NARRATIVE DESCRIPTIONS OF MIYO-MAHCIHOYĀN (WELL-BEING) FROM A

CONTEMPORARY NÉHIYAWAK (PLAINS CREE) PERSPECTIVE

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And mostly, I would like to thank the néhiyawak from my community, for their honesty and wisdom; I have truly grown personally and professionally from hearing their collective stories of what has made a difference to their mental health and well-being.

Dedication

To the Creator, my primary source of inspiration and motivation. This spiritual relationship has eased my path and inspired me to believe I could change my life for the better and make a difference for others.

To my grandfather, Pete Wapass, and my mother, Celia BF Wapass-Clennell, who had the foresight to value education and to encourage me from an early age to pursue further studies.

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Abstract

There are unequivocal health disparities, both physical and mental, between the Indigenous and non-Indigenous peoples of Canada. Utilizing narrative inquiry, a qualitative methodology, 15 néhiyawak (Plains Cree people) between 18 and 71 years of age from Thunderchild First Nation were interviewed to explore what improved their mental health and well-being and what they needed to attain optimal mental health and well-being. The néhiyawak interviewed for this study responded with descriptions of strength and resilience. By posing questions that focused on the positive, the strengths, and resilience of the néhiyawak in this study came to the forefront. Narrative thematic analysis of the interviews conducted with the néhiyawak from Thunderchild First Nation consistently revealed four overarching themes that highlighted what positively impacted their mental health and well-being and their perceived needs to attain optimal mental health and well-being: relationships; spiritual beliefs and cultural practices; tānisīsi wāpahtaman pimātisiwin (worldview); and ēkwa ōhi kikwaya piko ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān (these are the things that need to happen if I want to be healthy). The néhiyawak in this study described holistic health determinants that could best be associated with the medicine wheel and the determinants of health as making a positive difference to their mental health and as necessary for them to obtain optimal mental health and well-being. These results suggest that mental health programming and intervention should be harmonious with Indigenous culture; utilize a holistic approach that takes physical, emotional, mental, and spiritual well-being into consideration; and address the existing mental health disparities using the determinants of health as a framework, with an increased focus on the current socio-economic status of Indigenous peoples in Canada.

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Prologue

Narrative inquiry "typically begins with the researcher's autobiographically oriented narrative associated with the research puzzle" (Clandinin & Connelly, 2000, p. 41). Its purpose is to make known what the researcher believes about the research topic so that the researcher can then approach the topic honestly. Before beginning the research process, I wrote about my personal biases and assumptions regarding the research topic. Throughout the research process, I kept a journal regarding my personal thoughts and feelings, the decisions I made regarding this project, and the meetings with my supervisor. My research lens originates from my childhood experiences, professional practice as a registered nurse (RN) since 1985 in a variety of diverse settings and within different health care systems (Canadian and American), reading literature related to all aspects of nursing and psychology, and graduate studies.

I am a Treaty Band member of Thunderchild First Nation, Treaty No. 6, in Saskatchewan. My interest in mental health and well-being stems from both personal and professional experiences. Experiences from my childhood provided the impetus for me to pursue higher education and explore other ways of being in this universe. In addition, my experiences as an RN have forced me to question my original belief systems about health and well-being and resulted in my decision to pursue graduate studies. As a novice mental health therapist, I wanted to explore what was making a difference for the contemporary Plains Cree people from Thunderchild First Nation in terms of improved mental health and what they perceived as necessary to attain optimal mental health and well-being. The impetus for this research project came from my desire to be an effective, competent, knowledgeable, and research-informed mental health therapist, so that I could effectively facilitate healing with my Indigenous clients.

As a very young child, I innately knew that I wanted a different life for myself and my children than what I observed in my family and extended family while growing up. I was

acutely aware of their immense emotional pain. I remember being a little girl (around seven or

eight years old) watching television (this was rare), and thinking about the places and the people

I saw there. They all looked so happy travelling to different places, laughing, and eating exotic

food. At that time, their lifestyles were foreign to me and my family; television lives were like

fairy tales. However, I clearly remember thinking, "If others can live like that, why can't I?"

That one thought created a dream and made it possible for me to believe I could have a different

life; that I could travel, have my basic needs (food, safety, shelter, and clothing) met consistently

and, most importantly, be happy.

The strongest influence in my life is my faith in the Creator. From an early age I was

encouraged and able to participate in Cree cultural traditions, such as smudging, dancing in

sundances, attending pow wows, and when I was older I began to attend sweats with my mother.

However, my mother would not teach us the Cree language, as she told us we would have a

better chance to succeed in life if English was our first language. I started participating in

sundances in my community, Thunderchild First Nation when I was about eight or nine years

old. At that time, I fasted for the three days without food or water, while dancing from sunrise to

sunset, blowing my bone whistle. It was at a sundance when I was about eight or nine years old

that I was given my Cree name by a blind Elder who had dreamt about me. On the morning of

the last day, he gave me my Cree name, *okimāwahtik-iskwēw*. He told me in Cree (my mother

later translated for me) that it was a very important name with a lot of responsibility. He told my

mother that I would bring peace and happiness to those around me. *okimāwahtik* is the name of

the centre pole in the middle of the sundance lodge and *iskwēw* translates into woman. All the

dancers (male and female) focus on this central pole while praying, dancing, and blowing their

whistles to the beating drums. Participation in Sundances has been central to the development of

my character and spirituality.

My immediate and extended family has felt the impact of colonialism, the residential school system, poverty, addictions, abuse, violence, lateral violence, and racism. Historically, I have found my refuge in education, learning. My educational experience (elementary, junior, and high school years) was a blend of both positive and negative experiences. Fortunately, I enjoyed the learning environment of the school system; it was the social system within the school environment that caused me the greatest distress. My classmates openly discriminated against me and many of the Indigenous children attending my public school. Despite the relentless discrimination, I developed a passion for learning, and from an early age I had decided to pursue post-secondary education. Initially, I was not interested in a career in nursing; it was my mother's dream for me to become a registered nurse. When I was 17 years old, I applied and was accepted into a two-year diploma nursing program at the Kelsey Institute of Applied Arts and Sciences, now known as SIAST, in Saskatoon. I was barely 20 years old when I began practicing as a registered nurse.

Early in my nursing practice, I noticed the health care provided in First Nations communities was based on government priorities (Medical Services Branch, National Health and Welfare) and that these programs were universally applied in every community without consideration for the uniqueness of each community. Traditionally, the services and resources have not been culturally appropriate, and most importantly, the community had minimal if any involvement in the issues being addressed as priorities in their communities. Essentially, the focus has been on physical health with minimal consideration for the mental, emotional, and spiritual well-being of the individuals in the communities. The recognition of the need to consult with communities has been fairly recent and originated with the federal government transferring

the responsibility of health to the local band administration, which began in the late 1980s. Also, I had noticed that the statistics regarding Indigenous health were typically gathered by non-Indigenous people and organizations, with an emphasis on problems presented from a deficit framework. Thus, Indigenous strengths and resilience as individuals and as a community have not been adequately acknowledged or investigated. Essentially, Western philosophy and perspectives have dominated the delivery and evaluation of health services and programming within Indigenous communities.

Given the history and trauma Indigenous peoples have endured as a result of colonization and the continued legacy of colonization, mental health treatment should be prioritized and addressed as an urgent matter. I believe healing is a unique and personal journey that often requires a variety of diverse and varied interventions. For this reason, every effort should be made to accommodate a variety of methods and approaches in order to effectively address individual healing related to physical, emotional, intellectual, and spiritual needs using a culturally congruent, holistic approach, such as the medicine wheel. Indigenous peoples have their traditional ways of understanding mental health and well-being; however, because of the colonial relationship, their Indigenous traditional perspectives have been overlooked and suppressed. Yet this knowledge could inform program development and delivery: effective programs are those that are congruent with the target audience's culture, priorities, and self-identified areas of concern.

Once I became a RN, my interest and knowledge in health and well-being expanded. Thus, it was quite a natural progression for me to return to graduate studies after almost 20 years of nursing practice. I wanted to know what would improve contemporary mental health and well-being for the people from my community (Plains Cree) and what they perceived as necessary to

obtain optimal mental health and well-being. Therefore, my interest in this research project stems from being Indigenous, a treaty Band member of the Thunderchild First Nation Treaty No. 6; a registered nurse; and a novice mental health therapist. It is my hope that this research will assist my practice as a mental health therapist, support the healing journey that has already begun in my community, and provide the impetus for those who have not yet begun their healing journey.

It is our Cree custom to start with a prayer before sharing knowledge or at the beginning of a ceremony. As Wilson (2008) reminds us, research is ceremony. The following prayer was written by Daryl Chamakeese, the Cree Language Developer at the Saskatchewan Indian Cultural Centre. At our first meeting, he shared this prayer with me, and I want to share this prayer with you before beginning the journey of this research project. Within the Cree language there is no order of importance, thus, none of the words are capitalized (Darryl Chamakese, personal communication, February 2, 2011).

néhiyawak (Plains Cree) Prayer

kákísimowin

māmawiyohtāwīmaw kinanāskomitin āsay mīna ē-wāpahtihiyan ē-miyo-kīsikāk.

Father of all I thank you for showing me another good day.

sawēyimin, mīna sawéyim kahkiyaw iskwēwak, nāpēsisak, iskwēsisak ēkwa napēwak misiwē-askīhk,

Bless me and bless all women, boys, girls, and men all over the land,

wīcihinān ka-kitamākihtoyāhk, ka-miyo-wicihitoyáhk, mína ka-sawēyimitoyāhk pēyakwan kiya ka-isi-sawēyimíyāhk

Help us love one another and help us have good relations. Help us bless one another the way you bless us all.

wasēnamawinān anima mēskanaw ka-miyo-pimohtātamāhk, ka-takohtēhikoyāhk itē kā-mīywāsik

Light us the path so we may walk it together in a good way to that place which is good.

(D. Chamakese, personal communication, February 2, 2011).

Chapter 1 Introduction to the Study

"By all measurements of the human condition, indigenous people lead in the statistics of

suicide, alcoholism, family breakdown, substance abuse…they serve as direct indicators of the

serious stress connected with being an indigenous person in today's world."

(Antone, Hill, & Meyers, 1986, p. 6)

I am going to tell you a story about Indigenous peoples who lived in North America

before European contact. Before I begin, I would like you to close your eyes and take a moment

to imagine Indigenous peoples who were independent, autonomous, self-governing, who had

their own ways of being, celebrated their connection with the land on a daily basis, and were

proud of their culture. Imagine peoples who had their own social, economic, political, judicial,

religious, and cultural societies and, despite the harsh living conditions and climate, continued to

thrive (Hill, 2002; Paul, 2006; Ross, 1992). Visualize them as they were: free to be themselves,

Indigenous and autonomous. Imagine that context for a minute. Approximately, 500 years ago

(1492), Europeans came across the ocean and found this vast Indigenous-populated territory

(Paul, 2006; Wesley-Esquimaux & Smolewski, 2004), and this was the beginning of the end for

the Indigenous way of life. Now fast forward to the present and reflect on how their

(Indigenous) context for life has been altered, how it has been changed, and in some cases

disrupted forever (Duran & Duran, 1995; Mussell, 2005; Wesley-Esquimaux & Smolewski,

2004). Indigenous life was almost destroyed by the epidemics (Wesley-Esquimaux &

Smolewski, 2004); those who survived were subjected to the residential school experience and

other government assimilation policies (Chansonneuve, 2005), and today many are politically

controlled by the *Indian Act* (Office of the Treaty Commissioner [OTC], 2008). This ongoing

story of colonization and its continued impact on Indigenous mental health and well-being

(Duran & Duran, 1995) was the impetus for this research project, fueled by two questions. First, what is making a difference for the improved mental health of contemporary Plains Cree people from Thunderchild First Nation? Second, what do they need to obtain optimal mental health and well-being?

This story began with Indigenous peoples who were autonomous, then colonized, and now, approximately 500 years later, continue to be disproportionately represented in most physical and mental health issues when compared to non-Indigenous people in Canada (Antone et al., 1986; Health Canada, 2005b; Tookenay, 1996). As an Indigenous woman, I wanted to conduct research that was strength-based, was positive, and would give voice to contemporary Indigenous (Plains Cree) people. Given the different terminology used to describe and address Indigenous peoples, I have included a brief description of the different terms.

Defining Terminology: Indigenous, Aboriginal, First Nations, Indian, Métis, and Inuit

Throughout this research project I will use the terms Aboriginal, Indigenous, First Nations, and Indian interchangeably. The Canadian Constitution recognizes three groups of Aboriginal peoples: Indians (First Nations), Métis, and Inuit (Health Canada, 2005a). The *Indian Act* of 1876 determines who is registered or entitled to be registered as *Indians* and is used to determine eligibility for government benefits. According to the *Indian Act*, an Indian is defined as "a person who pursuant to this Act is registered as an Indian or is entitled to be registered as an Indian" (Indian Act, 2010, p.2). Registered means "registered as an Indian in the Indian Register" (Indian Act, 2010, p. 2). Non-status Indians are people who consider themselves Indians or members of a First Nation but whom the federal government does not recognize as status Indians. According to Health Canada (2005), Indian is a term that "collectively describes all the Indigenous people in Canada who are not Inuit or Métis" (para.

10).

In Canada, the term *Indian* has generally been replaced with the term *First Nations*; a term that came into common usage in the 1970s to replace the word Indian, which some people found offensive. Although the term First Nations is widely used, no legal definition of it exists (Health Canada, 2005a). The term *Aboriginal* is "a collective name for the original peoples of North America and their descendants" (Health Canada, 2005a, para. 10). The *Inuit* are "an Aboriginal people of Arctic Canada who live primarily in Nunavut, the Northwest Territories, and northern parts of Québec and Labrador" (Health Canada, 2005a, para 10), and according to Willows (2005), the "Inuit are culturally and linguistically distinct from First Nations and Métis" (p. S32). The Métis are "an Aboriginal people of mixed First Nations and European ancestry, distinct from First Nations people, Inuit and non-Aboriginal people" (Health Canada, 2005a, para. 10). The Merriam-Webster Online Dictionary (2010) defines Aboriginal as "being the first or earliest known of its kind present in a region" and Indigenous as "having originated in and being produced, growing, living, or occurring naturally in a particular region or environment."

With this as background, my preference is to use Indigenous to describe all Indigenous people including status, non-status, Métis, and Inuit. However, the terminology is not consistent within the literature, thus it is impossible to use only one term. In addition, the term *non-Indigenous people*, refers to individuals of European settler descent residing in Canada.

Note that when I am describing the research participants from my community, I will use *néhiyawak* whenever possible as requested by the health director and a Band Councillor from the Thunderchild First Nation. néhiyawak when translated means "Plains Cree" (John Spyglass, Saskatoon Cultural Center, personal communication, September 1, 2010).

Background of Problem

The current state of Indigenous health is of national concern (Health Canada, 2005a). Since European contact there has been a rapid decline in the health of Indigenous people in Canada (Wesley-Esquimaux & Smolewski, 2004). While the federal government has worked to address the health needs of Indigenous people since the late nineteenth century and much progress has been made, Indigenous people as a population do not have the same health status as other Canadians (Antone et al., 1986; Caron, 2005; Chansonneuve, 2005; Health Canada, 2005; Health Council of Canada, 2005; Hill, 2002; Tookenay, 1996; Waldram, Herring, & Young, 1995; Wesley-Esquimaux & Smolewski, 2004) and their socio-economic conditions are often cited as being similar to those in developing countries (Health Council of Canada, 2005; Mitchell & Maracle, 2005). For example, Indigenous people have higher rates of endocrine disorders, immune disorders, tuberculosis, and arthritis (Health Canada, 2004). Indigenous people also have elevated rates of injury (National Aboriginal Health Organization: Regional Longitudinal Health Survey [RHS, 2002/03], 2005), trauma (Karmali et al., 2005), and suicide (Health Canada, 2007; Kirmayer, Brass, & Tait, 2000).

In addition, it is important to know that historically the research conducted in Aboriginal communities has not been a positive experience for Aboriginal peoples, resulting in additional challenges for research (Schnarch, 2004; Smith, 1999), which will be addressed in the methodology section, chapter 3. Smith (1999) stated, "for Indigenous peoples who have been colonized, the experience, and the discourse, about research are shared" (p. 1). Ermine, Sinclair, and Jeffery (2004) explained the historical conduct of research with Indigenous peoples as follows:

Western knowledge, with its flagship of research, has often advanced into Indigenous

Peoples' communities with little regard for the notions of Indigenous worldviews and self-determination in human development. As a result, the history of Westernization in virtually all locations of the globe reads like a script of relentless disruption and dispossession of Indigenous Peoples with the resulting common pattern of cultural and psychological discontinuity for many in the Indigenous community. (p. 9)

Given the history and context in which research has been traditionally conducted in Indigenous communities, it was important for me to be aligned with the changing philosophy and research practices being recommended and endorsed by Indigenous peoples. I carefully selected a methodology—narrative inquiry—that is congruent with Indigenous worldviews to guide this research. Many investigators are now turning to narrative inquiry because "the stories reveal truths about human experience" (Reissman, 2008, p. 10). Essentially, telling stories, "makes meaning of our lives…the essence of Human sciences is to understand the meaning of human existence…stories are a way in which to achieve that understanding" (Martin-McDonald, 1999, p. 221). Narrative inquiry is a Western methodology, however, Roberts (2005) an Indigenous scholar, described narrative inquiry as a methodology that "most closely resembles Aboriginal ways…in relation to Elders and their stories" (p. 29).

Purpose of the Study

The primary goal of this research project was to explore what improved the mental health and well-being of the néhiyawak from Thunderchild First Nation and what they perceived as necessary to attain optimal mental health and well-being. According to Smylie et al. (2004), "the gaps in current health information are a major barrier to the effective planning and implementation of health-care services within Aboriginal communities" (p. 212).

Research questions.

This study was guided by two questions. First, what is making a difference for the contemporary néhiyawak from Thunderchild First Nation in terms of improved mental health? Second, what do the néhiyawak in this study perceive as necessary to attain optimal mental health and well-being?

Relevance and significance.

Recognizing that Thunderchild is only one of many First Nations communities, this research represents a contribution to the current body of knowledge addressing néhiyawak miyo-mahcihoyān (well-being). The insight gathered from an Indigenous perspective is essential for planning effective health promotion for Indigenous populations (Bartlett, 2005; Ermine, Sinclair, & Jeffrey, 2004; Fishbein & Ajzen, 1975; Hakim & Wegmann, 2002; Health Canada, 2005a). Most importantly, this inquiry highlights a contemporary Indigenous voice within Thunderchild First Nation on what is making a positive difference to their mental health and what they need to attain optimal mental health and well-being.

Summary and Outline for Dissertation

There is an abundance of literature that clearly describes the existing health disparities between Indigenous and non-Indigenous people in Canada. It is timely to collaborate respectfully with Indigenous peoples to ask them what contributes to their mental health and well-being. Having this first-hand knowledge is an important first step in mental health program planning. It will add to the current body of literature that addresses the mental health and well-being of Indigenous people, and will inform delivery of effective mental health care. This study provided an opportunity for the néhiyawak from Thunderchild First Nation to share what is making a positive difference to their mental health and what they perceived as necessary to attain

optimal mental health and well-being. In addition, this research contributed to my personal and professional development as a mental health therapist.

This first chapter introduced the study, terminology, background of the problem, and described the relevance and significance of the research questions. Chapter 2, the literature review, will describe a variety of factors that have influenced, and continue to influence, current Indigenous people's mental health and well-being. Chapter 3 will address the methodology used to guide this research project and the required ethical conduct to ensure that the study was a respectful and reciprocal process for both the néhiyawak and for me as the primary researcher. Chapter 4 will present the results and discussion that arose from the study. The last chapter, 5, will address the implications that arose from this study that will have an impact on education, counselling practice, government, and future research. Chapter 5 will also address the strengths and limitations of this study and conclude with the key findings and my final comment.

<center>**Chapter 2 Literature Review**</center>

"Contact with colonizers changed everything for Indigenous people."

(Wesley-Esquimaux & Smolewski, 2004, p. 4)

Why does the health and mental status of Indigenous people continue to lag behind non-Indigenous people in Canada? This is an important question, and the answer is embedded within the Indigenous/ non-Indigenous historical relationship, specifically colonization. This historical relationship is the fundamental root of the current health disparities experienced by Indigenous people on a daily basis (Chansonneuve, 2005; Kirmayer, Brass, & Valaskakis, 2009; Mitchell & Maracle, 2005; Mussell, 2005; Wesley-Esquimaux & Smolewski, 2004). I will begin by providing an overview of Indigenous health and mental health in greater depth, followed by a discussion of the historical and continued impact of colonization on contemporary Indigenous health and well-being. The impact of ongoing stress, trauma, and post-traumatic stress disorder (PTSD) on Indigenous health and well-being will be presented, along with Indigenous responses to colonization. An overview of the determinants of health will be provided as they are commonly accepted and known to influence the level of health an individual experiences (Public Health Agency of Canada [PHAC], 2010; Raphael, 2006;). I will conclude by sharing several studies conducted by Indigenous scholars that have provided empirical evidence of initiatives that have improved Indigenous mental health and well-being.

Indigenous Health

There are irrefutable health and mental health disparities between Indigenous and non-Indigenous people in Canada. Life expectancy for both Indigenous males (68.9 years) and females (76.6 years) are lower than the Canadian population of males (76.3 years) and females (81.8 years). The endocrine and immune disorders (including death related to diabetes) are 3 to

5 times higher than that of the general Canadian population. The tuberculosis rate among First

Nations was 8 times higher than that for the Canadian population. The incidence rate for

chlamydia was 7 times higher in First Nations living on reserve than for all Canadians (Health

Canada, 2005a, 2006).

The First Nations Regional Longitudinal Health Survey (RHS) 2002/03 was compiled

after 22,000 First Nations people were surveyed (adult, youth, and children), from 238

communities across Canada (National Aboriginal Health Organization [NAHO], 2005).

According to the RHS, the most common health conditions in the communities surveyed were

heart disease, hypertension, arthritis/rheumatism, asthma, cancer, and diabetes. The following

table shows the comparison between identified health issues in First Nations' communities and

the general Canadian population.

Table 1

Health Conditions for Adults Reported by the RHS 2002/03

Condition	First Nations Population	General Population (Canadian)
Arthritis/rheumatism	25.3%	19.1%
High blood pressure	20.4%	16.4%
Asthma	10.6%	7.8%
Heart disease	10.6%	7.8%
Injuries	Almost 3x higher	
Diabetes	14.5% (much higher)	
Smoking	Approx. 2x higher	
Disability	28.4%	25.8%*CCHS
		19.3%*NPHS

*CCHS Canadian Community Health Survey
*NPHS National Population Health Survey

These statistics clearly demonstrate the existing health disparities between Indigenous

peoples and other Canadians. Indigenous peoples "bear a disproportionate burden of illness in

this country" (Tookenay, 1996, p. 1581). The statistics for mental health are equally alarming

and warrant immediate attention from all levels of Indigenous and non-Indigenous governments and health care providers.

Indigenous Mental Health

Given the growing awareness of the many issues that have and continue to have an impact on First Nations communities, there has been increased interest in and urgency to develop and implement effective interventions and support services to address existing mental health issues. A range of epidemiological studies have documented high levels of mental health problems in many Canadian Aboriginal communities (Royal Commission on Aboriginal Peoples, 1995; Waldram et al., 1995). Social problems are also common. The Aboriginal Peoples Survey, conducted by Statistics Canada in 1991, asked both on and off-reserve Aboriginal respondents about a number of social problems in their communities. Family violence, sexual abuse, and rape were frequently identified as concerns. Among other health disparities, Indigenous peoples have disproportionately high rates of injury, trauma (Caron, 2005: Karmali et al., 2005), and suicide (Health Canada, 2004; Karmali et al., 2005). Kirmayer, Brass, and Tait (2000) asserted that the high rates of depression, alcoholism, suicide, and violence in many communities are linked to cultural discontinuity. Cultural discontinuity will be addressed under colonization.

Family violence, sexual abuse, and rape.

According to Hylton (2002) there are elevated rates of family violence, sexual abuse, and rape in Aboriginal and as compared to non-Aboriginal populations. Statistics Canada (2001) reported that Aboriginal peoples were more likely than other Canadians to report being assaulted by a spouse in a 5-year period, and approximately 20% of Aboriginal peoples reported being assaulted by a spouse as compared with 7% of the non-Aboriginal population. Bopp, Bopp, and

Lane (2003) remarked that at a minimum, one quarter of Aboriginal women experience violence

at the hands of an intimate partner; and that in some communities, that figure can be as high as

80–90%. They asserted that in most instances, this abuse happens repeatedly and involves

serious physical harm, as well as psychological and emotional abuse. Children witness more

than half of the violence that occurs between the adults in the home and are also targeted for

abuse, especially sexual crimes, with up to three quarters of Aboriginal girls under the age of 18

having been sexually assaulted (Bopp, Bopp, & Lane, 2003). The following table (Statistics

Canada, 2001) shows the rates of these social problems as reported by Aboriginal populations 15

years of age and older.

Table 2
Social Problems Reported by Aboriginal Populations

Population	Family Violence	Sexual Abuse	Rape
Total Aboriginal Sample	39.2%	24.5%	15.0%
On-reserve Indians	44.1%	29.0%	16.4%
Off-reserve Indians	36.4%	21.8%	13.3%
Métis	39.0%	23.0%	14.6%
Inuit	43.5%	35.1%	25.0%

Unfortunately, 90% or more of sexual crimes are never reported to the police and the under-

reporting for sexual offences is higher than for any other crime category (Hylton, 2002).

Injury.

RHS (2002/03) reported that, "in addition to death and disability, injuries (including

those resulting from sexual violence) can lead to a variety of other health problems including

depression, alcohol and substance abuse, eating and sleeping disorders, and HIV and other

sexually transmitted diseases" (p. 22). Injuries among First Nations people who are adults are

almost 3 times the Canadian average; almost one third of the adults required treatment, which is

twice the Canadian average. One in 20 reported they had suffered at least one instance of

violence in the previous year. Injury is one of our leading causes of death, and is responsible for approximately one quarter of all deaths and over half the potential years of life lost" (RHS, 2002/03, p. 22). Death from injury and poisonings is 2.9 times higher than that for the general Canadian population (Health Canada, 2004).

A more recent study done in the Calgary Health Region, Calgary, Alberta, found "Aboriginal Canadians had a nearly 4-fold greater risk of severe trauma than the non-Aboriginal population" (Karmali et al., 2005, p. 1010). Karmali et al.'s results are alarming, particularly, given the authors acknowledge that their study only included status (treaty) Aboriginal people, thus excluding many non-status Aboriginal and Métis groups. The study also failed to identify the relative incidence rates of non-severe trauma.

RHS (2002/03) asserted, "injuries are caused by a variety of factors that include low socio-economic status, cultural norms that support violence to resolve conflict and rigid gender norms" (p. 22). RHS asserted at the individual level "there is evidence to suggest that injury risk is linked to income and education as well as alcohol and substance abuse" (p. 22). According to the RHS, the most common causes of injuries among adults included, "falls, sports injuries, incidents with motor vehicles (cars, snowmobiles, ATVs), and violence (family violence or other assault)" (p. 22).

According to Health Canada (2005a),

From ages 1 to 44, the most common causes of death among First Nations were injury and poisoning. For children, these deaths are non-intentional; however, intentional injury and poisoning accounted for 38 percent of deaths among youth (10 to 19 years) and 23 percent of deaths for early adults (20 to 44 years). Motor vehicle accidents were a leading cause of death in all age categories except seniors. Even a partial reduction in the

injury death rates among First Nations would have a profound effect on premature death rates and on the health of that population in general. (p. 8)

Trauma.

There is limited research regarding injury and trauma among Aboriginal Canadians (Caron, 2005; Karmali et al., 2005) and less attention has been paid to quantifying the risk of nonfatal injury (Caron, 2005). In addition, Aboriginal peoples have been "faced with the challenge of working with little or no descriptive injury data relevant to the community level" (Auer & Andersson, 2001, p. 169). In addition, as a result of the colonization process, Indigenous peoples have been subjected to a multitude of traumatic experiences (Paul, 2006; Wesley-Esquimaux & Smolewski, 2004), and, unfortunately, contemporary Indigenous people continue to experience trauma either through neocolonial practices (Wesley-Esquimaux & Smolewski, 2004) or through injury (Caron, 2005). As previously noted, Indigenous peoples have approximately a four-fold risk of severe trauma (physical) when compared to the non-Indigenous population (Karmali et al., 2005). Caron (2005) asserted that in order to truly understand the reasons behind the statistics, the following issues need to be addressed: trauma within Aboriginal populations needs to be assessed and documented, not only for mortality but also for associated morbidity; it is vitally important to include all Aboriginal populations in research projects and programs aiming to reduce the health burdens of traumatic injury; factors contributing to Aboriginal trauma must be identified and quantified; it is necessary to address other health-services; and lastly, each step must be done in collaboration with Aboriginal peoples.

Suicide.

Suicide is one of the most dramatic indicators of distress in Aboriginal populations

(Kirmayer et al., 2001). First Nations youth commit suicide about 5–6 times more often than non-Aboriginal youth, and suicide rates for Inuit youth are among the highest in the world, at 11 times the national average (Health Canada, 2007). The RHS (2002/03) stated that 1 in 10 of the adults they surveyed reported having suicidal thoughts over their lifetime, and 50% of those people reported suicide attempts over their lifetime. In addition, they found 30.1% of all the adults surveyed have also experienced a time when they felt sad, blue, or depressed for two weeks or more in a row. Also, the RHS (2002/03) reported that at least 18% of attendees of residential schools have attempted suicide in their lifetime, and 30% have used one or more non-prescription drugs in the past year. In cases where one or more parent attended residential school, youth were more likely to have thought about or attempted suicide at least once in their lives. The same situation exists for youth with one or more grandparents who attended residential school (RHS, 2002/03). Within the RHS survey, two thirds of First Nations adults who experienced racism also reported that their self-esteem was negatively affected. Moreover, these individuals were also more likely to have thought about suicide in the past year (RHS, 2002/03).

According to Health Canada (2007), suicide and self-inflicted injury are the leading causes of death for First Nations youth and adults up to 44 years of age. Karmali et al. (2005) found that Aboriginal Canadians had "a 3-fold greater risk of traumatic suicide" (p. 1010). Kirmayer, Brass, and Tait (2000) identified risk factors that appear to be similar across the studies of Aboriginal youth suicide, including male gender, history of substance abuse (especially solvents or inhalants), history of psychiatric problems, parental history of substance abuse, or physical abuse. According to Kirmayer et al. (2007), suicide emerges from a complex interaction of biological, psychological, social, and cultural processes. They assert that "these

factors influence the person from infancy onward, increasing resilience or making individuals more vulnerable to the effects of stress, conflict, violence, and loss. [In addition,] social, economic, cultural, and political factors may create predicaments that drive vulnerable individuals to suicidal behavior" (p. 33). Later in this chapter, I will discuss the work of Chandler and Lalonde related to suicide under the section on positively impacting Indigenous mental health and well-being: community control or autonomy.

Colonization

Colonization has been "disastrous for Native culture, identity and pride" (Lee, 1992, p. 211). This phenomenon is not only limited to Canada's Indigenous peoples but has also occurred within Australia's Indigenous peoples (another settler colony of Britain). It is interesting to note the similarities between the rapid decline in health of Indigenous peoples of Canada and Australia since European invasion. Hains (1993) described the Australian Aboriginal peoples prior to European invasion as "arguably one of the healthiest races in the world" (p. 128) and since European invasion, their health status "has declined to such an extent that is now on par with many people who live in third world countries" (p. 128). According to Franklin and White (1991), the subsequent decline in the health of the Aboriginal peoples in Australia from European invasion were attributed to three reasons:

> First, the introduction of new diseases, second the forceful removal of their ancestral land, and third the substitution of a healthy lifestyle with a poor diet and living conditions. In addition there was physical confrontation, murder, and rape. The result has been, and continues to be, physical and psychological illness and spiritual despair.
> (p. 129)
> There are multiple layers in colonization that had and continue to have an impact on the

lives of Indigenous peoples in North America. Chansonneuve (2005) and Wesley-Esquimaux

and Smolewski (2004) asserted that the epidemics and residential schools had the greatest impact

on the demise of Indigenous culture and social organization, devastating Indigenous peoples'

ways of life. And, to enforce colonization, the Government of Canada in 1876 passed the first

Indian Act which gave the Government of Canada jurisdiction over First Nations peoples and

their lands. The *Indian Act* allowed the Canadian government to legally enforce colonization on

Indigenous peoples and continues to be utilized to maintain a colonist relationship with

Indigenous peoples to this day (Hill, 2002; Lee, 1992). Before discussing the impact of the

epidemics and the residential schools on Indigenous mental health and well-being, it is important

to be aware of how the *Indian Act* legally facilitated colonization and left the Indigenous peoples

vulnerable and without recourse.

Indian Act.

The *Indian Act* was not part of any treaty negotiations and did not involve First Nations

peoples in the development and implementation processes (OTC, 2008). The *Indian Act* was a

consolidation of pre-existing colonial legislation including the *Gradual Civilization Act*, 1857,

and the *Gradual Enfranchisement Act*, 1869. The *Indian Act*'s full title is *An Act to Amend and

Consolidate the Laws Respecting Indians*. The *Indian Act* was created to "guide Canada's

relations with First Nations peoples by imposing several restrictions on them in order to meet

two main goals, to 'civilize' the First Nations people and to 'assimilate' them into Canadian

society" (OTC, 2008, p. 22). The goals conflicted with treaty negotiations and caused poor

relations among First Nations peoples, the Canadian government, and other people of Canada.

There have been many amendments to the *Indian Act*. The Office of the Treaty

Commissioner (OTC, 2008) draws attention to the following amendments made in 1884, 1895,

1927, 1951, and 1985. The amendment in 1884, "prohibited Potlatch and Tamanawas Dance ceremonies" (p. 23). Those found participating in these activities were sentenced to a jail term of 2–6 months; this prohibition was in place for 75 years until the ban was lifted in 1959. The amendment in 1895, "prohibited Traditional dances and customs"; this ban was lifted in 1933 (p. 23). The amendment in 1927 made it "illegal for First Nations peoples to obtain legal assistance" (p. 23); this ban was lifted in the amendments to the *Indian Act*, 1951. With the amendments to the *Indian Act* in 1951, First Nations women could now take part in land decisions. Also, in the 1951 revisions, the government created Section 87 (now Section 88), which allowed provincial laws to cover areas that were not covered by the *Indian Act*. One area that was not covered by federal legislation was child welfare matters, thus, whenever there were concerns for First Nations children the province could now apply its laws on reserve lands (OTC, 2008). Previously, if a First Nations woman married a non-First Nations man, she would lose status, whereas if a First Nations man married out he would not lose status. In 1985, Bill C-31 passed and all women and their children who lost their status after marrying out could regain their treaty status. It is important to know that Bands can determine membership but still cannot grant Indian status, which is still left to the federal government to decide (OTC, 2008).

It is important to know that the pass system that "forced First Nations peoples to obtain consent from the Indian agent before leaving the reserve" (OTC, 2008, p. 23), was never a specific provision of the *Indian Act*; however, it was "enforced by Indian agents after the Resistance of 1885 and persisted as a policy on the prairies until the mid 1930s, remaining in practice until the mid 1950s" (p. 23). As a result of the restrictions on travel, they could not easily practice traditions that took place at different geographic locations. Given the ceremony ban was already in place, this added another barrier for First Nations people. This pass system

also "restricted parents from visiting their children who were in residential schools" (OTC, 2008, p. 23), thus, Indigenous peoples were effectively isolated from each other preventing social and political organization from occurring. The *Indian Act* was instrumental during the residential school era; Sections 114-122 (Indian Act, 2010, pp. 60–64) legally removed the rights of Aboriginal parents to their children, giving the government total control over the children's lives. For over a century, under the authority of Indian agents and enforced by the Royal Canadian Mounted Police (RCMP), Aboriginal children were taken from their families and incarcerated in residential schools. There was no recourse for the parents, families, or communities in this process (Chansonneuve, 2005). Remember, First Nations peoples were not allowed to obtain legal assistance until 1951 (OTC, 2008, p. 23).

In summary, the *Indian Act* was created to maintain control over Indigenous peoples in every aspect of their lives, from determining who was Indian, to enforcing a Western education and culture through the residential school system, banning sacred fundamental traditional cultural practices, controlling all economic endeavours, denying legal assistance, to denying Indigenous peoples' the right to vote, and restricting their travel by enforcing the pass system. The *Indian Act* maintains the paternalistic attitude and colonialist relationship to this day. Through this "authority" the federal government retains ultimate jurisdiction over reserve lands. The *Indian Act* has undergone revisions; however, its basic principle remains the same: "to assimilate, integrate, or annihilate" (Hill, 2002, p. 9).

Multiple layers of colonization.

Wesley-Esquimaux and Smolewski (2004) described colonization as having impacted five areas of Indigenous peoples' lives: physical, economic, cultural, social, and psychological. Physical impact is associated with the introduction of infectious diseases that "decimated the

Indigenous population and resulted in an intergenerational and culturally propagated (endemic) form of complex post-traumatic stress disorder" (p. 6). Economic impact is associated with the "violation of Native stewardship of land and forced removal of people from their natural habitat and life ways" (p. 6). Cultural impact is associated with "Christian missionization intended to bring about religious transformation and cultural destruction through prohibitions imposed on Aboriginal culture and belief systems" (p. 6). Social impact is associated with the stages of Aboriginal displacement through "colonial settlement, which brought alien social structure, introduced non-traditional coping mechanisms and silenced 'knowledgeable subjects' within the Aboriginal population; thereby, damaging families, altering gender roles [and] authority, and diminishing cultural values and mores" (p. 6). Psychological impact is associated with the "marginalization of Aboriginal people, as their social selves became largely diminished as well, any perception of control that they had over their lives became reduced and badly undermined and, ultimately, placing perceptions regarding locus of control on the colonizers" (p. 6). Every aspect of Indigenous life was altered or changed with colonization. The epidemics and the residential schools had the greatest impact on the collapse of Indigenous culture and social organization, forever changing Indigenous peoples' ways of life (Chansonneuve, 2005; Wesley-Esquimaux & Smolewski, 2004). And, as previously stated, cultural discontinuity has been linked to high rates of depression, alcoholism, suicide, and violence in many communities (Kirmayer, Brass, & Tait, 2000).

Epidemics.

The epidemics caused severe social disorganization for Indigenous societies. Traditional social structures, alliances, and kinship ties were disrupted as groups of infected members left the tribal community hoping to prevent further infection within their community. Confidence in

traditional leaders and healers was undermined when they were unable to alleviate the new diseases. Those who survived lost hope and social disintegration followed as the survivors were dealing with huge death tolls, horrible disfigurement, and displacement from their homes (Wesley-Esquimaux & Smolewski, 2004).

According to Adair who was an Indian Agent (Williams, 1930), these diseases took their toll on the minds and bodies of the Indigenous peoples who survived. Many of the survivors chose to end their lives rather than live with the shame of horrible disfigurement from the pock scarring. He stated, "a great many killed themselves…some shot themselves, others cut their throats, some stabbed themselves with knives" (Williams, 1930, p. 245). Wesley-Esquimaux and Smolewski (2004) estimated that 90–95% of the Indigenous population died within two generations of contact in 1492. They argue the epidemics are a critical component, "set as the point of departure for the cumulative waves of trauma and grief that have not been resolved within the Aboriginal psyche and have become deeply embedded in the collective memory of Aboriginal people" (p. iii).

The disease factor differentiates the history of colonization of the Americas from other regions of the world, explaining "why Europeans were successful in destroying civilization after civilization in the New World" (Wesley-Esquimaux & Smolewski, 2004, p. 5). Wright (1992) (as cited by Wesley-Esquimaux & Smolewski, 2004) proposed, "Europe possessed biological weapons that fate had been stacking against America for thousands of years. Among these were smallpox, measles, influenza, bubonic plague, yellow fever, cholera, and malaria—all unknown in the Western Hemisphere before 1492" (p. 5).

Interestingly, in Medieval Europe, the people had a similar experience with the bubonic plagues. The people experienced "social, moral and spiritual disintegration from the trauma of

hundreds of years from bubonic plagues" (Wesley-Esquimaux & Smolewski, 2004, p. 26).

However, once the crisis was over, "Europeans could go back to their 'roots' as their cultural

memory remained intact. In a way, 'they knew who they were' and this sustained identity helped

in the recovery process" (Wesley-Esquimaux & Smolewski, 2004, p. 26). However, this was not

the case with the Indigenous peoples of Canada whose "cultural identity became shattered and

the discontinuity of cultural identity prolonged the recovery process; sometimes rendering it

almost impossible" (Wesley-Esquimaux & Smolewski, 2004, p. 26).

Another factor was that Medieval Europe had 30- to 40-year intervals between major

plagues and Indigenous peoples had 7 to 14 years between the epidemics; this shortened time

frame precluded them from being able to reconstruct their societies or re-populate. However, the

European experience can explain what might have happened if Indigenous peoples had

experienced the same level of reprieve (Wesley-Esquimaux & Smolewski, 2004). Wesley-

Esquimaux and Smolewski (2004) asserted that the comparison with European experience during

and after the plagues "helps to illustrate that once traumatic events stop for a sufficient length of

time (at least 40 years) socio-cultural reconstruction and healing will begin" (p. 26).

On a more positive note, Waldram, Herring, and Young (1995) remind us that those

epidemics, especially tuberculosis, provided the impetus for the Canadian federal government to

initiate and organize health services for Aboriginal peoples. The increased surveillance and new

health initiatives have helped to contribute to a dramatic decline in many infectious diseases in

the post-Second World War era. However, Waldram et al. (1995) asserted that those epidemics

have been replaced by new epidemics:

But in their place, new epidemics of chronic, non-communicable diseases on the one

hand (such as heart disease, hypertension, obesity, and diabetes), and injuries, violence,

and the so-called social pathologies on the other hand, have come to the fore in

biomedical categorizations. Regardless of whether infectious diseases or social

pathologies predominate in epidemiological profiles, we must not lose sight of the fact

that biomedical definitions of health and disease are inextricably linked to larger

structures of authority and power. (p. 260)

It is discouraging when one considers the above comment made by Waldram et al. (1995) and

yet, it does offer hope that if the power differentials between Indigenous and non-Indigenous

peoples of Canada were to be addressed, there should be a significant increase in the health and

well-being of the Indigenous peoples in Canada.

