-quarters of Inuit seniors live off reserve in largely isolated areas (Turcotte & Schellenberg, 2007).

As is the case for the non-Aboriginal population, the Aboriginal senior population is disproportionately female (54%) compared to their male counterparts (46%). A notable exception is the Inuit population, where senior men outnumber women due to higher maternal mortality rates for this cohort (55% men and 45% women) (Turcotte & Schellenberg, 2007). However, despite the fact that, in general, women live longer than men in most societies worldwide, the survival rate of Aboriginal women over 65 is significantly lower than the national average. In fact, Aboriginal women, who live on average to 76.6 years, have a life expectancy not only significantly lower than that of non-Aboriginal women (81 years) but even lower than that of non-Aboriginal men (77.2 years) (Health Canada, 2006; Statistics Canada, 2005a).

Chronic and longer term illnesses such as type II diabetes, HIV/AIDS, cardiovascular disease and arthritis are much more prevalent among the Aboriginal population (Indian and Northern Affairs Canada, 2007; Kuran, 2002). Furthermore, researchers speculate that chronic diseases in this population are often under-reported (Turcotte & Schellenberg, 2007). Not only are these debilitating health problems more common for Aboriginal seniors as well, but they also tend to develop them at a much earlier age. A study of Aboriginal health revealed that one-third of First Nations and Labrador Inuit over 55 years of age had hearing problems, one-quarter had physical limitations that restricted them within their home, and one-eighth were unable to leave their residence and needed personal care in their home (Dumont-Smith, 2002; Curtis, 2007). Thus, a shorter life expectancy has led some to consider Aboriginal people to be "seniors" when they reach the age of 55, much younger than the comparable age of 65 for non-Aboriginal seniors (Dumont-Smith, 2002; O'Donnell, Almey, Lindsay, Fournier-Savard, Mihorean, Charmant, Taylor-Butts, Johnson, Pottie-Bunge & Aston, 2005). In fact, many Canadian Aboriginal people do not live long enough to qualify for "senior" services – which suggests that, among other things, the eligibility criteria for seniors' programs needs to be re-evaluated (Kramer, 1991).

Researchers estimate that the poorer health status of Aboriginal seniors, coupled with the predicted growth in their numbers in the next few years, will have a disproportionate impact on the Canadian health system. Not only does this leave many Aboriginal seniors at risk of ill health, but the downloading of responsibility for care to families without the resources to support them also puts Aboriginal seniors at an increased risk for elder abuse (Lemchuk-Favel & Jock, 2004; Dumont-Smith, 2002). Since many of the chronic illnesses that are prevalent in Aboriginal communities are tied to poverty and isolation, it has been speculated that improving the socio-economic conditions of Aboriginal peoples might also improve their senior mortality rates. Cass (2004 in Curtis, 2007) points out that it is important to consider health disparities of First Nation peoples through a broader view of the social determinants of health in order to understand why the difference between Aboriginal and non-Aboriginal health often disappears once socio-economic status is accounted for.

The challenges that rural seniors in general face for access to services has been well documented. Keefe, Fancey, Keating Frederick, Eales and Dobbs (2004) note that in rural communities, and particularly communities with low density populations such as those in the far north where many Aboriginal seniors reside, economies of scale make it difficult to provide services like home care, nursing homes and acute care because those who need them are often spread out over a wide geographic area. Rural areas have proportionately fewer health care professionals, and services. Not only are distances to medical centres significant in some rural areas, but distances to grocery and drug stores, banks, post offices etc. may also be considerable. This impacts upon the ability of seniors to remain living independently. There are few places where Inuit seniors can access a doctor, and when they remain in their communities their families' resources are often stretched, particularly when they must leave isolated communities in order to obtain care.

Few First Nation and Inuit communities have long-term care facilities, which means that seniors who need nursing home care may need to move great distances away from family and friends (Lafontaine, 2006). Jock (as cited in Special Senate Committee on Aging, 2007) notes that there is only one nursing home bed for every 99 individuals in First Nations communities compared to one for every 22 individuals in the general population. Moreover, nursing homes for Aboriginal seniors are mainly located in Ontario and Manitoba, leaving seniors outside of those provinces without access. A better understanding of Aboriginal family care networks and comparisons of Aboriginal seniors who live in urban compared to rural and remote environments would certainly shed light on many of these issues.

