CULTURE STRESS AND ITS IMPACT ON SELF-ESTEEM

by
Barbara Jean Veilleux

A Practicum Report
Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements
For the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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ACKNOWLEDGEMENTS

I would like to thank the people who have been of great assistance to me throughout the completion of this practicum report.

I want to express my sincere gratitude to Eveline Milliken, my Practicum Committee chair and principal supervisor in this practicum. I appreciate her ongoing support throughout this process – reading and re-reading draft copies of this report and providing constructive feedback, guidance, and direction. I am grateful for her ongoing encouragement and patience. I am very grateful to Shirley Grosser for her valuable input. Her knowledge and support are greatly appreciated. I greatly appreciate the input of Barbara Lavallee, my external advisor. I am thankful for the direction and encouragement she provided.

Thank you to the wonderful young woman who participated in this study, for without her, this study would not have been possible. She has been a great inspiration to me. I admire her for her courage and strength and her desire to work on her own healing so she can, as she stated, "Learn how to address obstacles in my life positively and learn how to live in a healthy way so that my children will learn a healthy lifestyle from me."

Thank you to my family members and friends for their love and support.

Thank you to my husband, Larry, for his patience and understanding throughout this process. His support - his prayers, his words of encouragement - assisted me in being able to reach my goal of completing this practicum.

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CHAPTER ONE

INTRODUCTION

> The value of self-esteem lies not merely
> in the fact that it allows us to feel better
> but that it allows us to live better - to
> respond to challenges and opportunities
> more resourcefully and more appropriately.
> (Branden, 1994, p. 5)

The intent of this practicum was to engage in case study research with a First Nation Cree woman who resides in a Northern Manitoba First Nation Cree community. She comes from a background of familial alcohol abuse, violence, sexual abuse, and culture stress – a woman whose self-esteem has been impacted by her experiences in coming from such a background. The practicum was intended to examine this case in-depth and apply healing concepts to solidify my own framework for direct practice with First Nation Cree women in First Nation Cree communities. Additionally, to explore the effectiveness of applying healing concepts that are consistent with tenets of Aboriginal theory such as knowledge of culture (how Aboriginal people lived prior to Western contact); understanding colonization history and the resulting culture stress; spiritual connection; interconnectedness (obtaining help/support from others); and balance (the development of the spiritual, physical, emotional, and mental aspects of the individual). The focus of the intervention was on applying culturally appropriate healing methods which focus on holistic healing – the

healing of body, mind, and spirit. The colonization experience has impacted all aspects of the Aboriginal individual (Longclaws, 1994; McCormick, 1995 Nabigon & Mawhiney, 1995; Hart, 1999) and, therefore, I believe that healing/treatment must focus on all aspects of the individual. Aboriginal theory, like ecological theory, takes into account the interface between the individual and their environment (Longclaws, 1994). It takes into account that stressful problems in living (life transitions, interpersonal processes, environmental obstacles) are consequences of person-environment transactions. It is important that Aboriginal people learn their history as a colonized people and understand the circumstances that led to their living conditions today. This, in itself, can be healing (McCormick, 1995; Hart, 1999)). Cognitive theory concepts focus on the client's conscious thinking processes, motivations, and reasons for certain behaviours. Cognitive restructuring can be instrumental in the healing of the Aboriginal individual in that the individual begins to understand the reasons for certain negative behaviours and takes steps to change the behaviours.

First Nation and Inuit Health Branch Mental Health Unit sponsor my position as a clinical social worker in Northern Manitoba First Nation communities. The setting for this practicum was in my office that is located in the Nursing Station in one of the four First Nation communities in which I have provided mental health services. The following practicum report outlines the practicum process, exploring the learning, the experiences, and the findings in the evaluation of the

study. First of all, however, there are several terms that need to be defined and discussed before continuing on with this report.

DEFINITION OF TERMS

The following terms will be defined and discussed for the purposes of this practicum: Aboriginal peoples, First Nation peoples, First Nation community, First Nation way of life, culture stress, interconnectedness, and self-esteem.