Residential schools.

Indigenous children attended residential schools in various regions of Canada from 1863

until 1996 under a partnership between the Canadian government and churches (Chansonneuve,

2005). According to the Aboriginal Healing Foundation (2002), "half of the Indian student

population were enrolled in 76 residential schools across the country" (p. 2). However, these are

national averages and in some regions—the North, British Columbia, and the Prairies—the

percentages were higher; these are the communities which "had all their children forcibly

removed" (Aboriginal Healing Foundation, 2002, p. 2). The purpose of residential schools was

to assimilate Inuit, Métis, and First Nations children into mainstream Canadian culture.

However, many of the schools went much further than separation and isolation to what has been

called *Kill the Indian, Save the Man* (Churchill, 2004). Duncan Campbell Scott, Deputy

Superintendent of Indian Affairs from 1913 to 1932, summed up the government's position when

he said, in 1920,

"I want to get rid of the Indian problem. […] Our objective is to continue until there is

not a single Indian in Canada that has not been absorbed into the body politic and there is

no Indian Question and no Indian Department" (as cited in Aboriginal Healing

Foundation, 2002, p. 3).

In the context of residential schooling, "killing the Indian meant disconnecting children

physically, emotionally, mentally and spiritually from their language, culture and their

communities and also, but most painfully, from their own sense of identity as being Indian"

(Chansonneuve, 2005, p. 44). Physical disconnection was achieved by "removing children from

loving families and communities and forcing them to grow up in institutions among prejudiced

strangers" (p. 44). Mental disconnection was achieved by "forbidding children to use their own

languages or any familiar customs that may have given them comfort. Without language, the key

to the distinctive worldview of Aboriginal cultures was lost" (p. 44). Emotional disconnection

was achieved by "teaching children that the parents, grandparents and Elders they so loved were

savages, and their own bodies and racial characteristics were sinful and dirty" (p.44). Spiritual

disconnection was achieved by "teaching children to adopt the new religion or suffer God's

wrath eternally" (p. 44).

The Aboriginal Healing Foundation (2002) stated there are "approximately 93,000

former students alive today" (p. 2) and hundreds of former students whose testimonies include

the following abuses:

Kidnapping, sexual abuse, beatings, needles pushed through tongues as punishment for

speaking Aboriginal languages, forced wearing of soiled underwear on the head or wet

bed-sheets on the body, faces rubbed in human excrement, forced eating of rotten and/or

maggot infested food, being stripped naked and ridiculed in front of other students, forced

to stand upright for several hours—on two feet and sometimes one—until collapsing,

immersion in ice water, hair ripped from heads, use of students in eugenics and medical

experiments, bondage and confinement in closets without food or water, application of

electric shocks, forced to sleep outside—or to walk barefoot—in winter, forced labour,

and on and on…. (p. 6)

In 2000, there was a 5-day residential abuse retreat in eastern Ontario that provided the

opportunity for counsellors, frontline workers, and Elders to share the impact of attending

residential schools. As a group, they shared the impacts of attending residential schools on

themselves, families, communities, clients, and the long-term implications (Chansonneuve,

2005). These retreat participants exemplify the continued impact that the residential school

system had on them personally, their families, and their communities and substantiates the

ongoing impact of the residential school legacy that continues to impact contemporary

Indigenous mental health and well-being.

The retreat participants described the personal impact of attending the residential schools

to include loss of their culture and language; low self-esteem related to the deep-rooted feelings

of humiliation, shame, abandonment, and loss of pride in being Indigenous; having difficulty

expressing themselves, especially an inability to express affection; being engrained with a

foreign belief system that denied the value and importance of women; and lastly, being left with

memories that were routinely triggered from the sounds and smells in their current environment

(Chansonneuve, 2005).

These same participants described the residential school experience as having impacted

their families in numerous ways. They described their families as being inconsistent with

expressions of love, going from one extreme to another and using gifts and material objects to

soothe wounds in the family. They spoke of families where there was no nurturing or affection

for generations; these families had difficulty expressing love for their children in physical ways, especially by giving hugs. The participants shared that their families were unable to talk to their children about their childhood because it involved so much abuse and this contributed to lack of communication within the family and affected the bonding. Familial bonding was further affected by children being removed from their home by an outside agency. Their families continue to struggle with the silence and shame of the abuse that occurred in the residential schools and regrettably have repeated the abuse in their home. They expressed deep remorse and wished that things had been different. In addition, they described family members participating in lateral violence that included displaying anger, jealousy, resentment, and gossiping towards each other (Chansonneuve, 2005).

According to Chansonneuve (2005), these participants from the abuse retreat perceived that many of their social problems and the issues in their communities were related to the residential school experience. They attributed the high rates of suicide, family violence, and addictive and self-destructive behaviours to the residential school legacy. They spoke about the lack of traditional skills and role models in their communities. They described living in an unhealthy environment, feeling isolated, and dealing with ongoing power and control issues related to abuse and dysfunction within their community. They specifically mentioned racism, racial scaling, splits between mixed/Métis and status vs. non-status; and spiritual splits and factions between Catholics, Protestants, Jehovah's Witnesses, other Christians, and those with traditional Aboriginal spiritual beliefs. They mentioned the lack of self-sufficiency and sustainability as a concern. In addition, the participants were concerned that the problems of their reserves and settlements were being transferred to urban communities, contributing to family feuds, bloodism, which Middleton-Moz (1989) explained as referring to rejecting or

accepting someone based on skin colour or the amount of full-blood vs. mixed-blood ancestry, and violence

The participants who were counsellors described the impact of attending residential schools on their clients to include an extensive list of addictive and self-destructive behaviours; mental illness and emotional disorders; histories of inter-generational family violence; abuse that impacted their Elders and children; histories of involvement with foster care; unhealthy coping, social, and life skills; denial of impact or residential abuse and intergenerational legacy; emotional numbness, with anger toward authority figures; feelings of being disconnected from family and culture; and fear that "opening up" (p. 47) will lead to insanity (Chansonneuve, 2005).

As a collective group, the participants at this 5-day residential abuse retreat articulated the following as long-term impacts of attending residential schools:

Cultural denigration, humiliation and shaming were standard practices in residential schools. This deprived the children of self-esteem and, in many cases, led to life-long feelings of self-hatred and depression; survivors report frequent sleep disturbances and nightmares. Links have been made between such symptoms and the fact that children were often sexually abused in their own beds; trust is a crucially important issue for Aboriginal Survivors. Being betrayed by caretakers who threatened children with God's wrath while abusing them, deprived children of faith in a higher power to protect and help them; the capacity for intimacy is severely disrupted by the traumatic loss in childhood, of persons with whom children are deeply connected. Fear of further loss can be so great it far outweighs the hope of sustaining intimate or loving relationships; and many Survivors experience ongoing trauma from flashbacks. Although this is the body's way of

signaling that healing is needed, too many Survivors resort to substance abuse to numb

these feelings instead of using them to heal. (Chansonneuve, 2005, p. 47)

The continued impact of attending residential schools on Indigenous people's health and

well-being was echoed by the RHS (2002/03). According to the RHS (2002/03), the First

Nations adults surveyed believed their parents' attendance at residential school negatively

affected the parenting they received as children, and their grandparents' attendance at residential

school affected the parenting that their own parents had received when they were children. The

respondents in the RHS reported that they suffered from depression, substance abuse, and were

likely to think about suicide. Further to this, those adults having at least one parent who attended

residential school were more likely to have thought about committing suicide in their lifetime:

37% compared to 25.7% of those adults who did not have parent(s) who attended residential

school. Furthermore, 20.4% of adults who had grandparent(s) who attended residential school

also had attempted suicide during their lifetime, in comparison to 13.1% of adults who did not

have grandparent(s) who attended residential schools. In addition, the attendees of the

residential school were more prone to suffer from tuberculosis, diabetes, arthritis, and allergies

(RHS, 2002/03).

After taking into consideration the extensive losses the Indigenous peoples have endured

as a result of colonization, specifically with the epidemics and the residential school legacy, it is

not surprising Chansonneuve (2005) addressed accumulated grief and loss. She stated, as a

result of the "historical trauma related to colonization, contemporary Indigenous peoples are

further burdened with accumulated grief and loss" (p. 48). Chansonneuve described their losses

to include:

Relationships with siblings, parents, Elders and extended family members; language and

other forms of communications; spiritual and healing customs and traditions; parenting

and grandparenting skills; homelands and ancestral territories; hunting and fishing skills

and other means of promoting self-sufficiency; and cultural identity and pride. (p. 48)

Without doubt, residential schools had a profound impact on Indigenous peoples,

affecting all aspects of their identity, culture, and autonomy. The current concerns and issues of

Indigenous peoples in Canada are now believed to be "directly related to multiple generations of

children who were not only abused in residential schools and disconnected from their families

and communities, but were also taught to feel shame for their heritage, language, customs and

spiritual traditions" (Chansonneuve, 2005, p. 40). Clearly, participants of the aforementioned

abuse retreat have articulated the ongoing impact of the residential school legacy and how this

contributes to current health and mental well-being of Indigenous peoples.

Summary of colonization.

Contact with colonizers changed everything for Indigenous peoples. As a result of

colonization, the Indigenous peoples of Canada lost their autonomy, their self-determination, and

their ability to practice their cultural and spiritual beliefs, and were separated from their families

and placed in residential schools. With the epidemics, the social, economic, political, cultural,

and community structure was severely disrupted and in some cases annihilated. Within the

residential school system, Indigenous children were exposed to physical, mental, emotional,

religious, and sexual abuse. These practices that were enforced by non-Indigenous peoples have

contributed to the current health disparities between Indigenous and non-Indigenous people in

Canada (Chansonneuve, 2005; Chartrand & McKay, 2006; Hill, 2002; Wesley-Esquimaux &

Smolewski, 2004).

Colonization, specifically the epidemics and the residential school experiences, led to

cultural discontinuity which has been linked to high rates of depression, alcoholism, suicide, and violence in many communities (Kirmayer, Brass, & Tait, 2000). The First Nations adults who were surveyed by the RHS (2002/03) believed that their parents' attendance at residential school had negatively affected the parenting they received as children. And, if one of their parents or grandparents had attended a residential school, they were more likely to have thought about committing suicide in their lifetime. According to Chansonneuve (2005) the participants at a five day Residential Abuse Retreat in eastern Ontario echoed the continued negative impact of attending residential schools to include: high rates of suicide; family violence; addictive and self-destructive behaviours; mental illness and emotional disorders; histories of inter-generational family violence and abuse; histories of involvement with foster care; unhealthy coping, social, and life skills; emotional numbness, with anger toward authority figures; low self esteem from deep-rooted feelings of humiliation, shame and abandonment; and disconnection from family and culture. Ermine et al. (2004) asserted, "Despite the unpalatable nature of colonial history … Indigenous people experience those realities daily. While it may be difficult to read about the realities of Indigenous Peoples, it is without a doubt more difficult to live those realities" (p. 9).

Stress, Trauma, and Post-traumatic Stress Disorder (PTSD)

Given the impact of colonialism and the collective and personal trauma Indigenous peoples have endured, it is reasonable to discuss the impact and the related physiology of ongoing stress and trauma, and post-traumatic stress disorder (PTSD), on Indigenous mental health and well-being. When one takes into consideration the physical impact (pathophysiology) of ongoing stress and trauma, the current statistics of Indigenous health and mental well-being take on a new meaning. In addition, a discussion of PTSD and its relevance to Indigenous mental health and well-being will be presented.

Stress.

Although stress and trauma are part of the same continuum, there is a difference in the physiological response of the body. Stress may be defined as "any negative stimulus that produces activation of the sympathetic nervous system and related hypothalamic/ pituitary/ adrenal axis (HPA) pathways" and trauma is "usually a sentinel event or events of great threat and magnitude, eliciting a maximal catecholamine-based arousal" (Scaer, 2001, p. 71). Trauma occurs when there is a "behavioral response of fear, horror, or a sense of helplessness, a state very suggestive of elements of the freeze/immobility response" (p. 71).

Selye (1950) first introduced the concept that prolonged or excessive exposure to stress could contribute to the development of specific diseases. Selye's theory not only addressed the acute fight/flight response but also the sustained effort of the body in the face of ongoing life-threatening stress. Given the historical and current Indigenous experience, it is relevant to consider the impact of ongoing stress and trauma when contemplating the health disparities between Indigenous and non-Indigenous people in Canada.

Selye's (1950) original work led to the conclusion that exposure of the organism to a variety of stressors would result in a complex neuroendocrine response primarily involving the hormones of the pituitary and adrenal cortex. These responses were critical to the survival of the organism when subjected to an acute stress, but exposure to prolonged or cumulative stress could result in damage to the organism, mostly related to the prolonged exposure to adrenal cortical hormones. More than a half century of research stimulated by Selye's findings has served to validate them and to support the role of pituitary/adrenal cortical activity in stress modulation (Scaer, 2001). For example, "rats subjected to prolonged, inescapable stress were found to develop erosion of the gastric mucosa, atherosclerosis, and adrenal cortical atrophy" (Scaer,

2001, p. 70).

Scaer (2001) confirmed that chronic and prolonged exposure to "unremitting life stress" is connected with a "cluster of vascular, hormonal, immunological, neuronal, and degenerative diseases that are largely attributable to exposure to abnormal amounts of glucocorticoids" (p. 71). These diseases include diabetes, atherosclerosis, hypertension, peptic ulcer disease, obesity, osteoporosis, and cognitive/emotional impairment (Scaer, 2001). As previously mentioned, according to the RHS (2002/03), the most common health conditions reported by Indigenous peoples were "heart disease, hypertension, arthritis/rheumatism, asthma, cancer, and diabetes" (p. vii). According to Health Canada's (2006) First Nations and Inuit Health Branch (FNIHB), Indigenous peoples have 2.7 times higher incidence of diabetes when compared to the rest of Canada. This incidence of diabetes is conservative when compared to Health Canada's (2004) statement of endocrine and immune disorders (including death related to diabetes) being 3–5 times higher than that of the Canadian population.

Hypothalamic pituitary adrenal (HPA) axis.

The hypothalamic/pituitary/adrenal (HPA) axis is the main neuroendocrine system regulating stress and anxiety (Freberg, 2006). According to Scaer (2001), clients with PTSD exhibit hormonal changes suggestive of abnormal function of the HPA axis. The HPA axis is activated by a stimulus or arousal that begins with the response of the locus ceruleus sending a message to the hypothalamus that triggers the release of corticotrophin-releasing hormone (CRH), which in turn stimulates the release of adrenocorticotropic hormone (ACTH) by the pituitary. ACTH stimulates the release of cortisol by the adrenal cortex, which in turn modulates the effect of norephinephrine-mediated messages within the brain, thereby controlling the arousal reflex.

Basically, the ordinary human response to danger is a complex, integrated system of reactions that involves both body and mind. Threat initially arouses the sympathetic nervous system, which allows an adrenalin rush causing the person to go into a state of alert. The body will then focus on the immediate situation and the threat will evoke intense feelings of fear and anger. These changes in arousal, attention, perception, and emotion are normal, adaptive reactions. They prepare the threatened person for action, either to fight or flight (to escape) (Herman, 1997). Traumatic reactions occur when "action is of no avail" (Herman, 1997, p. 34), when the person cannot defend himself or herself by fighting or fleeing (escaping).

Fight/ flight response.

Animals and humans cycle in and out of varying states of arousal many times a day in response to thousands of widely varying stimuli. This cycle takes place between the sympathetic and parasympathetic nervous systems. The main effects of activation of the sympathetic nervous system, mediated by epinephrine, are related to getting the body prepared to fight or flee (flight): vasoconstriction in skin and viscera; vasodilatation in skeletal muscles; and increase in pulse, blood pressure, and cardiac output. In addition, the release of cortisol promotes sodium retention, which results in increased blood volume, mobilizes serum lipids, and increases blood sugar (Scaer, 2001). Simply, the sympathetic nervous system is helping the body get ready to defend itself either by fighting or fleeing from the danger.

The main effects of activation of the parasympathetic nervous system, mediated by the neurotransmitter acetylcholine, include slowing of the heart, lowering the blood pressure, shunting blood away from the muscles and to the abdominal viscera, activation of the digestive process, and storage of nutrients. It is also the state in which acquisition of information and operation of declarative memory in storage of facts and events best take place. Simply, the

parasympathetic system helps return the body to homeostasis, the condition prior to the threat. Although the parasympathetic nervous system is relatively inactive in arousal, it does play a role in the freeze, or immobility response, the third and least understood or appreciated part of the fight/flight/freeze sequence (Scaer, 2001).

Freeze.

When faced with overwhelming threat, there are three primary responses available to reptiles and mammals: fight, flight, and freeze (Levine, 1997). The latter is when the animal falls to the ground and surrenders to its impending death. The stone-still animal is not pretending to be dead; it has "instinctively entered an altered state of consciousness shared by all mammals when death appears imminent" (Levine, 1997, p. 16). Physiologists call this altered state the "immobility" or "freezing" response, and according to Levine, "the freezing is the single most important factor in uncovering the mystery of human trauma" (p. 16).

According to Levine (1997) the immobility response serves two purposes. First, it serves as a last-ditch survival strategy. Levine described it as playing possum. There is a possibility that the predator may decide to drag its prey to another location and during this time the prey could awaken from its frozen state and make a hasty escape in an unguarded moment. When it is out of danger, the animal will literally shake off the residual effects of the immobility response and gain full control of its body. Second, in freezing, the prey (animal and human) enters an altered state in which no pain is experienced. What that means for the prey is that it will not have to suffer while being torn apart by the predator. The physiological evidence clearly shows that the ability to go into and come out of this natural response is the key to avoiding the debilitating effects of trauma. It is a gift to us from the wild (Levine, 1997).

Scaer (2001) described the immobility response (freeze) being associated with a dramatic

change in the state of autonomic equilibrium, along with the release of endogenous opioids. The

racing heart slows to a craw; blood pressure drops suddenly; tense muscles collapse; the focused

and alert mind becomes numb and dissociated, at least in part due to high levels of endorphins;

memory access and storage are impaired; and amnesia may be expected for at least some of the

events occurring during the freeze. The physiology of the freeze response in essence involves a

state of high-level parasympathetic tone, with additional residuals of the preceding state of high

sympathetic arousal, a distinct difference from the usual homeostatic equilibrium between

sympathetic and parasympathetic systems.

Trauma.

There are numerous definitions of trauma, however, there is a growing understanding that

"psychological trauma is an affliction of the powerless" (Chansonneuve, 2005, p. 49). Matsakis

(1996) described trauma as the "wounding of your emotions, your spirit, your will to live, your

beliefs about yourself and the world, your dignity, and your sense of security" (p. 17). Matsakis

explained how the assault on your psyche is so great that your normal ways of thinking and

feeling and the usual ways you have handled stress in the past are no longer helpful. Perry and

Szalavitz (2006) described one of the defining elements of a traumatic experience as a "complete

loss of control and a sense of utter powerless" (p. 52). Herman (1997) stated:

> At the moment of trauma, the victim is rendered helpless by overwhelming force. When
>
> the force is that of nature, we speak of disasters. When the force is that of other human
>
> beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care
>
> that give people a sense of control, connection, and meaning. (p. 33)

Historically, recognition of traumatization in individuals was associated exclusively with

war-related experiences. Eventually, it became clear that a relatively broad spectrum of

experiences could lead to a group of symptoms comparable to those experienced in combat (Scaer, 2001). The American Psychiatric Association (APA) (2000) described traumatic events as including but not limited to the following:

> Military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. (pp. 463–464)

With the residential school experience, many Indigenous children were essentially kidnapped and taken from their homes unwillingly (often enforced by agents under provision of the *Indian Act*). They were placed in a residential school (foreign and hostile environment) against their wills and subjected to all types of abuse (physical, sexual, emotional, mental, and spiritual). Many children experienced and witnessed numerous violent personal assaults. Clearly, using these definitions of trauma, Indigenous peoples have experienced and endured unrelenting trauma as a result of colonization. Given the multitude of personal and collective traumatic experiences Indigenous peoples have endured, it is appropriate to include an overview of PTSD.

Post-traumatic Stress Disorder (PTSD).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) published by

the American Psychiatric Association (APA, 2000) stated the essential feature of PTSD is the development of

> Characteristic symptoms following exposure to an extreme traumatic stressor involving
> direct personal experience of an event that involves actual or threatened death or serious
> injury, or other threat to one's physical integrity; or witnessing an event that involves
> death, injury, or threat to the physical integrity of another person; or learning about
> unexpected or violent death, serious harm, or threat of death or injury experienced by a
> family member or close associate. (p. 463)

In addition, the person's response to the event "must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior)" (p. 463). The DSM-IV-TR (APA, 2000) described the characteristic symptoms following exposure to extreme trauma to include "persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal." All of these symptoms must be "present for more than 1 month", and the disturbance must cause "clinically significant distress or impairment in social, occupational, and other important areas of functioning" (p. 463).

Individuals may re-experience the traumatic event by having one or more of the following:

> Recurrent and intrusive distressing recollections of the event, including images,
> thoughts, or perceptions … recurrent distressing dreams of the event … acting or feeling
> as if the traumatic event were recurring (includes a sense of reliving the experience,
> illusions, hallucinations, and dissociative flashback episodes, including those that occur
> on awakening or when intoxicated) … intense psychological distress at exposure to

internal or external cues that symbolize or resemble an aspect of the traumatic event;

physiological reactivity on exposure to internal or external cues that symbolize or

resemble an aspect of the traumatic event. (APA, 2000, p. 468)

Persistent avoidance of stimuli associated with the trauma and numbing of general

responsiveness (not present before the trauma) includes three or more of the following:

Efforts to avoid thoughts, feelings, or conversations associated with the trauma; efforts to

avoid activities, places, or people that arouse recollections of the trauma; inability to

recall an important aspect of the trauma; markedly diminished interest or participation in

significant activities; feeling of detachment or estrangement from others; restricted range

of affect (e.g., unable to have loving feelings); sense of a foreshortened future (e.g., does

not expect to have a career, marriage, children, or a normal life span). (APA, 2000, p.

468)

The persistent symptoms of increased arousal (not present before the trauma), includes

two or more of the following: "difficulty falling or staying asleep; irritability or outbursts of

anger; difficulty concentrating; hypervigilance; exaggerated startle response" (APA, 2000, p.

468). If the symptoms persist beyond three months it is considered chronic, and if symptoms

dissipate before three months, it is considered acute (APA, 2000).

Matsakis (1996) suggested that PTSD is a new name for an old problem. He explained

how under different names, PTSD has been documented by doctors, historians, and poets as far

back as the days of the ancient Greeks. Matsakis shared the example of an historian, Herodotus,

who wrote about the battle of Marathon in 490 B.C. Herodotus described an Athenian solder

who had suffered no wounds but became permanently blind after witnessing the death of a

soldier standing next to him. Perry and Szalavitz (2006) described how PTSD was initially seen

as a rare condition that only affected a minority of soldiers, however, the same kind of symptoms began to be described by rape survivors, victims of a natural disaster, and by people who had witnessed life-threatening accidents or injuries.

Statistically, according to Perry and Szalavitz (2006), 7% of all Americans are believed to be affected by PTSD and most "people are familiar with the idea that trauma can have profound and lasting effects" (p. 2). Bruce Perry is a child psychiatrist and neuroscientist who has dedicated his life to understanding how trauma affects children and to developing innovative ways to help them cope with it. His research has affirmed "that the impact [of trauma] is actually far greater on children than it is on adults" (p. 2). When considering that young Indigenous children were often forcefully removed from their homes to attend residential schools, it is logical to assume that that trauma had far reaching implications for these children and their mental health and well-being.

According to Perry and Szalavitz (2006), by conservative estimates, about 40% of American children will have at least one potentially traumatizing experience by age 18, which may include the death of a parent or sibling, ongoing physical abuse and/or neglect, sexual abuse, or the experience of a serious accident, natural disaster, or domestic violence or other violent crime. The American Psychiatric Association (2000) reports community-based studies reveal a lifetime prevalence for PTSD in approximately 8% of the adult population in the United States. Chansonneuve (2005) asserted PTSD is of concern to Indigenous peoples. She reported Indigenous children in residential schools were subjected to

Daily, ongoing, racially-based humiliation and shaming. As well, many suffered cruel physical punishments and/or sexual abuse and were also forced to witness the abuse and malicious humiliation of other children. As a result, many adult survivors of residential

schools suffer from undiagnosed PTSD. (p. 57)

It is alarming when one takes into consideration the studies of *at-risk* individuals and the potential for the development of PTSD. The DSM-IV-TR (APA, 2000) addressed the at-risk individuals specifically:

Studies of at-risk individuals (i.e., groups exposed to specific traumatic incidents) yield variable findings, with the highest rates (ranging between one-third and more than half of those exposed) found among survivors of rape, military combat and captivity, and ethically or politically motivated internment and genocide. (APA, p. 466)

Unfortunately, according to the APA (2000), Indigenous peoples meet the criteria for at-risk individuals. This increases their risk to develop PTSD from 8% (general public) to 33% – 50% or greater.

Corrado and Cohen (2003) also support PTSD as being a mental health issue for residential school survivors. They reported on the mental health needs of 127 survivors of residential schools in British Columbia, and affirmed, "64.2% were diagnosed with PTSD; of those diagnosed with PTSD, nearly half (49.5 %) were co-morbid with at least one other mental disorder" (p. 50). Corrado and Cohen (2003) reported that the most common diagnoses of individuals who attended residential schools in British Columbia were PTSD (64.2%), followed by substance abuse disorder (26.3%), major depression (21.1%), and dysthymic disorder (20%) (p. 50). These findings coincide with the co-morbidity of PTSD as described in the DSM-IV-TR (APA, 2000), which states PTSD is associated with "increased rates of Major Depressive Disorder, Substance-Related Disorders, Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Phobia, Specific Phobia, and Bipolar Disorder" (p. 465). These disorders can either "precede, follow, or emerge concurrently with the onset of

PTSD" (p. 465). Considering the potentially (undiagnosed) high incidence of PTSD within Indigenous populations, along with the increased risk for the above disorders, one must consider trauma (both collective and personal) as one possible root of the existing mental health issues experienced by contemporary Indigenous peoples.

Clearly, the body and mind respond in a complex manner to stress, threat, and trauma.

For the past five hundred years, entire Indigenous communities have been traumatized by "multiple deaths from disease, expulsion from their homelands, loss of economic and self-sufficiency, removal of children from their homes, assimilation tactics and incarceration in residential schools" (Wesley-Esquimaux & Smolewski, 2004, p. 4). Further, these historic experiences or trauma were compounded by a loss of ceremonial freedom, dance, song, and other methods that would have helped Indigenous peoples express and grieve their losses (Ross, 1992).

Without a doubt, the overwhelming, continuous, and relentless bombardment of collective and personal traumatic experiences have had an impact on Indigenous peoples' health physically (physiologically), mentally, emotionally, and spiritually. Further, it is reasonable, after exploring definitions of trauma and considering historical trauma, to deem Indigenous peoples as being at higher risk for the development of PTSD. And, according to Wesley-Esquimaux and Smolewski (2004), Indigenous peoples have identified this disorder themselves. Many communities have requested that PTSD be considered a diagnostic tool in the newly created healing centres across Canada. It is imperative that all health care providers, social workers, mental health workers, and psychologists working with Indigenous peoples have a comprehensive understanding and the necessary skills to effectively address PTSD. Further, PTSD plays a role in the influence of historic trauma transmission (HTT), which will be

discussed later in this chapter.

Critique of the Western use of the DSM- IV-TR and view of PTSD.

It is important to acknowledge that there are scholars and psychologists who disagree
with the current use of the DSM- IV-TR (APA, 2000) to diagnose PTSD within Indigenous
populations. G. H. Smith (2000), an Indigenous scholar, argued that there is an "important place
for critiquing Western theory, not in a reactive way, negative way but in order to make space for
our own theoretical frameworks" (p. 214) to ensure that theory and research have been
"reconstructed/reclaimed to work for our interests, rather than against them" (p. 214). The past
500 years have been devastating to our Indigenous communities; the effects of systemic
genocide are currently being felt by our people (Duran & Duran, 2000). Duran and Duran (2000)
asserted that the "effects of the genocide are quickly personalized and pathologized by our
profession via the diagnosing and labeling tools designed for this purpose" (p. 87). Again, in
2006, Eduardo Duran a clinical psychologist, expressed concern about over pathologizing
Aboriginal peoples.

Duran and Duran (1995) proclaimed, "Western psychology is in desperate need of
explanations for many of the illnesses that plague society in general; critically, the Western
system of disease conceptualization and treatment is inadequate for many of these problems" (p.
52). Further, they argued, if the "Western categorization of illness is falling short of the mark in
the white community, then these categories must obviously fall much shorter when applied to the
Native client" (p. 52). According to Kirmayer, Tait, and Simpson (2009) current trauma theory
and therapy tend to focus on post-traumatic stress disorder and "give insufficient attention to the
other dimensions of experience that may be profoundly transformed by massive trauma and

abrogation of human rights" (p. 27). For example, issues of secure attachment and trust, belief in a just world, a sense of connectedness to others, and a stable personal and collective identity (Kirmayer, Tait, & Simpson, 2009). They argued that an "emphasis on past trauma as an explanation for current suffering ignores the pervasiveness of everyday, routinized practices of exclusion and marginalization" (p.27).

Duran and Duran (2000) suggested it would be beneficial to Native American people if the APA (2000) considered that many Native American people are diagnosed based on erroneous criteria; and that the diagnostic process never takes a historical perspective in placing a diagnosis on the client. Until that day comes, they assert there will be little honesty from the Western healing traditions in their relationships with Native Americans, and the ongoing ethnocide will continue under the guise of Western healing. Duran and Duran (1995, 2000) argued, in order for the diagnostic process to have any historical truth, it should incorporate a diagnostic category that reflects the effects of genocide. They recommended the following diagnosis, "acute and/or chronic reaction to colonialism" (Duran & Duran, 2000, p. 88).

Waldram (2004), a medical anthropologist, agrees with Duran and Duran (1995; 2000) that approaching trauma "through [the lens of the] DSM [-IV- TR] by and large precluded a meaningful discussion of culture, and virtually excludes notions of history and collective, community, or cultural trauma" (p. 235). Waldram brings forth the following interesting questions. Can cultural bereavement, grief over the loss of the culture of one's people, be seriously thought of as 'traumatic' as psychiatry would understand it, or is this something altogether new and outside psychiatric parameters? He stated:

> Just as DSM's PTSD became a mechanism legitimizing the suffering of Vietnam
>
> veterans, so too has it become a means of legitimizing Aboriginal experiences, history

and suffering. Many Aboriginal peoples have embraced this particular disorder, not

always as a pathological condition, but as a metaphor for their historical relationship

with the Eurocentric settler society. (p. 236)

Mitchell and Maracle (2005) suggested a change in terminology, *Post-traumatic Stress*

Response (PTSR) versus *disorder*, as a less "stigmatizing and potentially culturally-appropriate

framework to view the [consequences of] inequalities in a historical and political light" (p. 14).

They presented this historical and political-based stress response to be utilized as the framework

for understanding the health inequalities between Aboriginal and non-Aboriginal peoples of

Canada. Post-traumatic stress response moves beyond the negative association of blaming the

person and "provides a compassionate lens from which to better understand a realistic human

response to trauma rooted in oppression and cultural domination" (p. 18).

Language is powerful. Changing one word from "disorder" to "response" alters one's

perception. Given the historical socio-political history between Indigenous and non-Indigenous

peoples of Canada and the continued oppression that Indigenous peoples face, it could be

beneficial to endorse a compassionate lens. At a minimum, changing the terminology may

empower Indigenous peoples by normalizing rather than pathologizing their current state

(Mitchell & Maracle, 2005). G. H. Smith (2000) cautions Indigenous peoples: "we need to be

careful about how we label ourselves…. labels can contribute to perpetuating our subordination

and may both produce and reproduce our cultural oppression and economic exploitation" (p.

212).

The idea of trauma as both experienced and witnessed, combined with the idea of

cumulative and collective trauma, points persuasively to the existence of trauma-related

disorders among some Aboriginal peoples living in troubled communities (Waldram, 2004).

However, it is important to remember that the DSM-IV-TR (APA, 2000) is a Western lens that does not take the individual's historical perspective into consideration (Duran & Duran, 1995, 2000; Kirmayer, Tait, & Simpson, 2009; Mitchell & Maracle, 2005; Waldram, 2004) and pathologizes what may be a normal and expected response to the past 500 years of colonization (Duran & Duran, 1995, 2000).

Indigenous Responses to Colonization

Indigenous peoples have survived colonization, enduring tremendous historical and personal trauma at great cost to their physical and mental well-being. In the literature, several authors have proposed and presented their interpretations of how colonization, and the trauma associated with colonization, have impacted Indigenous peoples, both historically and at this time. These authors have described Indigenous peoples' responses to colonization to include: intergenerational grief, historic trauma transition (HTT) (Wesley-Esquimaux & Smolewski, 2004, and ethnostress (Antone et al., 1986). These authors assert that these responses by Indigenous peoples contribute to and perpetuate the existing disparities in health and mental well-being between Indigenous and non-Indigenous people in Canada.

Intergenerational grief.

According to Wesley-Esquimaux and Smolewski (2004), during the past decade, Aboriginal people on the inside of these anthropological, psychological, and social welfare studies have identified a phenomenon termed "generational grief," defined as "a continuous passing on of *unresolved* and deep-seated emotions, such as grief and chronic sadness, to successive descendants" (p. 2). In *Historic Trauma and Aboriginal Healing*, these authors examined the effects of psychogenic (of mental origin) trauma and unresolved grief, both historic and contemporary. The effects of unresolved psychogenic trauma on Aboriginal peoples, termed

generational, intergenerational, or multigenerational grief has been described by the Aboriginal

Healing Foundation (1999) as follows:

> Intergenerational or multi-generational trauma happens when the effects of trauma are not
>
> resolved in one generation. When trauma is ignored and there is no support for dealing
>
> with it, the trauma will be passed from one generation to the next. What we learn to see
>
> as 'normal', when we are children, we pass on to our own children. Children who learn
>
> that physical and sexual abuse is 'normal', and who have never dealt with the feelings
>
> that come from this, may inflict physical abuse and sexual abuse on their own children.
>
> The unhealthy ways of behaving that people use to protect themselves can be passed on
>
> to children, without them even knowing they are doing so. (p. 5)

Wesley-Esquimaux and Smolewski (2004) described the experience of historic trauma

and intra-generational grief as "psychological baggage being passed from parents to children

along with the trauma and grief experienced in each individual's lifetime" (p. 3). The hypothesis

is that the residue of unresolved, historic, traumatic experiences and generational or unresolved

grief is not only being passed from one generation to generation, it is continuously being acted

out and recreated in contemporary Aboriginal culture. They asserted, "unresolved historic

trauma will continue to impact individuals, families and communities until the trauma has been

addressed mentally, emotionally, physically and spiritually" (p. 3). They argued these

accumulated losses underlie the unresolved, intergenerational grief, frustration and rage

experienced in many Aboriginal families and communities today.

A new model: historic trauma transmission (HTT).

According to Wesley-Esquimaux and Smolewski (2004), historic trauma "causes deep

breakdowns in social functioning that may last for many years, decades and even generations"

(p. iv). They assert Indigenous social and cultural devastation in the present is the result of

historical trauma. Aboriginal people "are not only suffering from the impacts of generational

grief, they are acting it out at personal and cultural levels and recreating trauma as a way of life"

(p. 3). Wesley-Esquimaux and Smolewski (2004) succinctly described the trauma Indigenous

peoples have endured since European contact:

> Unremitting personal and collective trauma due to demographic collapse, resulting from
>
> early influenza and smallpox epidemics and other infectious diseases, conquest, warfare,
>
> slavery, colonization, proselytization, famine and starvation, the 1892 to the late1960s
>
> residential school period and forced assimilation. (p. 1)

Without doubt, Indigenous peoples have experienced a multitude of traumatic experiences with

little or no reprieve since European contact (Wesley-Esquimaux & Smolewski, 2004). Certainly,

from this perspective there is a history of trauma or, as Wesley-Esquimaux and Smolewski

(2004) asserted, *historic trauma*. Wesley-Esquimaux and Smolewski propose historic trauma as

the foundation for a new model, *historic trauma transmission* (HTT) to create a better

understanding of the "aetiology of social and cultural diffusion that disrupted Aboriginal

communities for so many years" (p. iv).

Wesley-Esquimaux and Smolewski (2004) utilized Judith Herman's (1997) theory of

individual responses to psychogenic trauma, termed complex post-traumatic stress disorder, as

the foundation to the development of their model, historic trauma transmission (HTT). In this

model, historic trauma is "understood as a cluster of traumatic events and as a disease itself"

(Wesley-Esquimaux & Smolewski, 2004, p. iv). They proposed that "hidden collective

memories of this trauma, or a collective non-remembering, is passed from generation to

generation, as are the maladaptive social and behavioural patterns that are symptoms of many

social disorders caused by historic trauma" (p. iv). They asserted that there is "no single historic trauma response; rather, there are different social disorders with respective clusters of symptoms" (p. iv). For this model, social disorders are understood as "repetitive maladaptive social patterns that occur in a group of people and are associated with a significantly increased risk of suffering" (p. 65). They stated the following are examples of maladaptive social patterns: post-traumatic stress disorder (PTSD), dissociative disorders, suicide, domestic violence, sexual abuse, and interpersonal maladjustment. The symptoms are not caused by the trauma itself, instead "the historic trauma disrupts adaptive social and cultural patterns and transforms them into maladaptive ones that manifest themselves in symptoms" (p. 65). Wesley-Esquimaux & Smolewski argue that these symptoms, "may be passed to the next generations in a form of socially learned behavioural patterns" (p. 65). Essentially, symptoms that parents exhibit (for example, family violence and sexual abuse) act as a trauma and disrupt adaptive social adjustment in their children. Unfortunately, these children internalize these symptoms and, "not to trivialize, [but] catch a trauma virus and fall ill to one of the social disorders" (p. 65). In the next generation, this process perpetuates and repeats itself. Yellow Horse Brave Heart (as cited by Wesley-Esquimaux & Smolewski, 2004) described how this has passed from one generation to the next:

> With the break-up of the extended family, many indigenous women found they had no role models to teach them parenting skills. As many Native people were raised in boarding schools, the traditional roles and ways of parenting both by Native men and women were lost. The attitudes and norms, which then sprang up in parenting styles, such as harsh physical punishment, emotional abandonment, lack of parental involvement, and insensitivity to children's needs added to imbalance in the family. As generations

continued with these ways of parenting, the trauma was passed down until many believe

it has become a cycle of despair and desperation. (p. 65)

According to Wesley-Esquimaus and Smolewski (2004) transmission of trauma always

takes place in a social environment. Aboriginal children of today did not witness the death,

terror and suffering of their ancestors. However, many of them have "witnessed rampant

domestic abuse, alcoholism and drug addiction of their parents who witnessed the lack of self-

esteem and unresolved grief of their parents" (p. 76). Wesley-Esquimaus and Smolewski (2004)

proposed that the HTT model is perpetuated by the traumatic memories being passed to the next

generations through different channels, including biological (in hereditary predispositions to

PTSD), cultural (through story-telling, culturally sanctioned behaviour), social (through

inadequate parenting, lateral violence, acting out of abuse), and psychological (through memory

processes) channels. The DSM-IV-TR (APA, 2000) supports evidence of "a heritable

component to the transmission of Posttraumatic Stress Disorder…a history of depression in first-

degree relatives has been related to an increased vulnerability to developing Posttraumatic Stress

Disorder" (p. 466). Further, Wesley-Esquimaux and Smolewski (2004) argued that the

complexity of the transmission process, as well as the complexity of the 'image of loss'

that is being passed on, must be recognized in order to fully understand why unresolved

grief and the residue of despair are still present in the Aboriginal people's collective

psyche. (p. 76)

Historic trauma transmission stems from the impacts of epidemics immediately after

European contact during the 1400s, followed by the transmission of overwhelming and

unresolved emotions to contemporary generations (Wesley-Esquimaux & Smolewski, 2004).

The HTT model is one lens through which to view how trauma is transmitted from one

generation to the next within Indigenous peoples. This model provides a context to understand how trauma has become intertwined with being Indigenous. In addition, the varied trauma response reflects the diversity within individual expression or personal coping strategies. This model certainly elicits alarm and urgency to address Indigenous peoples' mental health in a timely and effective manner.

Ethnostress.