Considering what has been noted above, it is perhaps no surprise that income levels among the Aboriginal population are significantly lower than for the non-Aboriginal population, making it difficult both for seniors to live independently and for seniors and their caregivers

to have the resources needed to gain access to privately purchased care (Buchignani & Armstrong-Esther, 1999; Status of Women Canada, 2005). Aboriginal elderly are nearly twice as likely to be living with extended family members compared to non-Aboriginal seniors (Dumont-Smith, 2002), yet this could be more of an economic rather than a cultural issue per se. Some older Aboriginal people, particularly older women, have never engaged in the workforce and therefore do not have even basic CPP coverage. This significantly restricts the number of options available for housing, medical and social support, and puts a heavy financial burden on family caregivers (Special Senate Committee on Aging, 2007). U.S. research on American Indians shows that families with seniors in residence have three times the proportion of their population living in poverty compared to that of non-Aboriginal families (Kramer, 1991).

While Health Canada (1998) notes that, in general, a majority of Canadian seniors and their families feel uninformed about existing programs and services that may be available to them, given the significant diversity of languages, and the fact that over 12% of Aboriginal seniors speak neither English or French, information about programs and services is hard to communicate easily (Health Canada, 1998; Norris, 2007; Canadian Council on Learning, 2007). In isolated Aboriginal communities few people receive newspapers or magazines, and radio/television programs are only informative if they are broadcast in a language that can be understood (Health Canada 1998). Instead, seniors in these communities tend to depend upon a wide network of family and friends from whom they can obtain information or call for assistance.

## Family Caregivers of Aboriginal Seniors

### *a) Issues Associated with Gender and Work*

In most non-Aboriginal Canadian cultures, the care of the elderly often falls to the women in families. Census information tells us that Canadian caregivers in general are predominantly middle-aged women, who are employed full time, and who tend to be caring for more than one person - typically a parent (Fast & Keating, 2001) in addition to their own children. Gender roles in Aboriginal households generally mirror those of the non-Aboriginal population and women are primarily responsible for housework, childcare, meal preparation, 'emotional work' and most of the care of older people (Buchignani & Armstrong-Esther, 1999). A strong sense of family obligation is considered to be an integral part of Aboriginal culture, and women are expected to be the primary caregivers (Buchignani & Armstrong-Esther 1999; Levesque, Trudeau, Bacon, Montpetit, Cheezo, Lamontagne & Sioui Wawanoloath, 2001). Studies of Metis women have found that their concept of health and wellness is often defined by their ability to care for family members (Bartlett, 2005).

Although Aboriginal women are expected to play a prominent role in family caregiving, unlike their non-Aboriginal counterparts there appears to be little gender-specific difference in the percentages of those who report that they provide care to seniors. Approximately 24% of Aboriginal women and 20% of Aboriginal men reported spending time caring for seniors in 2001 (Hull, 2006). The same holds true for providing intense caregiving, with 49% of Aboriginal men reporting that they provide more than 5 hours of care to seniors per week (considered high intensity) compared to 52% of Aboriginal women who report spending the same amount of time doing so (Hull, 2006).

Inuit women and Registered First Nation women on reserves are more likely than other Aboriginal groups to be caring for seniors, even though 72% of all Aboriginal women spend less than 10 hours per week caring for seniors (Hull, 2006). With a predominantly younger population and more children on average than their non-Aboriginal counterparts, 54% of Aboriginal women also spend 30 hours or more per week caring for their children – which presumably impacts upon the time left for engaging in care for seniors (Hull, 2006). Given greater gender-specific differences in the type and intensity of care activities that are reported by the general population, more research on the gendered nature of care in Aboriginal families may help to tease out new and important insights on these differences.

Nevertheless, if Aboriginal women are expected to play a pivotal role in caring for the elderly, it is important to highlight a number of emerging trends and their implications in this regard. First, over half of Aboriginal women live off-reserve, in contrast to the higher proportion of Aboriginal seniors who live on-reserve. Second, Aboriginal women, including middle-aged women who are more likely to be providing care to seniors, have high migration rates, as seen between 1996 and 2001 when 36% of Aboriginal women between the ages of 45 to 64 changed residence (O'Donnell et al., 2005). This means that a significant number of Aboriginal women may need to provide care to elderly family members from a distance. Yet very little is known about how Aboriginal caregivers provide and manage care to seniors when they live far away.