Antone, Hill, and Meyers (1986) wrote *The Power Within People* to help explain "the confusion we experience in our Indian communities" (p. 1) with hopes of making the world a better place for our Indigenous children. They asserted:

> By all measurements of the human condition, indigenous people lead in all the statistics of suicide, alcoholism, family breakdown, substance abuse, etc. These conditions are prevalent within indigenous communities in both Canada and the United States. They serve as direct indicators of the serious stress connected with being an indigenous person in today's world. (p. 6)

According to Antone et al. (1986), Indigenous peoples' reactions to the accumulated effects of 400 years of contact with non-Indigenous peoples have surfaced as "response patterns, feelings of powerlessness and hopelessness that … disrupt the life of the individual, family, community, and nation" (p. 6). They believe that the negative conditions in Indigenous communities are symptoms of much deeper, underlying problems. Their research into these underlying problems led them to explore a concept known as *ethnostress*. They asserted ethnostress occurs when:

> The cultural beliefs or joyful identity of a people are disrupted. It is the negative experience they feel when interacting with members of different cultural groups and

themselves. The stress within the individual centers around this self-image and sense of place in the world. (p. 6)

The concept of ethnostress is based on the premise of fundamental human and psychological needs not being met (Antone et al., 1986). From the time a person is born, until they are 8 or 10 years of age, they form an image of themselves that will affect them for the rest of their lives. According to these authors, this time of life is referred to as the *Days of Decision*. During this time of critical human development, these needs are either met positively or negatively. They described an individual's needs as being

to be seen; to be heard when we communicate; to know that our communication is accepted and believed; to know that others have faith and trust in us; to be allowed to take their our place in the world; to feel secure about, and at peace with one's self; to feel that one's existence is not detrimental, but beneficial to the important people in their life. (p. 7)

The needs associated with this time of life are fulfilled through interaction with others, and perceptions individuals form about themselves are related to the information that they have received from others (Antone et al., 1986). These needs form part of a broader theory developed by Western psychologists in their work on hierarchy of human needs. Essentially, if people are able to meet their basic needs, they will "move up a pyramid of human development until they become 'holistic' human beings, in balance with one another and the world" (p. 7). Antone et al. identified 10 basic needs that are essential to human survival: water, food, shelter/housing, energy/fuel, an environment, clothing, health care, communication, education, and a spiritual/cultural base. They clearly distinguish between needs and wants: "needs are those elements essential to human survival" and wants are "short-term in nature, immediate

gratification types of rewards… [not] essential to survival and well-being of the individual" (p. 8). They asserted if human needs are fulfilled, people will become empowered and motivated to take control over their lives. In addition, Antone et al. address the importance of identity. They stated:

> To reach our highest human potential, humans must satisfactorily meet the need for identity. Our identity is our ego; the image we hold of ourselves. A satisfying image of ourselves will give us the power to act within the world with self-confidence, direction, and control. A failure to meet the necessary needs in a stressful environment will result in the development of self-destructive behavior patterns. (p. 10)

There is an abundance of literature to support that these basic needs as described by Antone et al. (1986) for Indigenous peoples' have been disrupted by colonization (Churchill, 2004; Paul, 2006; Wesley-Esquimaux & Smolewski, 2004) and continue to be unmet.

Positively Impacting Indigenous Mental Health and Well-being

Health and mental health and well-being are connected, complex, and interdependent on several factors, now known as the *determinants of health* (PHAC, 2010). Therefore, it is necessary to include an overview of the determinants of health in relation to Indigenous health and well-being. In addition, I will share the results from several studies that have contributed to the current body of knowledge toward improving Indigenous mental health and well-being.

Determinants of health.

Health Canada (2007) reported there are many factors that affect one's health and mental health and refer to these as the determinants of health. The Lalonde Report (1974) set the stage by establishing a framework for the key factors that seemed to determine health status: "lifestyle, environment, human biology and health services" (PHAC, 2010, para. 3). These key factors have

been expanded and are now known as the determinants of health and include: income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture (PHAC, 2010). PHAC (2010) stated "at every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behavior" (para. 2) and "they do not exist in isolation from each other and it is the combined influence of the determinants of health that determines health status" (para 3). In addition, Health Canada (2007) commented on the historical determinant of the residential school legacy as having "shaped the mental health of Aboriginal people" (para. 4). Using this frame—the determinants of health—to evaluate Indigenous health and well-being, quickly draws attention to the existing deficits that Indigenous peoples are currently facing on a daily basis, contributing to their ill-health.

According to Health Canada, the 2001 unemployment rate of on-reserve registered Indians was almost 4 times higher than the off-reserve Canadian rate. The highest unemployment rate was seen in the 15 to 24-year-old group, at 41%. For both populations, greater educational attainment has been correlated with lower unemployment rates (Health Canada, 2005b). There is strong and growing evidence that higher social and economic status is associated with better health. In fact, according to PHAC (2010) and Raphael (2006), these two factors seem to be the most important determinants of health. There are a number of recent studies that show limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involved the immune and hormonal systems (PHAC, 2010). This statement supports the work pioneered about 60 years ago by Selye

(1950) and more recently by Scaer (2001), both previously discussed under the impact of ongoing stress on health and well-being. According to PHAC (2010), employment has a significant effect on a person's physical, mental, and social health. Employment provides money, a sense of identity and purpose, social contacts, and opportunities for personal growth. When a person loses these benefits, the results can be devastating to both the health of the individual and his or her family. Further, unemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job (PHAC, 2010).

Education is a determinant associated with health status; Indigenous peoples consistently have lower graduation rates than other Canadians. For example, 58.9% of on-reserve registered Indians compared to 31.1% of off-reserve Canadians have less than a high school diploma. This trend continues throughout the different levels of educational attainment. The disparity is clearly visible when comparing the attainment of a University certificate, diploma, or degree. Only 3.6% of on-reserve registered Indians graduate from post-secondary programs compared to 18.1% of off-reserve Canadians (Health Canada, 2005b). Education contributes to health and prosperity by providing people with knowledge and skills for problem solving, helps provide a sense of control and mastery over life circumstances, increases opportunities for job and income security, and finally, improves an individual's ability to access and understand information to help keep them healthy (PHAC, 2010). There are many variables that influence health; however, Hull (as cited by Health Canada, 2005) asserts that education (post-secondary graduates) will likely provide better employment and income levels. Given the graduation disparity, it is reasonable to focus on education to increase self sufficiency and autonomy. However, the federal government is currently trying to withdraw funding for post-secondary education effective 2010 (C. Thunderchild, Post-Secondary Coordinator, personal communication, June 5,

2009).

Housing is another issue. Indian and Northern Affairs Canada (INAC) (as cited by

Health Canada, 2005b) noted that 55.8% of the homes on First Nations reserves were considered

inadequate in 2000/01; this figure represents an increase of 12 percentage points compared to 10

years earlier. In addition to the housing inadequacies, overcrowding remains an issue. Nineteen

percent of the dwellings on reserves have more than one person per room, compared with 2% of

dwellings for Canadian homes. Overcrowding may increase the risk of transmitting

communicable diseases such as tuberculosis.

Indigenous culture has been severely disrupted by colonization and only recently has

there been a strong revival of Indigenous culture (Friesen, 1998). PHAC (2010) asserted some

individuals or groups may face additional health risks due to a socio-economic environment,

which is largely determined by dominant cultural values that contribute to the perpetuation of

conditions such as marginalization, stigmatization, loss or devaluation of language and culture,

and lack of access to culturally appropriate health care and services.

Given the previous discussion regarding ethnostress (primarily related to the positive

development of identity and culture) and the determinants of health, the vast majority of

Indigenous peoples are at risk for lower levels of health when compared to non-Indigenous

people within Canada.

Community control or autonomy.

In 1998, Chandler and Lalonde examined the highly variable rates of youth suicide

among the Indigenous peoples of British Columbia. Their results demonstrated a link between

the levels of community control or autonomy and rates of suicide among Indigenous peoples in

British Columbia. They examined six indicators they called "cultural continuity"; essentially

they examined local community control regarding police and fire services, education services, health services, existence of local facilities for cultural activities, self-government, and involvement in land claims. They found the presence of each of these variables was associated with a lower level of suicide in communities compared to those where such local control was absent. An index created by summing these factors was strongly negatively correlated with suicide rate across the 196 bands in the study. According to Chandler and Lalonde (1998), this was clear evidence for a strong association between lack of local community control and high rates of suicide. Kirmayer et al. (2001) concurred, finding "in many cases, the health of the community appears to be linked to the sense of local control and cultural continuity" (p. 19). Wesley-Esquimaux and Smolewski (2004) agreed; they asserted that the relationship between loss of control and the onset of poor health has been well documented and "uncontrollable events are consistently more strongly associated than controllable events with depressive outcomes (clinical depression, depressive symptoms, suicide attempts)" (p. 70). Chandler and Lalonde (2009) have now replicated and broadened their earlier research efforts in three ways: (a) by including an additional 8-year period from 1993 to 2000, (b) by collecting comparable information on adult as well as youth suicides, and (c) by expanding the list of cultural continuity factors from the original six included in their 1998 study to a current total of eight with the addition of participation of women in local government and the provision of child and family services within the community (Chandler & Lalonde, 2009). It is important to note that Chandler and Lalonde (2009) found their original set of six factors to be predictive of suicide rates when they examined the adult suicide rates. Their studies (1998; 2009) demonstrated a link between community control and suicide rates, with increased community control resulting in decreased suicide rates.

Facilitating Indigenous healing.

In 1995, Rod McCormick conducted a study to explore the facilitation of healing with Indigenous peoples in British Columbia, Canada. In this study, 50 adult First Nations volunteers who were residents of British Columbia, and also in a position to observe what facilitated their own healing, participated. McCormick (1995) administered the Critical Incident Technique (Flanagan, 1954) that elicited 437 incidents from the 50 participants. These 437 critical incidents were organized into 14 categories that facilitated the 50 participants in their healing journey. The results from McCormick's study indicate that healing can be facilitated in the following 14 ways: obtaining help or support from others (91), establishing a connection with nature (72), expressing oneself (55), establishing a spiritual connection (34), participating in a ceremony (33), anchoring self in tradition (32), gaining an understanding of the problem (22), helping others (21), exercising (20), establishing a social connection (16), learning from a role model (16), setting goals (15), becoming involvedin challenging activities (7), and self care (3). The numbers in parentheses indicate the frequency with which the participants availed themselves of each of the 14 components identified from the study as facilitating their healing. From this study, McCormick (1995) suggested an effective healing program for First Nations people would invoke empowerment, cleansing, balance, discipline, and belonging.

McCormick (1997) later discussed healing through interdependence and the vital role of connection in First Nations' healing. He asserted, "effective healing focuses on interconnectedness rather than on autonomy which is a more common goal for Euro-American therapy" (p. 183) and successful healing can be facilitated through practices such as "connecting to family, community, spirituality, and nature" (p. 172). McCormick's (1995; 1997) research has been cited as an appropriate starting point in exploring possible healing strategies for Aboriginal

people given that his findings are supported by empirical evidence (Wesley-Esquimaux & Smolewski, 2004).

Stewart's (2007) dissertation, *Indigenous Mental Health: Canadian Native Counsellors' Narratives,* explored mental health and healing from a Native counsellor's perspective. Stewart (2007) found four metathemes that were integral to mental health and healing for Native clients: (a) community, "generally refers to social/collective grouping with others, any others, with whom some link to Indigenous culture exists" (p. 4); (b) cultural identity, provided meaning and pride; (c) a holistic approach taking into consideration the physical, emotional, mental, and spiritual needs and for these four areas to be in balance; and (d) interdependence (mutual reliance). Stewart (2007) talked about the "act of connecting that represents the crux of mental health and healing" (p. 109). Her findings provide further support for McCormick's (1997) research.

Pooyak's (2009) thesis explored how relationships with families contributed to resilience. Her participants were five Indigenous women from Saskatchewan who were involved in the sex trade. Pooyak (2009) found that these women's resilience was "directly attributed to these relationships where they received unconditional love, support within the context of a long-lasting relationship that provided them with the security of knowing that they could rely on them [their family]" (p. 138). The women spoke about the "ability to be self-forgiving … to accept responsibility, perseverance, and family support" (p. 146) as key factors to their resilience that eventually enabled them to leave the sex trade.

Summary

This literature review attempted to capture the salient historical and current factors that impact contemporary Indigenous mental health and well-being. This chapter provided an

overview of Indigenous health and mental health with an emphasis on the impact of colonization and Indigenous peoples responses' to colonization, and concluded by discussing factors known to improve Indigenous mental health and well-being.

The story that began this research project is about Indigenous peoples' strength, perseverance, tenacity, and ultimately about their collective and individual survival. Now, the question is, given the historical and continued colonial relationship between the Indigenous and non-Indigenous peoples of Canada and the current health disparities, *what is making a difference for Indigenous peoples from Thunderchild First Nation in terms of their improved mental health, and what do they perceive as necessary to attain optimal mental health and well-being?* Before I present their responses, the methodology that guided this research process will be presented.

Chapter 3 Methodology

"The Elders teach, be careful of the words we use, as words can change the energy around us"

(L. Okanee, personal communication, September 1, 2010).

In this chapter, I will outline the methodology guiding this research project. After careful consideration of my primary research questions, exploring what is making a difference to the positive mental health and well-being of the néhiyawak of Thunderchild First Nation, I chose narrative inquiry as a culturally appropriate methodology. Considering the long-standing socio-political history between the Indigenous peoples and non-Indigenous peoples of Canada, it is also important to discuss the vulnerability of Indigenous peoples, the history of research with Indigenous peoples, ethical considerations, and the newly established guidelines for research with Indigenous peoples proposed to avoid traditional research pitfalls.

Given that the nature of the questions asked were related to the nature of human experience, I chose to use a descriptive qualitative research design. Gillis and Jackson (2002) described qualitative research as "concepts, classifications, and attempts to interpret human behavior that reflects not only the analyst's views but the views of the people whose behavior is being described; the emphasis is on verbal descriptions as opposed to numerical ones" (p. 712). Qualitative research explores some portion of human experience (Polkinghorne, 1988; Reissman, 2008). The goal of this study was to explore and learn more about what was making a positive difference in the mental health and well-being for the Plains Cree people of Thunderchild First Nation, with no intent to generalize my findings to other Indigenous peoples.

After careful consideration of the different philosophical and theoretical perspectives of research ethics, methodologies, and paradigms pertaining to the Western world and the Indigenous world, I chose to utilize narrative inquiry to guide the research process, and thematic

narrative analysis to analyze the data. Narrative inquiry enabled the nêhiyawak of Thunderchild

First Nation to share their descriptions in a storytelling format that allowed for a wide latitude of

descriptions and was culturally appropriate for the Plains Cree people of the Thunderchild First

Nation.

Narrative Inquiry

According to Polkinghorne (1988), human science investigations related to narrative can

be distinguished according to the purpose of the research. Narrative research is either descriptive,

to "describe the narratives already held by individuals and groups" or explanatory, "to explain

through narrative why something happened" (p. 161). Using these descriptors, this study falls

under the classification of descriptive narrative research.

Clandinin and Connelly (2000) described narrative inquiry as "stories lived and told … a

way of understanding experience" (p. 20) that allows all of us to learn. By telling stories people

communicate the meaning of their daily lives, and telling stories during the difficult times in our

lives creates order, contains emotions, and allows us to search for meaning and connect with

others (Martin-McDonald, 1999; Reissman, 2008). Reissman (2008) added that stories must

always be "considered in context, for storytelling occurs at a historical moment with its

circulating discourses and power relations"; and always "involves persuading an audience that

may be skeptical.… narratives work to convince audiences of veracity, but the 'truth claims', in

turn, can be questioned" (p. 8). Narratives "invite us as listeners, readers, and viewers to enter

the perspective of the narrator … moves us emotionally through imaginative identification" (p.

9); and the "entertaining function of narrative deserves brief mention" (p. 9); lastly, stories can

"mobilize others into action for progressive social change" (p. 9). Reissman pointed out that the

major resistance movements of the twentieth century (including civil rights, feminist, and gay

and lesbian movements) were born as individuals sat together and told stories about small moments of discrimination. Polkinghorne (1988) eloquently described the pervasiveness of narratives:

> The products of our narrative schemes are ubiquitous in our lives: they fill our cultural and social environment. We create narrative descriptions for ourselves and for others about our own past actions, and we develop storied accounts that give sense to the behavior of others. We also use the narrative scheme to inform our decisions by constructing imaginative 'what if' scenarios. On the receiving end, we are constantly confronted with stories during our conversations and encounters with the written and visual media. We are told fairy tales as children, and read and discuss stories in school. (p. 14)

In narrative inquiry, "people are looked at as embodiments of lived stories … people are seen as composing lives that shape and are shaped by social and cultural narratives" (Clandinin & Connelly, 2000, p. 43). Since the contribution of a narrative inquiry is "more often intended to be the creation of a new sense of meaning and significance with respect to the research topic than it is to yield a set of knowledge claims" (p. 42), I found myself drawn to this approach and will discuss the congruency of this approach to Indigenous culture and my research questions later in this chapter.

Some of the basic terminology in narrative inquiry such as narrative, story, and plot require clarification. The term "narrative" is often used "interchangeably with the term 'story' in literature on narrative research" (Emden, 1998, p. 35). Polkinghorne (1988) asserted the most "inclusive meaning of 'narrative' refers to any spoken or written presentation" (p. 13). However, he confines his use to a more specific meaning, "a kind of organizational scheme expressed in a

story form" (p. 13) or "a meaning structure that organizes event and human actions into a whole" (p. 18). Although narrative clearly involves stories, it is "more than a single story" (Emden, 1998, p. 35). Plots are "meaning expressions…the logic of syntax of narrative discourse, it is a linguistic expression that produces meaning through temporal sequence and progression" (Polkinghorne, 1988, p. 160). According to Emden (1998), the term "plot" is used interchangeably with "theme" or "main point" (p. 160).

The use of narrative inquiry as a method is relatively new, and the process has not been well defined. Clandinin and Connelly (2000) provided a research framework, a three dimensional narrative inquiry space that allows inquiries to "travel inward, outward, backward, forward, and situated within place" (p. 49). By inward, they mean toward internal conditions, such as feelings, hopes, aesthetic reactions, and moral dispositions. By outward, they mean existential conditions, the environment. By backward and forward, they are referring to temporality—past, present, future.

Clandinin and Connelly (2000) used the following terminology to describe their inquiry space: interaction (consists of personal and social), continuity (includes past, present, and future), and situation (place). This set of terms creates a "metaphorical three dimensional narrative inquiry space," with "temporality along one dimension, the personal and social along a second dimension, and place along a third" (p. 50). Using these terms, they asserted that any particular inquiry is defined by this three-dimensional space. Ideally, all three spaces should be kept in mind throughout the research project. Clandinin and Connelly asserted that "to do research into an experience is to experience it simultaneously in these four ways and to ask questions pointing each way" (p. 50). They explained when a researcher is positioned on these dimensional spaces they ask questions, collect field notes, derive interpretations, and write a research text that

address both personal and social issues by looking inward and outward and address temporal issues by looking not only to the event but to its past and to its future. This framework is well suited to the goals of this study, as it allows for the socio-political history of Indigenous peoples to be acknowledged temporally and provides an opportunity to explore the participants' perspectives both from a personal and social context while taking place into consideration.

According to Clandinin and Connelly (2000), extensive field experience is essential in the data collection phase. Ideally, narrative inquirers "settle in, live and work alongside participants, and come to experience not only what can be seen and talked about directly but also the things not said and not done that shape the narrative structure of their observations and their talking" (p. 68). It was not feasible for me to relocate for the data-collection phase; however, I chose this setting because I wanted to go home and work in my community with people who share my cultural customs, traditions, and beliefs. I anticipated that I would understand and integrate the data more accurately because I shared a similar paradigm as the néhiyawak of Thunderchild First Nation. In addition to being a band member of the Thunderchild First Nation and a long-time resident of the area, I anticipated I would be readily accepted by the néhiyawak of Thunderchild First Nation as I had for my last research project in the community; this proved to be true throughout this research project. Also, being a registered nurse and a mental health therapist was definitely an asset, as people are generally accustomed to and comfortable with discussing health and mental health concerns with health professionals. For several weeks, I travelled on a daily basis to Thunderchild First Nation to answer questions, meet with potential néhiyawak about the research project, and interview néhiyawak. The days were spent at the health clinic; I arrived at approximately 8:30 in the morning and left promptly at 4:30 in the afternoon.

Clandinin and Connelly (2000) described data as being comprised of personal journals, interviews, letters, conversation, documents, and photographs. Their primary concern is to ensure the field texts fit within their three dimensional narrative inquiry space: situation, continuity, and interaction. The interview is the method chosen most frequently within narrative inquiry (McCance, McKenna, & Boore, 2001). According to Fielding (as cited in McCance, McKenna, & Boore, 2001), there are three forms that an interview can take: the structured interview that follows the same format for each participant; the semi-structured interview in which the researcher asks the same major questions, but has freedom to alter the sequence and to probe for more information depending on participants' response; and the unstructured interview in which the researcher has a list of topics. I decided to interview néhiyawak of Thunderchild First Nation using a semi-structured format, which allowed me to clarify their responses and gave them the option to share additional information at their discretion.

Using Clandinin and Connelly's (2000) framework to guide the narrative inquiry ensured a holistic approach, one that I hope invites the reader to consider the impact of colonization on the present and future Indigenous peoples' mental health and well-being. Narrative inquiry is culturally appropriate and congruent with the Plains Cree worldview because of its alignment with Indigenous epistemology and the centrality of the story (Kovach, 2009). Kovach stated "narrative is the primary means for passing knowledge within tribal traditions, for it suits the fluidity and interpretative nature of ancestral ways of knowing" (p. 94).

Narrative Inquiry as Culturally Appropriate

My childhood did not consist of being read the traditional Western stories (i.e., Cinderella) at bedtime, rather my family practiced the oral tradition of storytelling. In fact, there were no books in my home until I was 13 years old. Interestingly, when I was around four or

five years of age, I was known for telling *coloured* stories. Coloured stories were something my grandfather and I shared whenever we visited. My grandfather visited at least once a week and would start our visit by asking me what I wanted to be when I grew up, and then he would tell me a story. After he told me a story, he would ask me to tell him a coloured story. Essentially, a coloured story was about an event that had recently occurred in my life and before I told the story to my grandfather, I would attach a colour to it making it a coloured story. Amusingly, if he asked for a red story, I would tell him a blue story, never telling him the colour of story he wanted to hear. I would tell him, "I know you want to hear a blue story, but I want to tell you a yellow story today"; he would laugh and then encouraged me to share my coloured story. That was our special way of visiting until he passed away when I was 13 years old. To this day, when my family gathers to visit they share stories about one another. Most often the stories are humorous, at times related to past experiences, or they are shared as a way to teach a lesson, to provide warning of what has happened in similar situations. Telling and listening to stories has been an integral part of my childhood and identity.

Telling stories is a traditional practice of Indigenous peoples (Banks-Wallace, 2002; McLeod, 1999; Stevenson, 1999; Wolfe, 1988) and is a "natural function of our capacity for using language to communicate with each other" (Nelson, 2004, p. 93). Kovach (2006) asserted "story …honours the interpretive, oral tradition of Nêhiýaw (Plains Cree) culture" (p. 4). Roberts (2005), an Indigenous scholar, concurred, and stated that narrative inquiry is a methodology that "most closely resembles Aboriginal ways … in relation to Elders and their stories" (p. 29). Given that narrative inquiry provides a "methodology, a set of broad procedural ideas and concepts, rather than a pre-set method or specified technique, and it encourages responsiveness to the dynamics of the research context" (Stanley, 2006), it is well-suited to this

research project.

According to Wolfe (1988), the grandfathers used a saying in the Saulteaux language, "Mawesha Anishnawbak Keyutotunmok"; this means "in times past Indian people listened" (p. vi). Wolfe eloquently described oral tradition:

From centuries past comes a path. On this path the grandfathers walked as did their grandfathers before them. Each in his time carried the history of their people, their identity and a way of life … I now know why the grandfathers felt that listening was important. The oral tradition, in which history is embedded, requires the use of memory. The teachings that instruct a person in their identity, their purpose in life, their responsibility and contribution to the well-being of others are put in the memory for safe keeping. The grandfathers wanted young people to listen, to use their minds to the utmost capacity as a storeroom. In later times, when they too became grandfathers, the stories would be passed on to the next generation, ensuring the survival of their history and way of life. As the years passed, the grandfathers passed on. Suddenly there were none. The grandfathers were gone, but not their stories. (p. xii)

Stories, both telling and listening have been an integral part of Indigenous cultures. McLeod (1999) stated, "Storytelling has been the way Nêhiyawak (Crees) have preserved collective memory for countless generations" (p. 36). Therefore, utilizing a narrative approach is culturally congruent with Indigenous paradigms and values.

History of Research with Indigenous Peoples and Ethical Considerations

Despite the well-meaning intentions of past researchers, there is an abundance of literature that describes the unethical treatment of recruited participants. Most researchers are familiar with the Tuskegee syphilis study done in the United States with the African-American

population. This study was done to determine the effects of untreated syphilis on living subjects.

The Tuskegee Syphilis Study is one of the most horrendous examples of research conducted

without any regard for basic ethical conduct. The publicity surrounding the study was one of the

major influences leading to the codification of protection for human subjects in the United States

(Jones, 1993).

Similarly, there is an abundance of testimony to the ethical breaches in the history of

research involving Indigenous peoples in North America and many parts of the globe (Ermine et

al., 2004). Historically, research in Aboriginal communities has not been a positive experience,

therefore creating additional challenges for research (Canadian Institute of Health Research

(CIHR), 2007; Schnarch, 2004; Smith, 1999). Castellano (2004) stated research acquired "a bad

name among Aboriginal peoples because the purposes and meanings associated with its practice

by academics and government agents were usually alien to the people themselves and the

outcomes, were, as often as not, misguided and harmful" (p. 98). Peacock (1996) asserted that a

lot of the prior research conducted by non-Indigenous peoples was inaccurate, biased, and not

told from a tribal perspective. Smylie and colleagues (2004) advocated for "culturally

appropriate and community-controlled collaborative research" to "avoid the old pitfalls of health

research in Aboriginal communities" (p. 215). Indeed, there has been a shift to ensure the

knowledge created and disseminated authentically represents Indigenous peoples and Indigenous

understanding of the world (Castellano, 2004). Given this history, I will begin by addressing

vulnerable populations.

Vulnerable populations.

Even though there is "broad agreement that the vulnerable have a claim to special

protection, defining vulnerable persons or populations have proved more difficult than we would

like" (Hurst, 2008, p. 191). According to Flaskerud and Winslow (1998), vulnerable populations are "social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality" (p. 69). The Council for International Organizations of Medical Sciences (CIOMS) (2002) defines vulnerable as a substantial incapacity to protect one's own interests. Stanhope, Turner, and Riley (2008) describe vulnerable people as "[the] homeless, marginalized groups, pregnant women in violent relationships, those who are dying, drug court program clients (addictions and substance abuse), [those with] memory loss" (p. 329). Schwenzer (2008) differentiates between vulnerable and special research populations. She described vulnerable to include "children and minors, pregnant women, fetuses and human in vitro fertilization, cognitively impaired persons, and prisoners" (p. 1343). According to Schwenzer, special populations include: "students, residents, employees, terminally ill patients, and minorities" (p. 1343).

Given these definitions, there are a multitude of individuals and groups who could be considered vulnerable at some point in their lives. Vulnerability in some instances is dynamic and not a permanent state. Hurst (2008) raises an important point that the concept of vulnerability "has lost force through the inclusion of too many groups identified as vulnerable … [A]s individuals who belong to such groups are systematically and sometimes inaccurately labeled as vulnerable, … classifying groups as vulnerable can be stereotyping" (p. 195). Rogers (1997) defined vulnerability in terms of "experiences that create stress and anxiety and affect the physiological, psychological, and social functioning of the client" (p. 65). She continues to explain the theoretical underpinnings of vulnerability include the relationship between vulnerability, environmental supports, and personal resources. A client who is more vulnerable has fewer environmental supports and personal resources, whereas the client who is less

vulnerable has more supports and resources (Rogers, 1997). According to the above definitions, Indigenous peoples appear to fit within the realm of being considered vulnerable and therefore require special considerations throughout the research process. One must also take into consideration that the Indigenous population in Canada as a whole is vulnerable, given the history of colonization and past research practices. Thus, individually and collectively, Indigenous peoples are vulnerable and require special considerations throughout the research process. Therefore, it is timely that the Canadian Institutes of Health Research (CIHR) have developed guidelines for health research involving Indigenous peoples.

Newly Established Guidelines for Research with Indigenous Peoples

The history of research in Aboriginal communities has been a negative experience (Bishop, 1998; Ermine et al., 2004; Peacock, 1996; Schnarch, 2004; Severtson, Baumann, & Will, 2002; Smith, 1999). Given the negative history of research with Indigenous peoples, there has been a shift to new research paradigms as a result of the "decolonization agenda that has as a principle goal, the amelioration of disease and the recovery of health and wellness for Indigenous populations" (Ermine et al., 2004, p. 9). So, it is timely that the research institutes, which include the Canadian Institutes of Health Research, the Social Sciences and Humanities Research Council, and the Natural Sciences and Engineering Council, have engaged in their own process of critical reflection and are attempting to revise research guidelines and policies to reflect a greater sensitivity to Indigenous knowledge and the rights of Indigenous peoples and communities (Ermine et al., 2004).

In the last few years, Canada's research granting agencies have revised the Tri-Council Policy Statement regarding the ethical conduct of research involving humans. In the spring of 2004, the Interagency Advisory Panel on Research Ethics (PRE) called for input in the form of

literature reviews from Aboriginal organizations across the country. In 2004, the Indigenous Peoples' Health Research Centre (IPHRC) in Saskatchewan responded and summarized the current state of Aboriginal health research ethics and made recommendations for the following to be addressed when conducting research with Indigenous peoples: Indigenous peoples' jurisdiction; advancing the ethical space; research agreement; empowerment and benefits; protection of intellectual and property rights; ownership, control, access, and possession; education; dissemination of guideline principles; and consent and timeline conflicts (see Appendix A for IPHRC Recommendations).

The National Aboriginal Health Organization (NAHO) released a critical analysis of contemporary First Nations research, called Ownership, Control, Access, and Possession (OCAP) that provided principles to adhere to when conducting research with Indigenous communities (Schnarch, 2004). OCAP is self-determination applied to research and is a political response to persistent colonial approaches to research and information management. OCAP research guidelines were initially developed in 1998 by the National Steering Committee of the First Nations Regional Longitudinal Health Survey to guide Indigenous communities and researchers. OCAP was originally coined as OCA, a more resonant acronym with its nod to the 1990 Oka Crisis (Schnarch, 2004) Adhering to OCAP principles would allow Indigenous communities to maintain ownership of their knowledge systems, control any research that happens in their communities, and have access to and maintain possession of all research documents (Schnarch, 2004).

The Canadian Institutes of Health Research (CIHR) have published their CIHR Guidelines for Health Research Involving Aboriginal People. The 2007 CIHR Guidelines have incorporated the information and recommendations presented by both the IPHRC and NAHO.

These guidelines have been prepared by the Ethics Office of the CIHR (2007), in conjunction with its Institute of Aboriginal Peoples' Health to assist researchers and institutions in carrying out ethical and culturally competent research involving Aboriginal people. These guidelines are comprehensive and provide an overview of the historical research background, the ethical principles of Aboriginal health research, and the step-by-step procedures for the research process. These guidelines address the principles of OCAP and the 10 recommendations made by the IPHRC in their report to the Interagency Advisory Panel on Research Ethics (PRE), with the exception of recommendation #9: Consent and Timeline Conflicts not being addressed. The CIHR offer additional guidelines to enhance ethical and culturally appropriate research. These guidelines include: (a) communities should be given the option of a participatory-research approach; (b) a researcher should, if possible, translate all publications, reports, and other relevant documents into the language of the community; (c) basic principles for the collection, disclosure, use and transfer of data and biological samples to protect privacy and confidentiality of data; (d) secondary use requires REB review; and lastly, (e) the community should be able to decide how its contributions to the research project should be acknowledged (CIHR, 2007).

And, most recently the Tri-Council Policy Statement (TCPS) (2010) included a new chapter, 9, to provide guidance to researchers on the ethical conduct of research involving Aboriginal peoples. Given this study was conducted before the new guidelines were available, I adhered to the first edition of the TCPS and CHIR's guidelines for health research involving Aboriginal peoples. The second edition of the TCPS was implemented April 1, 2011.

Lessons learned.

It is clear that history has shaped current research relationships in one way or another. Research within Aboriginal communities is constrained and defined by the historical relations of

dominance, ongoing issues of achieving sovereignty and reclaiming ownership of Indigenous knowledge, and prior experiences of negative research practices (Ermine et al., 2004; Mitchell & Baker, 2005). It is critical to develop trust, build long-term relationships, and build partnerships with Indigenous communities. It is through building trust and mutually beneficial research relationships that the past historical relationships may be ameliorated. It is time for both worlds, Western and Indigenous, to establish mutual and respectful spaces to negotiate and advance research for all participants (Ermine et al., 2004). Honouring the recommendations from the IPHRC report, principles in OCAP, CHIR Guidelines for Health Research Involving Aboriginal People, and adapting research methodology to fit the context of the Indigenous community will contribute to positive research relationships between Indigenous and non-Indigenous peoples.

Ethical Considerations and Consent

Throughout this research project, I followed the Canadian Institutes of Health Research (CIHR) Guidelines for health research involving Indigenous peoples and the University of Saskatchewan Behavioural Research Ethics Board protocol. Prior approval was obtained from the Thunderchild Band (see Appendix B for a copy of the consent, Band Council Resolution (BCR) and the University of Saskatchewan Behavioural Research Ethics Board (see Appendix C for a copy of the approval) before initiating the research project. Two presentations were done for the Thunderchild Chief and Council (April 2008 and 2009), providing an opportunity for discussion regarding the research project. This power point presentation (see Appendix D for a copy of the presentation) outlined the purpose of the study, expectations, contact information for myself and my supervisor, questions to guide the interview (see Appendix E), and dissemination of the information. I submitted their letter of approval (BCR) with my proposal for this research project to the University of Saskatchewan Behavioural Research Ethics Committee (see

Appendix F for copy of submission to University of Saskatchewan Behavioural Research Ethics Committee).

As the primary researcher, I obtained verbal and written consent from participants according to University of Saskatchewan Behavioural Research Ethics Board and the cultural protocol in Thunderchild First Nation. This process ensured that the néhiyawak in this study were informed about the procedure and purpose of the research project in an ethical and culturally appropriate manner. A translator (of their choosing) was offered prior to obtaining consent and before proceeding with the interview. One néhiyaw used a translator for the first interview and not for the second interview. The translator signed a confidentiality agreement (see Appendix G) before beginning the interview. The néhiyawak of Thunderchild First Nation were provided a copy of the consent (Appendix H), data/transcript release form (Appendix I), a letter describing the study (Appendix J), and contact information for both myself and my supervisor.

There were several néhiyawak of Thunderchild First Nation who were unable to meet a second time to discuss their initial interviews and read their transcripts. Some of the néhiyawak in this study had relocated (unanticipated), and two individuals were attending school and unable to meet at the clinic during the office hours. Their initial interviews had been conducted at the health clinic before school had resumed. Thus, I submitted an amendment to the Behavioural Research Ethics Board (BREB) (see Appendix K) requesting permission to conduct the second interview over the telephone. This amendment allowed me to obtain feedback and clarify the data I had collected from all interviews and obtain a transcript release (either written or verbal) from all néhiyawak with the exception of one. One néhiyaw in this study unexpectedly moved from the community, and I was not able to locate him for a second meeting. The data collected

from his interview was destroyed and not included in the data analysis. After discussion with my supervisor, we decided that I would interview an additional néhiyaw. Fortunately, there had been one néhiyaw of Thunderchild First Nation who had been unable to keep her appointment for a previously scheduled interview. When I called and inquired if she was still interested in participating, she readily agreed to participate in the project.

The néhiyawak in this study were assigned a code number to be used on the data collection during the interview. The master list with the real names, code numbers, and addresses were kept secure and only accessible by me until after the second meeting. Once the participant had signed the transcript release, his or her name was removed from the master list. With obtained consent, audiotapes were used during the interview process. The audiotapes and transcripts were kept in a locked cabinet, restricting access to the information to myself and my supervisor. As per University of Saskatchewan protocol, my faculty supervisor will keep all original data for five years.

Special considerations.

Given the néhiyawak in the study may have experienced trauma and given the sensitive nature of the topic, I informed the néhiyawak (a) of the potential risks of participating (see Appendix E for Consent); (b) that they may discontinue the interview at any time without any repercussions and that in the event that a néhiyawak decides to discontinue, the data collected would be destroyed immediately and would not be included in the data analysis; (c) that I have an obligation and duty to report any disclosures of current child abuse (physical or sexual), suicidal ideation, and homicidal ideation; (d) that there is risk of emotional stress and that they may require additional support either from a family member/friend or require professional assistance after the interview; (e) that the mental health services in the community were aware of

the study and willing to provide support to the néhiyawak if necessary; (f) to only make comments that they would be comfortable making in a public setting, and if they were sharing an experience about something that has happened to them not to identify anyone else in the story by name; and (g) that after the data has been analyzed, the themes will be presented to Chief and Council and the Health Board of Thunderchild First Nation.

Currently, Red Echo Associates, a husband-and-wife team, are providing clinical counselling services to the residents of the Thunderchild First Nation. I spoke with both therapists at different times about the research project. I met with one of the therapists at the health clinic and gave him the same handouts and information that the néhiyawak in the study had received. In return, he gave me their business card with their cell number written on the back for the néhiyawak in the research project to call if they needed additional support.

To my surprise, my mother wanted to participate in this research project. Her request initiated a discussion about my dual role in the community, first, being a Band member and having many relatives in the community and, second, being the primary researcher for this project. These roles were discussed at length with my supervisor. We decided that my immediate family members (my mother, my siblings, and my children) would not be eligible to participate in this study. I informed my family of this decision before the study began. Another concern was the possibility that I may work in the community as a psychologist in the future, and I did not want this to potentially affect my relationship with the néhiyawak in this study or a therapeutic relationship in the future. These dual roles were discussed with the néhiyawak in this study prior to obtaining their consent and in the recruitment letter (see Appendix J for a copy of the recruitment letter).

In the local Cree culture, before asking a question with the intent of engaging a néhiyaw

in a discussion to share their knowledge or wisdom, it is appropriate to give an offering of

tobacco and a gift, typically a blanket. This practice of offering tobacco in exchange for stories

and ways of pursuing knowledge and truth existed in Indigenous cultures thousands of years

prior to European contact (Michell, 1999). Michell explained that the offering of tobacco

reinforces the ethic of reciprocity in a cosmological understanding of interdependence, balance,

and harmony. During prior consultation with the Chief and Council of Thunderchild First

Nation, we had discussed this custom of gifting and the offering of tobacco. There was

discussion about whether the nêhiyawak would be gifted with a blanket or receive a small

honorarium. There was general consensus that an honorarium would likely be more useful to the

nêhiyawak. Adhering to the local Cree cultural protocol, the nêhiyawak in this study received an

offering of tobacco and $30.00 (thirty dollars) as an honorarium at the initial interview in

appreciation for sharing their knowledge.

Location and Self-care of Myself, the Researcher

My research lens is described in the prologue. Self-care was critical throughout this

research project. Several times while I was immersed in the literature review, I was

overwhelmed with emotions of sadness, grief, and anger as I read about the history of

colonization from an Indigenous perspective, the vivid descriptions of what my people had

endured and ultimately survived. After careful consideration, thoughtful reflection, and with

encouragement from my dissertation committee, I decided to share the following self-care

practices that I engaged in throughout this research process.

Self-care.

As I embarked on the literature review for this research, I was excited and thrilled to have

finally reached this stage in my Doctoral studies. After five months of being completely

immersed in the literature, I could no longer deny the incredible surge of emotions and feelings I was experiencing. As I read numerous journal articles, reports, and books, I started to feel like my body was filled with intense grief and sadness. It was like I was feeling the grief from the grandfathers as I read and wrote about the historical trauma my people (Indigenous) have endured. Despite my intense sadness, I also felt energy and urgency which compelled and inspired me to continue with my academic journey.

My self-care was critical throughout the research process and followed the traditional teachings of the medicine wheel (Mussell, 2005). The medicine wheel is a symbol used to represent the dynamic system of mind, body, emotions, and spirit and the needs related to each of these areas that must be met for the development of human potential. Mussell (2005) asserted when the model is used in this way and applied to oneself, it becomes a powerful tool for increased self-knowledge and self-care.

Figure 1

Medicine Wheel
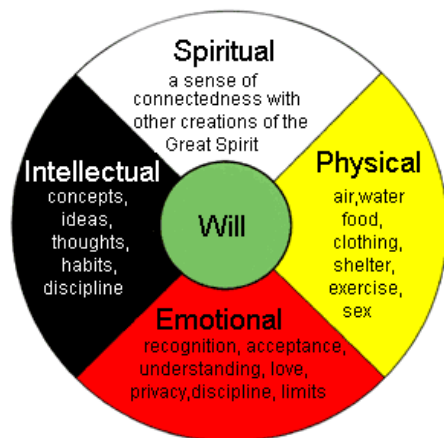
Mussell, 2005.

As a rule, the physical dimension is the easiest for me to attend to on a regular basis. I eat a well-balanced diet most of the time. Exercise has been a regular part of my life from an

early age. Every day I express gratitude for having my own home. Being born in Canada, one

often takes for granted the exceptional quality of the air and water. Having lived and travelled in

other countries, I appreciate the air and access to safe water every day. When my children were

very young, we lived in Texas; both my children were convinced that *earth juice* was the greatest

drink, until we returned to Canada, and my family explained how earth juice was just water. In

addition, I see my chiropractor regularly and my naturopathic doctor as needed, before

consulting my medical doctor about any health concerns.

At the present time, my emotional needs as described by the medicine wheel (Mussell,

2005) are being met by my family and friends. My mother and brother have been exceptionally

supportive and are available to talk with me whenever I need to vent or share my feelings. My

two teenagers have been supportive despite the fact that they are tired of me being a graduate

student. Surprisingly, my son (now 20 years old) is an exceptional listener! I have two adorable

dogs, a Bichon named Odin and a Rottweiler, Shilo. These dogs have become a source of

incredible emotional support; they provide me with unconditional love and acceptance every

day! In addition, I now have a wonderful husband, Bruce, who has the ability to keep me

laughing even on the difficult days. All my family and friends are respectful of my time

constraints and academic commitments. At times when I feel my family support network does

not grasp the depth of my unique challenges of being a graduate student, I turn to a wonderful

friend, Val, who by simply listening makes things better. Thankfully, I practice Reiki and use

this traditional Japanese healing method for relaxation and to rejuvenate my energy on a regular

basis. In addition, I had individual sessions with a somatic-experience-certified therapist to

assist with self-regulation. These sessions are required as part of the certification process of

becoming a certified somatic experience practitioner. The certification process takes three years,

and I have just completed the second year. Somatic experiencing is a wonderful skill that assists my work with clients who have experienced trauma and have PTSD.

My intellectual dimension tends to be on overload. Up until very recently, the literature review for this project had been dominating my thoughts. However, writing over the past couple of months seems to have ameliorated my feelings and emotions related to the literature review. I have found taking the training in somatic experiencing to be refreshing and the four days provided respite from academic reading and writing. In addition, I find it helpful to journal (on the computer) when I am feeling frustrated or tired. Also, listening to pow wow music, Indigenous singing and drumming, is calming and enables me to focus on writing.

The spiritual dimension—the connection to life—is what inspires and sustains my energy. I pray to the Creator on a daily basis for the many blessings I have received. Every day I express gratitude for a multitude of reasons—personal health and well-being, my husband, my children, my extended family, having my own home, being alive, my career, the beauty of nature, and my faithful, four-legged companions. When I am in need of extra support, I will go to a sweat and talk with a trusted Elder.

Using the medicine wheel ensures a holistic approach to my well-being. As part of the teachings, I re-evaluate every dimension (physical, emotional, intellectual, spiritual) on a regular basis, especially when a crisis erupts. Adhering to the teachings from the medicine wheel has been central to my self-care for the last couple of decades.

Research Setting

This research project was carried out at Thunderchild First Nation, located by Turtleford, Saskatchewan. The community has a rich and diverse population of Plains Cree people, with many of the community members being fluent in both Cree and English. Thunderchild First

Nation is approximately 230 kilometres west of Prince Albert along highway #3 and 113 kilometres northwest of North Battleford. This First Nation has a population of 2,618, of whom 939 reside on the reserve (Indian and Northern Affairs Canada, 2010). The closest emergency health services, including hospital services, are located in Turtleford, approximately 20 kilometres from the community.

The Director of the Thunderchild Human Services Corporation is responsible for the overall operation of the Thunderchild Human Services Corporation, including the departments and programs of Health, Home and Community Care, Social Development, Justice, Daycare, HeadStart, and Youth/Sport/Culture/Recreation. Key functions include program planning, accountability, supervision, leadership to the Board of Directors and staff, and administration of the annual operating budget (Thunderchild First Nation, 2006).

Health Programs and initiatives include Community Health Nursing, Home Care Nurse Manager, Community Health Representative, Home Health Aids, Hospital/Community Liaison, Medical Transportation, Drinking Water Safety Program, Aboriginal Diabetes Initiative, Prenatal Nutrition Program, Health Information System, water quality monitoring, and a dental therapy program (contracted service). Home and Community Care is funded jointly by Indian Northern Affairs Canada (INAC) and First Nations Inuit and Health Branch (FNIHB) and with their own reporting requirements. FNIHB and the Home and Community Care policies guide program delivery for nursing, coordination, assessment, and Home Health Aides. The Board of Directors is exploring the feasibility of developing an Adult Care Facility on Thunderchild and has set aside funding for a Feasibility Study (Thunderchild First Nation, 2006).

Mental health services consist of clinical counselling, a community wellness program, and two special projects workers. Currently, a husband-and-wife team are privately contracted

to provide clinical counselling in Thunderchild First Nation one day a week (either the husband or the wife), for a total of four days a month. There is a Community Wellness Program that has a community wellness (addictions) worker, Awasisak Nikan Youth Supervisor, and a youth worker. In addition, there is an Elder who works at the school and is available to lead cultural activities with the students and provide cultural counselling as requested. The special projects workers are responsible to plan, organize, deliver, and report on programs and services related to the awareness and prevention of special health concerns, including but not limited to HIV/AIDS, Fetal Alcohol Syndrome, injury prevention, and tobacco control (L. Okanee, personal communication, September 1, 2010).

Participant Recruitment

A variety of mediums were used to inform the community members in Thunderchild First Nation of the research study. I met with the Chief and Council three times over the year to discuss the research project, and once with the Health Director and health staff. After obtaining approval for the research project by the Thunderchild First Nation and the University of Saskatchewan Behavioural Research Ethics Board, posters were hung in the school, Band office, and the health clinic. Alongside the poster (see Appendix L), there were recruitment letters (see Appendix J) for potential néhiyawak to take that included information on the nature and purpose of the research, criteria to participate, and my contact information. In addition, the local radio station read a scripted announcement (see Appendix M) outlining the research study and directed interested néhiyawak to the posters in the community or to contact me directly for more information. On the days I was in the community, the radio announcer would read the script and alert individuals that I was in the community and available to interview and or answer their questions related to the study.

I utilized convenience snowball sampling to obtain néhiyawak. Snowball sampling is when the researcher completes an interview and asks the participant if there is anyone else who may be appropriate for the study (Gillis & Jackson, 2002), and numerous néhiyawak were obtained in this manner. Creswell (2007) described the purpose of snowball or chain sampling as to identify cases of interest from people who know people who know what cases are information-rich. Using this format of inquiry facilitated the successful recruitment of several Elders from the community. If the néhiyawak thought they knew someone who might be interested in participating in the study, I encouraged them to give that person my contact information. This process ensured that the néhiyawak who were interested in participating initiated the initial contact with me. Other individuals saw me hanging the posters in the community, which led to conversations about the project, and they often expressed their interest to participate at that time.

Creswell (2007) asserts there are many examples in narrative research "with one or two individuals, unless a larger pool of participants is used to develop a collective story" (p. 126). According to Speziale and Carpenter (2003) saturation occurs "when no new themes or essences have emerged from the participants and the data are repeating" (p. 68). Initially, when I commenced the project, I was undecided if I would be utilizing individual narratives or creating composite stories from the narratives. Therefore, I interviewed néhiyawak until I was certain theoretical saturation had occurred. In the end, the four themes derived from this study were supported by their individual narratives. After 15 interviews were completed, I removed the posters and informed the staff at the Health Clinic and Band office that I did not require any more néhiyawak for the research project.

néhiyawak inclusion criteria.

I utilized convenience snowball sampling to obtain participants. For this study, I used the following criteria for the néhiyawak: (a) Band member of Thunderchild First Nation, living on or off reserve, (b) 18 years of age, and (c) interested in participating in this project. Interested néhiyawak were given a letter (see Appendix H) outlining the purpose of the study, expectations, and contact information to reach myself and my supervisor. Elders were defined as (a) Band member of Thunderchild First Nation, living on or off reserve, and (b) greater than 50 years of age, (c) identified by Chief and Council or other members of the community, and (d) interested in participating in this project.

Description of participants.

I conducted 15 semi-structured interviews with a cross-section of Thunderchild Band members between 18 and 71 years of age. Of the 15 participants, there was fairly equal representation from both genders, with seven males and eight females participating. Of these 15 participants, three were Elders, two female Elders who were 62 and 70 years old and one male Elder who was 62 years old. The néhiyawak level of education varied from grade 4 to completion of a university degree. In addition, 13 of the 15 néhiyawak had a source of income either from being employed, receiving a pension, or living with their parents while attending high school.

Data Collection Process

After a néhiyaw of Thunderchild First Nation expressed interest in participating in the study, I provided them with the following information: a letter explaining the purpose of the study, a copy of the consent, and contact information to reach me and my supervisor. I explained to each potential néhiyaw that we would meet two times. The first meeting would include

answering their questions, obtaining consent, and the interview which would be recorded. Each

interview was transcribed verbatim from the audiotapes. The second meeting would be an

opportunity for them to review their transcript from the first interview and change any content if

desired.

Approximately two to three weeks later, I met a second time with most of the néhiyawak

to obtain feedback and to clarify the accuracy of the data collected during the initial interview.

For the néhiyawak in this study who were unable to meet a second time at the health clinic, I

arranged for their second interviews to be conducted over the telephone. During the second

interviews, the participants had the opportunity to read the transcript (or if the interview was

conducted over the telephone, I read the transcript to them) from the initial interview and to add

or delete information as they wished. The transcript had three different colours of text. Black

represented the participant's comments. Red represented my comments throughout the interview

and my notes that I added to the end of the transcript. At the end of each question, I typed in the

notes that I had taken during the interview, which were clearly labeled and bulleted in red. Light

blue represented the changes/additions made by the participant in the second interview (done

during second meeting). Each transcript was organized to ensure the interview and my notes for

each participant were kept together and provided an opportunity for each participant to verify

that I had captured their main points. After they were certain the transcript accurately reflected

the initial interview, they signed a transcript release form (see Appendix G for a copy of the

transcript release). Interestingly, néhiyawak who were interviewed over the telephone for the

second meeting did not make any changes to their original transcript.

After the data were collected and analyzed, I provided an opportunity for the Chief and

Council and Health Board of the Thunderchild First Nation to meet with me and discuss the

results. However, the time frame coincided with an election, meaning that all meetings and decision making by the Chief and Council were deferred for six weeks. When the election is over (currently the results are being protested), I will offer to meet with the Chief and Council at their earliest convenience to share the results of this study. In the interim, I met with the Health Director and the Band Councillor who holds the portfolios for Health, Justice, and Indian Child Family Services (ICFS) to share and discuss the results from this study. This meeting will be discussed in greater detail at the end of this chapter.

Semi-Structured Interview Questions

The purpose of this research was to explore first, what improved the néhiyawak mental health and well-being, and second, what the néhiyawak of the Thunderchild First Nation perceive as necessary to attain optimal mental health and well-being. The challenge was to find the appropriate terminology to explore what improved their mental health and well-being, despite the adversity they may have experienced in their past and in the present (without specifically asking about traumatic experiences). It is commonly accepted that stress impacts an individual's health and well-being, thus, it seemed natural to use *stressors* in the semi-structured interviews. In the last chapter, the section on implications, I suggest an alternative to this semi-structured interview guide.

All interviews followed the same format, a semi-structured interview guide of six questions (see Appendix L). The interviews began with a scripted prelude to ensure each néhiyaw received the same information about the process. The questions in the semi-structured interview were:

1. Tell me what mental health/wellness means to you?

   After the néhiyawak answered this question, I shared two descriptions of mental health.

The first description was from a Western paradigm and the second was from an Indigenous worldview. I started by sharing the characteristics used by the Canadian Mental Health Association (CMHA) to assess mental health. The script was: "The Canadian Mental Health Association (2009) uses the following key characteristics to assess mental health:"

Ability to enjoy life (can you live in the moment and appreciate the 'now'?); resilience (are you able to bounce back from hard times?); balance (can you recognize when you might be devoting too much time to one aspect, at the expense of others?); self-actualization (do you recognize and develop your strengths so that you can reach your full potential?); flexibility (do you feel, and express, a range of emotions? When problems arise, can you change your expectations—of life, others, and yourself—to solve the problem and feel better?). (para. 5)

Next, I described an Indigenous perspective by referring to Wheatley's (1996) description, "Traditional American Indian health embodies a holistic health concept in which an individual has harmony with oneself, mind, body, and spirit; with others; and with his or her surroundings or environment" (p. 48). After I shared these descriptions of mental health and well-being with the néhiyawak, I continued with the interview and posed the following questions:

2. What is making a difference for you to be ("mentally" was added later) healthier (if required ask: share an example)?

3. How have you coped with the stressors in your life (if required ask: share an example)?

4. Tell me what has helped you deal with the stressors in your life (if required ask: share an example)?

5. Tell me what gives you hope (for the future/keeps you going) (if required ask: share an

example)?

6. Imagine yourself as mentally healthy/well as possible: what would have to happen for you to achieve that?

This format allowed me to ask for clarification as needed or to encourage elaboration throughout the interview.

Data Analysis

There are numerous approaches to narrative analysis cited in the literature. However, Creswell (2007) asserted that "suggestions for narrative analysis present a general template" (p. 159) when contrasted with another approach such as phenomenology, where there have been specific, structured methods of analysis for qualitative researchers. For this study, I utilized thematic narrative analysis as described by Reissman (2008).

The goal of data analysis is to "uncover the common themes or plots in the data" (Polkinghorne, 1988, p. 177). Emden (1998) described a plot as "trying to capture … the powerful potential of stories to give meaning to people's lives …[A] story is much more than an aimless string of words; it has parts to it; it is constructed; it conveys meaning" (p. 35). And Emden cautioned that a story may have more than one theme or main point, and that the plot of a story may not "be found neatly packaged … by the narrator … it may require some painstaking work … to identify the plot of a story" (p. 35).

Data collection resulted in a collection of short stories. After the néhiyawak in this study signed the data transcript release, either by meeting with me or by a telephone conversation, formal data analysis began. The data analysis was done manually after careful consideration of the advantages and disadvantages of computer analysis (Gillis & Jackson, 2002). Each interview was recorded, transcribed verbatim, and I listened to each session numerous times to ensure

accuracy. All language was transcribed with noted pauses, laughter, and silence throughout the interview. Given that the questions were structured and organized to elicit a temporal perspective of what was making a difference for the participants in terms of improved mental health, I spent minimal time isolating and ordering relevant episodes into a chronological biographical account. Essentially, I was able to take the néhiyaw response as a complete narrative making minor changes. In thematic narrative analysis, emphasis is on "the told," the content of speech (Reissman, 2008). As a result, I made minor edits to the language in the narratives to "make it easily readable" (Reissman, 2008, p. 58). A file was created for each of the six questions, and each participant's response/narrative was put into each respective file. In addition to a file being created for each question, manually and on the computer, I created a visual of the néhiyawak responses by taping their individual answers together under each question. Creating this visual allowed me to analyze their responses from a broader context before selecting components, fragments of ideas, or key words. After the data were organized, thematic narrative analysis began.

Thematic narrative analysis.

Narrative analysis "refers to a family of methods for interpreting texts that have in common a storied form" and "as in all families, there is conflict and disagreement among those holding different perspectives (Reissman, 2008, p. 11). According to Reissman (2008), there are four broad approaches to analyzing narrative texts: thematic analysis, structural analysis, dialogic/performance analysis, and visual analysis. She asserted that these "four approaches to narrative inquiry are not mutually exclusive, in practice, they can be adapted and combined", keeping in mind "with all typologies, boundaries are fuzzy" (p. 18). All narrative inquiry is concerned with "content—'what' is said, written, or visually shown—but in thematic analysis,

content is the exclusive focus" (Reissman, 2008, p. 53).

However, it is important to note that the suggestions for narrative analysis present a general template for qualitative researchers (Creswell, 2007). In addition, Reissman (2008) cautioned:

By our interviewing and transcription practices, we play a major part in constituting the narrative data that we then analyze. Through our presence, and by listening and questioning in particular ways, we critically shape the stories participants choose to tell. (p. 50)

Throughout each interview, I attempted to maintain a consistent approach; however, given the familiarity was different between me and each individual (in some cases I knew the individual prior to meeting for this research project), there was a possibility that their level of comfort impacted the outcome of the interviews.

As I began narrative thematic analysis, I adhered to Reissman's (2008) general outline. She asserted that narrative scholars keep a "story 'intact' by theorizing from the case rather than from component themes (categories) across cases" (p. 53) with the primary attention being on *what* is said. She described narrative thematic analysis as follows:

The investigator works with a single interview at a time, isolating and ordering relevant episodes into a chronological biographical account. After the process has been completed for all interviews, the researcher zooms in, identifying the underlying assumptions in each account and naming (coding) them. Particular cases are then selected to illustrate general patterns-range and variation-and the underlying assumptions of different cases are compared. (p. 57)

Narrative study relies on "extended accounts that are preserved and treated analytically as

units, rather than fragmented into thematic categories as is customary in other forms of qualitative analysis, such as grounded theory" (Reissman, 2008, p. 12), thereby enabling the integrity of their responses to remain intact. One of the reasons I choose narrative inquiry, and narrative thematic analysis, was to ensure individual voice was at the forefront. Reissman acknowledged that "honoring individual agency and intention is difficult when cases are pooled to make general statements" (p. 12). Individual agency is what brings truth to narrative, by participants sharing their experiences and perceived meanings of their life events (Reissman, 2008).

In narrative analysis, we attempt to keep the individual story intact for interpretative purposes, although "determining the boundaries of stories can be difficult and highly interpretive" (Reissman, 2008, p. 74). According to Reissman (2008), a fully formed narrative has six structural elements: an abstract, which is a summary and or point of the story; orientation to time, place, characters, and situation; a complicating action, the event sequence, or plot, usually with a crisis or turning point; evaluation, where the narrator steps back from the action to comment on meaning and communicate emotions—the "soul" (p. 84) of the narrative; resolution, the outcome; and finally a coda, ending the story and bringing action back to the present. It is important to remember that not all stories contain all elements, and they occur in varying sequences; however, "the approach remains a touchstone for narrative analysis" (p. 84). Reissman's (2008) description of a fully formed narrative guided this research process.

As I began narrative thematic analysis using Reissman's (2008) guidelines, it became apparent that the nêhiyawak responses could be organized using the medicine wheel (Mussell, 2005). Using the framework and the definitions described by Mussell (2005) provided a solid and consistent foundation, a conceptual framework, for me to organize and to evaluate the data.

Given there are a multitude of descriptions and uses of the medicine wheel described in the literature (Absolon, 1993; Hart, 2002; Roberts, 2005; Sevenson & Lafontaine, 2003), I have included a brief overview of Indigenous knowledge to clarify the relationship between Indigenous knowledge and the medicine wheel. Although my references to the determinants of health throughout this study are an important consideration when discussing Indigenous mental health and well-being, the determinants of health were not used as a conceptual frame for the data analysis.

Indigenous knowledge.

Indigenous knowledge is a national and internationally growing field of inquiry that is "systemic, covering both what can be observed and what can be thought" (Battiste, 2002, p. 7). Battiste (2002) described other names for Indigenous knowledge (or closely related concepts to include: *folk knowledge*, *local knowledge* or *wisdom*, *non-formal knowledge*, *culture*, *indigenous technical knowledge*, *traditional ecological knowledge*, and *traditional knowledge*. Duran and Duran (2000) also use the term *cosmology* when describing Indigenous knowledge. The Aboriginal peoples have their own epistemology and pedagogy (Battiste, 2002; Deloria, 1999; Little Bear, 2000). In Eurocentric thought, "epistemology is defined as the theory of knowledge and pedagogy involving the processes by which children come to learn or know" (Battiste, 2002, p. 18). Battiste (2002) described Indigenous knowledge as follows:

> Indigenous knowledge thus embodies a web or relationships within a specific ecological context; contains linguistic categories, rules, and relationships unique to each knowledge system; has localized content and meaning; has established customs with respect to acquiring and sharing of knowledge (not all Indigenous peoples equally recognize their responsibilities); and implies responsibilities for possessing various kinds of knowledge.

(p. 14)

Aboriginal worldviews are eloquently described by Aboriginal languages. Battiste
(1998) described Aboriginal languages as being sacred, that they are a "central source of survival
for the people, as well as a critical link to knowledge given to us by our Creator who blessed us
with our languages and in them gave instructions for our development and survival" (p. 17). She
asserted Aboriginal languages provide distinctive perspectives on and understandings of the
world (Battiste, 2000b). Battiste (1998) explained Aboriginal languages provide "a direct and
powerful means of understanding the legacy of tribal knowledge. They provide the deep and
lasting cognitive bonds that affect all aspects of Aboriginal life" (p. 18). Through sharing a
language, Aboriginal people create a shared belief in how the world works and what constitutes
proper action. The "sharing of these common ideals creates a collective cognitive experience for
tribal societies that is understood as tribal epistemology" (Battiste, 1998, p. 18). Aboriginal
languages are the basic media for the transmission and survival of Aboriginal consciousness,
cultures, literatures, histories, religions, political institutions, and values (Battiste, 2000b). Little
Bear (2000), an eminent Blackfoot philosopher and scholar, further described how language is
fundamental to Aboriginal worldviews:

Language embodies the way a society thinks. Through learning and speaking a particular

language, an individual absorbs the collective though processes of a people. Aboriginal

languages are, for the most part, verb-rich languages that are process- or action-oriented.

They are generally aimed at describing 'happenings' rather than objects. The languages

of Aboriginal peoples allow for the transcendence of boundaries … everything is more or

less animate. Consequently, Aboriginal languages allow for talking to trees and rocks, an

allowance not accorded in English. If everything has a spirit and knowledge, then all are

like me. If all are like me, then all are my relations. (p. 78)

According to Little Bear (2000), inherent within Aboriginal philosophy is the belief that all things are "animate, imbued with spirit, and in constant motion," and that "existence consists of energy" (p.77). In this realm of energy and spirits, "interrelationships between all entities are of paramount importance" and space is a more important referent than time (p. 77). Little Bear described all things as being in constant motion or flux, and that this leads to a holistic and cyclical view of the world. Deloria (1999), a Lakota scholar, supported this concept of interrelationships, that "the universe is alive and everything is connected to everything else" (p. 38).

According to Deloria (1999) the most important components of the Indian universe are (a) the universe is alive, (b) everything is related, (c) all relationships are historical, (d) space determines the nature of relationships, and, (e) time determines the meaning of relationships. Aboriginal values flow from an Aboriginal worldview or philosophy. Aboriginal traditions, laws, and customs are the practical application of the philosophy and values of the group (Little Bear, 2000). Little Bear described Aboriginal philosophy to include: value of wholeness or totality, strength, sharing, honesty, and kindness. Little Bear described these four values (strength, sharing, honesty, and kindness) together will create balance, harmony, and beauty. This relational concept of the universe can be symbolized by the medicine wheel (Hart, 2002).

Medicine wheel.

Indigenous knowledge provides the philosophical foundation for the medicine wheel. The medicine wheel "illustrates symbolically that all things are interconnected and related, spiritual, complex, and powerful" (Battiste, 2000a, p. xxii). It is "an ancient symbol of the universe used to help people understand things or ideas which often cannot be seen physically. It

reflects the cosmic order and the unity of all things in the universe" (Hart, 2002, p. 39).

Although the medicine wheel symbol has different meanings and expressions for different First

Nations, some of the principles are universal (Absolon, 1993; Sevenson & Lafontaine, 2003).

Sevenson and Lafontaine (2003) affirmed "that everything is related to everything else, that

things cannot be understood outside of their context and interactions, and that there are four

aspects to the human condition-the physical, the emotional, the mental and the spiritual" (p. 190).

Mussell (2005) asserted that an individual's physical, emotional, mental, and spiritual needs

must be met for the development of human potential and "are required for survival and personal

growth" (p. 115).

According to Waldram (2004), the expression *medicine wheel* has two meanings. It

refers to a stone structure, roughly like a wheel with spokes, that has been found through-out the

northern plains in particular, "the meaning of which is not readily apparent" (p. 333). It also

refers to a pedagogical device, a "drawing of a circle partitioned in various ways to represent

Aboriginal philosophy and world-view" (p. 333). According to Waldram there is "considerable

doubt as to the authenticity [of the medicine wheel being] … a strictly Aboriginal modality" (p.

333). Kehoe (1990) suggested that the medicine wheel was actually invented by a *New Age*

author, Hyemeyohsts Storm, however, Kehoe stated that Storm "seems to have lifted the

medicine wheel from George Bird Grinnell's classic ethnographic study of the nineteenth-

century Cheyenne" (p. 200). I suggest there may be an element of truth to the contemporary

representation and use of the medicine wheel as a New Age concept, as the symbol is usually

accurately described; however, the deep philosophical underpinnings of the medicine wheel tend

to be excluded. Given that Indigenous worldviews have been primarily transmitted orally, the

answer to this question may not be resolved within an empirical context as defined or accepted

by Non-Indigenous peoples.

Little Bear (2000) stated that anthropologists have done a fairly decent job of describing Aboriginal custom; however, they have "failed miserably in finding and interpreting the meanings behind the customs. The function of Aboriginal values and customs is to maintain the relationships that hold creation together" (p. 81). Deloria (1999) concurred: "We are, in the truest sense possible, creators or co-creators with the higher powers, and what we do has immediate importance for the rest of the universe (p. 47).

The medicine wheel is a concept "central to the cultures of many Native Nations, [and] illustrates the importance of balance for wellness" (Weaver, 2002, para. 5). For this research project the medicine wheel was a culturally appropriate tool to assist with the organization of the data. The medicine wheel is an Indigenous paradigm/model that embraces a holistic approach to health and well-being and can be utilized to address all aspects affecting individuals, families, communities, and nations (Hart, 2002; Mussell, 2005).

Narrative thematic analysis yielded four overarching themes that will be supported by individual néhiyaw narratives in the next chapter. When the néhiyawak in this study were asked what improved their mental health and well-being and what they perceived as necessary to attain optimal mental health and well-being, they mentioned relationships, spiritual beliefs and cultural practices, tānisīsi wāpahtaman pimātisiwin (worldview), and ēkwa ōhi kikwaya piko ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān (these are the things that need to happen if I want to be healthy).

Operational Techniques Supporting the Rigour of Narrative Inquiry

Researchers have to make arguments to persuade audiences about the trustworthiness of their data and interpretations—that they did not simply "make up the stories they claim to have

collected, they followed a methodological path, guided by ethical considerations and theory, to story their findings" (Reissman, 2008, p. 186). Reissman (2008) argued that "fixed criteria for reliability, validity, and ethics developed for experimental research are recommended and misapplied" and that "they are not suitable for evaluating narrative projects" (p. 185). Investigators, like all storytellers, face audiences when they present their analysis of the stories. Therefore, Reissman asserted there are two levels of validity when evaluating narrative projects. First, the story told by the research participant and second, the validity of the analysis, or the story told by the researcher. According to Reissman, there are no formal rules or standardized technical procedure for validation; she recommended the following four facets of validity as being relevant to narrative research: historical truth and correspondence; coherence, persuasion, and presentation; pragmatic use; and finally, political and ethical use.

Historical truth and correspondence.

According to Reissman (2008), the idea of "correspondence (the preferred term of philosophers) is one route to establishing historical truth" (p. 187), and there are two levels of correspondence. First, "does the reported sequence of events in a personal narrative match accounts from other sources, give or take an expected degree of variation?" (p. 186). Essentially, is a story consistent with other evidence? She argued that the validity of a narrative inquiry is strengthened when there is "correspondence between self-reports and archival evidence" (p. 187). The themes identified through thematic narrative analysis in this research project are supported by the néhiyawak narratives and correspond with the published literature; this correspondence will be discussed with the results in chapter four.

The second level of correspondence concerns the interpretative work by the investigator. Evaluating this concept is less clear; however, Reissman (2008) recommended that

To support theoretical claims, students must demonstrate how they developed and/or used

methods appropriate to their research question, epistemologies, and situated perspectives.

Students need to document their sources, and bring the reader along with them as they

uncover a trail of evidence, and critically evaluate each piece in relation to others. From

the cumulative evidence, the student can then construct an interpretive account of his or

her findings, storying the stories collected. (p. 188)

Earlier in this chapter, I discussed in detail the methodology—narrative inquiry—and

how this approach was appropriate for the research questions and was culturally congruent with

the Plains Cree people. I discussed my research lens in the prologue as a way of sharing my

assumptions and perspective before beginning this project. In addition, I clearly outlined and

followed the methodology (Reissman, 2008) that guided the data analysis.

As part of the audit trail (trail of evidence), I recorded the interviews and took field notes

during the interviews to increase the accuracy of the transcription and interpretation of the

interviews. While taking notes, I added my own perceptions of the nonverbal communication

and documented when the participants laughed or paused for a significant amount of time.

Taking notes was an additional precaution in case of mechanical failure of the recorder. These

notes were included as part of the final transcription and for the data analysis. After the

transcription was completed, I provided an opportunity for each participant to review the

transcript and to modify, edit, or remove any comments he or she made during the initial

interview. All changes or additions made during the follow-up interview were made to the

transcript in blue, so I could easily identify new information gleaned from the second interview.

Since I analyzed the data manually, it was imperative to use a systematic framework to

categorize the data in a meaningful and consistent manner for accuracy and to maintain an audit

trail. I created a file for each of the questions asked during the interview, and each of the 15

néhiyawak responses were put in the corresponding file of the question. On the back of each

response I wrote the néhiyaw code number. Using the medicine wheel and the definitions

described by Mussell (2005) provided a solid and consistent foundation for me to organize and to

evaluate the data. Utilizing the medicine wheel and its clearly defined criteria will allow for

other researchers to follow the decision path I made and ideally arrive at the same or comparable

findings, given the same information (researcher's data, perspective, and situation).

Coherence, persuasion, and presentation.

Reissman (2008) explained the coherence of the participants' narratives, and the

investigator's interpretative work with them, is a related facet of trustworthiness. According to

Reissman, the following questions can be used to assess coherence when evaluating narrative

data: (a) do episodes of a life story hang together?, (b) are sections of a theoretical argument

linked and consistent?, (c) are there major gaps and inconsistencies?, and (d) is the interpreter's

analytic account persuasive? The validity of interpretations of the narrative data will "rest on the

coherence of data interpretation" (p. 190). In the final analysis, good narrative research

persuades readers. Persuasiveness is strengthened when the investigator's theoretical claims are

supported with evidence from participants' accounts, negative cases are included, and alternative

interpretations considered. Reissman (2008) insisted that, whenever possible, researchers

> tape-record conversations so they can represent what was said with greater accuracy.
>
> Providing descriptive evidence of the precise words spoken or written by narrators
>
> strengthens persuasiveness, and allows the investigator (and reader) to examine language-
>
> a hallmark of narrative research. (p. 191)
>
> All 15 interviews were recorded, transcribed verbatim, and reviewed by each néhiyaw,

either in person (in a second meeting) or by telephone, to ensure accuracy of the content and to provide an opportunity for them to make changes if desired. I presented the narratives using the néhiyawak words, making very minor adjustments to the language to enhance readability, and ensured the content was not changed.

In addition, Reissman (2008) discussed the importance of keeping a diary or log of decisions and inferences made during the course of the research project. This practice "fosters ongoing reflexivity—critical self-awareness about how the research was done and the impact of critical decisions made along the way" (p. 191). A log helps when writing up a project, jogging memory and encouraging truthfulness. Leaving an audit trail strengthens persuasiveness (Reissman, 2008).

The log of decisions and inferences I made, and those that arose during discussions with my supervisor, was kept alongside the most recent draft of my dissertation (in a binder). This chronological log (comprised of my notes and emails received from my supervisor) recorded the consistency and further development of the identified themes. Also, the struggle to determine the most truthful way to present the results of this research project is documented within this log.

Pragmatic use.

Reissman (2008) asserted the ultimate test of validity is "does a piece of narrative research become a basis for others' work?" (p. 193). *Others* in this sense are members from the scholarly community. Reissman acknowledged this pragmatic use may not be of immediate comfort to individual investigators wanting to make arguments for the trustworthiness of their data and interpretations, but, with transparency, a researcher can provide detailed information that will enable others to follow the path taken by (a) making explicit how methodological decisions were made; (b) describing how interpretations were produced, including alternative

interpretations considered; and (c) making primary data available to other investigators where appropriate. The final methodological decisions were made in collaboration by me and my supervisor. As previously mentioned, the thematic narrative analysis was guided by Reissman's recommendations. My primary supervisor had access to the transcripts throughout the project and will be keeping the data for five years after completion of this project as per the requirements if the University of Saskatchewan Behavioural Research Ethics Board. Ultimately, future communities of human scientists will evaluate whether this study is trustworthy and worthwhile to pursue as a line of inquiry (Reissman, 2008).

Political and ethical use.

Does a narrative inquiry contribute to social change? Most of us want our scholarly work to be of use to participant communities and encourage dialogue (Reissman, 2008). Reissman (2008) asserted that testimonies and narratives can function politically, so that others in similar circumstance can better understand and change their situations. This facet of validity was the impetus for me to conduct this research project; I wanted to know what was making a difference for the Plains Cree people of Thunderchild First Nation in terms of improved mental health so I could effectively facilitate healing with my Indigenous peoples. Having this knowledge was beneficial for me as a novice therapist and for other designated helpers, the néhiyawak in this study, and the Thunderchild First Nation community. By participating in this project, the néhiyawak were able to share their perceptions and descriptions of what was making a difference for their mental health and what they perceived as necessary to obtain optimal mental health and well-being. Participating in this project also provided an opportunity for others to hear their voices. In addition, the Health Director and the Chief and Council have access to the findings and recommendations, which allowed them to incorporate these findings into their current

mental health programming.

Ethically and ideally, the participants would be included in every stage of a project, beginning with the design, data gathering, interpretation, and publication of results (Reissman, 2008). Since this research project was not a participatory action research design, it does not meet these criteria. However, the project was planned collaboratively with the administration of the Thunderchild First Nation; implemented in an ethical manner guided by the University of Saskatchewan Board of Ethics and the Chief and Council of Thunderchild First Nation; interpreted adhering to a culturally congruent methodology; and the results were shared with the Health Director and a Band Councillor to allow for discussion and to provide an opportunity for them to express any concerns related to the results or any aspect of the research project. The discussion from this meeting will be presented in the next section.

Dissemination of Findings

As part of an ethical research process, I met with the Health Director and one of the Band Councillors as previously requested by the Chief and Council of the Thunderchild First Nation to (a) share the results from this research project, (b) provide an opportunity for them to express any concerns about the results or the research process, and (c) to reiterate possible venues that these results may be presented in the future. I told them that the dissertation will be available in the library and online at the University of Saskatchewan, results may be published in journals (nationally and internationally), results may be presented at conferences, and results may be shared at meetings related to Indigenous health and well-being.

I started the meeting with the Health Director and the Band Councillor by providing an overview of the research project, and finished with the results. I reviewed the two primary research questions: 1) what is making a difference for the nēhiyawak in this study to improve

their mental health?; and 2) what do the néhiyawak of Thunderchild First Nation need to obtain

optimal mental health and well-being? To answer the research questions, I read them several

narratives that supported each of the identified themes.

Throughout the presentation, they shared their thoughts about the results. There was

discussion throughout the meeting by all parties. Interestingly, at the end of the meeting the

Health Director shared that they had just contracted a consultant to assist with their program

planning to address mental health concerns in their community. The information and

recommendations I had presented were *the same* as the findings generated by the consultant.

The Health Director and the Band Councillor talked about people being comprised of

energy and shared, "the Elders teach, be careful of the words we use as words can change the

energy around us" (L. Okanee, personal communication, September 1, 2010). They said, "what

you are doing is actually sacred" and advised, "if you want to talk about something, it is good to

open your words with spiritual words" (L. Okanee, personal communication, September 1,

2010). For this reason they wanted me to begin the dissertation with a prayer, preferably of a

Plains Cree origin. They were very pleased and interested with the use of Cree language to

present the results. I took advantage of this opportunity to check the use and translation of the

Cree text and was pleased that their responses were congruent with what was written. Both of

them commented and shared their appreciation for the narratives; they appreciated the words

coming directly from the participants.

The Health Director and the Band Councillor expressed a preference to have the

participants from the Thunderchild First Nation community referred to as *néhiyawak* and wanted

this explained at the beginning alongside the definition of terms (Indigenous, First Nations,

Aboriginal, and Métis) as explained in the introduction of this study. When translated,

néhiyawak means Plains Cree (L. Oakanee, personal communication, September 1, 2010). Also, there was discussion about the demographic questions, particularly regarding education: there were Elders in the community who, by their cultural standards, would have the equivalent to a Ph.D. in an academic setting. The Health Director and the Band Councillor's last comments were regarding my location of myself as described in the prologue—they wanted me to describe myself as a treaty band member of Thunderchild First Nation, Treaty No. 6. Currently, their administration is heavily involved in the Medicine Chest, which is designated under Treaty No. 6. Overall, the meeting was pleasant, informative, and supportive. They both expressed their support for the results derived from this study. For me as an Indigenous researcher, this meeting reassured and validated that the research process had been a positive and collaborative experience for both me and the community.

Chapter 4 Results and Discussion

As the Renaissance of the Indian culture continues in North American, it becomes increasingly evident that at the time of first contact, the First Peoples had more to share with the European newcomers than land. Their traditional way of life was rich with customs, ceremonies, rituals and knowledge, most of which has been largely ignored by the dominant North American society. Today the scene is quite different, and Aboriginal Peoples all over the continent are actively resuscitating a variety of revered traditions and practices—the Sun-dance, the pipe, sweet-grass and sweat-lodge ceremonies, and pow-wows are on the comeback trail, backed by a strong sense of spirituality.

(Friesen, 1998, p. 3)

In this chapter, I will present the results derived from interviewing 15 participants of Thunderchild First Nation about what was is making a positive difference to them in terms of their mental health and what they perceived as necessary to attain optimal mental health and well-being. Narrative thematic analysis of the interviews consistently revealed four overarching themes that highlighted what positively impacted the participants' mental health and well-being, and their voiced needs to attain optimal mental health and well-being: relationships; spiritual beliefs and cultural practices; tānisīsi wāpahtaman pimātisiwin (worldview); and ēkwa ōhi kikwaya piko ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān (these are the things that need to happen if I want to be healthy). The four themes from this study will be supported by individual narratives, and followed by integrating a discussion at the end of each of the four themes. Given it is customary within Indigenous cultures for the listeners to understand and learn from a story (Roberts, 2005), I invite you as the reader to respond to what resonates for you. Epes-Brown (2001) remarked that when Elders tell the young people a story, they show them respect by not

providing too much didactic analysis. To do so is "thought to be wrong, for it would rob the child

of his or her own true learning experience through direct observation" (p. 51). Clandinin and

Connelly (2000) asserted that the narrative inquirer "does not prescribe general applications and

uses but rather creates texts that, when well done, offers readers a place to imagine their own

uses and applications" (p. 42).

When the néhiyawak of Thunderchild First Nation were asked what improved their

mental health and well-being and what they perceived as necessary to attain optimal mental

health and well-being, they responded with descriptions of strength and resilience. The

néhiyawak in this study appeared to be relatively content with their mental health and well-

being. I had anticipated greater elaboration on the challenges they had faced and overcame—

descriptions of many different types of losses. However, the néhiyawak primarily remained

positive and in the face of their challenges they eagerly shared what improved their mental health

and well-being. By posing questions that focused on the positive, the strengths and resilience of

the néhiyawak came to the forefront. Despite the colonial history Indigenous people have

experienced, the néhiyawak in this study were doing well and in several instances the néhiyawak

expressed complete satisfaction with their current level of mental health and well-being.

Narrative Descriptions of Improving néhiyawak Mental Health and Well-being

When the néhiyawak were asked what was making a difference for them in terms of their

mental health, they responded by sharing concepts and values that are inherent within Indigenous

worldviews and they mentioned the necessity of self-sufficiency as making a difference for their

mental health and required for them to obtain optimal mental health and well-being. The

néhiyawak described four overarching themes that improved their mental health and were

perceived as necessary for them to obtain optimal mental health and well-being: relationships;

spiritual beliefs and cultural practices; tānisīsi wāpahtaman pimātisiwin (worldview); and ēkwa

ōhi kikwaya piko ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān (these are the things that need to

happen if I want to be healthy). Interestingly, the néhiyawak were using the same resources to

improve their mental health and well-being that were disrupted and in some cases destroyed by

colonization (Chansonneuve, 2005; Mussell, 2005; Wesley-Esquimaux & Smolewski, 2004). In

fact, they considered these four resources as necessary for them to attain optimal mental health

and well-being.

Interestingly, the themes derived from this study appear analogous with Indigenous

worldviews that have been described by various Indigenous and non-Indigenous scholars. The

findings from this study were organized and presented as separate themes; yet from an

Indigenous worldview, one can see the connection/interconnection and relationship between the

themes and the relational concepts inherent within the teachings of the medicine wheel.

McCormick (2009) described traditional Aboriginal worldviews to include: "balance,

connectedness, spirituality, nature, ceremony, and culture" (p. 357). Hart (2002) described

Aboriginal worldviews to include: wholeness, balance, harmony and described the key

supporting values to be: respect, caring, faith, honesty, kindness, and sharing. Epes-Brown

(1992) described core Indigenous values and perspectives to include: interconnectedness,

reciprocity, language, and ceremony. The Indigenous concepts and values shared by these

authors were voiced and reiterated numerous times throughout the néhiyawak interviews.

Connectedness is fundamental to Indigenous worldviews and, as previously discussed

colonization was the beginning of "dis-connection." In the context of the residential school

legacy, Fournier and Crey (1997) spoke about *Killing the Indian in the Child*. Chansonneuve

(2005) described this process as "dis-connecting children physically, emotionally, mentally and

spiritually from their language, culture and their communities…but most painfully, from their

own sense of identity as being Indian" (p. 45). However, despite the legacy of colonization, the

néhiyawak in this study were relatively content with their mental health and well-being. It is

interesting that asking different questions—focusing on strengths as opposed to deficits—

allowed the néhiyawak in this study to shine, bringing their strengths and resilience to the

forefront. Asking different questions will result in different answers. The results from this study

show the vast majority of the néhiyawak in this study were connected to their families, spiritual

beliefs, and cultural practices in contrast to the disconnection described by Chansonneuve (2005)

that has plagued Indigenous peoples since European contact.

Relationships.

The néhiyawak in this study spoke at great lengths, numerous times throughout their

interviews, about the importance of their relationships when they were asked what was making a

difference for their mental health and what they required to attain optimal mental health and

well-being. Relationships are defined broadly in this study and included spouses, children,

extended family, friends, Elders, professionals (therapists, psychologists), and organizations (i.e.,

Alcoholic Anonymous).

Relationships, being connected, and interconnectedness are fundamental concepts of the

medicine wheel. This interconnected, relational perspective is a teaching from the medicine

wheel (Hart, 2002; Mussell, 2005). As previously discussed, the medicine wheel is a way of

understanding life (Rutherford, 2008); it is a symbol that can be used to represent the dynamic

system of the mind, body, emotions, and spirit and the needs related to each of these aspects that

must be met for the development of human potential (Mussell, 2005). The four dimensions of

oneself (physical, emotional, mental, and spiritual) are connected, interrelated, and require

balance for individuals to achieve mental health and well-being, beginning with oneself and extending outward (Hart, 2002). Hart (2002) described balance as "giving attention to what connects each part of the medicine wheel" (p. 42). This concept of the medicine wheel, interconnectedness, is an Indigenous worldview (Epes-Brown, 2001; Hart, 2002; Mussell, 2005).