Third, as Leipert & Reutter (2005) note, the political environment of the Canadian north, where many Aboriginal communities can be found, is characterized by the undervaluing of both the region and of women themselves. As services decline in rural communities, the downloading of responsibilities for care of seniors

from government to family members becomes more and more necessary, exploiting women in their role as care provider. Family caregivers are asked to undertake health care procedures that they are not necessarily qualified to perform (Joseph, Leach & Turner, 2007). They become "sandwiched" by the sometimes competing demands of childcare and senior care. When Aboriginal caregivers are torn between their responsibilities for childcare and senior care, or torn between their responsibilities for work and family, life can become complicated and stressful. When caregivers must take time away from work in order to assist or care for seniors locally or at a distance, this can translate into higher levels of absenteeism which may lead to greater strains on employment and general caregiver well-being. Employment-related costs such as absenteeism, reduced hours, work-family conflict, having to quit work or turn down opportunities are evident in various studies of caregivers (Lero, Keating, Fast, Joseph & Cook, 2007), but few studies have explored the impact of these factors on the employed Aboriginal caregiver.

Although the unemployment rate of Aboriginal women is much higher than their non-Aboriginal counterparts, it is important to note that 50% of Aboriginal women aged 45 to 64 were in the labour force in 2001 (O'Donnell et al., 2005). The employment rate for Canadian women in general, and middle-aged women in particular, increased significantly over the past two decades, up from 44% in 1985 to 64% in 2005 for women aged 45 to 64 (Pyper, 2006). This may present employed Aboriginal and non-Aboriginal women caregivers with similar challenges. For example, approximately sixty-percent of Aboriginal women are employed in low-paying occupations in either sales, services, business, finance or administration (O'Donnell et al., 2005; Luffman & Sussman, 2007). For Aboriginal and non-Aboriginal women who are employed in these occupations, few of these low-paying jobs would be likely to offer the flexibility for employees to arrange for care services during normal working hours, or to respond to care crises which are often unpredictable (Lero & Joseph, 2007).

The fact that Aboriginal people tend to have lower incomes only exacerbates the problems that care providers in general report about the significant layout of financial resources associated with caring for seniors (Fast, Eales & Keating, 2001). For all employed caregivers, but particularly for those who are forced to cut back working hours in order to provide care to family members, take lengthy unpaid leave, or find they have to leave the workforce to meet caregiving needs, it is well documented that the economic costs of caregiving can be significant, including the impact on caregiver pensions, benefits and economic independence that is not only short term but long term as well (Lero & Joseph, 2007). It can also affect the opportunities for younger generations when resources for education must be diverted or sacrificed for caregiving. Yet these are circumstances that are often overlooked in policy development.

While caregivers who are proximate to their senior care recipients may be in a better position to engage in care management or to provide face-to-face care during lunch breaks or after work if needed, those who live in another city or in another time zone are at a significant disadvantage. In fact, the type of workplace that a caregiver works in, and the job she/he does, can cause significant problems for arranging long distance care by telephone. Employees who are tied to a desk with internet and a telephone may be more fortunate, while those working in retail, restaurants, services or on assembly lines are the least fortunate because they do not have access to communication resources, or flexible time during working hours to connect with agencies or other support people (Joseph, Leach & Turner, 2007).

In addition to needing flexibility to access formal support mechanisms to assist them and their senior care recipients, Aboriginal care providers may also need ceremonial or spiritual support as well (Leipert & Reutter, 2005). Yet for employed care providers these circumstances are not often foreseeable. The unpredictability of the course of illnesses that are more prevalent among Aboriginal seniors, and the length of the dying process, makes it difficult to plan for and to pace the management and hands-on provision of care to seniors (National Aboriginal Health Organization, 2002). Moreover, the fact that Aboriginal people are at higher risk for chronic illness has important implications not only for the care recipient, but also for care providers who may find themselves caring for a senior who has a chronic illness while suffering with the same chronic condition themselves.

Considering these points together, Aboriginal seniors may be facing a declining pool of family caregivers as the people most likely to provide care to them are increasingly facing their own health issues, leaving reserves and/or engaging in the workforce. Researchers note that existing studies on Aboriginal health have failed to adequately focus on the unique health needs of women (Young, 2003). How Aboriginal women and men provide care to seniors from a distance, or how they face the significant challenges associated with balancing the demands of work with the needs of family are important topics that need to be explored further.

***b) The Impact of Isolation***

Isolation is another factor in the lives of Aboriginal caregivers, including that at the individual and community levels. Individual isolation refers to the isolation that an individual experiences when seeking help, as in the

case where cultural expectations and mores collide. For example, non-verbal communication such as personal space, or proxemics as it is called, is culturally defined (LeBaron, 2003). Aboriginal people tend not to use direct physical or eye contact when speaking to another person and it is often considered to be a sign of disrespect to look at someone directly. Unfortunately, this conflicts with the dominant Western cultural view that considers people who do not make eye contact as being rude or untrustworthy (Kramer, 1991). Many Aboriginal people find non-Aboriginal Canadians to be intolerably rude, overly forthright and loud (Kramer, 1991). Such cultural factors could pose a problem when Aboriginal seniors and their caregivers are seeking help and/or assistance from non-Aboriginal service providers. If service providers are uncomfortable and, in turn, make Aboriginal seniors or their caregivers feel uncomfortable about their behavior, it is less likely that a senior or caregiver in need will take part in a program or service, or will return for more information or assistance (Kramer, 1991).