The néhiyawak in this study found that relationships met their emotional needs, increased their self awareness, provided opportunities for personal growth, and gave them hope. The néhiyawak in this study consistently described these relationships as improving their mental health and required for them to attain optimal mental health and well-being. The following narratives demonstrate how their relationships improved their mental health and well-being.

Met their emotional needs.

One very young lady described how the support she received from her friends, family, and coaches made a difference to her mental health and well-being. Being able to talk about her concerns with others gave her ideas and different perspectives on problem solving.

> Friends, they're always there to talk, listen, and a lot of the times they have similar problems. They tell me what THEY did at that time, so then I have an idea of how maybe I'd like to handle my situation. My mom too, I call her a lot. I couldn't see her whenever I wanted, so I'd call her. I actually have become a lot closer to her since I moved away. When we lived together, we don't gel. But since we have been living apart, I think we have gotten closer, so she really helps a lot. Grandparents, both of my grandmas give support in different ways, and I need that a lot, more than I actually like to admit. Some of my aunties, they do the same thing. One auntie likes to give me advice about college, university, what I should be thinking about and should not be thinking about; the other auntie she jokes around about silly things that I've done. So I've got a

balance of a more serious outlook and then a more joking outlook. I guess it balances each other out. Coaches; my first coach gave a lot of metaphors to life. You'd actually have to think about them, they were really positive, and it's a good way to lead your life. They gave constant reminders not to stray from the trail. It sounded really cheesy and we all made fun of it at the time. But coaches along the way, they've probably helped a lot too because they were like my second family.

One middle-aged woman said helping others made a difference to her mental health and well-being. She had earned respect, felt needed, and enjoyed a sense of pride from helping others with their problems. She shared:

I learned how to deal with matters by helping kids when they have problems.…When they are in need, they come to my house. I give them a place to sleep and a place to eat. I have a lot of respect from young kids, and a lot of the kids call me mom. That's the way I cope; I help them with some of their problems. It makes me feel proud; it makes me feel that I'm wanted.

In contrast, one young man described how his troubled relationship with his father when he was younger was the impetus for him to start experimenting with marijuana. He described being very upset about the conflict in their relationship; he stated "he used to make me cry lots." This young man started using marijuana to forget about the conflict with his father and to manage his emotions. He shared that after he smoked a joint, "it wouldn't matter what he [dad] said." In addition, he found support from peers in similar predicaments, looking for acceptance and support. He asserted, "I found a group of friends there."

The participants' narratives demonstrate how their relationships were fundamental to meeting their emotional needs. Relationships provide the context in which a variety of human

needs are met, from basic survival to socialization and cultural transmission (Mussell, 2005). Mussel (2005) described emotional needs to include love, belonging/attachment, recognition, acceptance, understanding, privacy, limits, boundaries, and discipline. Mussell asserted acceptance from others is the basis for the emergence of self-acceptance and self-esteem, particularly early in life.

Increased self awareness.

The néhiyawak in this study described their relationships as contributing to their self awareness by providing an opportunity to reflect on their past experiences, and consider different perspectives and different ideas. One middle-aged woman reflected how both the negative and positive relationships in her life and her past experiences had impacted her mental health and well-being. She shared how she had been abused while she was in foster care and when she was adopted her life drastically improved. She freely acknowledged the ongoing psychological and physiological impact from the abuse that had occurred early in her childhood; she was candid about how she managed and how her family supported and continues to support her. She acknowledged the relationship with her adoptive mother as being important; despite describing her mother as "nagging", this relationship did provide guidance and was the impetus for her to make positive changes in her life. In addition, she talked about being able to identify her emotions and the importance of allowing herself to feel them as they surfaced as having improved her mental health:

> Probably the nagging my mother—my adopted mother—did to me when I was growing
> up [laughing]… She was constantly kicking me in the butt to make better positive
> changes in my life. And a lot of her morals and her upbringing really had impact on the
> way I think.... Mom's always said, 'life is tough, life is what you make it.' ... When I was

growing up and put in foster homes, I was so badly abused. If somebody jumped, my heart would feel like it was right in my throat and I couldn't breathe. Being sexually molested when I was a kid, thrown in a dark room in the basement and being left there in the dark. The only kind of light was the pilot light from the stove [and] I was only three at the time. In that foster home that lady stuck me up against the corner and said, 'don't you sleep'! I would stand there for the longest time trying to keep my eyes open. Every time my eyes would shut and I'd feel like I was going to go to sleep, she would hit the wall with a meter stick and bang me awake again. This was at a foster home. [I was] adopted when I was four and a half. … My mom said, 'When we got you, you had a sleeping disorder, you wet the bed, you had cigarette burn marks all over your body, [and] you had scars. [If] anybody yelled, you would burst out crying.' She said, 'That the first couple of years it was really hard to get you to talk and open up. But then once you knew that you were safe, you started to grow.' Nowadays, I feel like I get flashbacks and I know it's from the early trauma. When I get a flashback, I know it is something from the past and I just deal with it by acknowledging the feeling. Now I can distinguish between different emotions and can name the feeling. If it is a lonely feeling or a scared feeling, I just acknowledge it by allowing my body to feel it. I usually talk to my kids about it and my kids know it is a journey. My kids know what I have been through and all the abuse.

According to Walker (2004), a psychologist with a relational-cultural perspective, "people grow through action in relationship with others" (p. 4). She described conflict as the source of all growth and an "absolute necessity if one is to be alive" (p. 4). This narrative demonstrated how the conflict with her adoptive mother made a difference to her mental health,

by encouraging her to examine her perspective and her attitude toward life, and resulted in her making positive changes in her life.

Another young woman expressed how starting a job improved her mental health and well-being. She spoke about how going to work decreased her isolation and how talking to others, especially her mother, made a difference to her mental health. She shared:

> It's helped for me to start working and talking to people; because I used to be by myself all the time. I had trust issues. I didn't know who to trust, who to talk to before. Because you hear all these stories if you go tell somebody something personal, then it'll just be flying around everywhere, and everyone will know. So, I just started talking to my mom. It really does work! Just talking is helping me with my stress issues.

According to the RHS (2002/03), when First Nations youth are dealing with problems, most will turn to a parent or guardian; then they will turn to friends their own age; and then no one. The percentage of youth who turn to no one when dealing with problems is of great concern (RHS, 2002/03). In this case, this young woman was able to deal with her stress by talking to her mother. It is important to note that as a result of the historical and contemporary oppression, trustworthiness is probably more of an issue for Indians than it is for non-Indians seeking psychological assistance (LaFromboise, Trimble, & Mohatt, 1990).

Provided opportunity for personal growth.

One woman shared how ending her marriage improved her mental health and well-being. Leaving her abusive husband enabled her to develop closer relationships with her children and grandchildren, and to develop new friendships with other people. In addition, she felt she was now free to pursue personal interests and try new things. For this woman, being with her family was the most significant factor that contributed to her mental health and well-being:

Being with family makes the most difference, because when I was growing up I wasn't that close to my parents. I have eight grandchildren now! Friends, talking to other people and stuff like that. Because when I was married, I couldn't enjoy anything, he was so abusive. When I left him, I just felt like I was free. I could talk to people, just anybody with no problem at all, and this made a lot of difference in my life. That's when I went out more, finding jobs, and I had to go in public and speak. I've never done that before! I had more encouragement, I just felt so different and I was happier too. Even with my kids, I'm spending a lot more time with my kids; my own children. Before I couldn't.

A male Elder shared that he initially used Western professional relationships and organizations to address his mental health concerns but now uses both Western and Indigenous approaches. He openly advocated counselling, Alcoholics Anonymous (AA), and attending workshops as making a difference:

In the past to cope with stressors I've received counselling, seen therapists, and psychologists. I would recommend utilizing Western counselling. With Alcoholics Anonymous (AA) I've gone through some meditations, all the 12 steps within the Big Book. I had to go through all the steps and I found that helpful; and with the support of the AA members to vent about my problems or issues; to be able to talk and to release those emotions, the stressors [helped]. At the time I also had a counsellor and I was able to talk to other counsellors, therapists, and mental health workers at workshops.

Mussell (2005) asserted that each person grows emotionally through the maturity of the significant others with whom they interact and feeling understood contributes a great deal to a person's sense of security. Emotional growth and maturity takes place through the fulfillment of

needs within one's environment and "nurturing relationships are the key means for this fulfillment" and "when adequately met, relational needs affirm the essence of one's social being and promotes one's emotional growth" (p. 117). Both participants grew emotionally from developing new relationships and when their needs were met, they were able to enjoy improved mental health.

Gave the néhiyawak hope.

When the néhiyawak were asked what gave them hope, what kept them going, their first response was generally related to their relationships. One very young man voiced how his family gave him hope because "they are always there when I need them. I never bug them, and when I need someone, they just happen to be there." He spoke about the importance of his relationship with his mother "my mother, she really keeps me going. She always talks with me and calms me down. I just feel relaxed when I hear her voice. She buys me a lot of stuff … [laugh (both)] … spoils me." Another young woman also spoke about the importance of her relationship with her mother as contributing to her mental health and well-being. She shared, "I starting to talk to my mom about everything and that seems to be helping me a lot … I've quit [using] drugs … [for] one year." One middle-aged man spoke about his children giving him hope and keeping him going: "My kids give me hope. I don't want my kids to see me as being a quitter or giving up."

The Merriam online dictionary defined hope as "to cherish a desire with anticipation" or "to desire with expectation of attainment" (n.d.). Duggleby et al. (2010) completed a metasynthesis of the hope experience of family caregivers of persons with chronic illness. Their findings described hope as being complex and circular, that the outcomes of hope impact conditions influencing specific hopes. Duggleby et al. (2010) described hope to be influenced by

internal and external factors. The internal factors (within the individual) influencing hope were

(a) positive outlook, (b) spirituality and faith, (c) physical and psychosocial well-being. The

external factors (outside the individual) included (a) level of support, (b) situational events, (c)

illness of family member, (d) relationship with family member, and (e) information about the

patient's condition. Their findings suggest internal and external factors have either a positive or

negative impact on the specific hope of family caregivers, "reflecting a dynamic interaction of

possibilities" (p. 153). These narratives demonstrated the participants' reliance on external

factors, the relationships with their family members, to provide them with hope. However,

collectively throughout their interviews, the participants referred to both internal and external

factors as described by Duggleby et al. as positively influencing their hope.

Discussion.

Pooyak (2009), an Indigenous woman, sought to understand how familial relationships

contributed to resiliency for Indigenous women who had been involved in the sex trade. She

found that sustaining and maintaining family bonds were integral to the resilience of the women

who participated in her study. These familial relationships provided the women who had been

involved in the sex trade with unconditional love, support within the context of a long-lasting

relationship, and a sense of security knowing that they could always rely on their families.

Further, Pooyak identified family support as one of four key factors enabling these Indigenous

women to eventually leave the sex trade. LaVallee (2007), a Métis woman, explored strategies

for success and well-being for Indigenous women enrolled in graduate studies and found

maintaining close connections with family provided her participants with strength, support, love,

and motivation for continuing their educational journeys.

McCormick (1997) discussed healing through interdependence and the vital role of

connection within First Nations' healing. He stated, "effective healing focuses on

interconnectedness rather than on autonomy which is a more common goal for Euro-American

therapy" (p. 183). McCormick asserted successful healing can be facilitated through practices

such as "connecting to family, community, spirituality, and nature" (p. 172). From his study, he

described interconnectedness as "the individual's connection to the world outside the self" (p.

178). McCormick described connectedness as being part of Aboriginal worldviews and stated an

individual's connection to the world outside the self plays a significant role in Aboriginal

healing. This theme of interconnectedness has been described by Epes-Brown (1989) as being

central in all Aboriginal cultures and has been described as a series of relationships that are

always reaching further and further out, starting with the family and extending to the universe.

Relationships are considered a determinant of health, categorized under social support

networks. Labonte (2003) asserted "support from families, friends, and communities is

associated with better health" arguing the "health effect of the support of family and friends who

provide a caring and supportive relationship may be as important as risk factors such as smoking,

physical activity, obesity, and high blood pressure" (p. 11). Labonte referred to social networks

as *social capital*, the web or relations and ties that bind people together into communities.

Networks are different from friendships or relationships, they are more impersonal; they are the

larger pot from which friendships and relationships may develop. They are also the range of

groups, affiliations, and loose connections through which potential and resources flow.

Connecting individuals to other groups, organizations, and neighbourhoods are all ways in which

programs can broaden participants' social networks (Labonte, 2004).

The Mental Health Commission of Canada (2009) developed a framework for a Mental

Health Strategy for Canada to support all people living in Canada as they journey toward

recovery and well-being. This framework has seven goals; the fourth goal recognized and

addressed the unique role of families in promoting well-being and fostering recovery across the

lifespan. Families are to be engaged and helped through education programs, and whenever

possible, families are to become partners in the care and treatment of their loved ones and to be

integrated into decision-making in a way that respects consent and privacy.

Summary.

The néhiyawak in this study discussed the ongoing significance and importance of their

relationships as positively impacting their mental health and well-being and as necessary for

them to obtain optimal mental health and well-being. Considering the history of colonization

and the federal government's policy of assimilation and the devastating effect on the unity and

sense of belonging for the Indigenous peoples of Canada (McCormick, 2009), it is not surprising

that the néhiyawak highlighted the importance of their relationships as a resource, as

significantly improving their mental health and well-being. In this study, their relationships met

their emotional needs, increased their self-awareness, provided opportunities for personal

growth, and gave them hope. These relationships allowed them to express their feelings;

provided acceptance and a sense of belonging, pride and respect; provided the opportunity to

reflect on their past experiences, different perspectives, and new ideas; ending and beginning

new relationships fostered personal growth and self awareness; and finally, provided them with

hope, knowing that they can always turn to a family member for support. The significance of

relationships positively impacting mental health and well-being is not a new concept. However,

given the history of colonization and especially the residential school legacy, it is essential to

understand the increased significance of relationships on contemporary Indigenous peoples'

mental health and well-being.

Spiritual beliefs and cultural practices.

Throughout the interviews, the néhiyawak in this study spoke numerous times about the importance of their spiritual beliefs and cultural practices as improving their mental health, and required for them to attain optimal mental health and well-being. Their spiritual beliefs and participation in their cultural activities may be likened to enculturation as described by Zimmerman, Ramirez-Valles, Washienko, Walter, and Dyer (1996). They define *enculturation* as "the extent to which individuals identify with their ethnic culture, feel a sense of pride in their cultural heritage, and participate in traditional cultural activities" (p. 296). Ross (1992) spoke about traditional ceremonies providing a culturally acceptable venue for Indigenous peoples to express their feelings. The néhiyawak said that their spirituality, praying, participating in cultural events such as a sweat, sundance, and pow wows improved their mental health and well-being. The following narratives demonstrate how their spiritual beliefs and cultural practices improved their mental health and well-being.

Spirituality and prayer.

One middle-aged woman shared how her spirituality was making a positive difference to her mental health. She explained how spirituality had been integrated into her daily life and that to her was religion. She wondered how others cope without having spiritual connection and expressed empathy for those who attended the residential schools and were forbidden to practice their spirituality and culture:

> My spirituality was integrated into my daily life. For example, if you go pick sweet grass, don't pick in excess, only pick what you need, and make sure you put tobacco there for Mother Earth. That is religion to me; you're connecting with your spirituality that way. The Creator is that close, intertwined in your life, that's how I feel. I'm not religious. I

see other young people whose parents went to residential school [and] when those parents

came home, they didn't go to church and they didn't practice Indian culture. I often …

wonder when they have hard times or when they struggle, how do THEY go forward to

the next day, to the next year, without having that spiritual connection.

Another young man shared returning to his Indigenous spirituality was a key factor for

him to have a balance in his life and improved his mental health. He articulated, "getting back

into my own spirituality/religion has played an important part for me to be healthier. Spirituality

provides a balance in my life." One woman shared she smudged and prayed on a regular basis.

She voiced the importance of tolerance, respecting all religions and the different ways people

have been raised to connect to their spirituality made a difference to her mental health. She

asserted:

I smudge myself, pray constantly every chance. I respect all other religions. The way I

pray and live is not the only way, I respect other peoples' way and religions. It is the way

they were raised. We all pray, we say Creator and they say Jesus. They have their own

churches to go to. My sweats are just like a church.

The meaning and definition of spirituality varies. For many northern Quebec Cree,

"one's sense of spirituality is inseparable from one's sense of being" (Adelson, 2009, p. 275).

Fundamental to Cree life for many "is a spiritual awareness and belief that is embedded in a

hunting and land-based culture that simultaneously permeates everyday social relations and

practices" (p. 275). When we speak about Native spirituality today, many associate the term

with particular beliefs and practices. However, even though we may associate Native spirituality

with particular practices, such as the sweat lodge, healing circles, and pipe ceremonies, it is

important to remember that these are only the more highly visible elements of a far more

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complex, integrated, and holistic spiritual belief system (Adelson, 2009).

Among Aboriginal groups, spirituality is a component of all aspects of life and is integral to the promotion of health and well-being (Reynolds, 1993). Spirituality includes faith in supernatural forces such as the Great Spirit and seeking harmony with nature and the universe (Meisenhelder & Chandler, 2000). Meisenhelder and Chandler (2000) surveyed 71 Native Americans over 65 years of age living in the general community on their frequency of prayer, importance of faith, and their health status. Interestingly, they found people who prayed more often and those who indicated a high importance of their faith scored higher in the mental health subscale.

One male Elder said that his culture and spirituality were paramount in making a difference to his mental health. He shared his journey, beginning with his childhood, and realizing he needed assistance to heal. He spoke about how he utilized Western and Indigenous approaches to heal; however, to ultimately heal he spoke about the necessity to find himself as a Cree man and that meant reclaiming and practicing his Plains Cree culture. He shared:

> I believe in our culture, our spirituality and I practice it. I would like to go back to the beginning. I come from a dysfunctional family; and I've learned behaviours because of alcoholism. At twenty one years of age I realized I had an addictive personality and started going to treatment centres for addictions and personal issues, like resentment and anger. I had been verbally and physically abused as a child. I feel my dad went overboard when he strapped me; he left bruises. It is not necessary to discipline so harshly, we need to focus on teachings to start healing, and there are other means of discipline. We picked that up harsh discipline from somewhere, it was not part of our traditional teachings or culture. Now I am learning how not to be resentful through

proper teachings. We live with nature and have our own way of discipline. Willow was given his job, to discipline. People do need a little hit [if you were told], 'go get a willow', knew you were going to be disciplined. The willow was smudged first. A tap, but not to make bruises; [was] done to feel emotional not physical pain. I've gone to treatment centres right across Canada to deal with my attitude, my behaviour, my well-being, stressors, and my problems. Really, my mind was confused, my way of life was confused. Treatment centres helped me; the modern world helped me. But in time I met an Elder and found out that I had to find my identity, who I really was as a Cree person. I needed to find out about my morals, my beliefs and my values as a Cree person. Which I did! I started going to sweat lodges to deal with myself physically, mentally, spiritually, and emotionally. I went to sundances, started fasting, and working with Elders. Because of my recovery, I took training for addictions and I worked in a treatment centre for years. I have always believed being well in order to help people. I need to be healthy to be able to work in the field of helping; and I've been successful. I've learned the western way of life, like AA meetings, going to workshops and roundups, how to cope with anger and emotions. It helped, I believe it helped me. I believe in traditional counselling and that is how I do my counselling. Traditional counselling is learning about self, the values, learning about honesty, and how to deal with stressors in our culture. In our culture there are ways of dealing with stressors. Like if a person is mourning, we have ceremonies to help, like a feast, a memorial round dance. There's so much to talk about.

This Elder's story reinforces that recovery cannot be done to, or on behalf of, people. Recovery must be the result of an individual's own efforts and must be accomplished using their choice of services and support (Mental Health Commission of Canada, 2009).

One middle-aged woman told me a story about her struggle with spirituality and how she decided what she believed, despite being pressured by a close family member to practice Christianity. She shared her difficulty to understand how two siblings raised in the same household and with the same parents could have such different beliefs. She shared how the death of her mother provided the impetus for this deep self-reflection and ended with her feeling assured she was on the right path. She began by saying:

I'll tell you another story. I first found out about what I believe in spirituality when my mother died. She was one of the greatest influences in my life. When she died, my oldest sister is a holy roller she tried to cram religion down my throat and said, 'You are lost, you're lost, you know. If you don't take Jesus as your personal saviour you're going to be lost'. My mom died and she was full Cree. I never saw my mom go to a service, throw her hands in the air, cry out and fall down because she's in the rapture. That's how my sister's religion is, that's how I see it. Then it battled me, inside here [she pointed to her heart] [when] my mom died. Do you think [my] mother would come back in a dream and say, 'you know what this is, this is what you believe.' No, I never dreamt of her. Then I battled with that thing inside. What do I do? What religion am I supposed to do? What am I supposed to believe? I don't have nobody that I can run to now because my mother's gone. She can't do my praying for me. I have to pray. I have to pray this way or that way or whatever. I went and stood at her grave about three or four months after she died. Now [as I] think back maybe it was my sister's way of talking about the grief that we shared. She was trying to help me how she was dealing with her grief, with her religion. But then it seemed like she was pushing me, do this, do this, do this and I had no choice. And I kept stalling. So I went and stood at my mother's grave.

I didn't speak out loud but I stood there and I processed. This is what my sister is telling me to do and I have no choice but I got to do it. And I told her this is how I grew up, this is how I believed. Spirituality [is] being connected. It was a belief [for example], you wake up [in the morning]and smudge. That's just normal for me. I told her, am I supposed to not do that and to take her road? But then honest to God something came over me. I was standing there and tears were coming down. I felt a tear but this teardrop—the water—as it goes down it had a warm pocket of air that I felt inside. Then once it reached here [pointed to her heart] I said, 'oh, is that all? Why did I make myself go through months of torment, when it was right here? I didn't have to take my sister's religion. I'm me now. I'm for myself. I'm going to apply the things that I know. I am going to believe the way that you [mother] taught me, that's what's important here. So from that day on, that's when I picked up and continued on.…I don't think I need my soul to be saved, I know who the Creator is, you know [laughed]. That's one thing in my life that I'm sure of!

LaFromboise et al. (1990) asserted that people are capable of taking control but are unable to do so because of social forces and institutions that are hindering their efforts. In this case, this woman was able to take control, make her own decision without outside support, and felt confident in her chosen path. The new *Framework for a Mental Health Strategy for Canada* has acknowledged that different cultural, spiritual, and religious traditions have a variety of ways to express their shared outlook on life and that this diversity must be respected (Mental Health Commission of Canada, 2009).

Another middle-aged woman spoke about believing in her dreams and how this gave her hope, and improved her mental health and well-being. She explained some of her dreams

provided direction or offered her reassurance, and reaffirmed a connection between herself and the Creator. She shared:

I believe in my dreams [and] I believe the Creator gives us dreams.… I'll share a beautiful dream that I had with you. I was thinking about this person a lot and went home. I dreamt I was sitting with my hands clasped like this [fingers interlocked across lap], I was looking up and noticed I was sitting on a big mound of garbage. I was thinking, what is going to happen to all that water? I wonder if it's safe to drink or how can we get rid of this garbage? It must have been the pollution I was thinking about, and it manifested into a big giant wall in my head. So in my dream, I was sitting on this wall of garbage that also looked like a globe. I was sitting there and I look up and I saw the clearest aquamarine turquoise sky, it was blue. And I heard a voice behind me, from an old Elder that was like an old family member. He sang a song and he said, 'don't worry, the Creator is looking after, the Creator knows what you see and the Creator cares. You will be looked after'. It meant things will take care of itself, if people care. That is beautiful! That is what I mean, sometimes you have to sit back and listen. Think about your dreams, they have a meaning. I know some dreams do not have meanings, some of them [dreams] try and give you direction, but it's up to you to find out.

Dreams occupy an important place in Aboriginal customs. It is believed that dreams provide significant information about our past as well as our future, including warnings of impending misfortune or needs that must be fulfilled to promote healing (Chansonneuve, 2005).

Ceremony.

One female Elder said participating in cultural ceremonies made a difference to her mental health and well-being. She talked about prayer, gratitude, and most importantly wanted

others to know they can use their cultural ceremonies to empower themselves. She shared:

> The first thing I do when I get up is I thank the Creator that I'm up this morning and I
>
> pray for everybody. At nights I pray, I thank the Creator for giving me a strong body, to
>
> be able to move around, for my mind, and things like that. When I am sick, I will go to a
>
> sundance and walk out in good health. Twice I was able to walk out without my
>
> crutches, there have been many surprises. I participate in sweats as well, with many
>
> surprises. I would like people to know they have the power [ability] to use their cultural
>
> ceremonies, and they should respect them. So, it is good to maintain our culture, our
>
> tradition, our values are very important.

Another young woman concurred; she shared how lost she felt when she moved and going to a sweat gave her direction:

> When I moved it kind of felt like I lost who I was. So at least twice a year I go to a sweat
>
> and then that kind of puts me back on, like, the healthy path. It just kind of evens me out.
>
> It reminds me of where I'm going, what I'm leaving, and where I'm going to.

A middle-aged man said participating in cultural activities improved his mental health. He shared that when he was at a cultural activity, he was able to clear his mind and forget about his problems. He was able to become positive, feel good, connect with his friends, and he enjoyed meeting people who were involved in cultural activities. He explained:

> It has helped going to pow wows on weekends and playing that traditional stick game.
>
> That has really helped me out a lot, and really given me a good healthy mind. The
>
> traditional stick game is a cultural event, and when you get there, you forget about time or
>
> problems. You just have a good feeling, a good positive feeling; meeting up with all your
>
> friends and meeting new people. And, nothing bothers you, nothing on your mind, and

no worries. To go and have a sweat at a sweat lodge, that really helps out a lot. Going to sundances, and all kinds of cultural events, like chicken dances are also helpful. Talking, to other people who are culturally orientated has made a difference.

Another woman spoke about how attending cultural ceremonies with her son improved her mental health and well-being. She explained how watching the dancers move to the beat of the drum enabled her to forget about her problems; cleansed her mind, body, and soul; resulted in her feeling calm; and provided clarity in her life. She shared:

I try to go to gatherings like pow wows, sundances, and sweats. But I haven't went to a sweat in like ten, twenty years. But pow wows I like going to because my son likes to sing and dance. We try to go to those [pow wows] as much as we can because it makes me happy seeing him dance, sing, and everybody likes it. It cleanses my soul. When you watch them dance to the drum, there is a connection. The way they [the dancers] move to the music the drum beat and everything. It actually calms me down, it makes me think about what I want out of my life. I don't know, it just makes me happy. It makes me forget about my problems. It seems like it cleanses my mind, body, and soul.

One young woman routinely participated in a variety of cultural activities, which improved her mental health and well-being. She emphasized the support from peers available at these cultural events:

I guess a lot of traditional ways like sweats, sundances, smudging and stuff … I've done a lot of those and they seem to work really well actually, so I'll continue doing that. With pow wows you have so many friends there who are WILLING to just listen to your problems or say 'snap out of it; it's not a problem you're just making a big deal out of it, out of nothing.'

Colonization has disrupted Indigenous peoples' spiritual beliefs and cultural practices (Chansonneuve, 2005; Mussell, 2005; Ross, 1992). It was only in 1933 that Indigenous peoples in Canada were allowed to participate in their traditional cultural practices without legal repercussions (OTC, 2008). Culture has been recognized as a determinant of health (PHAC, 2010). PHAC (2010) acknowledged that various individuals or groups may face additional health risks due to their socio-economic environments, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture, and lack of access to culturally appropriate health care services. This acknowledgement by PHAC reinforces the importance of providing culturally appropriate health care services for Indigenous peoples to decrease the increased health risks associated with being a minority. The *Framework for a Mental Health Strategy for Canada* has acknowledged that in a transformed mental health system, policies, programs, treatments, services, and supports would be culturally safe and culturally congruent (Mental Health Commission of Canada, 2009). Specifically, the third goal of this framework is to respond to the diverse needs of all people in Canada by providing culturally safe and culturally congruent care to all peoples of Canada.

However, in recent decades, there has been a revival of Indigenous strength and determination across Canada driven by the restoration of traditional systems of beliefs and cultural practice, the recovery and reclamation of languages, the growth of First Nations' sense of national identity, and the reconstruction and deconstruction of Aboriginal people's history (Wesley-Esquimaux & Smolewski, 2004). Today more Indigenous peoples are participating and finding renewed strength and spiritual resolve from participating in cultural ceremonies (Epes-Brown, 1992). According to Kirmayer and Valaskakis (2007), the recovery of tradition may be

healing both at individual and collective levels. They assert restoring linguistic, religious, and communal practices as fundamental acts of healing. Further, receiving and transmitting the knowledge associated with healing practices reaffirms core cultural values and maintains the historical continuity of Indigenous cultures (Kirmayer & Valaskakis, 2007). In addition, cultural ceremonies provide "individuals, families, and communities structures within which to acknowledge and mourn common wounds. Group healing, within ceremonies, reduces isolation; alleviates guilt, shame, and anger; and enhances feelings of self worth" (Mitchell & Maracle, 2005, p. 19).

Ross (1992) pointed out that the prohibited and denigrated facets of traditional culture such as the sweat lodge, pipe ceremonies, and the regular ritual offering of tobacco as a symbol of gratitude, "must be seen for what they really were: tools to maintain and deepen a belief in the inter-connectedness of all things" (p. 184). He argued that these cultural practices serve a second function, for they "offer an alternative focus to that of our individualistic and materialistic value system" (p. 184).

Discussion.

These first two themes—relationships and spiritual beliefs and cultural practices—are related to connection and interconnectedness and are integral with Indigenous worldviews (Epes-Brown, 1992; McCormick, 1997). The word *connection* has become popular in the recent years. In conventional usage, the term is used to describe encounters characterized by interpersonal harmony, warm support, and pleasant feelings. The term may also connote a relationship among people with similar interests and inclinations or with someone who can facilitate movement toward some desired goal (Walker, 2004). Relational-cultural theory views chronic disconnection as the "primary source of human suffering, resulting in paralyzing psychological

isolation and impaired relational functioning" (Walker, 2004, p. 6). Walker explained, that these disconnections are "exacerbated by patterned and protracted abuses of power in relationship, whether the relational context is interpersonal, familial, or institutional-cultural- or, in many instances, some combination of the three" (p. 6). As a result of colonization and the continued impact of colonization, Indigenous peoples have experienced abuses of power in all of these relational contexts - interpersonal, familial, and cultural. Walker explained that a "common response to the chronic absence of safety and respect in relationship is to resort to strategies of disconnection" as "these are ways of withdrawing from relationship for protection" (p. 9). Walker asserted these individuals who have disconnected often retain an appearance of connection while lacking its substance. This perspective—relational-cultural theory—suggests another plausible explanation for why Indigenous peoples disconnected. This disconnection was likely essential for their survival, especially in relation to the residential school experience.

Many Aboriginal Elders and healers believe that reconnection to "culture, community, and spirituality is healing … [T]his belief makes sense when one realizes that, for many individuals and communities, it was disconnection from these sources of meaning and support that made Aboriginal people unhealthy in the first place" (McCormick, 2009, p. 349). McCormick (2009) pointed out that Aboriginal culture is "collectively oriented" (p. 349) and is more likely to provide sources of meaning "through family, community, and cultural values than is an individually oriented culture" (p. 349); and to be "disconnected from those values is to be disconnected from potential sources of meaning" (p. 349). McCormick argued that there is a strong link between cultural disruption and sickness and that the path to well-being is "reconnection to one's 'spirit' and 'culture' and to one's inherent sources of meaning" (p. 350). Kirmayer, Brass, and Tait (2000) concur; they asserted that cultural discontinuity has been

"linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the most dramatic impact on youth" (p. 5). Ultimately, connection to traditional Aboriginal culture and values means "that a person must become connected to extended family, community, the natural world, and the spirit world-in essence, to all of creation" (McCormick, 2009, p. 350).

Summary.

Aboriginal cultures are rich with ceremonies designed to build strength, restore balance, and promote healing (Chansonneuve, 2005). The participants' narratives demonstrated their perceived benefits from attending cultural ceremonies. They described how, by attending and participating in the cultural and festive ceremonies, a cleansing of their mind, body, and soul occurred; this enabled them to have a "clear mind" and provided clarity in their lives. Despite the federal government's extensive efforts in the past to aggressively assimilate them into mainstream society (Mussel, 2005; Wesley-Esquimaux & Smolewski, 2004), Indigenous peoples are currently enjoying a strong cultural and spiritual revival (Friesen, 1998). The recovery of traditional ceremonies and practices engage individuals, families, and communities in ways that can promote solidarity, social support, and collective transformation (Kirmayer, Brass, & Valaskakis, 2009).

tānisīsi wāpahtaman pimātisiwin (worldview).

Through narrative thematic analysis, several concepts emerged related to the participants' view of life, and ultimately, their perspective made a difference to their mental health and well-being. I struggled to find an English word or phrase to accurately describe this theme—their perspective of life—and ultimately decided a Cree phrase would provide the most accurate description of the data. This phrase, *tānisīsi wāpahtaman pimātisiwin*, when translated means "worldview, how you see life, how you see the whole piece of life" (C. Ross, Cree Language

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Instructor for Northern Teacher Education Program and University of Saskatchewan, personal

communication, May 30, 2010,). Within this theme, tānisīsi wāpahtaman pimātisiwin, the

néhiyawak in this study described how their worldview was influenced by their past experiences,

formal, and informal education. tānisīsi wāpahtaman pimātisiwin (worldview) is related to the

mental/intellectual component of the medicine wheel, which refers to the capacity to involve

concepts, ideas, thoughts, habits, and discipline (Mussell, 2005). The néhiyawak spoke about

three primary areas that affected their tānisīsi wāpahtaman pimātisiwin (worldview) that

improved their mental health and well-being: taking personal responsibility, their attitude, and

wícihisowin. This Cree phrase, *wícihisowin*, means "helping oneself" (D. Chamakese, personal

communication, Jan 20, 2011).

Personal responsibility.

The néhiyawak spoke about how taking personal responsibility in different areas of their

lives improved their mental health and well-being. They spoke of how the importance of having

healthy communication patterns; taking personal responsibility for making changes in their lives;

acknowledging, addressing, and dealing with their emotions and feelings; having healthy

boundaries; and exercising personal choice made a difference to their mental health and well-

being. The following narratives demonstrate the néhiyawak taking personal responsibility for

their mental health and well-being.

One very young woman shared how listening to her mother's perspective about the

importance of communicating her feelings made a difference for her mental health:

My mom helped by bringing this to my attention; she says I keep everything internal until

I explode. So something little like losing a DVD could bring me to tears because of

everything else I've kept inside. So she helped me realize by that one comment, that I

can't be internal and that was four years ago. Now I try talking to people, but it's hard. I

try to deal with my problems more openly, instead of keeping them to myself until they

eat away at me.

Another young woman shared that she had considered going to therapy but upon deeper

reflection realized that she was responsible for changing her life to improve her mental health

and well-being, so she did. She exclaimed:

I was thinking of going to therapy, but I think I'm doing my own therapy. Before when I

was thinking a lot, I wanted to go to therapy. But I just kept thinking about it and I just

thought no one else is going to change my life but me. So I did and I like it. I love it!

A male Elder shared how taking personal responsibility to make the changes in his life,

attending AA, dealing with his anger, addressing his low self-esteem, focusing on positive

thoughts, and having therapists who believed in him contributed positively to his mental health

and well-being:

What helped me is to really work hard on my problems, to listen, to practice, and to make

changes in my life. Not just talking about it, but to make that change! With my

alcoholism I had to make changes; I could never drink again, that's what AA taught me.

I couldn't drink, be with people that use, or be in high-risk places such as bars or parties.

That's what helped me. Also, to deal with my anger, my resentment toward people who

had hurt me, I used the Big Book in AA. I have talked to people that I have resented and

told them why I was resentful towards them. In the Big Book, they call it making amends

to people that have harmed you as well as those you have harmed. Today I see a lot of

people who are insecure, and when people are feeling insecure they get jealous or

envious. To me it is low self esteem; a person that has low self esteem thinks less of

themselves. I needed to build up my self esteem, because I was a very insecure, very

jealous person. At one time I didn't trust, I was always thinking negatively. I had to

change to positive thinking rather than being negative; and that made a difference for me.

It was a combination of everything, because at that point I had a confused mind, and I

really thought that was the end of the rope for me. I just gave up. But counselling—

talking [to] therapists, psychologists—helped me build up my self esteem. To me, that's

very important in life, to have somebody to believe in me, that there's hope.

Another middle-aged woman spoke about creating healthy boundaries with others, the

importance of healthy communication, and not being drawn into gossip made a difference for her

mental health and well-being:

To a certain extent I've learned to not enable people. I've learned not to carry so much.

I've now learned to say, 'hey you want to do it, let's do it together. I'll help you, and

we'll support each other.' I'm big on that. One thing I do not do is gossip; gossip is

vicious. I think gossip can make a person feel weak; it's not a good thing. You hear

gossip about you and it makes you feel weak because you already feel bad. I'm a bad

person to talk to on the telephone. Sometimes my sisters will call me, and ask 'so what

did you do today?' 'Hmm, I went to work, that's it.' They will ask me, 'did you see

anything?' 'Hmm, uh, no, I just went to work, came home, and I'm tired.' That's one

thing I've learned, not to badmouth other people. If you don't have anything nice to say,

don't say it! Because, sometimes what spews out of our mouth is not good; sometimes

what people say is hurtful. And, then they say oh, I shouldn't have said that. My dad had

a lot of influence, of how I look at people and what comes out of my mouth. Sometimes

people speak out in anger and they don't mean it or they mean well, but their words are

still damaging. Always be careful of what you say!

One middle-aged woman talked about the importance of choice, as she reflected on the decisions she had made as a teenager. She clearly recalled the day she decided to abstain from drugs and alcohol and how her mother's teachings made a difference to her mental health and well-being:

I chose. I don't know how old I was, but I remember that day I looked at my friends who were teenagers and they were starting to experiment with drinking. And that day I was standing outside with them, and I decided, no. I'm not going to do that and that's not going to be me. I decided that day, that I wasn't going to have a lifestyle of smoking, smoking up, and sniffing. That wasn't for me. It's so clear in my mind, I still remember that day. I can still see myself standing there thinking. Since I made that decision, I know it has affected the way that I think. A lot of the teachings that I grew up with helped me. Things that I was told and raised with, I have applied to my life. I always consider myself a very lucky person to have had a mom and a dad. My dad went to a day school until he was in grade four or five; my mother was a full-blooded Cree Indian. She never spoke a word of English and she passed her life's teachings on to me.

McCormick (1995) found setting goals facilitated healing for the First Nations people of British Columbia. Examples ranged from setting career goals to goals of improving one aspect of one's life. Before setting goals many of his participants reported feeling depressed and powerless due to lack of options and direction. Thus, the action of setting a goal resulted in the participants feeling more optimistic and empowered (McCormick, 1995).

Hart (2002) explained that it is "through the taking of responsibility for their own personal healing and growth that individuals will be able to attain *mino-pimatisiwin*", meaning

"the good life" (p. 44). This growth and challenge to reach the good life extends beyond the individual and involves the family and community (Hart, 2002). Healing begins with a person deciding that it is time to find help and to take the necessary risks involved in healing; often beginning by talking and expressing the feelings they have kept inside (Mussell, 2005).

Interestingly, in the Cree language there is one word that describes taking responsibility for all aspects of one's life, *manācihisowin*. When translated, manācihisowin means "a person's responsibility to look after all aspects of their lives. This entails living a clean lifestyle, physically, emotionally and spiritually" (D. Chamakese, personal communication, February 1, 2011). The Indigenous language contrasts with Western language. With Indigenous language the meaning is in the word; the word and meaning are one experience (Epes-Brown, 1992). Thus, the one word manācihisowin implies taking personal responsibility and entails a vivid description of how to take responsibility for one's life. Having this understanding of how the Indigenous language is structured explains the significance of being able to speak the language in order to fully comprehend, teach, and explain Indigenous worldviews. My mother has tried to explain this concept to me numerous times in the past; when she has tried to translate a Cree word into English, she has often been at a loss for words to encompass the Cree meaning.

néhiyawak attitude.

The néhiyawak explained that their attitude made a difference to their mental health and well-being. They described appreciating every day, thinking positively, abstaining from drugs and alcohol, accepting, having respect, helping others, having hope, and believing in an afterlife to improve their mental health. The following narratives demonstrate how their attitudes improved their mental health and well-being.

One young woman asserted, "just living every day to the fullest!" improved her mental

health and well-being. A female Elder stressed the importance of being positive all the time and not worrying about the gossip. She was adamant in her belief that people often create their own stressors as a result of their lifestyle choices. She asserted:

A lot of people create their problems, because their lives or stories catch up with them. So, it's best to be honest with yourself. I am constantly hearing negative stuff and constantly overturning negative into positive. And I feel good. It doesn't matter how difficult, or negative a story is, I overturn it to something positive. I don't focus and concentrate on the negative because I know that's what causes stress and for people to become depressed. It doesn't matter what other people say or think about you. What really matters is how you feel about yourself!

A middle-aged man improved his mental health and well-being by having a positive attitude, working hard to achieve goals, and engaging in daily self reflection. In addition, he stressed the importance of abstinence from drugs and alcohol made a difference to his mental health. He said:

It's the way I look at life; and everything has to be positive. You have got to work hard at everything you do. Anything you want, work hard for it. Every day after I'm done work, I go back and think about things. Like, how could I have done this better? So the next day when I'm out there, I have thought about things and about how I could improve. There's times when in the spur of the moment you have to think fast, a lot of times it's not the right decision made. So I'm always prepared, what are you going to say, and what are you going to do tomorrow? There is always room for improvement. Like I look back now and ask myself, what could I have done so my kids could be better at what they are doing now? I should have spent more time with them instead of working. But those

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times have passed, and I look ahead. I have grandchildren now; I'm working with them and I get to spend a little more time with them. I can sit and relax. It's like I have more time now then when I was younger and my mind is more relaxed. When I was young and what I thought was a problem, wasn't. It was not a big deal at all. Always be positive! Always! I don't wake up in the morning feeling negative. This was passed on to me by my grandfather, and my parents, be happy when you wake up every morning, somewhere along the way things might change, but at least start your day off right. In my house, I don't allow anybody to be grumpy, or mad, in the morning, I just say, not now, don't do that now, it's the morning, let's get up happy. And you never give up, you never ever give up! Sometimes I block everything out completely and don't think [chuckles]. Just clear it, clear your mind just like you are shutting a TV off, for a while. I never ever in my life have gone out there and intentionally hurt somebody's feelings or hurt them physically. I never wake up in the morning thinking I'm going to do this or that to somebody today. No, I have always looked at it positively. Hey, this guy can change. If you don't like me, well let's try and work it out. I'll always think that it's possible, that anything is possible in a good way. It is important to abstain from drugs and alcohol because it never was a part of our culture and it doesn't fit in our culture. I've never done drugs of any kind, including pain killers.

Another middle-aged woman concurred with the importance of having a positive attitude. She shared how her past experiences have continued to motivate her to abstain from drugs and alcohol and taught her how to ask for help, and how exercising personal choice has made a difference to her mental health. She asserted:

What keeps me going is thinking that tomorrow will be a better day. I had a shitty day

today, maybe tomorrow will be better. I just want to have a sober, clean life. I've lived

on the streets for eighteen months. During that time I lived in parks, sleeping on park

benches, under bridges, and I've starved for three days. My life now compared to 25

years ago, is a hell of a lot better. I never want to go back to that life. It was my self-talk

and my self-motivation that sent me back to school. To push for a little bit more and

keep pushing, knocking on doors and to ask for help. Asking for help was something I

couldn't do when I was younger. I don't know whether it was my ego or if I just was

never brought up to ask for help, in that way. So now that I'm older, I know I can make

my own choices. Life is what you make it and if you don't like it, change it!

Another middle-aged man reflected on and spoke about the insights he had once he quit

using drugs. He talked about how spending time with his children gave him a sense of peace and

enabled him to stay focused and to abstain from further drug use. He also talked about the

importance of being physically active and spending time with people who abstain from drugs and

alcohol. He asserted:

> I quit my drug problem. Now, I get to spend more time with my kids. I have taken a real
>
> good look at myself, and how I've been running my life while I was doing drugs. That
>
> has helped me to stay off of the drugs. Spending more time with my kids gives me a little
>
> peace of mind, which helps me to stay focused. Taking the time to go for long walks
>
> every day, and taking the time to visit my brother's kids, my brother and his wife. They
>
> don't drink, so that really helps me to visit and spend time talking to them.

Rupert Ross is an Assistant Crown Attorney, with a specialty in criminal law, and

practices in Kenora, Ontario. He offers a perspective on the issues related to alcohol

consumption within Indigenous communities that warrants attention and further investigation.

Ross (1992) begins his perspective by sharing *The Rules of Traditional Time*; within these rules there is an ethic, *the ethic that anger not be shown*. He argued that "one of our first acts after contact was to denigrate or outlaw the very mechanisms which permitted them to cope with the traumas of life" (p. 143). Ross asserted "we took away much of their capacity to heal themselves … we stamped out their traditional practices … having no idea that we were destroying their healing institutions" (p. 143). Indigenous peoples were left to face overwhelming social disintegration and "defenseless against the anger, grief and sorrow that inevitably followed" (p. 143). He argued that this principle—that anger must not be shown—supports the rise in explosiveness that Indigenous peoples experience while under the influence of alcohol. Ross believes anger that has been stored up, never shown, not ventilated and discharged, comes pouring out when the person is intoxicated. To further support his perspective, Ross draws attention to a study that was done in Moose Factory. Forty-four percent of the (Indigenous) people who presented in that study for psychiatric treatment were suffering from a grief reaction. They had lost a child, husband, or parent and had not recovered. Ross asserted that, "at the same time as our culture effectively took away all traditional mechanisms for coping, it added a different, a very seductive 'coping' assistant: alcohol" (p. 148). According to Ross, alcohol "permits the saying and doing of things which would otherwise not be tolerated… [allows an individual to say] it wasn't really me who broke all those traditional rules and did all those immoral things, I was drunk" (p. 149). According to Ross, numerous individuals have suggested that this abuse of alcohol has been caused by idleness and deprivation; he agrees that this is partly true, at least to the extent that those factors lead to feelings of anger and frustration which have no other form of release. His conjecture is that "Native people use alcohol in exactly the same way that many of us do: to blow off steam" (p. 149). In addition, Ross explained there are

two unique factors specific to Indigenous peoples: (a) "that their 'steam' has reached a point of pressure that is hard for us to imagine, given all of the losses" (p. 149); and (b) this factor may be the most critical, for it involves the fact that Indigenous peoples may have been left with no other culturally sanctioned way to vent that steam. Clearly, "their sources of sorrow, anger, and personal desperation regularly exceed anything the rest of us are ever likely to experience" (p. 149). He advocated and supports the use of traditional ceremonies to facilitate the expression of emotions within a culturally sanctioned forum to address their repressed feelings.

One middle-aged man stressed the importance of acceptance, taking personal responsibility for his life, passing on his knowledge/teachings to his children and grandchildren, and having positive feedback from others, such as a compliment, improved his mental health and well-being. He stressed the importance of always considering the possibility of a positive outcome in every situation:

It's my attitude again towards life. I accept things as they are, there's no way I can change them. That's not saying that I give up; I never give up. But there is always a chance of something good, coming out of every situation. In the past I've talked to others, Elders, but now they are all gone. I have nobody to talk to and if nobody is there to talk to, then it's time for me to smarten and start thinking for myself. Now I have to! Whatever I have learned, it is now my responsibility to pass that knowledge on to my kids and grandchildren. I had a friend one time that I used to talk to a long time ago; she used to help me a lot. This friend helped me by motivating me. There was this one time I was about to give up, and I saw her at a pow wow. She told me I was looking good and it really made me feel good. Her comment motivated me and I started working harder. Nobody had ever said anything like that before, nobody gave a shit. She motivated me

by acknowledging me, that I mattered somehow. Not many people do that, to acknowledge or comment on positive changes you have made. Especially in the reserve, everyone criticizes you and nobody gives each other a pat on the back for the good they do. They find your faults first, always; and that is something we have to change on the reserve to actually heal.

One middle-aged woman spoke about how the importance of mutual respect, being friendly, and helping others improved her mental health and well-being:

I respect all other people and I want them to respect me the way I am in return. I'm a happy-going person. I like to chat with people and I like to help others when they have problems, be there for them.

Within the interviews, respect was mentioned several times by the néhiyawak. Hart (2002) described respect as a key value of the Cree people. Nabigon (as cited in Hart, 2002) suggested "harmony includes respect for one's relationships with others and within oneself" (p. 43). According to Mussell (2005), respectful behaviour "honors the wholeness of a person and acknowledges the significance of his or her life experience, self-knowledge, ability to change and uniqueness as a human" (p. 18). From an Elder's perspective, an Indigenous person's success is measured by their attainment of an attitude of respect (Ross, 1992). A respectful individual will not impose their views particularly through judgment onto another person (Hart, 2002); this action of respect was described by the above néhiyaw.

Another female Elder shared volunteering, not gossiping, and being positive improved her mental health and well-being. She said:

I do a lot of volunteer work. I feel good when I do one good deed a day and I do that every day, so I feel good about myself. At all times, there's no need for me to waste my

time on gossiping. Anybody who talks about me is giving me good health and better luck, they may not realize that. Even when people are gossiping, I turn it to something positive. They could spend their time talking about culture, this way they would have respect for themselves and give themselves some strength and empowerment. People who gossip belittle themselves and make themselves very small…Nobody can lie to the creator; he knows exactly who we are. This is how I was raised. I think I live a real good life. I'm not a sarcastic person; I'm polite, and gentle with everybody. I feel good about myself at all times.

McCormick (1995) found that helping others facilitated healing for the First Nations people of British Columbia. This included any form of helping ranging from volunteering to helping someone get home safely. The concept of helping others or community service is a traditional value among many First Nations cultures and is seen as a healthy activity. The participants in his study reported that they felt empowered by helping others.

A male Elder believed there is hope for everyone as a result of his own healing journey. He asserted many of the challenges and obstacles we face in life are necessary for our own growth and development. He spoke about caring for others and participating in cultural activities improved his mental health and well-being. He shared:

What keeps me going is I firmly believe in wellness. That gives me hope, if I can do it, then others can as well. I was a person that had a lot of problems; and I believe that I've overcome my problems by using different types of therapy. I believe today that other people can as well. They need to believe in themselves that they can do it and be encouraged by others. There is hope for everyone! I have children, and grandchildren. My children are going through hardships, but they are learning through the difficulties

that they're going through. I often think about that, and I sometimes think/feel that in some way we need to go through these difficult times to learn from our mistakes, to make a change and to become a better person. I believe that is necessary to grow. I feel sometimes that the Creator gives us these obstacles for us to learn from, to make us stronger. As I look back at my life, the difficulties, the hardships that I've put myself through because of my alcoholism, I now know my drinking added to my resentment and to my problems. I had to come to terms with my problems in order for me to be able to be where I am today. I've learned that I could not practice my culture, my spirituality, especially working with the different Elders, the pipe, and the sacred items if I was involved with alcohol; I'd have nothing. People wouldn't trust me; people wouldn't have any respect for me. So I had to earn that respect in order to be respected. What we give, is what we will get. I believe it's important to be a mentor or a role model to our people. In AA they would say, walk the talk. Not just talk but to take action, make some kind of a movement.

Another middle-aged man asserted that what keeps him going and gives him hope is his belief in an afterlife, knowing he will be reunited with his loved ones after his death. He stressed the importance of being positive and that our attitude will determine the kind of a life we live. He voiced the importance of taking responsibility for one's life and advocated working hard to attain one's goals. He asserted:

What keeps me going is knowing that *this* isn't it. When we die, I don't believe that's it. I think there is another world out there, another spiritual world. As a matter of fact I believe there is. I think that when we lose a loved one, we will see them again; I just know it! There is going to be a day when they say, hey you made it! (chuckles). I had a

dream a few years ago. I went to this place and my grandfather met me. When he died he had no legs, but when I saw him he had legs. He asked me what I was doing here, I said, 'I came to visit', and he said, 'ok'. So as he showed me around I was seeing all these people that left us [passed on]. Some of them were cutting meat, and some of them were getting ready to go hunting. The women were drying meat, gathering berries, and all talking just like you and me. I asked him, 'Is it lonely here'? He said, 'At first, but then they start coming, they start arriving'. That's why I say there is another place we go after death. So I'm always positive towards life. You can make life as good as you want it. I think it's all about the attitude of people. You can have a miserable life if you want it; and usually people do have one because they are miserable and they make everyone else miserable around them. It seems like that is what they want. You want a good life? Work so that you have a good one. There's no work at all to being miserable. It doesn't take much effort to be miserable and you can have a miserable life. If you don't want to do anything, well then you are never going to get anywhere. Nobody is going to come and give you anything and I don't believe anyone owes you a living.

Rose Auger, a Cree Elder, (as cited in Hart, 2002) confirmed the necessity for people to take responsibility to reach mino-pimatisiwin.

When you choose to make your life good, it will be good.… The Creator gave you a sound mind and an incredible spirit and a way of being so that you can do anything right now! You can change that attitude same as you wake up in the morning and it's a new day. Your mind and everything else can be new. I've lived through hardship and horror, and I'm a loving, caring, and giving person because I choose to be that way. I choose to listen to the other side to guide me. (p.44)

This Cree Elder's words succinctly summarized the collective voices and perspectives in this study and reinforced the importance for Indigenous peoples to take responsibility for their attitude and to make healthy choices so they can reach mino-pimatisiwin.

wícihisowin (helping oneself).

The néhiyawak improved their mental health and well-being by wícihisowin. This Cree word, *wícihisowin*, means "helping oneself" (D. Chamakese, personal communication, Jan 20, 2011). wícihisowin was achieved by the néhiyawak participating in formal and informal educational opportunities. The following narratives demonstrate how wícihisowin made a difference to their mental health and well-being.

One man talked about taking the training to be a life skills coach improved his mental health and well-being. As a result of the training, he was reacting differently to his environment and had changed his lifestyle. He said, "For myself, it is having that ability to … notice things and react differently to situations. I'm a life skills coach; it helped me a lot personally to adjust myself and my lifestyle." Another very young man claimed that staying in high school was of the greatest importance for his mental health and well-being. He shared, "for me to finish school and that's it!"

One very young woman attributed her environment and her children as her inspiration to make changes and improve her mental health. She spoke about living in an area that was surrounded by alcoholics; when she was incarcerated she continued to be surrounded by negativity; thus, these experiences provided the impetus for her to change the direction of her life. She talked about the importance of the courses she completed while incarcerated. These courses helped her to understand and manage her emotions, addressed relationships, and parenting. She spoke with enthusiasm about graduating this year, making new friends, and

celebrating two years of abstinence from marijuana. She articulated:

> Just seeing everything around me! I live in the town site, and it's nothing but alcoholics.
> I don't want to live that way; I don't want to end up living like that. My kids! I don't
> want to smoke anymore. I want to watch them have kids and be there to support them. I
> actually just got out of jail, being in there and seeing all that negative stuff was like,
> 'whoa.' It really was an eye opener! I took a bunch of classes in jail that were very
> helpful. I took emotions management, relationship skills, and two parenting classes. The
> classes were all for self-help. Living with my mom, she is non-smoker, not alcoholic
> [also makes a difference for me to be mentally healthier]. My schooling, I'm doing my
> adult 12 this year. I actually quit smoking up for almost two years now. Yeah! I lost
> some friends, but obviously they weren't friends. I made new friends. I'm not such a
> burnout [laughs] anymore.

This young woman's narrative demonstrated the concept of manāchihisowin. This one word, manātisiwin, holds a multitude of Indigenous teachings and provides guidance to how one should conduct oneself on a daily basis. *manāchihisowin*, implies taking personal responsibility for one's life (D. Chamakeese, personal communication, February 2, 2011).

Discussion.

Several of the néhiyawak in this study discussed the importance of education, which allowed them to view situations from a different perspective, increased their problem solving ability, and provided them with hope for a different future. McCormick (1995) found that when his participants obtained an understanding of their problem by learning to identify, clarify, and make sense of their problem, their healing was facilitated. His participants described a range of incidents from understanding their problems through their dreams to obtaining understanding

them through a treatment program. McCormick's (1995) participants reported that understanding their problems was empowering because it gave them optimism and self-confidence to deal with them. McCormick also described involvement in challenging activities to facilitate First Nations healing. By exercising self-discipline and perseverance through challenging activities, his participants were able to feel better about themselves (McCormick, 1995).

Overall, the concepts described within tānisīsi wāpahtaman pimātisiwin (taking personal responsibility, attitude, and wícihisowin) correlate with 8 of the 14 categories known to facilitate First Nations healing as described in McCormick's study (1995). McCormick found the following categories facilitated healing for the First Nations people of British Columbia: exercise; involvement in challenging activities; expressing oneself; setting goals; helping others; gaining an understanding of the problem; learning from a role model; and establishing a connection with nature. The vast majority of the néhiyawak in this study were already engaged in these *healing activities* as described by McCormick (1995).

Within the Determinants of Health (PHAC, 2010), tānisīsi wāpahtaman pimātisiwin (worldview) would be categorized under personal health practices and coping skills, and education. Personal health practices and coping skills refer to those actions by which an individual can prevent diseases and promote self-care, cope with challenges, develop self-reliance, solve problems, and make choices that enhance health. It is important to note that there is growing recognition that personal life *choices* are greatly influenced by the socio-economic environments in which people live, learn, work, and play (PHAC, 2010). According to PHAC (2010), these socio-economic influences impact lifestyle choice through at least five areas: (a) personal life skills, (b) stress, (c) culture, (d) social relationships and belonging, and (e) a sense

of control. PHAC (2010) advocated for the creation of supportive environments to enhance the

capacity of individuals to make healthy lifestyle choices. And, as previously discussed there is

empirical evidence initially presented by Selye (1950) and further supported by Scaer (2001) that

described the impact of prolonged or excessive exposure to stress contributing to the

development of specific diseases. PHAC (2010) acknowledged that there are "powerful

biochemical and physiological pathways that link the individual socio-economic experience to

vascular conditions and other adverse health events" (p. 9). The lower socio-economic status of

an individual corresponds to increased adverse health (PHAC, 2010). Education is a determinant

of health and will be discussed in greater detail later in this chapter, under *ēkwa ōhi kikwaya piko*

ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān.

Summary.

Within this theme, tānisīsi wāpahtaman pimātisiwin, the néhiyawak voiced several

concepts related to their worldviews, the lens through which they view the world. They

described how taking personal responsibility, their attitude, and wícihisowin improved their

mental health and well-being. Personal responsibility entailed practicing healthy communication

patterns; making the required changes in their life; acknowledging, addressing, and dealing with

their emotions and feelings; having healthy boundaries; and exercising choice. Having a positive

attitude made a difference to their mental health and well-being. A positive attitude included:

appreciating every day; thinking positive at all times; abstaining from drugs and alcohol;

practicing acceptance and respect; helping others; having hope; and a belief in an afterlife.

wícihisowin, "helping oneself", was achieved by participation in both formal and informal

educational opportunities.

ēkwa ōhi kikwaya piko ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān.

This Cree phrase, *ēkwa ōhi kikwaya piko ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān*, translates to "these are the things that need to happen if I want to be healthy" according to D. Chamakese (personal communication, August, 20, 2010). Chamakese explained that the one word in Cree, *miyo-mahcihoyān*, takes into account the physical, emotional, mental, and spiritual well-being of an individual. When the néhiyawak were asked what they needed to attain optimal mental health and well-being they emphatically reiterated the importance of their relationships, spiritual beliefs and cultural practices, and their tānisīsi wāpahtaman pimātisiwin; however, there was an increased emphasis on aspects related to their socio-economic status, elements described by both the medicine wheel and the determinants of health. However, several of the néhiyawak in this study expressed that they were content with their current state of mental health and well-being and did not need anything else to attain optimal mental health and well-being. One female Elder responded, "I consider myself strong, healthy, as possible. I've did the best that I can." Another very young lady asserted, "Right now nothing…I just like the way it's going right now, I just like it…I love it, you caught me at a time where I'm thriving." One middle-aged man felt that he would be able to manage whatever challenges the future may hold:

> I think I'm in that place where I have that ability to change with whatever comes good or bad; it's up to me. I know a lot of times it hurts and at some point you have to stand up and say, 'Ok, now I have to go on.' I don't need to see a shrink or anything. Well, at one point I thought of it, but would never do it. Really it is self-pity; it's just self-pity that you come out of. I do anyway. I just laugh [he laughed] and say, 'Ok big baby, life goes on'.

The remaining néhiyawak clearly articulated what they required to attain optimal mental

health and well-being. Their voiced needs are organized according to the four quadrants of the medicine wheel as described by Mussell (2005). Note, given I have already presented the néhiyawak narratives to support the three previous themes, this theme will address their remaining voiced needs to improve their mental health and well-being and perceived as necessary to attain optimal mental health and well-being.

The néhiyawak physical needs.

The vast majority of the néhiyawak in this study voiced needs to attain optimal mental health and well-being related to their physical needs as described by the medicine wheel (Mussell, 2005) and/or by two determinants of health—(a) employment/working conditions, and (b) income and social status (PHAC, 2011)—to be met. The néhiyawak physical needs were related to securing employment; having a home, a safe environment to live in; being able to buy sufficient nutritious food; being able to manage their chronic health conditions; and exercising on a regular basis.

Numerous néhiyawak mentioned that being employed made a difference to their mental health and well-being and employment was perceived as necessary to attain optimal mental health and well-being. They described employment as providing stimulation, giving them hope, the income increasing their personal freedom, and providing structure for their lives. One young woman spoke about how having a job prevented boredom and, more importantly, provided her with stimulation: "working, just keeping busy all the time, not being bored." Another young woman described how her approaching graduation and the anticipation of obtaining employment gave her hope and made a difference to her mental health and well-being. She said, "I hope to graduate from university soon. Yes, upcoming graduation. That would definitely be one. From there you could hope to get a good job, you can hope to pursue further." Another woman

articulated how she had worked most of her life, she enjoyed her job, and most importantly the income allowed her more personal freedom. She asserted, "I've worked most of my life. I just enjoy working, I get along with people. Keeps me busy, I don't get bored and stuff. The money, that I think that's the main thing, I can do more."

Another very young woman concurred that she required employment to attain optimal mental health and well-being. She shared, "Right now if I want to be as mentally healthy as possible I would need to have a steady job." A middle-aged man echoed these voices; he spoke about how having a job would provide structure and keep him busy. He asserted, "try to get a steady job to keep myself busy, keep myself occupied"; he was currently in the process of trying to secure employment.

One young man quickly responded that he required a home; however, he wanted a higher standard of living than his parents had provided. He expressed:

A home, a base camp whatever you want to call it. I really look back to how my mom and dad's life are, just a step above them. What I seen throughout my life was my mom and dad working. After the bills were paid, instead of them going out and partying, drinking, or whatever, they put their money toward furniture or into their house like an investment. So that's what I would want. After you pay all the bills you buy something for the house like a big TV. I love their TV. I have seen my dad work, come home, play with us, and that's all I've seen for 18 years. So I don't know life any other way.

One female Elder said her stress levels would decrease if there was no drinking or drug use within her living environment: "no drinking, no drugs, and no drunks, there would be less stress and [I] would feel better." One middle-aged man spoke about his living environment being negative and he believed that moving would be better for his and his children's mental

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health and well being. He made the following comment:

> The environment around me, I'd have to move away from where I am right now. I'm
> pretty well located right in the central [part] of the community and a lot of negative things
> happen around me. If I was to move away that would probably be a lot better for my
> health and for my kids. I am getting a new house so I'm looking forward to [moving].
> It's already up just the finishing touches, and it's supposed to be done by the end of
> September.

Numerous néhiyawak spoke about the importance of accessing adequate and healthy
nourishment and ensuring adequate rest, and how being physically active improved their mental
health and well-being. A female Elder articulated that a multitude of factors were necessary for
her mental health and well-being. She spoke about how following a traditional diet, exercising
regularly, having a choice of clothing, and enjoying nature's natural landscape made a difference
to her mental health. She explained:

> Well, a lot of things. My exercises, the way I dress, I walk, I dance, eat good healthy
> food. Boil my food, eat some vegetables, eat less steak [laughter], less fried food. I eat a
> lot of wild meat, smoked meat, smoked ribs, smoked ducks, fish. I still eat the old way,
> the traditional food. We have a garden every year where I get fresh potatoes and veggies.
> So to eat good proper, you feel good about yourself, everything is good. And just to look
> out to see the wild country, the country [is] so beautiful. You see deer, ducks, moose,
> and bear. It's really amazing where we live and it's a good spiritual place.

McCormick (1995) found that establishing a connection with nature facilitated healing
for the First Nations people of British Columbia. This included being in nature and connecting
to nature. Examples of connecting to nature ranged from the use of water in healing to the

healing benefits of being among trees in the forest. McCormick stated that many incidents were reported in this category, suggesting the important role nature plays in healing for First Nation peoples. The participants in his study reported that nature helped them to feel relaxed, cleansed, calm, and stronger.

Another young woman improved her mental health by exercising, having a healthy diet, being able to talk to people that she trusted, and spending time with her son. She articulated, "exercising, eating right, talking about my problems with people that I know I can trust. Spending what time I have with my son since I started working." Another néhiyaw spoke about self-care and nutrition: "It's the way I look after myself and the way I eat at home." One young woman spoke about the importance of being independent, making sure she was getting enough sleep, eating healthy, and being physically active as positively impacting her mental health. She asserted:

> Right now in my life, I'd say moving out on my own and having to support myself. I feel a lot healthier that I'm not leaning on my parents and relatives to support me. And that's a huge thing for me because I don't want to be a burden to them. I moved out when I was fifteen. My parents have helped me along the way but I still get that feeling of independence. So for me to feel healthy, I have to live on my own, have my own rules, and not have to depend on other people. A lot of times I don't get enough sleep, so I have to catch up on sleep a lot of times. But like sleeping, eating healthy, physical activity. I play [sports] all summer [and] in the fall. Without those I don't think I'd feel healthy at all.

The ability for the néhiyawak to meet these needs is related to their income, whether or not they have employment. Income determines an individual's living conditions, such as safe

housing or whether they will be able to buy sufficient healthy food (PHAC, 2010). According to

Statistics Canada (2010), Aboriginal people are still less likely to be employed than their non-

Aboriginal counterparts. In 2006, the employment rate was 60.4% for First Nations people aged

25 to 54 compared to 81.6% for non-Aboriginal people in Canada. The employment rate for

First Nations people living on reserve was 51.8% compared to 66.3% for those living off reserve.

Health status improves at each step up the income and social hierarchy, and there is mounting

evidence that higher socio-economic status is associated with better health. In fact, these two

factors (income and social status) seem to be the most important determinants of health (PHAC,

2010; Raphael, 2006) from a Western perspective.

According to Statistics Canada (2010), the median total income of the Aboriginal

population aged 25 to 54 in 2005 was just over $22,000, compared to over $33,000 for the non-

Aboriginal population in the same age group. For First Nations people living off reserve, the

median income was about $22,500, compared to just over $14,000 for First Nations people living

on reserve. At the time of this study, all the participants, except one, resided on the

Thunderchild First Nation. And, the vast majority (all but two) of the nêhiyawak in this study

had a source of income.

Several of the nêhiyawak mentioned that their level of physical well-being had an impact

on their mental health and well-being. They voiced concerns about their weight, having a

chronic condition that impacted their mobility, maintaining their current level of fitness, and the

importance of being active on a regular basis. One middle-aged man reported that his only need

to obtain optimal mental health and well-being was related to decreasing his weight: "My basic

concern is me being overweight. I guess it's my only concern." A female Elder spoke about

having a chronic condition that had a negative effect on her mobility and prevented her from

obtaining optimal health and well-being. She explained:

> I got arthritis on my legs. Otherwise … heart is good … not short of breath, but [my]
>
> legs bother [me]. If I didn't have problems with my knees, … I'd be running eeeee [all
>
> laugh] or playing ball eeeee [more chuckles].… That's the only health problem, [my]
>
> knees.

One young man talked about the need to maintain his current level of fitness to obtain optimal mental health and well-being; he described his physical and mental state as being connected. He was concerned that if his current level of fitness deteriorated, it would effect his ability to pass on his hunting and sporting skills to his [future] sons. He asserted:

> I'd have to be fit, physically fit. So I could take my boys hunting or show them sporting
>
> or show them skills that I have. If I'm a big fat guy, can't run or something, I just feel
>
> that would hold me back somehow. I wouldn't be all mentally fit, stable, if I couldn't do
>
> something to my full ability.

Another young woman spoke about being physically and mentally healthy. She talked about maintaining her current level of physical fitness by exercising regularly versus her current habit of erratic exercise. She said, "I'd like to be physically fit along with mentally. It'd just be more STAYING in shape and not like having the binge [exercise] days, regular exercise." Another young woman improved her mental health and well-being by exercising regularly: "[Being] active, exercising. I go to the track in the evenings." There is an outdoor track available for the community to use in Thunderchild First Nation.

In McCormick's (1995) study of facilitating healing for First Nations people in British Columbia, he found exercise helped his participants to feel better about themselves because they were able to feel stronger and more capable. We have known for a long time about the benefits

of exercise as a proactive way to enhance our physical condition and combat disease; now, exercise is recognized as an essential element in building and maintaining mental fitness (Canadian Mental Health Association [CMHA], 2011). According to the CMHA (2011), exercise has many psychological benefits. Exercise (a) has a positive impact on depression and anxiety; (b) can be as effective as psychotherapy for treating mild to moderate depression, and therapists report their clients who exercise on a regular basis feel better and are less likely to overeat or abuse alcohol and drugs; (c) can reduce anxiety; (d) helps to counteract the withdrawal, inactivity, and feelings of hopelessness that characterize depression; (e) positively affects moods such as tension, fatigue, anger, and vigour; (f) can improve an individual's perception of physical condition and body image can enhance self-esteem; and (g) brings an individual into contact with other people in a non-clinical, positive environment.

The néhiyawak intellectual/mental needs.

According to Mussell (2005), the intellectual/mental needs described by the medicine wheel include an individual's ideas, concepts, thoughts, habits, and discipline. Essentially, thoughts represent an individual's accumulated knowledge, beliefs, and judgments; all the mental tools used to make sense of, and to cope with, life (Mussell, 2005). Numerous néhiyawak in this study thought it was necessary to abstain from drugs and alcohol, and this was perceived as necessary for them to attain optimal mental health and well-being. One middle-aged woman said that she didn't want to die as a statistic related to alcohol abuse even though both her parents did and she feared her biological siblings would die in the same manner. In addition, she said that she would have to change her social circle of friends to include non-drinkers. She proclaimed:

I don't want to die as a statistic from alcohol or from abuse. Both of my biological

parents had passed away that way. Even to this day my biological sisters and my brother,

I think that they're going to die from alcohol abuse. I just don't want to be like that...

Getting rid of some of my drinking buddies, [laughed] I guess. And going to bed at a

decent hour and getting up at a decent hour. Because I know when I was drinking my

alcohol I'd go to bed at four in the morning, expect to be at work at seven, and [work] all

day for twelve hours. Then go home and party all over again. That's kind of stupid.

Another middle-aged woman said that she would have to make some changes in her

lifestyle, starting with abstaining from alcohol. However, even though she has been advised to

quit smoking, she has no intention of becoming a non-smoker:

Quit drinking altogether I guess. I know quit smoking too but I don't know if I can do

that! [laughter] Every time I go to a doctor that's what they say, quit smoking. I don't

want to quit smoking, it makes me relax. I like to think I could [quit smoking]. I tried

once, didn't work!"

One very young lady was clear about what she needed to obtain optimal mental health

and well-being. Her first comment was "refrain from drugs, alcohol." This was the same young

lady who had recently celebrated two years abstinence from marijuana use and was now pursing

her grade 12 with support from her family and new-found friends.

According to the RHS (2002/03), community wellness is dependent on some form of

sobriety. The RHS reported that only one third (36.4%) of the adults surveyed felt there was

progress in reducing the amount of alcohol and drug abuse in their community. The remaining

two thirds felt there was no progress at all. Sinclair, Smith, and Stevenson (2006) prepared a

report for Indigenous Peoples' Health Research Centre (IPHRC) that provided an overview of

the key issues in Indigenous health and pointed to directions for the Indigenous health research

agenda in this province. According to their community consultations, the most significant health issues for many Métis and First Nations communities were in relation to mental health and addictions. A number of respondents observed that substance-related addictions were shifting from primarily alcohol related to primarily drug related, and that the kinds of drugs were shifting to substances such as cocaine, solvents, and crystal methamphetamine. A number of respondents also noted that mental health and addiction issues were related to the larger social determinants of health, particularly poverty, and lack of education and employment opportunities (Sinclair, Smith, & Stevenson, 2006).

Several of the néhiyawak in this study brought up the importance of continuing their education as being necessary for them to obtain optimal mental health and well-being. One very young man who was currently in grade 12 said, "School, just having a feeling of going there every day … something to do … nothing bugs me there." Another young lady in the process of completing her GED cited "my schooling" as required for her to obtain optimal mental health and well-being. Another young lady was looking forward to graduating and being employed: "I hope to graduate from university soon." One very young man emphatically declared that he and his spouse required careers in order for him to achieve optimal mental health and well-being. He declared:

> Me and my spouse have careers, we would both have to have a career. She wants to be a massage therapist, that is her goal. Mine, I don't know … kind of a cop [or] a teacher. We, we both, we need, *we need* to have careers, not *I want* …

Education and literacy is a determinant of health, and health status improves with an individual's level of education (PHAC, 2010). Education is closely connected to an individual's socio-economic status, and effective education for children and lifelong learning for adults are

key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving and helps provide a sense of control and mastery over life circumstances. Education increases opportunities for job and income security, and job satisfaction. It also improves people's ability to access and understand information to help keep them healthy (Labonte, 2003; PHAC, 2010).

According to Statistics Canada (2010), Aboriginal adults consistently have lower graduation rates than other Canadians. In, 2010, one third (33%) of Aboriginal adults aged 25 to 54 had less than a high school education compared to nearly 13% of the non-Aboriginal population, a difference of 20 percentage points. The 2010 Census showed that Aboriginal adults between 25 and 54 years of age were more likely to have a trades certificate than a university degree. The proportion of Métis and non-Aboriginal people with a college certificate was 22%, compared to 18% for First Nations people and Inuit. The largest difference was for those with university certificates at the bachelor's level and above. One quarter (25%) of non-Aboriginal adults had a university degree, compared to 9% of Métis, 7% of First Nations people, and 4% of Inuit. According to Health Canada (2009), there is greater disparity when comparing the levels of education between the Indigenous and non-Indigenous peoples of Canada. Health Canada (2009) reported that 58.9 % of on-reserve registered Indians have less than a high school diploma compared to 31.1% of off-reserve Canadians. And, when comparing the attainment of a university certificate, diploma, or degree, only 3.6% of on-reserve registered Indians graduate from post-secondary programs compared to 18.1% off-reserve Canadians.

The néhiyawak emotional needs.

According to Mussell (2005), the emotional needs described by the medicine wheel

include love, belonging/attachment, recognition, acceptance, understanding, privacy, limits, boundaries, and discipline. Interestingly, there was only one néhiyaw who expressed the need to explore the blocks in her life so she could attain optimal mental health and well-being. The need to heal would be categorized under the emotional and intellectual needs of the medicine wheel as described by Mussell (2005), and, in the determinants of health, under personal health practices and coping skills (PHAC, 2010). This woman spoke about a specific workshop, Return to Spirit (RTS) and thought it might help her address the blocks in her life:

> One thing I have never done and I would like to, but I'm not ready, is attend a Return to Spirit [RTS] journey/workshop. I know there are some blocks in my life. Why have I never left Thunderchild? I don't know. What did my parents tell me? Why am I so afraid to go out and enter? That's one thing I'd like to know. But then sometimes I think, well maybe I am happy in my spot, maybe I don't need to do that. I'd like to explore the real me inside. It's a little scary to me. Why? I don't know. Or am I doing enough by being aware of what's going on and by dealing with [it]? I don't know and only I can answer that. I know that because I'll tell you another story…

As a novice therapist, I was surprised that only two of the néhiyawak in this study expressed the need to address their personal issues in order to attain optimal mental health and well-being. My surprise is likely a result of my personal philosophy toward mental health and well-being. I clearly remember a lecture that was given very early in my doctoral coursework. The professor started the ethics class by asking us what type of a psychologist we were going to be as we began to practice. The professor proceeded to described three types of psychologists. The first psychologist was one who had issues; however, they were not aware of their issues. The second psychologist had issues, was aware of them, but was not addressing them. The third

psychologist was aware of their issues, and was addressing their issues. The bottom line was that everyone has issues that need to be addressed, whether one is a psychologist or not. Second, given the socio-political historical context between the Indigenous and non-Indigenous peoples of Canada, specifically colonization, I expected the participants to express an awareness or desire to address their personal healing at some level. However, this was not the case in this study. As previously mentioned, the nêhiyawak in this study were for the most part content with their current mental health and well-being, and voiced needs only when they were asked what they required to attain optimal mental health and well-being.

Discussion.

There are many factors that can influence one's health, including one's mental health. These factors are commonly known as the determinants of health (Health Canada, 2007; PHAC, 2010). It has become increasingly accepted that health is interdependent on a variety of factors (Mental Health Commission of Canada, 2009; PHAC, 2010; Raphael, 2004). Raphael (2004) explained that the social determinants of health are the economic and social conditions that influence the health of individuals and communities. The economic and social conditions of a person's life have "far greater influence on health and the incidence of illness than traditional biomedical and behavioural risk factors" (p. 2). However, despite it being well documented that individuals in various socio-economic groups experienced differing health outcomes, "the specific factors and means by which these factors led to illness remains to be identified" (p. 5).

The second goal in *A Framework for a Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2009), acknowledged the need to attend to the complex interaction of economic, social, psychological, and biological or genetic factors that is known to determine mental health and mental illness across the lifespan. Within this goal there is

reference to address adequate housing, and to reduce whenever possible those factors that increase the risk of developing mental health problems and illnesses—such as poverty, abuse, and social isolation (Mental Health Commission of Canada, 2009).

Irrefutably, there are unacceptable disparities between the economic and social conditions of Indigenous people and non-Indigenous people in Canada (Statistics Canada, 2010; Health Canada, 2005). The four themes derived from this narrative inquiry correspond to the four quadrants of the medicine wheel (Mussell, 2005) and to six of the determinants of health: income and social status; social support networks; education and literacy; employment; personal health practices and coping skills; and culture (PHAC, 2010). Socio-economic status has been cited as the most important determinant of health (Labonte, 2003; Raphael, 2004) and without dispute, this determinant was disrupted by colonization (Paul, 2006; Wesley-Esquimaux & Smolewski, 2004).

In a previous study (Graham & Stamler, 2010), I explored the perceptions of health from a Plains Cree perspective and my findings supported the determinants of health as an appropriate framework to address the health needs of Indigenous peoples and as a framework for federal, provincial, and local policy makers to implement structural changes necessary to decrease the health disparities between the Indigenous peoples and the rest of Canada. Using a consistent framework, such as the determinants of health, is useful to provide a benchmark from which to evaluate existing disparities, initiate changes in existing policy and program implementation, and to measure and evaluate improvement.

Summary

Despite the glaring disparities between Indigenous and non-Indigenous people in Canada, when the néhiyawak of Thunderchild First Nation were asked what improved their mental health

and what they perceived as necessary to obtain optimal mental health and well-being they responded with descriptions of strength and resilience. By posing questions that focused on the positive, the strengths and resilience of the néhiyawak came to the forefront. Despite the unpalatable colonial history, the néhiyawak in this study were doing well and several of them expressed complete satisfaction with their current state of mental health and well-being. Narrative thematic analysis of the interviews consistently revealed four overarching themes that improved néhiyawak mental health and were perceived as necessary for them to attain optimal mental health and well-being: relationships; spiritual beliefs and cultural practices; tānisīsi wāpahtaman pimātisiwin (worldview); and ēkwa ōhi kikwaya piko ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān (these are the things that need to happen if I want to be healthy). Narrative inquiry allowed the individual voices of the néhiyawak to be at the forefront of this study, giving voice to where there has been silence and truth where there has been speculation.

Chapter 5 Implications

Our contributions must be of a different sort. We must first understand how little we

actually understand. Only then will we realize that it is impossible for us to offer

anything like sound advice about what will be most productive for them. We must also

acknowledge the complexity of their choices and learn to be patient … we must agree

that only they can run their own experiments, and we must work to be certain that they

have the freedom to do so. We, must, in this process, share our sustaining resources with

them, just as they have shared the resources of this continent which now sustain us. They

will, in their own fashion, ultimately find ways to become once again self-sustaining in

every sense, for that is their history and their goal. (Ross, 1992, p. 186)

The above quote by Ross (1992) expresses the gestalt of all the implications arising from

this study. The necessity of understanding and respecting one another is a good starting point for

both Indigenous and non-Indigenous peoples of Canada, so that we may work together to

improve Indigenous mental health and well-being. At the very beginning of this study, I shared a

story about Indigenous peoples who lived in North America before European contact. I asked

you to close your eyes and to take a moment to imagine Indigenous peoples who were

independent, autonomous, self-governing, who had their own ways of being, celebrated their

connection with the land on a daily basis, and were proud of their culture. A people who had

their own social, economic, political, judicial, religious, and cultural societies and, despite the

harsh living climate and conditions, they continued to thrive and expand. I asked you to

visualize them as they were: free to be themselves, Indigenous, and autonomous. Imagine that

context again. Now, fast forward and reflect on how their Indigenous context for life has been

altered, changed, and in some cases disrupted forever by colonization. It was this ongoing story

of colonization and its continued impact on Indigenous mental health and well-being that was the impetus for this research project. I wanted to know what improved the néhiyawak mental health and well-being and what they needed to attain optimal mental health and well-being.

The néhiyawak in this study responded by sharing their strengths, resources, and stories of resilience in the face of the daily challenges they endure. Focusing on the positive by asking questions that were strength-based allowed the néhiyawak to share what mattered in their lives and what made a difference to their mental health and well-being, and allowed the strengths and resilience of the néhiyawak in this study to come to the forefront. These néhiyawak appeared to be relatively content with their mental health and well-being. Despite the effects of colonialism, the néhiyawak in this study were doing well, and in several instances the néhiyawak expressed complete satisfaction with their current level of mental health and well-being. They described four overarching themes that improved their mental health and well-being and were perceived as necessary to attain optimal mental health and well-being: relationships; spiritual beliefs and cultural practices; tānisīsi wāpahtaman pimātisiwin (worldview); and ēkwa ōhi kikwaya piko ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān (these are the things that need to happen if I want to be healthy). These four themes, as described by the néhiyawak in this study, have elements that parallel the needs for development of human potential as described by the medicine wheel (Mussell, 2005) and the determinants of health (PHAC, 2010).

Given the historical and current context of colonization, it is not surprising that the néhiyawak in this study identified and are using the same resources to improve their mental health and well-being that were disrupted and in some cases destroyed by colonization (Chansonneuve, 2005; Mussell, 2005; Wesley-Esquimaux & Smolewski, 2004). These findings have implications for education, counselling practice, government, and future research. I will

also address the strengths and limitations of this study, and provide a concluding comment.

Implications for Education

When I asked the néhiyawak in this study what improved their mental health and well-being they responded by sharing their strengths, resources, and stories of resilience despite the ongoing legacy of colonization and the daily challenges they face. However, I would be remiss to not share some of the general recommendations in the literature intended to improve the relationships between Indigenous and non-Indigenous peoples of Canada. It is necessary to understand how contemporary health disparities between Indigenous and non-Indigenous people have evolved (Chansonneuve, 2005; Kirmayer, Brass & Valaskakis, 2009; Mitchell & Maracle, 2005; Mussell, 2005; Wesley-Esquimaux & Smolewski, 2004), the processes required to address the inaccurate portrayal of the historical relationship between Indigenous and non-Indigenous peoples of Canada (Mitchell & Maracle, 2005; Wesley-Esquimaux & Smolewski, 2004), and finally, to ensure a process that reinforces an universal attitude of all mental health care providers (NAHO, 2008). After the general recommendations, I will discuss specific implications for education related to the results of this study.