Community isolation occurs for a number of reasons, but primarily when a community feels isolated due to lack of communication with the outside world and because of limited resources (Health Canada, 1998). Although community isolation is often associated with geographically remote, northern First Nation reserves, it is important to remember that this type of isolation can also be experienced by communities that are located in resource-scarce urban areas, as well as through racism and ethnocentricity.

Isolation can also occur when needs continually go unmet. Because of the nature of federal versus provincial government mandates in Canada, problems for care providers can occur when it is unclear as to who should be contacted or who is responsible for funding, maintaining or providing services and programs for Aboriginal seniors. Many services and policies for Aboriginal people are overseen by the federal government. However, the boundaries between provincial versus federal mandates can sometimes be very foggy. Fiddler (as cited in Special Senate Committee on Aging, 2007) notes that Metis are often caught between provincial and federal governments and tend not to have government services available to them despite their ethnic connection and culturally-specific needs. Gaps can arise when there is confusion over which level of government should take responsibility to provide what aspect of services and Aboriginal seniors and their caregivers can fall through the cracks (Indian and Northern Affairs Canada, 2004).

Service delivery in remote communities can also consist of institutional discrimination leading to isolation when programs are absent or culturally inappropriate and thereby ineffective in meeting their goals (Ellerby, McKenzie, McKay, Gariepy and Kaufert, 2000). This can include factors such as the space needed for privacy and comfort in the delivery of patient care, which for Aboriginal seniors could happen when the only hospital bed available is in a family's living room, or when lack of access to a wheelchair – or the space available in a dwelling to use it – limits mobility (National Aboriginal Health Organization (NAHO), 2002). In Metis culture, health and well-being exists as a collective concept, yet most programs are oriented toward a more individualistic approach (Bartlett, 2005). Therefore, resources that are initiated without a thorough understanding of culture and context can, unintentionally, create institutional and social barriers that may prevent access, and may perhaps even doom programs to unnecessary failure.

## Conclusion

The context within which Aboriginal families provide care to seniors is a challenging one. Of the 1.3 million Aboriginal peoples in Canada, approximately 40,000 are aged 65 and older. Although primarily a younger population compared to non-Aboriginal people, the rapidly increasing number of Aboriginal seniors will have important implications for Canada's economic, social and political agendas in the next decade.

It has been suggested that like women in most European cultures, women in Aboriginal communities are encouraged to take on the role of care provider for family members. However, trends in Aboriginal women's health, employment, migration and economic security will continue to raise concerns about who is available to provide care to the elderly, particularly in rural and remote communities.

The low life expectancy of Aboriginal seniors, generally poor health, low incomes and difficulties accessing formal services and supports increases the financial and psychological burden of those who must assume the responsibility of care to seniors, both locally and from a distance. Those who must balance the demands of care to seniors with childcare, with the added dimension of employment, may be at significantly greater risk.

Programs that fail to take into consideration the unique and diverse cultural mores and traditions of Aboriginal people will result in institutional discrimination, rendering programs that may be ineffective in their goals to support Aboriginal seniors and their caregivers. Yet few studies evaluate programs using an Aboriginal cultural lens.

Information about gender differences, long distance care and work-life balance have been teased out for other populations but are scarce in the Aboriginal context. The

impact of individual and community isolation, along with institutional discrimination and ethnocentric assumptions about seniors and their caregivers, are important topics that need to be more fully explored. As the number of seniors continues to rise, it is important to reflect on the fact that it is estimated that unpaid family caregiving has a replacement value that saves Canadian taxpayers over 5 billion dollars annually (Fast & Frederick, 1999). The impact of caregiving can affect caregivers not only into the longer term, but it also can ripple to affect future generations. It is therefore important to explore trends across Aboriginal cultures and to highlight the challenges associated with providing care to Aboriginal seniors. Qualitative studies that give voice to caregivers would provide important insights into this experience. Only this way will there be a fuller understanding of what supports are needed, and what innovative solutions can be appropriately facilitated to improve the lives of those who provide care. Without this information, we stand in danger of failing to address the issues relevant not only to those who care for Aboriginal seniors, but to all older Canadians and their care providers, as their numbers continue to rise.

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