First, if our goal is to provide culturally appropriate care for Indigenous clients, it is essential to understand the ongoing legacy of colonization and how this continues to impact on contemporary health and mental health disparities between the Indigenous and non-Indigenous peoples of Canada (Chansonneuve, 2005; Kirmayer, Brass & Valaskakis, 2009; Mitchell & Maracle, 2005; Mussell, 2005; Wesley-Esquimaux & Smolewski, 2004). All Canadians, both Indigenous and non-Indigenous, require an accurate account of the colonial relationship between the Indigenous and non-Indigenous peoples of Canada (Mitchell & Maracle, 2005). Paul (2006) titled his book, *First Nations History: We Were Not the Savages, as* a reminder that both

Indigenous and non-Indigenous peoples require healing to prevent further atrocities of this nature. As long as the "government and the officials of this country continue to act as if the original peoples are the only ones in need of instruction and improvement, so long will suspicion and distrust persist" (Ross, 1992, p. ix). Healing and recovering from colonization will require all levels of government support, social change, and individual perseverance to rebuild what was destroyed and forever changed (Wesley-Esquimaux & Smolewski, 2004).

Second, in order to address the inaccurate portrayal of the historical relationship between the Indigenous and non-Indigenous peoples of Canada, it is necessary to implement a process for all Canadians (Indigenous and non-Indigenous) to challenge their current beliefs by providing an alternative point of view for their existing observations or experiences. The "public and Indigenous people themselves, must be given enough information about their history to recognize the often illogical nature of the convictions some people hold on Indigenous people and an opportunity to revise their beliefs" (Wesley-Esquimaux & Smolewski, 2004, p. 81). In order to address this current gap of knowledge, Battiste (1998) and Wesley-Esquimaux and Smolewski (2004) recommended (a) that a highly coordinated information campaign publicize accurate historical facts, and that this information be promoted within schools, social institutions, mass media, and political organizations; (b) that a properly rewritten history of Indigenous peoples be included in the school curriculum; (c) that an accurate de-colonized account of the Indigenous people's suffering replace falsified images often spread by public media; and, (d) that an appropriate deconstructive narrative of Indigenous peoples' lives accompany any social or political action directed at helping those who have been dispossessed and marginalized. Providing an accurate account of the historical relationship between Indigenous and non-Indigenous peoples within Canada is an essential step to addressing existing health and mental

health disparities between the Indigenous and non-Indigenous peoples of Canada.

Third, it is logical to assume that if we recognized the need for change, awareness, and increased sensitivity to Indigenous peoples' issues, there would have to be a process that ensures, or at the very least initiates or reinforces, a universal attitude of all mental health care providers, counsellors, and psychologists. Theory and practice are closely related; theory affects practice and practice affects theory. To ensure mental health workers are adequately prepared to meet the increasing demands of providing culturally appropriate health care to diverse populations, it is necessary to promote cross-cultural training within professional education. This cross-cultural training should be inclusive of the different ethnic and minority groups, with an emphasis on Indigenous culture. Given the trend toward inter-professional education, it is reasonable to extend this recommendation to include all health care professionals.

Cross-cultural training regarding the Indigenous peoples of Canada should include information about and exploration of the initial and continued impact of colonization, with an emphasis on the impact of the epidemics and the residential school legacy, and the *Indian Act*. According to NAHO (2008), understanding the historical context of colonization and its relation to current Indigenous economic, political, social, and health disparities may prevent health care providers from adopting a victim-blaming attitude toward Indigenous peoples. Alternative holistic models of health, such as the medicine wheel, should be examined, presented, and explored as a culturally appropriate model for care (psychotherapy) and mental health promotion with Indigenous peoples. In addition, special attention should be given to the determinants of health to provide a larger context to situate the complex factors that are interrelated and impact an individual's health and well-being. To enhance the effectiveness of cross-cultural training, counselling students should be encouraged to take electives that provide a foundation to

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understand the origins of racism, sexism, and classism within the Canadian context. Understanding the history of how Canada developed as a country provides a context to effectively understand the current complexity of the existing health and social problems experienced by many individuals, particularly the Indigenous peoples in Canada.

Cultural safety involves recognizing that health care providers bring their own culture and attitudes to the helping relationship (NAHO, 2008). Rew (2000) asserted that only when we know ourselves can we begin to understand differences, thus knowing ourselves is the first step towards developing cross-cultural awareness and sensitivity:

> Once we know who we are, we can appreciate how our attitudes, beliefs, and behaviors may be in conflict with others who are not a part of our unique culture. We can begin to acknowledge our own biases and then begin to understand how others might be biased in an entirely different direction. (p. 204)

It is important to know that "Aboriginal peoples will not access a health care system (and its practitioners) when they do not feel safe doing so—and where encountering the health care system places them at risk for cultural harm" (Aboriginal Nurses Association of Canada, 2009, p. 2). According to NAHO (2008), cultural safety is rooted in the education of health care providers. NAHO (2008) asserted that cultural safety goes beyond cultural awareness (being aware of the differences) and emphasizes personal and professional responsibility for ongoing self-reflection in the following areas: (a) understanding their professional roles and being willing to examine personal values, ethics, and epistemologies (ways of knowing); (b) recognizing that they may have conscious or unconscious conceptions of cultural/social differences in health care; and, (c) identifying pre-existing attitudes and be willing to transform their attitudes by tracing them to their origins and seeing their effects on practice through reflection and action.

According to NAHO (2008), cultural safety refers to what is felt or experienced by a client when a health care provider communicates with the client in a respectful, inclusive way, empowers the client in decision-making, and builds a health-care relationship where the client and the provider work together as a team to ensure maximum effectiveness of care. In addition, culturally safe encounters require that health care providers treat clients with the understanding that not all individuals in a group act the same way or have the same beliefs. It is imperative that the educator/health care provider recognize the distinctiveness of First Nations people as similar to yet different from Inuit and similar to yet different from Métis, and so on. While they share a common history and have been subject to similar constraints of colonialism, each group of peoples has great diversity within its own population (NAHO, 2008).

The results of this study, specifically wāpahtaman pimātisiwin (worldview), addressed the importance and the value of education, both formal and informal, as contributing to the participants' mental health and well-being. Ideally, a wide selection of culturally safe educational opportunities of an individual's choice would be available, including but not limited to attending cultural camps/cultural celebrations, seeing a mental health care provider or Elder, attending a variety of workshops or presentations that include both Indigenous and non-Indigenous perspectives, upgrading, and attending post-secondary education. However, it is important to note that some Indigenous peoples may never feel safe in a formal school or academic environment because of their residential school experiences. Fournier and Crey (1997) share a narrative that described the ongoing impact of the residential school experience on one man:

> I could have been an engineer, earned big money if I'd gone back to school, but I can't go near any kind of school even now—it gives me the cold sweats … the residential school finished me for learning for life. (p. 62)

This Indigenous man's experience suggests the necessity of ensuring our educational institutions provide a culturally safe environment for Indigenous learning. Battiste (2004) advocated that this gap in "education and the traumatic effects of schools must be addressed with an education that is therapeutic and nourishing" and that "each person's journey can be whole and satisfying with appropriate processes" (p. 10).

Implications for Counselling Practice

Information discussed in the preceding section on implications for education, will facilitate the integration of the findings of this study with mental health care practice with Indigenous peoples. There is no consensus in the literature regarding a *best practices* approach to use when counselling Indigenous peoples. The majority of the literature that examines healing for Indigenous peoples tends to be based on opinion and conjecture, not on research. In the field of counselling, the literature often provides advice to counsellors so that they can be more effective with Aboriginal clients, but it does not provide empirical evidence to support such advice (Hill & Coady, 2003; McCormick, 2009; Yellow Horse Brave Heart, 2005). Some scholars propose that conventional Western methods of therapy may actually harm some minority clients (Calabrese, 2008; Gone, 2008). Because Western psychotherapies are based on symbolic systems, values, methods, and interactional styles which are culturally inappropriate for Native people, they also increase the likelihood that clients may leave treatment prematurely (Mohatt & Varvin, 1998). In addition, Peacock (1996) described a cliché—"to live in both worlds" (p. 1)—as a concept that included both traditional culture and mainstream Americana; Indigenous peoples living in both worlds is a contemporary reality and adds to the challenge of providing culturally appropriate mental health intervention. Little Bear (2000) eloquently described the complexity of worldviews:

All colonial people, both the colonizer and the colonized, have shared or collective views of the world embedded in their languages, stories, or narratives. It is collective because it is shared among a family or group. However, this shared worldview is always contested, and this paradox is part of what it means to be colonized. Everyone attempts to understand these different ways of viewing the world and to make choices about how to live his or her life. No one has a pure worldview that is 100 percent Indigenous or Eurocentric; rather, everyone has an integrated mind, a fluxing and ambidextrous consciousness, a precolonized consciousness that flows into a colonized consciousness and back again … It is also this clash that suppresses diversity in choices and denies Aboriginal people harmony in their daily lives. (p. 85)

Thus, I will share the salient points discussed in the literature related to counselling Indigenous peoples. I will present foundational fundamental knowledge required by mental health care providers *prior* to engaging with Indigenous peoples and some general guidelines for counselling Indigenous peoples within the context of therapy. I will also discuss the need to integrate Indigenous and non-Indigenous approaches when working with Indigenous peoples and highlight some paradigm clashes between Indigenous and non-Indigenous worldviews that may impact the therapeutic process. I would like to clarify that as a novice therapist I will continue to seek and explore all the issues and concerns raised by these authors related to counselling Indigenous peoples. The specific implications for counselling practice derived from this study will be discussed in the section on general guidelines for mental health care providers. Note that the suggestions for counselling practice are broad in nature in an attempt to provide a holistic and informed lens through which to view and approach counselling with Indigenous peoples.

Fundamental knowledge required by mental health care providers.

Counselling and psychotherapy cannot take place without communication, and we cannot communicate with someone unless we have a shared language and worldview (Torrey, 1986). To enhance communication with Indigenous clients, mental health care providers require the following basic knowledge: (a) an understanding of colonization and the continued impact of colonization on current Indigenous mental health and well-being (Chansonneuve, 2005; Kirmayer, Brass & Valaskakis, 2009; Mitchell & Maracle, 2005; Mussell, 2005; Wesley-Esquimaux & Smolewski, 2004) and neocolonial practices (Ermine et al., 2004; Smith, 1999)**;** (b) cross-cultural training, specific to Indigenous peoples of Canada, with an emphasis on Aboriginal worldviews (Calabrese,2008; Gone, 2008; NAHO, 2008) and, Indigenous cultures and traditions (Calabrese, 2008; Chansonneuve, 2005; McCormick, 1995; Ross, 1992); and, (c) a comprehension that all peoples' mental health and well-being are impacted by their socio-economic status (PHAC, 2010; Raphael, 2006).

According to Duran and Duran (2000), successful clinical interventions are not possible unless the provider or agency is cognizant of the socio-historical factors, namely colonization, that have had a devastating effect on the dynamics of the Native American family and community. As previously discussed, the residential schools that were enforced by government policy (the *Indian Act* in Canada), resulted in the "systematic destruction of the Native American family system" (Duran & Duran, 2000, p. 97), in addition to the numerous losses previously identified in chapter 2.

Cross-cultural training was addressed under general implications for education; however, I will expand on this concept in relation to providing culturally appropriate mental health intervention. Duran and Duran (2000) asserted that providing mental health services to Native

American people has been a "failure" (p. 89). According to Duran and Duran (2000) all people

of ethic-minority groups have higher dropout rates from counselling services because most

mental health care providers are trained only in delivering services to the majority or dominant

population. They explained, "usually, therapists are completely unaware of the life experiences

not defined by Western subjectivity" (p. 89). Thus, effective mental health care providers should

strive to become knowledgeable regarding Indigenous worldviews and value systems specific to

their Indigenous clients. Providing culturally appropriate mental health intervention will differ

from client to client. Macdonald (2009) raised an important consideration regarding culture.

She cautioned, "culture must not be essentialized using a rigid reading of community and

tradition or a pan-Indian version of identity" (p. 392). Culture should be read as an "emergent

process that is continually invented, transformed, and recreated" (p. 392). She suggested

approaching clients with an openness that can tailor care to the individual client's "perspective

on reality" (p. 392) with an awareness that individuals may negotiate between social and cultural

communities and modes of belonging throughout the course of their quests for help (Macdonald,

2009).

   Indigenous worldviews have been described in the literature as being relational,

interconnected, and holistic (Calabrese, 2008; Hart, 2002; McCormick, 1995 & 1997; Ross,

1992). Duran and Duran (1995) described Native American psychology as being "one of

oneness and harmony with the environment" (p. 33). Several authors have described the vast

differences between Indigenous and non-Indigenous worldviews (Calabrese, 2008; Hill &

Coady, 2003; Gone, 2008) which will be discussed in the section on paradigm clashes between

Indigenous and non-Indigenous worldviews.

   The connection between Indigenous well-being and the determinants of health, especially

in relation to socio-economic status, was discussed in chapter 2 and further in chapter 4, in the sections on néhiyawak-voiced needs to obtain optimal mental health and well-being. As previously mentioned, income is a determinant of health in itself, but it is also a determinant of the quality of early life, education, employment, and working conditions across the lifespan; quality of housing; food security; and the experience of social exclusion (Raphael, 2006). Thus, socio-economic status has the greatest influence on an individual's overall health and well-being (PHAC, 2010; Raphael, 2006).

General guidelines for mental health care providers.

Within the context of therapy, mental health care providers should (a) address issues from a social/community context versus an individual approach; (b) encourage and support the Indigenous client's interpersonal and social relationships; (c) support the Indigenous client to relearn or maintain their traditional spiritual beliefs and cultural practices; (d) utilize a holistic approach to address their mental health concerns; (e) address the power imbalances; and, (f) utilize proven psychoeducational and therapeutic approaches.

Address issues from a social/community context versus an individual approach.

According to McCormick (1997), healing in Euro-American culture tends to "reflect the philosophy of individualism in its practice" (p. 172) and since Indigenous peoples "tend to have a more collective orientation towards life, they do not respond well to the individual orientation of mainstream counselling practice" (p. 172). Numerous authors have recommended addressing Indigenous issues from a social/community context versus an individual approach (Calabrese, 2008; Epes-Brown, 1992; McCormick, 1995, 1997; Mitchell & Maracle, 2005; Ross, 1992; Torrey, 1986). This issue will be expanded on in the section on paradigm clashes between Indigenous and non-Indigenous worldviews.

Support Indigenous clients' interpersonal and social relationships.

It is essential to encourage and support an Indigenous client's interpersonal and social relationships with others (Herman, 1997; Gone, 2008; McCormick, 1995, 1997; Mussell, 2005). The results of this study suggest the importance of cultivating healthy relationships with oneself, family, community, and the universe. McCormick (1995; 1997) and Epes-Brown (1992) discussed connectedness as an Indigenous worldview and as necessary for optimal Indigenous mental health and well-being. McCormick (1997) asserted that by restoring connection (interconnectedness) to oneself, family, community, and the universe will enhance Indigenous mental health and well-being. Further, many Indigenous Elders believe that reconnection to "culture, community, and spirituality is healing" (McCormick, 2009, p.349).

Support Indigenous clients to relearn or maintain cultural practices.

One of the major roles of therapy and healing for traditional Aboriginal people is to re-affirm cultural values (LaFromboise et al., 1990). Tradition and culture are central to healing for Indigenous peoples (Calabrese, 2008; Gone, 2008; Kirmayer, Brass, & Valaskakis, 2009; McCormick, 1995; Mussell, 2005; Ross, 1992; Yellow Horse Brave Heart, 2005). This movement toward reconnecting with cultural beliefs, tradition, and ceremony as a way to overcome problems has been referred to as "retraditionalization" (LaFromboise et al., 1990). The results of this study support the contention that the connection or reconnection to an Indigenous person's spiritual beliefs and cultural practices enhances their mental health and well-being. Encouraging Indigenous peoples to participate in their traditional cultural customs will foster their interconnectedness with others and the universe, which will enhance their mental health and well-being (Hart, 2002; McCormick, 1995). In addition, communal healing and cultural ceremonies provide individuals, families, and communities with supported structures to

acknowledge and grieve their common wounds (Mitchell & Maracle, 2005).

   Utilize a holistic approach to address their mental health concerns.

   In an ideal world, all mental health care providers would aspire to routinely promote and practice from a holistic perspective. Mental health care providers should consciously promote a holistic perspective by expanding their vocabulary to include physical, mental/intellectual, emotional, and spiritual elements of well-being. This holistic practice would reinforce to clients the interconnectedness and the relationship between their physical, mental/intellectual, emotional, and spiritual well-being with their overall health status. Clinically, Duran (2006) argued that the impact of abuse occurs at the physical, psychological, and spiritual levels, therefore, "the issue must be addressed at all of these levels" (p. 21).

   Duran (2006) acknowledged that the use of the terms *spirit* and *soul* may have some readers feeling uneasy because "these terms are not part of the Western psychological terminology" (p. 19). However, Duran explained the literal definition of our profession (psychologists) has deep roots that are enmeshed with spiritual metaphor. It is important to be cognizant that the word *psychology* literally translates into "study of soul" (Duran, 2006, p. 19). The Webster's 1913 dictionary defined psychology as the "science of the human soul; specifically, the systematic or scientific knowledge of the powers and functions of the human soul, so far as they are known by consciousness; a treatise on the human soul" (n.d.). Duran (2006) described how the so called *enlightenment* and the *Cartesian splitting of the world* caused our profession to lose the essential meaning of our root metaphor. Duran stated, "we literally have done that, we have been split off from our world-soul" (p. 19). He argued that if healers are split from their souls, they will not be able to facilitate the integration of soul in their clients. In addition, Duran noted, from a philosophical standpoint, that it is interesting that therapy focuses

on cognition when the root of the word *psychology* is soul. Duran (2006) argued that between

the root meaning of psychology and the world of clinical practice there appears to be an

"inconsistency at best and, perhaps, dishonesty at worst" (p. 20). This practice impacts the ethics

of our profession "if we inflict a system that is based only on cognitions, as in the logocentric

Euro-American tradition, we are committing hegemony (imposing a different worldview on

someone)" (p. 20) on the client who may believe otherwise. This type of cultural incompetence

illustrates how someone operating from innocent ignorance actually can practice a form of

hegemony that goes against all of the principles of our profession (Duran, 2006).

Address the power imbalances.

Mental health workers should strive to be cognizant of the socio-economic, cultural, and

power imbalances that may impact or impede communication with Indigenous peoples. It is also

essential to acknowledge and address oppression (Duran, 2006). Indigenous peoples face

challenges related to oppression regardless of their socio-economic status. Using cross-cultural

concepts, having a comprehensive understanding of the historical and socio-political context of

Canadian Indigenous history, and having a thorough understanding of the determinants of health

and their impact on individual health and well-being would enable mental health care providers

to provide care and information within the appropriate context of the client's environment in a

sensitive manner. Mental health care providers should seek to understand and respect that every

client is a unique individual with a different baseline of knowledge regarding health and well-

being that has been influenced by their past experiences, cultural practices, and language. This

baseline of knowledge needs to be examined on an individual basis when interacting with people

from different cultures and ethnicities. In addition, NAHO (2008) advocated that as part of

practicing in a culturally safe manner, one must understand the power imbalances that can exist

(in favour of the health care worker) between the health care provider and the client. Thus, it is important for mental health care providers to learn how to exchange and negotiate power within the helping or healing relationship.

Utilize proven psychoeducational and therapeutic approaches.

Ideally, mental health care providers should utilize proven psychoeducational and therapeutic approaches (Mitchell & Maracke, 2005) with their Indigenous clients. However, this is not possible at this time given the paucity of research on best practices with Indigenous peoples (Hill & Coady, 2003; McCormick,2009; Yellow Horse Brave Heart, 2005). Yellow Horse Brave Heart (2005) explained that evaluation of Native practices is complicated for the following reasons: (a) there are certain taboos about sharing information regarding the process and content of ceremonies; (b) criteria for effective outcomes may also be different from the dominant cultural framework for best practices; and, (c) current methods for determining which interventions are recognized as best practices are dominated by Western scientific models, ideas, and paradigms. It is worth mentioning that Native communities are often required by funding agencies to utilize and culturally adapt models normed with non-Native populations and which emerge from a dominant cultural paradigm (Yellow Horse Brave Heart, 2005). As a result, Yellow Horse Brave Heart stated that instead of meaningful cultural adaptation, most often there are superficial changes such as substituting terms with Native words or using Native designs on intervention manuals. Consequently, she argued that the model remains inherently non-Native with non-Native values and worldviews.

Blending of both the Indigenous and non-Indigenous worldviews.

Duran and Duran (2000) suggested mental health care providers integrate Western and traditional approaches when counselling Indigenous peoples, however, to date this effort has

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remained primarily in the realm of "academic discussion" (p. 90). They acknowledged that there are valuable ideas in the Western world and they believe that by integrating worldviews and psychological understanding, a model could be developed that would benefit both Indigenous and non-Indigenous peoples. By "reinterpretating some of the theoretical constructs developed by Jung, and taking this reinterpreted psychology and integrating it with traditional psychology and other Native epistemologies, we can arrive at ideas with some theoretical and clinical evidence" (Duran, 2000, p. 93).

At the onset, Duran and Duran (2000) urged practitioners to use creative methodologies that "do not reinforce scientific and epistemic colonialism" (p. 95). In addition, Lafromboise et al. (1990) speak to the importance of individual assessment:

Knowledge of and respect for an Aboriginal worldview and value system—which varies according to the client's tribe, level of acculturation, and other personal characteristics— is fundamental not only for creating the trusting counsellor-client relationship vital to the helping process but also for defining the counselling style or approach most appropriate for each client. (p. 629)

Duran (2006) suggested, after two decades of amalgamating Western theory and traditional Aboriginal theory and practice, that clinical assessment and treatment for Indigenous peoples should include the following elements: Western clinical practice, internalized oppression, historical trauma, and traditional Aboriginal theory. Morgan (1995) made the following comment about Duran's approach:

Eduardo, drawing on ethnic tradition (Pueblo and Apache) and psychological framework (Jungian, empowerment, identity and individuation, self-esteem) had found a middle ground for effective clinical intervention. He used dreams, sandtray, cultural and

personal metaphor, and nondirective technique in a way simultaneously congruent with millennia of Native American tradition and contemporary psychological practice. More important, this special blend worked. Clients with severe alcohol and substance abuse problems returned to health. Even those with chronic psychosis or character disorder responded. Violent and chaotic home situations improved. My continuing curiosity as a supervisor flourished: How did he do it? (p. xi)

Given most mental health care providers are familiar with Western clinical practice, I will discuss the less familiar approaches/interventions that are considered more appropriate to use when counselling Indigenous peoples. I will briefly describe internalized oppression, historic trauma, and traditional Aboriginal theory as suggested by Duran (2006) to address within the clinical setting.

Internalized oppression stems from oppression (Mussell, 2005). Mussell (2005) defined oppression as the

systematic subjugation of a group of people by another group of people with access to social power, the result of which benefits one group over the other and is maintained by social beliefs and practices. Because oppression is institutionalized in society, target group members often believe the messages and internalize the oppression.… When target group members believe the stereotypes they are taught about themselves, they tend to act them out and thus perpetuate [them] … [this] reinforces the prejudice and keeps the cycle going. (p. 16)

According to Duran (2006), there are diverse manifestations of internalized oppression; however, there is a common thread that weaves all of them together. Duran explained that the pain and learned helplessness of internalized oppression has continued to plague Indigenous

peoples, despite massive amounts of interventions that have been provided to treat individuals'

symptoms. He described internalized oppression as a wound, like a vampire bite, that becomes

embedded as the individual or group is undergoing the abuse or trauma. Unless the victim is

able to consciously explore the dynamics of the abuse and find meaning in the situation, that

individual is doomed to repeat the abuse on someone or something else (Duran, 2006).

Duran (2006) equated the term "soul wound" (p. 7) with intergenerational trauma or

historical trauma. Duran described that the Native idea of historical trauma "involves the

understanding that the trauma occurred in the soul or spirit" (p. 7). Yellow Horse Brave Heart

and Debruyn (1998), a Lakota clinical social worker and a French Canadian medical

anthropologist, advocated the need to attend to the resolution of historical unresolved grief

through an integration of both clinical and traditional American Indian interventions. They

suggested individuals can continue the healing process through individual, group, and family

therapy as well as attending to their own spiritual development. This approach would require

First Nations communities to facilitate communal grief rituals, incorporating traditional practices

(Yellow Horse Brave Heart & Debruyn, 1998).

The use of traditional Aboriginal theory will vary from client to client and community to

community. As Duran (2006) has noted, "many of the patients seen in these settings prefer and

respond to Western methods" (p. 38). However, Duran recommended that it is best to have

flexibility in clinical and theoretical practice. The significance of Indigenous knowledge,

worldviews, spiritual practices and cultural traditions has already been discussed and will be

elaborated on in the next section.

Paradigm clashes between Indigenous and non-Indigenous worldviews.

L. T. Smith (1999) asserted that "to hold alternative histories is to hold alternative

knowledge" and argued that the pedagogical implication of this "access to alternative knowledges is that they can form the basis of alternative ways of doing things" (p. 34). Duran and Duran (2000) asserted, "in reality, the thought that what is right comes from one worldview produces a narcissistic worldview that desecrates and destroys much of what is known as culture and cosmological perspective" (p. 93). Battiste (2000b) spoke of *cognitive imperialism* or *cognitive assimilation* as the "imposition of one worldview on a people who have an alternative worldview, with the implication that the imposed worldview is superior to the alternative worldview" (p. 193). Battiste shared that scholars with the United Nations have called cognitive imperialism or cognitive assimilation, "cultural racism" (p. 192).

Unless Western systems—which "belong to the power brokers—began to accept non-Western forms of knowledge as legitimate, Western therapy will continue to be impotent" (Duran & Duran, 1995, pp. 52–53). Currently, there is a scarcity of research on Aboriginal healing methods (Hill & Coady, 2003; Yellow Horse Brave Heart; 2005), and for this reason Hill and Coady (2003) argued for the importance of advancing theoretical versus empirical arguments for the effectiveness of Aboriginal approaches to healing. These theoretical arguments are based on the paradigm clashes between Indigenous and non-Indigenous peoples. Calabrese (2008) succinctly described 10 areas of cultural difference contributing to the paradigm clash between Euro-American theories of psychotherapeutic intervention and traditional healing systems of the Navajos. Understanding these paradigm clashes will broaden our understanding of what psychotherapeutic intervention entails.

The first area addressed by Calabrese (2008) is the individualist dyad versus communal group process. The most typical contrast drawn between modern Euro-American cultures and many non-European cultures is that between individualist and more communal or collective

ideologies. Typically, when one thinks of psychotherapeutic intervention, what typically comes to mind in the Euro-American context is the therapeutic dyad: a client and a therapist (often taking notes or calmly probing with questions). Calabrese explained that anthropological research has revealed the centrality of ritual approaches to healing in many cultures outside the industrialized West. In these traditions, a technique of *emplotment* (the ritual-based symbolic or rhetorical approach to shaping consciousness and symbolic healing) of the client using ritual symbols, songs, and myths are typical, and are often used in connection with a technique of *consciousness modification* (any cultural technology used to alter the consciousness state of self or others). Calabrese stated that ecstatic emotions and luminal symbolism are central to ritual approaches. In contrast, he described talk therapy to be a very modernist, Euro-American enterprise in that it tends to limit itself to calm rational argumentation within one to one relationships and discussions. The psychotherapeutic process generally refers to elements of verbal interaction and interpersonal relationship between a therapist and a client in one-to-one settings which differs from dramatic communal ritual common in many cultural traditions (Calabrese, 2008).

Another difference between Euro-American psychotherapeutic healing approaches is related to the role of the healer. Many Western theories of psychotherapeutic efficacy focus on the personal characteristics of the therapist as central to the healing process. In contrast, in many Native American healing traditions, the healer's role is less central with little direct verbal interaction between the parties. Within Native American healing traditions it is often said that an individual is responsible for their own healing and that the most important therapeutic communications are often those that come to the individual not from the healer but directly from God or the Peyote spirit in the form of visions or other sacred experiences (Calabrese, 2008).

The third difference is the expectation of the client's calm self-disclosure to a professional stranger. This type of disclosure seems specific to Euro-American psychotherapy. Calabrese (2008) explained that some of the Native American healing rituals, such as the sweat lodge or peyote meeting, do involve expression of emotion, however, this expression occurs in an emotionally charged group context involving a supportive gathering of family and friends.

The fourth difference is the time factor: the duration of the intervention is another difference in approach. Typically in the Euro-American setting, clients tend to see their therapist for one hour. Within this time frame they are expected to be ready to self-disclose and it is assumed that their problems can be addressed effectively with an hour. In contrast, a sweat lodge or peyote meeting, six or seven hours may elapse before an individual is ready to disclose or express feelings. Some traditional Navajo healing rituals may extend to five or even nine nights. From a comparative perspective, there is a vast difference in the dose of psychotherapeutic intervention (Calabrese, 2008).

The fifth contrast relates to secular versus spiritual intervention (Calabrese, 2008). The role of spiritual beings or supernatural beings is a particularly vexing question for psychotherapists. Modern secular clinical approaches tend to view talk of spiritual beings as a symptom of a possible psychotic disorder; however, for most of human history, spiritual beings have been an intimate part of how people healed. This heritage continues in many traditions that were never secularized (Calabrese, 2008).

The sixth contrast described by Calabrese (2008) concerns the mechanism of therapeutic change, change as a rational decision versus ecstatic experience of hypnotic suggestion. The dyadic model of rational discussion of one's problems tends to imply a model of change as a rational decision based on a variety of rational methods to help clients achieve insight into their

problems. On the other hand, in some traditional approaches, therapeutic change may involve ecstatic emotions, visions, conversion experiences, feelings of religious significance, relationships with divinities, and various forms of suggestion. In many cases, Calabrese (2008) found that a radical transformation involving a shift in consciousness, and often a shift toward spiritual life, seemed the only way to interrupt dangerous behaviours and initiate change. This sort of shift was facilitated by ritual interventions.

Calabrese (2008) described a seventh contrast, individualized narratives versus performed narratives. A modern therapist tends to elicit and work with the significant narratives of the client. Whereas, traditional Native American healing more often embeds the individual in preformed narrative structures that are implicit in myths and ritual symbolism. For example, the Navajo create a sand painting depicting a particular myth and the individual is literally placed on top of this narrative-laden mythic depiction (Calabrese, 2008).

Another conceptual difference asserted by Calabrese (2008) relates to psychotherapeutic intervention as being remedial-stigmatized versus preventative-valorized. In the Western mode, psychotherapeutic intervention tends to be remedial and stigmatized. Most Euro-Americans do not see a therapist unless something is wrong, even then going to see a therapist may be seen as a personal failure. In contrast, in many Native American healing practices, psychotherapeutic intervention is seen as preventative and growth-oriented as well as remedial. Stigma connected with ritual treatment is not as apparent. In fact, the person who actively seeks psychological harmony through ritual is valorized rather than stigmatized (Calabrese, 2008).

Another area of cultural difference is related to the dualist separation of meaning-centred and pharmacological interventions versus integration (Calabrese, 2008). Psychopharmacology in the Euro-American context aims at correcting a malfunctioning biochemical mechanism,

whereas psychopharmacology within the Navajo culture focuses on interrupting the addiction process, reawakening spirituality, supporting emplotment, and facilitating the individual's insight. Calabrese (2008) advocated that in the absence of serious research on both traditions, it is not acceptable to assume that the molecule-focused Euro-American psychiatric paradigm is the only valid approach and that the higher-order semiotic-reflexive paradigm is ignorant or mistaken. The safest assumption is that this is a psychopharmacological paradigm clash and, thus, interesting for cross-cultural research (Calabrese, 2008).

The last area of cultural difference Calabrese (2008) addressed, is related to the clashing of psychopharmacologies, synthetic-processed versus natural plant forms. Calabrese (208) explained that clinical psychopharmacology is limited to the exclusive use of lab-created psychological medicines that are profitable for drug companies and that are rationalized scientifically (although they often have significant negative side effects of their own). Conversely, the psychoactive plant medicines of other societies have been labeled in classic Western biomedicine as drugs of abuse or are assumed to be inferior to lab-created medicines, ensuring the hegemony of the Euro-American cultural norms and the incomes of drug companies (Calabrese, 2008).

These paradigm clashes between Euro-American and Navajo Peyotist traditions of psychotherapeutic intervention are profound and multifaceted. Calabrese (2008) argued that the generative sources of these contradictions are differences in basic cultural orientations to epistemology, the person in social context, the role of spirituality in healing, and the separation or integration of mind and body. Calabrese's (2008) analysis illustrated the complex relationship of clinical understanding and cultural ideology and contributes to critiques of biomedical hegemony and the view that the cultural *other* holds culturally determined and often "erroneous

beliefs" (p. 347); whereas, science is clearly not sure what "traditional healing means and therefore reverts to the default position of assuming that it pertains to medicine in the scientific sense, perhaps only more primitive" (Waldram, 2004, p. 297).

In addition to these 10 clinical paradigm clashes, Gone (2008) raised another important consideration when counselling Indigenous peoples. Gone stressed the cultural divergences in Western professional and American Indian therapeutic traditions, however, he explored this divergence from an ethno-psychological orientation, which addressed the psychologies of *space* and *place*. Gone described space in this context to mean, "an experiential domain that relates entities to one another in terms of position and movement" (pp. 371–372) and place, "an experiential domain that marks and situates particular entities or bounded fields of situated entities" (p. 372). Gone pointed out that these two definitions represent a "potentially fruitful point of departure for the systematic comparison of Western professional and Indigenous therapeutic traditions" (p. 372).

Gone (2008) explained that one therapeutic space was constituted by traditional Indigenous religious rites, while the other was constituted by modern professional health services. Gone argued that reservation-based mental health clinics, despite their intentional designation as therapeutic spaces, may be seen to "function as sites of colonial incursion and Native resistance in cultural-and especially ethnopsychological-terms" (p. 369). One of the participants in Gone's study, Traveling Thunder, explained that he has never accessed the Indian Health Service clinic and that he would never take his grandchildren there for mental health services. Traveling Thunder explained that the United States Indian wars continue, not in military terms (i.e. they are not using bullets anymore) but in cultural terms (i.e. so they could join the melting pot of the modern White society). He elaborated, "they're liable to do more

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harm than they are good … if they're gonna force their White ways and White beliefs on them" (p. 381). Thus, Traveling Thunder viewed the therapeutic services provided by the "White psychiatrists" as a form of "brainwashing to be undertaken only by those who want to end up looking good to the Whiteman" (p. 382). For Traveling Thunder and others sharing his cultural standpoint, this critical perspective might be summarized as follows, "if therapeutic culture promoted by the various 'psy'-disciplines has become established as the new civil religion of the industrialized West at the turn of the 21st century (Ward, 2002), then mental health professionals are the missionaries for a new millennium" (Gone, 2008, p. 391).

In summary, providing appropriate mental health care for Indigenous peoples is challenging and complex given the history of colonization in Canada and the growing concern related to perpetuating colonial and neocolonial practices. Given that there are no best practices that have been empirically tested with Indigenous peoples (Hill & Coady, 2003; Yellow Horse Brave Heart, 2005), I leave you to ponder the above authors suggestions and concerns. Perhaps most important, is that these authors have created space and opportunity for mental health care providers to critically evaluate their current practices and approaches to counselling Indigenous peoples.

Implications for Government

Despite the resilience of the néhiyawak in this study, the current statistics portray unacceptable health disparities between the Indigenous and non-Indigenous peoples of Canada (Health Canada, 2005a, 2005b; MacMillan, MacMillan, Offord, & Dingle, 1996; Statistics Canada, 2010; Tookenay, 1996). Interestingly, the determinants of health as described by PHAC (2010) are the same factors that were disrupted by colonization. These determinants of health, especially income and social status, require immediate attention to allow Indigenous peoples an

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opportunity to attain the same level of health as non-Indigenous people in Canada. Levels of

income, employment, education, housing, health, and mental health vary considerably between

Indigenous and non-Indigenous people in Canada (Health Canada, 2005a, 2005b; Statistics

Canada, 2010). It is time to restore the imbalance that was created with colonization, to

collaborate and expeditiously implement the structural changes required to address the existing

health disparities between the Indigenous peoples and non-Indigenous peoples of Canada. The

challenge is to restore autonomy and self-sufficiency within a contemporary context as

Indigenous peoples cannot feasibly return to their traditional lifestyle (pre-European contact).

Ideally, this endeavour would involve joint collaboration between all levels of government, both

Indigenous and non-Indigenous. Ultimately, improving the health of Canada's Indigenous

peoples will depend on improving their economic and social conditions as well as assisting

Indigenous peoples to identify and address their own health needs.

Implications for Future Research

A next step for this research on Indigenous mental health and well-being would be to

replicate this study, using the following questions: (a) what is making a positive difference for

your mental health? and (b) what do you need to attain optimal mental health and well-being?, in

different regions of Saskatchewan and across Canada. Replication and further validation of this

study would provide direction for program planning and allocation of resources. In addition,

results from different communities, on and off-reserve, urban and rural, would enhance our

understanding of the role of context on Indigenous mental health and well-being.

The themes generated from this study could be utilized to develop a survey instrument or

questionnaire that included both quantitative (scaling) and qualitative questions to assess the

similarities and differences in the perceptions of other Indigenous peoples. Thus, large numbers

of Indigenous peoples could be accessed across Canada; having this knowledge would increase our understanding and ability to provide appropriate mental health services for Indigenous peoples.

The vast majority of the néhiyawak in this study (with the exception of two) had a sustainable source of income. Thus, further research could explore if their income was the major contributing factor to their relative satisfaction with their mental health and well-being or if this is an exemplar showcasing the positive impact of employment on Indigenous mental health and well-being. It would be interesting to do longitudinal studies to compare the results from participants who had a sustainable source of income to those without employment as to their responses and voiced needs using a narrative approach.

A follow-up study could be done to evaluate the efficacy of implementing an Indigenous mental health program based on the findings of this research project. Perhaps a longitudinal study spanning 5–10 years would provide information to substantiate the efficacy of this Indigenous mental health program and become a model for addressing mental health and well-being within Indigenous populations.

The medicine wheel is a well-supported framework for addressing both the health (Roberts, 2005) and mental health needs of Indigenous peoples (Hart, 2002; Mussell, 2005). Further research could explore the efficacy of mental health therapists (Indigenous and non-Indigenous) utilizing the medicine wheel and the traditional teachings to improve mental health and well-being for Indigenous peoples.

Strengths and Limitations

One of the underlying strengths of this research project was the support of the administration of Thunderchild First Nation, the Health Board, and the community. The Chief

and Council, Health Board, and the Director of Health were receptive and supportive throughout the project. In addition, community members were eager to participate, which facilitated the recruitment process. I was also fortunate to have a diverse group of participants with variation in education and gender.

Another strength, that did not become apparent until I started data analysis, was the impact that the néhiyawak socio-economic status may have had on their mental health and well-being. As mentioned, the vast majority of the néhiyawak were relatively content with their mental health and well-being, and they had a source of sustainable income (student living at home, employment, pension plan) with the exception of two. Interestingly, the two participants without a sustainable income were the two who voiced that they were struggling to improve their mental health and well-being; both were adamant about needing employment to attain optimal mental health and well-being. I wonder if this research project could be considered an exemplar showcasing the positive influence of employment/sustainable income on Indigenous mental health and well-being.

In retrospect, I would change the semi-structured interview guide to have one open ended question (excluding four of the questions and combing two of the questions into one), such as "tell me what is making a positive difference for you in terms of your mental health and what do you need to attain optimal mental health and well-being?" for the following reasons. First, an open ended question would have allowed the participants to direct the conversation and share information at their discretion, as the interview guide may have limited or constrained their response. Second, during the interview and data analysis, I noticed that the néhiyawak responses were very similar for three of the six questions.

Another concern is the number of néhiyawak recruited for this research project.

Typically, narrative studies entail a few participants unless the intention is to construct composite stories. In this case, when I began this study I was uncertain whether I was going to construct composite stories or present individual narratives. Initially, during data analysis, I did construct composite narratives and decided the composite narrative did not honour individual agency. Thus, I presented the individual narratives obtained from the néhiyawak in this study.

Final Comment

Look at what I have learned by asking the néhiyawak of Thunderchild First Nation what improved their mental health and well-being and what they perceived as necessary to attain optimal mental health and well-being! Narrative inquiry allowed their individual experiences, stories, and truths to be heard and, brought their strengths and resilience to the forefront. The néhiyawak narratives represented what truly mattered in their lives. The narrative approach made sense of their collective voices and, most importantly, allowed the néhiyawak of Thunderchild First Nation to be heard.

The wisdom I have gained from the néhiyawak interviews has enhanced my personal and professional understanding of the néhiyawak and of myself as a néhiyaw woman. For this, I am forever grateful to the néhiyawak in this study who shared their wisdom, strengths, and insights. I am proud of my ancestors who managed to ensure the survival of our culture and language in the face of virtually insurmountable odds! As a result of our ancestors' valour, contemporary Indigenous peoples are now enjoying a strong cultural and spiritual revival. The néhiyawak in this study have emphasized the importance of their relationships; spiritual beliefs and cultural practices; tānisīsi wāpahtaman pimātisiwin (worldview); and ēkwa ōhi kikwaya piko ka-ispayiki kīspin ka-nohtē-miyo-mahcihoyān (these are the things that need to happen if I want to be healthy) as resources that have improved their mental health and well-being and necessary for

them to attain optimal mental health and well-being. If we, Indigenous and non-Indigenous peoples, are invested in providing culturally congruent mental health intervention that makes a difference, it is time to honour their voices.

<center>**Appendices**</center>

Appendix A IPHRC Recommendations

Report of the Indigenous Peoples' Health Research Centre to the Interagency Advisory Panel on Research Ethics

Recommendation #1: Indigenous Peoples' Jurisdiction

The jurisdiction of Indigenous Peoples to use their culture, heritage, knowledge, and political and intellectual domains must be explicitly recognized in the Tri-Council Policy Statement. Indigenous communities' rights to cultural and intellectual property must be respected and considered in the formulation of the rules of ethical research conduct because it is Indigenous Peoples' right and duty to develop their own cultures and knowledge systems. Appropriate mechanisms need to be established by the three granting agencies in concert with Indigenous authorities for the approval and review of research proposals in involving Indigenous Peoples. It would then be the responsibility of institutions and governments to adapt to this principle of jurisdiction in any research involving Indigenous Peoples.

Recommendation #2: Advancing the Ethical Space

Further conceptual development needs to take place in regards to an ethical space as the appropriate venue for the expression of an ethical research order that contemplates crossing cultural borders. A concrete conceptualization of the ethical space, as a meeting place of worldviews where excess baggage of interests and hidden agendas are left behind, will further enhance the visualization of an ethical research methodology. Ethical space is also has the potential for the creation of a 'possible theory' in ongoing human research. The conceptual development of the ethical space will require guideline principles put into effect by the three granting agencies that cement practices of dialogue, negotiation, and research agreements with

Indigenous authorities in any research involving Indigenous Peoples.

Recommendation #3: Research Agreements

In recognition of Indigenous jurisdiction, research agreements need to be negotiated and formalized with authorities of various Indigenous jurisdictions before any research is conducted with their people. The three granting agencies must enact this in policy and hinge any funding to researchers and institutions entertaining research involving Indigenous Peoples upon research agreements negotiated and approved by tribal authorities.

Recommendations #4: Empowerment and Benefits

Empowerment and benefits must become central features of any research entertained and conducted with respect to Indigenous Peoples. Empowerment not only refers to any benefits that may accrue from research, but also includes formulating research agendas in ways that advance community development, capacity building, knowledge transfer, and peoples' cultural vitality. Research is organized into appropriate methods such as renaming, reclaiming, and remembering community existence, must be one of the priorities in Indigenous Peoples' research and one that research programs must make explicit. Governments, international organizations and private institutions should support the development of educational, research and training centers which are controlled by Indigenous communities, and strengthen these communities' capacity to document, protect, teach and apply all aspects of their heritage.

Recommendation # 5: Protection of Intellectual and Property Rights

Ongoing efforts by scholars and political groups to formulate the parameters of national copyright laws and the protection of Indigenous Peoples' Intellectual and cultural property rights must take extreme urgency. The appropriation of Indigenous Peoples' intellectual and cultural property that entails a wide array of human, natural, and spiritual creations that are the exclusive

property of groups such as the family, community, tribe, or nation is continuing at an astonishing pace in new waves of neo-colonialism and imperialism. This property entails special relationships with the natural and spiritual world manifested as knowledge of plants, herbs, and other natural substances. The origin of such dangers as exploitation and appropriation of Indigenous knowledge often lies with university-sponsored research as enacted through funding agreements, scientific initiatives, and social and political developments brought on by economic globalization. Protection and recognition of Indigenous Peoples' intellectual and cultural property rights by researchers and institutions must be part and parcel of any funding received from the three granting agencies.

Recommendation #6: Ownership, Control, Access, and Possession

To protect their heritage, Indigenous Peoples must also exercise control over all research conducted within their territories, or which uses their peoples as subjects of study. This includes the ownership, control, access, and possession of all data and information obtained from research involving Indigenous Peoples. Researchers and scholarly institutions should return all elements of Indigenous Peoples' heritage to the traditional owners upon demand, or obtain formal agreements with the traditional owners for the shared custody, use and interpretation of their heritage. Additionally, researchers must not publish information obtained from Indigenous Peoples or the results of research conducted on flora, fauna, microbes or materials discovered through the assistance of Indigenous Peoples, without identifying the traditional owners and obtaining their consent to publication. The three granting agencies must stipulate this in policy and as conditions of any funding for researchers and institutions contemplating doing research involving Indigenous Peoples.

Recommendation #7: Education

Understanding Indigenous social structures and systems, and the role of education in the process of knowledge and cultural transmission, is a vital necessity in coming to terms with research involving Indigenous Peoples. Confronting neo-colonial practices requires a broad and protracted process of conscientization about research ethics, cultural imperialism, and the protection of Indigenous knowledge through the curricula of universities and research institutions that receive funding from the three granting agencies. Education in these respects must be supported with appropriate funding and resources.

Recommendation #8: Dissemination of Guideline Principles

Professional associations of scientists, engineers and scholars, in collaboration with Indigenous Peoples, should sponsor seminars and disseminate publications to promote ethical conduct in conformity with these guidelines and develop processes and structures to discipline members who act in contravention.

Recommendation #9: Consent and Timeline Conflicts

Steps must be taken to immediately implement policy that will ameliorate inherent conflicts between Research Ethics Board policies and Indigenous ethical requirements, the primary example being the process of negotiating consent with communities and participants prior to the receipt of formal consent that restricts participant contact. In order to negotiate the consent process, contact with the community/participants is required, however, contact prior to the granting of formal consent is prohibited by many Research Ethics Boards. In order to follow an ethical path with the Indigenous community in question, the researcher may be required to violate their institutional ethics. This extremely problematic situation must be addressed immediately by the three funding agencies. Further, the conflict between Indigenous constructions of the research relationships must be examined vis a vis institutional timelines and funding schedules and how these processes undermine ethical conduct.

BAND COUNCIL RESOLUTION
Made at a duly convened Council meeting of

The Council of the	**THUNDERCHILD FIRST NATION**
Date of the duly convened meeting	0 9 0 4 2 3
	Year Month

Support for Holly Graham for research project
"Perceptions of Factors Impacting Mental Health Positively and Negatively from an Indigenous (Plains Cree) Perspective"

Whereas the Chief and Council of the Thunderchild First Nation met at a duly convened Chief and Council meeting on April 23rd, 2009 at Thunderchild First Nation, Saskatchewan;

Whereas Holly Graham, a citizen of the Thunderchild First Nation, made a presentation to the Chief and Council with regard to a research study entitled " Perceptions of Factors Impacting Mental Health Positively and Negatively from an Indigenous (Plains Cree) Perspective" to complete her PhD Degree and;

Whereas Holly Graham requested permission from the Chief and Council of the Thunderchild First Nation with respect to capturing quantitative and qualitative data relating to " Perceptions of Factors Impacting Mental Health Positively and Negatively from an Indigenous (Plains Cree) Perspective" of Thunderchild citizens at no cost to Thunderchild and;

Whereas Chief and Council of Thunderchild recognize the opportunity in capturing data that will assist Thunderchild citizens;

Now Therefore Be It Resolved that the Thunderchild First Nation hereby give permission to Holly Graham to complete research relating to " Perceptions of Factors Impacting Mental Health Positively and Negatively from an Indigenous (Plains Cree) Perspective" of Thunderchild Citizens.

Quorum 5
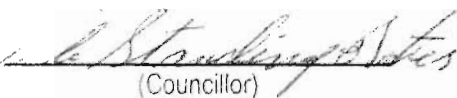
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(Councillor)

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	BEH#
Stephanie L. Martin	Educational Psychology and Special Education	09-155

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED
University of Saskatchewan

STUDENT RESEARCHERS
Holly Graham

SPONSOR
INDIGENOUS PEOPLE'S HEALTH RESEARCH CENTRE (IPHRC)
THUNDERCHILD FIRST NATION BAND

TITLE
Descriptions of Factors Positively Impacting Mental Health from a Contemporary Indigenous (Plains Cree) Perspective

ORIGINAL REVIEW DATE	APPROVAL ON	APPROVAL OF:	EXPIRY DATE
06-Jul-2009	19-Aug-2009	Ethics Application Consent Protocol	18-Aug-2010

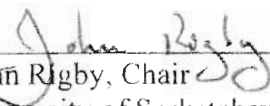Full Board Meeting ☐   Date of Full Board Meeting:

Delegated Review ☒

CERTIFICATION
The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: *http://www.usask.ca/research/ethics_review/*

John Rigby, Chair
University of Saskatchewan
Behavioural Research Ethics Board

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DESCRIPTIONS OF FACTORS IMPACTING
MENTAL HEALTH/WELLNESS POSITIVELY
FROM AN INDIGENOUS (PLAINS CREE)
PERSPECTIVE

INDIGENOUS PEOPLES
HEALTH RESEARCH CENTRE

IPHRC

Background

- Indigenous people as a population do not have the same level of health as other Canadians
- History of providing health care based on Eurocentric (Western) ideology
- Limited research
- Mental health issues have been long overlooked, especially in First Nation communities
- Recently, with the growing awareness of the many issues that have and continue to impact First Nation communities, there has been increased interest and urgency to initiate effective intervention and appropriate support/services to address the existing mental health issues

Significance of Research

- Insight gathered from an Indigenous perspective is crucial to planning effective mental health promotion, modifying lifestyle, and address existing mental health issues (**Indigenous voice**)
- Will create a better understanding of issues currently faced in First Nation communities and would assist health professionals to provide appropriate culturally sensitive mental health care (**contemporary**)
- **Implications** for health professionals, education, and further research will be identified
- **Strength-based** with a focus on exploring resilience within Thunderchild First Nation

Methodology

- Narrative Inquiry, a qualitative research method that focuses on stories or narratives
- Semi-structured interviews will be conducted with a cross-section of band members from Thunderchild First Nation
- Dissemination: shared with the Chief and Council of Thunderchild First Nation and the Health Board before official publication and dissemination of the information gathered

Methodology

- Narrative Inquiry
  - "stories lived and told...a way of understanding experience", natural use of language, traditional practice of Indigenous Peoples
  - Culturally appropriate
  - Holistic
- Clandinin & Connelly's 3 dimensional narrative inquiry space: situation (place), continuity (past, present, future), and interaction (personal & social)
  - Allows inquiries to travel inward (feelings, hopes), outward (environment), backward, forward, and situated in place

Interview Guide

- Basic demographic questions: age, gender, highest level of education, related marital status, number of children, and living arrangements
  Guiding Questions to Explore:
- 1. Tell me what mental health/wellness means to you?
- 2. What is making a difference for you to be healthier?
- 3. How have you coped with the stressors in your life?
- 4. Tell me what has helped you deal with the stressors in your life?
- 5. Tell me what gives you hope?
- 6. Imagine yourself as mentally healthy as possible. What would have to happen for you to become mentally healthy as you just imaged?

Expected Outcomes

- Provide an opportunity for the researcher, participants, Health Board, and the Chief and Council of Thunderchild First Nation to further explore, assess, analyze, and respond to the perceptions and beliefs identified to impact mental health/wellness in Thunderchild First Nation
- Recommendations for education, practice and identify areas for further research

Acknowledgements & Support

- My community, Thunderchild First Nation
- Indigenous Peoples Health Research Center (IPHRC)
- University of Saskatchewan
- Supervisor: Dr. Stephanie Martin
- My children: Teagan & Aiyana

Appendix **E Semi-Structured Interview Guide**

I am going to ask you some questions about mental health and wellness. I am interested in getting as many ideas as possible, so feel free to talk as long as you would like when answering a question. At times, I may ask for clarification or ask you to give an example.

Confidentiality:

As a researcher I have promised not to tell anyone your name. This is called a confidentiality agreement. It is important to remind you to only make comments that you would be comfortable making in a public setting; and to refrain from comments that you would not say publicly. Also, if you are sharing an experience about something that has happened to you do not identify anyone else in the story by their name. Do you have any questions about this?"

Demographics:

Location: _____ Interviewer: _____

Name/Code Number: _____

Age: _____ Gender: _____

Marital Status: _____ Number of children: _____

Living arrangements: _____

Highest Level of Education completed: _____

The interview questions are meant as prompts to discussion.

Semi-structured Interview Guide:

1. Tell me what mental health/wellness means to you?

Researcher will provide two definitions of mental health/wellness after their response: "I am going to share two different definitions of mental health with you":

A) The Canadian Mental Health Association uses the following key characteristics to assess

mental health: ability to enjoy life (can you live in the moment and appreciate the "now"?); resilience (are you able to bounce back from hard times?); balance (can you recognize when you might be devoting too much time to one aspect, at the expense of others?); self-actualization (do you recognize and develop your strengths so that you can reach your full potential?); flexibility (do you feel, and express, a range of emotions? When problems arise, can you change your expectations-of life, others, yourself-to solve the problem and feel better?)

B) According to Wheatley (1996): "Traditional American Indian health embodies a holistic health concept in which an individual has harmony with oneself, mind, body, and spirit; with others; and with his or her surroundings or environment" (p. 48).

2. What is making a difference for you to be healthier?

3. How have you coped with the stressors in your life?

4. Tell me what has helped you deal with the stressors in your life?

5. Tell me what gives you hope?

6. Imagine yourself as mentally healthy as possible. What would have to happen for you to become mentally healthy as you just imaged?

Thank you for taking part in this study.

Appendix **F Submission to the University of Saskatchewan Behavioural Research Ethics**

   Board

Research Proposal:

Descriptions of Factors Positively Impacting Mental Health from a Contemporary Indigenous

(Plains Cree) Perspective

Student: Holly Graham

Special Case PhD in Educational Psychology and Special Education

University of Saskatchewan

Supervisor: Dr. Stephanie Martin

June 22, 2009

1. Background Information for the Research Study:

After obtaining approval and consent from the Research Ethics Office and from the Chief and

Council of Thunderchild First Nation, I will start the research project. It is anticipated to start

data collection in August and submit the first draft of the results and recommendations in

October, 2009. This timeline may change, depending on the completion of data collection and

the availability of dissertation committee members to meet and recommended revisions. It is

anticipated that the dissertation and defense will be completed by December 20, 2009.

Researcher: Holly C. Graham, Special Case PhD Student

Supervisor: Dr. Stephanie Martin

Department: Educational Psychology and Special Education, University of

                     Saskatchewan

2. Title of the Study:

Descriptions of Factors Positively Impacting Mental Health from a Contemporary Indigenous

(Plains Cree) Perspective

3. Abstract:

There are unequivocal health disparities, both physical and mental, between the Indigenous and non-Indigenous peoples of Canada. Mental health issues have been long overlooked, especially in First Nation communities. Recently, with the growing awareness of the many factors that have impacted First Nation communities, there has been increased interest and urgency to initiate effective intervention and appropriate support to address the existing mental health issues. Utilizing narrative inquiry, a qualitative methodology, this study will explore current factors positively impacting mental health from a contemporary Indigenous (Plains Cree) perspective. Semi-structured interviews will be conducted with Band members from Thunderchild First Nation. These descriptions of factors positively impacting their mental health will create a better understanding of what is making a difference for them to be mentally healthier, identify what is helping them cope and manage the stressors in their life, and what gives them hope. This insight from an Indigenous perspective is crucial to planning effective health promotion and to effectively address the existing mental health disparities. Implications for health professionals, education, and further research areas will be identified and discussed.

4. Funding:

5. Expertise:

Vulnerable Population

This research project will be conducted with an Indigenous population (Plains Cree) whom are

considered a vulnerable population. Rogers (1997) defined vulnerability in terms of

"experiences that create stress and anxiety and affect the physiological, psychological, and social

functioning of the client" (p. 65). She continues to explain the theoretical underpinnings of

vulnerability include the relationship between vulnerability, environmental supports, and

personal resources. A client who is more vulnerable has fewer environmental supports and

personal resources, whereas the client who is less vulnerable has more supports and resources

(Rogers, 1997). According to the above definitions of vulnerable, Indigenous peoples do indeed

fit within the realm of being considered vulnerable therefore requiring special considerations

throughout the research process.

Relationship

The primary researcher, Holly Graham, is a band member of the Thunderchild First Nation and

has maintained ties with her community throughout the years and to the present. The Chief and

Council and the Health Board of Thunderchild First Nation worked in collaboration with Holly

when she did her research in the community for her masters thesis. During that time and since

the research has been completed, the Thunderchild administration has been supportive and

expressed a continued interest in remaining involved in the research for her dissertation. The

Chief and Council of Thunderchild First Nation have signed a Band Council Resolution (BCR),

indicating their consent and support for this research project (See Appendix A for a copy).

Expertise

The primary researcher: is a registered nurse (RN) who has worked extensively with Indigenous

peoples in Saskatchewan regarding a variety of health issues since 1985; specialized with

dissociative identity disorders (DID) and post-traumatic stress disorder (PTSD) as a psychiatric

nurse for 3.5 years in Texas; has completed the required courses and practicums for the Special

Case PhD that provide the baseline to work with clients from all backgrounds and sensitive issues; has taken additional training/certification to work with trauma: eye movement and desensitization (EMDR) and somatic experiencing (SE); passed her PhD comprehensive exams and one of the papers dealt specifically with trauma and current treatment options; and upon completion of the dissertation Holly is eligible to start the registration process to be a registered psychologist in Saskatchewan.

6. Conflict of Interest

Relationships

The primary researcher, Holly Graham, is a member of Thunderchild First Nation. Even though there are no plans at this time, there is a possibility that Holly may work in her community in the future as a psychologist. In addition, some of the participants may be closely or distantly related to the primary researcher. For this study, Holly will ensure her immediate family, mother and siblings, will be exempt from participating. This information will be disclosed and discussed with the participants during initial contact and as part of the consent process, before they agree to participate in the study. The primary researcher will ensure they understand that she may work in their community as psychologist and that they are under no obligation to participate in the research if they are uncomfortable or related.

In the past and present, Holly has worked with relatives/members from Thunderchild First Nation in a professional capacity as a nurse (RN), previous research for her masters, and more recently as a mental health therapist in Saskatoon. In each setting, Holly has acknowledged the relationship and provided the opportunity for them to express any discomfort and provided options of not participating or referral to another health professional. To date, this has not been an issue; however, Holly is certainly aware of the possibility and will respond in an ethical

manner to ensure participation in this study is completely voluntary.

Financial

There is no additional monetary gain for the primary researcher to conduct this study in her

community.

Dissemination

The Chief and Council of Thunderchild First Nation are aware the complete process of this

research project will be written in a dissertation (book) format and that Holly does plan to

publish aspects of this study. They are aware the researcher is in the process of publishing the

results from the last research project completed in their community (thesis research). Any

concerns mentioned by the band members will be resolved in a manner acceptable by both the

Thunderchild First Nation and the researcher before written documentation is presented

elsewhere in either a publication or dissertation format. The Research Ethics Office will be

notified in writing after the researcher and the Chief and Council of Thunderchild First Nation

have met and mutually agreed on the dissemination of the study (pending).

7. Participants:

Advertising by word of mouth using the local radio station (Appendix B), posters (Appendix C),

leaving a letter (Appendix D) attached to the posters describing the study, and a presentation to

Chief and Council and the Health Board should ensure reaching interested participants. The local

radio station will read the scripted information (Appendix B) and will encourage interested

participants to go to the Band office or the Health clinic to read the poster and the attached letter

for more information about the study. In addition, the researcher will post dates and times by the

poster when she will be at the Health Clinic to answer questions about the study and to interview

interested participants. The interviews will take place at the Health clinic. The Health Clinic is an

ideal location; participants will not be readily identified as many of the community members attend the Health Clinic on a regular basis for a wide variety of health related activities (dental, immunization, health and wellness presentations, screening clinics, eye appointments, utilize the medical taxi services etc.). These dates and times will be determined after this proposal has been approved by the Research Ethics Office at the University of Saskatchewan.

Participants will have the option to either contact the researcher by email or telephone in advance or show up and meet with the researcher when she is in the community. A combination of purposeful and convenience snowball sampling will be utilized. The Chief and Council and the Health Board will be given the option to identify Elders they think may be interested in participating in the study and encourage them (the Elders) to contact the researcher. The primary researcher will ensure all participants (especially when they have been asked by Chief and Council or the Health Board) have a choice, a right to decline, and if they want to participate they will be offered a translator of their choice. If a translator is utilized, the translator will sign a confidentiality agreement (Appendix H) signifying they will keep the interview confidential. It is estimated that approximately 10 to 15 participants will be required for data saturation. The researcher is aware that some of the participants may be closely or distantly related to her; for this study she will ensure her immediate family, mother and siblings, will be exempt from participating.

Criteria for Elders and Inclusion

For this study, Elders will be defined as: 1) Band member of Thunderchild First Nation, living on or off reserve AND 2) Greater than 50 years of age AND 3) Interested in participating in this project AND 4) not the mother of the researcher, Holly Graham.

Criteria for Participants

The criteria for remaining participants will be: 1) Band member of Thunderchild First Nation, living on or off reserve AND 2) Greater than 18 years of age AND 3) Interested in participating in this project AND 4) not the mother or a sibling of the researcher, Holly Graham.

A letter (Appendix D) outlining the purpose of the study, expectations, and contact information to reach the researcher and supervisor will be available at the Band Office (general reception) and at the Health Center (reception) for interested participants.

8. Consent:

Prior approval will be obtained from the Chief and Council of Thunderchild First Nation and the Research Ethics Office, University of Saskatchewan, before starting the research project. A presentation has been done for the Thunderchild Chief and Council, providing an opportunity for discussion regarding the research project. This presentation outlined the purpose of the study, expectations, contact information for both the primary researcher and supervisor, questions to guide the semi-structured interview, and plans for dissemination of the study (dissertation format and publication). The Thunderchild Chief and Council have signed a Band Council Resolution (BCR) indicating their consent and support for this research project to be done in Thunderchild First Nation (Appendix A).

The researcher will obtain verbal and written consent (Appendix E) according to Cree cultural protocol (in Thunderchild First Nation) and ensure participants are fully informed about the procedure and purpose of the research project. If literacy is an issue, an oral consent will be obtained. The consent allows for both a written and oral consent to be obtained. As part of cultural protocol, participants will receive a pouch of tobacco and $30.00 (thirty dollars) in appreciation for sharing their knowledge as a participant in the study. Traditionally, a blanket would have been given instead of cash. However, at the meeting with the Chief and Council, it

was decided that cash would be more appropriate and reflective of modern times. A translator (of the participants' choice) will be provided if necessary or requested, to obtain the consent and to interview the Elders. If a translator is utilized, the translator will sign a confidentiality agreement (Appendix H) signifying they will keep the interview confidential. Participants will be provided a copy of the consent, data/transcript release form (Appendix F), a letter describing the study (Appendix D), and contact information for both the researcher and supervisor.

Participants will be informed they may discontinue the interview at any time without any penalty before they have signed the data/transcript release form. At the second interview, participants will have an opportunity to add, delete or alter their comments from the initial interview. Once they are satisfied with the transcript they will be asked to sign the data/transcript release form. After they have signed the data/transcript release form, their code number will no longer be linked to their data and it would be impossible for the researcher to retrieve the information they shared during the interview. At this point (after signing the data/transcript release form) it is no longer possible for participants to remove themselves from the study. In the event that a participant decides to discontinue, the data collected will be destroyed immediately and will not be included in the data analysis. Participants will also be informed that the researcher has an obligation and duty to report any disclosures of current child abuse (physical or sexual), suicidal ideation, and homicidal ideation to the appropriate authorities (i.e., child protective services, local police). In addition, participants will be informed there is risk of emotional stress and they may require additional support either from a family member/friend or require professional assistance after the interview. The primary researcher will ensure that the mental health services (Red Echo Associates) in the community are aware of the study and willing to provide support to the participants if the need arises, before commencing with the study.

Participants will be assigned a code number to be used on the data collected. The master list with the real names and contact information will be destroyed after the second meeting with the participant. This second meeting provides an opportunity for the participants to review their transcript from the initial interview. At this time they may add, alter or delete information as required and will be required to sign a data/transcript release form, indicating their final approval of the transcript. Participants will be informed that once they have signed the data/transcript release form, they may no longer withdraw from the study and that the link between their name and information that they have shared in the interview will no longer exist. After this meeting, there is no further need for their names and contact information to be kept on file. The researcher will be taking notes and recording the interview process. The notes, audiotapes, and verbatim transcriptions will be kept in a locked cabinet with only the researcher and the dissertation committee having access to the information. Once the transcription has been completed and the participant has signed the data/transcript release form the audiotapes will be destroyed. The primary researcher will ensure the participants are aware that even with precautions to ensure their anonymity and by presenting the results in an aggregate form, there is a possibility that someone may be able to identify them from the illustrative quotations shared. The demographics of the participants will be shared as part of a group description that will include the age range, gender, and level of education. No identifying or descriptive information will be utilized during the discussion regarding the data analysis or the findings.

9. Methods/Procedures:

Participants who meet the criteria and have consented to participate will receive tobacco and $30.00 (thirty dollars) as a token of appreciation for sharing their knowledge. The gifting is cultural protocol for the Plains Cree people of Thunderchild First Nation. The participants will

be encouraged to talk and converse without any limitations imposed by the researcher. The semi-structured interview guide (Appendix G), has six open-ended questions to facilitate elaboration during the interview process. Approximately two to three weeks later, the researcher will meet a second time with each participant to obtain feedback and to clarify the data collected during the initial interview. Participants will have an opportunity to read the transcript from the initial interview and may add or delete information as they wish. After they have reviewed the transcript and are in agreement with the contents, they will sign a transcript release form (Appendix F). After the second meeting the master list with names, contact information, and audiotapes will be destroyed. After the data has been analyzed, the themes and recommendations will be presented to the Chief and Council, the Health Board, and upon request to individuals who participated in the research.

10. Storage of Data:

At the initial interview participants will be assigned a code number to be used on the data collected. The master list with the real names and addresses will be kept under lock and key and will be destroyed after the researcher meets with the participant for a second and final meeting. The researcher will take notes as well as record (audiotape) the interview process. The audiotape from the interview will be destroyed as soon as it has been transcribed and the participant has signed the data/transcript release form. Once data analysis has been completed, the electronic transcriptions will be copied on to a disc (submitted to my supervisor) and will be erased from the hard drive of my personal computer. Prior to the above mentioned precautions to protect the anonymity of the participants, the verbatim audiotapes, transcriptions, and researcher's notes will be kept in a locked filing cabinet. My personal computer (laptop) will have password protected files for all information (data collected) related to this study. Only the researcher and the

dissertation committee will have access to the data. The supervisor, Dr. Stephanie Martin, will securely store the data at the University of Saskatchewan for a minimum of five years upon the completion of the study.

11. Dissemination of Results:

Once the data is collected and analyzed, the information and themes will be presented to the Chief and Council, the Health Board, and upon request to individuals who participated in the study. This sharing of information is required and necessary to align with new research protocol with Indigenous Peoples and as part of a collaborative research relationship. The primary researcher does plan to publish aspects of this research project and has shared this with the Chief and Council of Thunderchild First Nation. Any concerns mentioned by the band members will be resolved in a manner acceptable by both the Thunderchild First Nation and the researcher before written documentation is presented elsewhere in either a publication or dissertation format. This is also congruent with the cultural mores and an expectation of the funding organization (IPHRC) and national guidelines (NAHO) for research with Indigenous Peoples'. The Research Ethics Office will be notified in writing after the researcher and the Chief and Council of Thunderchild First Nation have met and mutually agreed on the dissemination of the study (pending).

12. Risk or Deception:

Due to the sensitive nature of the topic, mental health, there is a risk of emotional stress and participants may require additional support either from a family member/friend or require professional assistance. The primary researcher will ensure that the mental health services in the community (Red Echo Associates) are aware of the study and willing to provide support to participants enrolled in the study if the need arises.

The primary researcher will ensure the participants are aware that even with precautions to ensure their anonymity, there is a possibility that someone may be able to identify them from the information they shared. The demographics of the participants will be shared as part of a group description that will include the age range, gender, and level of education. No other descriptive information will be utilized during the discussion regarding the data analysis or the findings. The researcher will be taking notes and recording the interview session. Participants may ask the researcher to shut the recorder off at any time during the interview. At the second meeting, participants will have a chance to review the transcript and add, alter, or delete their comments as they wish. After this meeting, the master list with names, and contact information, will be destroyed; and participants may no longer withdraw from the study.

As part of the Cree cultural protocol participants will receive a pouch of tobacco and $30.00 (thirty dollars) as a token of appreciation for sharing their knowledge with the researcher. The financial compensation is approximately equal to the value of buying a blanket which is traditionally offered in exchange for information. In the Chief and Councils' and researcher's opinion, the financial compensation in lieu of a blanket is a reflection of modern times and will not entice or coerce Band members to participate.

13. Confidentiality:

Participants will have the option to either contact the researcher by email or telephone in advance or show up and meet with the researcher when she is in the community. After approval has been obtained by the Research Ethics Office, the researcher will list dates, times, and location (Health Clinic) by the poster when she will be in the community to answer any questions about the study and to do the interviews with interested participants. Participants will be assigned a code number to be used on the data collected; any identifying descriptors such as names will be removed from

the data. The master list with the real names and addresses will be kept secure and only accessible by the researcher; and will be destroyed after the second and final meeting with the participants. Verbatim audiotapes will be used during the interview process. The researcher's notes, audiotapes and transcriptions will be kept in a locked filing cabinet with the researcher and the dissertation committee having access to the information.

The primary researcher will ensure the participants are aware that even with precautions to ensure their anonymity, there is a possibility that someone may be able to identify them from the information they shared. The demographics of the participants will be shared as part of a group description that will include the age range, gender, and level of education. No other descriptive information will be utilized during the discussion regarding the data analysis or the findings.

14. Data/Transcript Release:

The researcher will meet with each participant at the Health Clinic approximately 2 to 3 weeks after the initial interview. This second meeting is for participants to read the transcript from the initial interview and to add, alter or delete information as they wish. To facilitate this process, the researcher will read through the transcript (line by line) beside the participant. After the participant has reviewed and is satisfied with the transcript, they will sign a transcript release form. For a copy of the transcript release, see Appendix F.

15. Debriefing and Feedback:

Any questions concerning any aspect of this study will be answered by Holly Graham (306) 227-7891 or by her supervisor Dr. Stephanie Martin, Registered Psychologist, (306) 966-5259. Debriefing and feedback will be done during the second interview with each participant. After data analysis has been completed, participants may have a copy of the results by contacting the primary researcher or her supervisor. Participants will be advised that the information gathered

and findings will be shared with the Chief and Council and the Health Board before written documentation is presented elsewhere.

16. Required Signatures:

Holly Graham, Student: _____

Dr. Stephanie Martin, Supervisor: _____

Dr. David Mykota, Department Head: _____

17. Contact Name and Information:

Name: Holly C. Graham

Phone: XXXX

Fax: XXXX

Email: XXXX

Mailing address: XXXX

Name: Stephanie Martin

Phone: (306) 966-5259

E-mail: stephanie.martin@usask.ca

Mailing address: Department of Educational Psychology and Special Education

College of Education, University of Saskatchewan

28 Campus Drive,

Saskatoon, SK, S7N 0X1

***Appendix* G Translator Confidentiality Agreement**

I_____ have agreed to serve as a translator for

_____ (name of participant) in an interview for a research

project, *Descriptions of Factors Positively Impacting Mental Health from a Contemporary*

Indigenous (Plains Cree) Perspective, conducted by Holly Graham, a Doctoral student in

Educational Psychology, at the University of Saskatchewan.

 I recognize that what I am translating is a confidential conversation, and I agree to keep

confidential anything that is said or that I have translated.

If I have concerns regarding this research I may contact the Research Ethics Office at the

University of Saskatchewan (306) 966-2084. Out of town participants may call collect.

Translator _____ Date _____

Researcher _____ Date _____

Appendix **H Participant Consent**

University of Saskatchewan Consent Form

You are invited to participate in a study called ***Descriptions of Factors Positively Impacting Mental Health from a Contemporary Indigenous (Plains Cree) Perspective***. Please read this form carefully, and feel free to ask questions you might have.

Researcher: Holly Graham, Doctoral student in Educational Psychology, Department of Educational Psychology and Special Education, College of Education, University of Saskatchewan (Phone: 306-XXX-XXXX; email: h_graham_@msn.com)

Supervisor: Dr. Stephanie Martin, Associate Professor, Department of Educational Psychology and Special Education, University of Saskatchewan (Phone: 306-XXX-XXXX).

Purpose of Study

The purpose of this study is to explore descriptions of factors positively impacting mental health from a contemporary Indigenous (Plains Cree) perspective.

Procedures

Participation in this study means that you will meet with the researcher twice at the Health Clinic. During the first meeting, you will be interviewed by the researcher about your perceptions of what positively impacts your mental health. This interview will take approximately one and a half hours and will be audio taped, but you may request for the recorder to be turned off at any time. Also, the researcher will be taking notes during the interview. You will be asked questions like, "tell me what mental health/wellness means to you?"and "how have you coped with the stressors in your life?" During the second meeting (to occur about 2 to 3

weeks after the first meeting), you will have an opportunity to review the transcription from the interview and you may add, alter, or delete information as you wish. If you prefer, I can arrange for a translator (of your choice) to be present for each of these meetings.

Potential Benefits

The benefit of this study is that your perspective may expand the knowledge available to mental health care professionals about what is making a difference for the Plains Cree people from Thunderchild First Nation to be mentally healthier. You will also be given tobacco and $30.00 (thirty dollars) at the first interview as a token of appreciation for sharing your knowledge.

Potential Risks

There are four main foreseeable risks involved in participating in this study. First, you may experience some emotional stress as you share your descriptions of what has made a difference for you to be mentally healthier and may require additional support either from a family member/friend or require professional assistance after the interview. Should your require professional assistance, please call Red Echo Associates at 306-XXX-XXXX. Red Echo Associates are aware of the study; they will provide support to participants if the need arises. Second, as a researcher, I also have an obligation and duty to report any disclosures of current child abuse (physical or sexual), suicidal ideation, and homicidal ideation to the appropriate personnel/authorities (i.e., child protective services, local police). Third, even with precautions to ensure anonymity, there is a possibility that someone may be able to identify you as a result of what you share. Fourth, I am a member of Thunderchild First Nation. There is a possibility that I may work in this community as a psychologist in the future. Please understand that you are under no obligation to participate in the research if this makes you uncomfortable and/or if you are a relative or family member.

Confidentiality

I will make every attempt to protect your confidentiality as a research participant. You will be given an identification number, and all information obtained will be coded to maintain your anonymity. Although results will be presented in a general format, quotes from your own story may be used; therefore you may be identifiable on the basis of what you have said. The original audiotapes, transcripts, and notes will be kept in a locked cabinet and will be available only to the researcher and her supervisor and kept for a period of five years after the study has been completed. The master list that contains names and addresses will be destroyed once the need for it has passed (after the second meeting and you have signed the data/transcript release form).

Right to Withdraw

You may withdraw from the study for any reason, at any time, without penalty of any sort before you sign the data/transcript release form (at the end of the second meeting). If you withdraw from the study any data that you have contributed will be destroyed. You may refuse to answer any questions during the interview. If you want to withdraw at any time, just tell me and we stop the interview.

Questions

If you have any questions about this research or your participation, please feel free to contact the researchers at the numbers provided. This research has been approved on ethical grounds by the University of Saskatchewan Research Ethics Office. Any questions regarding your rights as a participant may be addressed to the committee through the Research Ethics Office (306) 966-2084. Out of town participants may call collect.

Dissemination

Results of the study will be presented to the Chief and Council and the Health Board. Any

concerns mentioned will be resolved in a manner acceptable by both the Thunderchild First

Nation and the researcher before submitting for publication or in dissertation format. If you are

interested in a copy of the results from the study, you may let the researcher know at the

interview or you may contact her later by telephone. Once requested, the researcher will provide

a copy of the data analysis upon completion to you. Also, the Research Ethics Office at the

University of Saskatchewan will be notified in writing after the researcher and the Chief and

Council of Thunderchild First Nation have met and mutually agreed on the dissemination of the

study.

Consent to Participate

I have read and understood the purpose of this study and what is being asked of me as a

participant. I have been provided with an opportunity to ask questions, and my questions have

been answered. I consent to participate in the study described above and understand that I may

withdraw this consent at any time. A copy of this consent form has been given to me for my

records.

Signature of Participant

_____ (date) _____

Signature of Researcher

_____ (date) _____

Oral Consent Obtained

I have read and explained this Consent Form to the participants before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

Signature of Researcher

_____ (date) _____

***Appendix* I Data/transcript Release Form**

I, _____, have reviewed the complete

transcript of my personal interview in this study of *Descriptions of Factors Positively Impacting*

Mental health from a Contemporary Indigenous (Plains Cree) Perspective and have been

provided with the opportunity to add, alter, and delete information from the transcript as desired.

I acknowledge that the transcript accurately reflects what I said in my personal interview with

Holly Graham. I hereby authorize the release of this transcript to Holly Graham to be used in the

manner described in the consent form. I have received a copy of this Data/Transcript Release

Form for my own records.

_____   _____

Name of Participant   Date

_____   _____

Signature of Participant   Signature of researcher

Appendix **J Participant Recruitment Letter**

Dear Participant:

This letter is to introduce you to a research study and to ask you to participate in the study. I am a Doctoral student in Educational Psychology at the University of Saskatchewan. The purpose of the study is to explore ***Descriptions of Factors Positively Impacting Mental Health from a Contemporary Indigenous (Plains Cree) Perspective***. The information you share will assist in providing insight and awareness of what is working and making a difference in the mental health and wellness for Band members of Thunderchild First Nation.

There is a possibility that we may be related and I wanted you to be aware of how our connection may impact your participation in this research project. Also, even though there are no plans at this time, there is a possibility that I may work in this community in the future as a psychologist. I want you to consider if participating in this study would make you uncomfortable to potentially seek my services as a psychologist in the future, and if so, then to consider not participating in this research project.

I am interested in talking with: Band members of Thunderchild First Nation, men and women who are 18 + years old, and individuals interested in participating in this study as long as you are not an immediate member of my family (my mother or sibling). If you prefer to be interviewed in the Cree language, I will arrange for an interpreter.

Participation in the study means that I will interview you two times at the Health Clinic. The first interview will be as soon as possible, after you contact me, and the second interview will be approximately two to three weeks later and is an opportunity for you to respond to the transcript from the first interview and to add or change any of the information previously discussed. All interviews will be audio taped, and you will be assigned a code number to protect your

confidentiality. Each interview is expected to last about one and a half hours but can be longer or shorter if you wish. In addition, I will ask you some information such as your age, gender, marital status, number of children, living arrangements, and level of education. You will be asked questions like, "tell me what mental health/wellness means to you?", and "tell me what has helped you deal with the stressors in your life"?

At the beginning of the first interview, you will receive tobacco and $30.00 (thirty dollars) as a token of appreciation for sharing your knowledge. If you meet the criteria listed above and are interested in participating in the study, please call me at (306) XXX-XXXX for more information. I look forward to hearing from you!

Sincerely,

Holly Graham RN, MN

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (REB)

Certificate of Approval
Study Amendment

PRINCIPAL INVESTIGATOR	DEPARTMENT	Beh #
Stephanie L. Martin	Educational Psychology and Special Education	09-155

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT
University of Saskatchewan

STUDENT RESEARCHER(S)
Holly Graham

SPONSORING AGENCIES
INDIGENOUS PEOPLE'S HEALTH RESEARCH CENTRE (IPHRC)
THUNDERCHILD FIRST NATION BAND

TITLE
Descriptions of Factors Positively Impacting Mental Health from a Contemporary Indigenous (Plains Cree) Perspective

APPROVAL OF	APPROVED ON	CURRENT EXPIRY DATE
Revised data collection protocol	30-Sep-2009	18-Aug-2010
Revised transcript release protocol		

Full Board Meeting ☐   Date of Full Board Meeting:

Delegated Review ☒

CERTIFICATION
The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: *http://www.usask.ca/research/ethics_review/*

John Rigby, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to
Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1602-110 Gymnasium Place
Saskatoon SK S7N 4J8

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Appendix **L Recruitment Poster**

Looking for Participants for a Research Study called:

Descriptions of Factors Positively Impacting Mental Health from a Contemporary Indigenous

(Plains Cree) Perspective

1. Are you a Band Member of Thunderchild First Nation?

2. An Elder (50 years and older) or an adult greater than 18 years of age?

3. Interested in participating by sharing what is making a difference for you to be mentally

healthier?

*Participation in the study means you will be interviewed two times, in English or Cree, taking

approximately one and half hours each time. In addition, you will be asked questions such as

your age, gender, and marital status. You will be asked questions like, "tell me what mental

health/wellness means to you?", and "tell me what has helped you deal with the stressors in your

life"?

*These descriptions of factors positively impacting mental health will create a better

understanding of what is making a difference for Plains Cree people of Thunderchild First

Nation to be mentally healthier, what helps them cope and manage the stressors in their life, and

what gives them hope. This information is important to for health professionals and communities

to plan and promote effective mental health intervention.

*If you would like more information about the study or are interested in participating, you can

contact Holly Graham by telephone (306) XXX-XXXX or by email: XXXX

***Appendix* M Scripted Radio Announcement/Advertisement**

A research study called, "*Descriptions of Factors Positively Impacting Mental Health from a Contemporary Indigenous (Plains Cree) Perspective*", is going to be done in our community later this summer. The researcher is looking for people who are: a Band Member of Thunderchild First Nation, Elders (50 years and older) or an adult greater than 18 years of age, and interested in participating by sharing what is making a difference for you to be mentally healthier.

Participation in the study means you will be interviewed two times, in English or Cree, taking approximately one and a half hours each time. This time may be shorter or longer, it depends on how much you want to talk. You will be asked some personal questions such as your age, gender, and marital status. You will be asked questions like, "tell me what mental health/wellness means to you?", and "tell me what has helped you deal with the stressors in your life"? These descriptions of factors positively impacting mental health will create a better understanding of what is making a difference for Plains Cree people of Thunderchild First Nation to be mentally healthier, what helps them cope and manage the stressors in their life, and what gives them hope. This information is important to for health professionals and communities to plan and promote effective mental health intervention.

If you would like more information you can go to the Band office or the Health Clinic for a copy of a letter that describes the study (copies of this letter is attached to the poster) or you can call Holly Graham (306) XXX-XXXX for more information.

Thank you!

References

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