Aboriginal Peoples – Hamilton & Sinclair (1991, p. 7) refer to the *Constitution Act*, 1982 to arrive at the following definition: "The Aboriginal people of Canada include the Indian, Metis and Inuit people.

First Nation People – According to Hamilton & Sinclair (1991, p. 7), Indian or First Nation people refer to Aboriginal people who are entitled to be registered as Indians pursuant to the *Indian Act* of Canada. They are also referred to as status or registered Indians, as they are entitled to be registered as such in the Indian Register maintained by the Department of Indian Affairs in Ottawa.

First Nation Community – According to Hamilton & Sinclair (1991, p. 8):

> Manitoba's status Indians are organized in bands or, as they have come to refer to themselves, First Nations. Most First Nations have lands reserved exclusively for them under the *Indian Act*". Manitoba First Nations generally are small, with approximately 40 of them having populations of less than 1,000, and approximately 25 with populations of less than 500. Of all the regions in Canada, Manitoba has the highest proportion of its band population living in remote areas; for nine or 10 months a year, approximately 20 Aboriginal communities are accessible only by air.

First Nation way of life – According to Adams (1989, pp. 20-22):

...Indian society was governed according to tribal and clan organization. The basic unit was the clan, a kinship group claiming a common ancestor. Strong bonds of solidarity and mutual assistance bound members of the clan. Each clan had its own council, a democratic governing body composed of both men and women that selected and dismissed leaders. Most leaders held office only for a specific duty and length of time; for instance, a certain leader would be selected for a certain buffalo hunt because of his special skills as a hunter and organizer, and the people would respect his leadership and authority for this particular hunt. However, at the end of the hunt, he ceased to be a leader and thus had no further authority. These positions of leadership had no permanence or authority in any other capacity apart from the specified duty.

The next level of authority was the tribe, which was composed of several clans. The tribal council consisted of members from each individual clan. Each tribe had territory held in common by members from each individual clan. Each tribe had territory held in common by its members, consisting of settlements as well as hunting and fishing areas. A tribe had its own dialect or language, its own religious beliefs, rites of worship, and specific religious festivals during which dancing played an important part. The common land of each tribe was usually respected by neighboring tribes.

The most important aspect of the tribal council was its governing functions. Councils met regularly and in public. Every man and woman had the right to attend council meetings and take part in the discussions.... The council set policy with regard to the economic affairs of the tribe and established working relationships with neighboring tribes. Since Indian society was based on consensus in public assemblies, single authoritarian rule played only a minor role: 'Tribes had little formal government. Most bands were autonomous under their own leaders or chiefs, who, by their courageous exploits, wisdom, or other abilities and qualities, had won the respect and support of followers. But they gave advice rather than orders; councils of leading men made decisions based on unanimous agreement' (Josephy, 1968, p. 120).

Although Indian society did not have a highly developed system of government, it nevertheless had a social order, more organic than systematic, that dealt with organization and administration: 'Most of the bands on the plains observed strict codes of rules that regulated behaviour between people who were related to each other' (Josephy, 1968, p. 121). Order and discipline were maintained in various ways. In

> the first place, the individual had a strong sense of his or her responsibility to the clan and to the tribe. Also, public shaming and ostracism were effective in deterring unsanctioned behavior....
>
> Before the Europeans arrived, Indian society was governed without police, without kings and governments, without judges, and without a ruling class. Disputes were settled by the council, among the people concerned. Indian government was neither extensive nor complicated, and positions were created only to ensure effective administration for a given period of time. There were no poor and needy by comparison with other members, and likewise no wealthy and privileged; as a result, on the prairies there were no classes and no class antagonisms among the people. Members of the community were bound to give each other assistance, protection, and support, not only as part of their economics, but as part of their religion as well. Sharing was a natural characteristic of their way of life. Each member recognized his or her responsibility for contributing to the tribe's welfare when required, and individual profit making was unknown. Everyone was equal in rights and benefits.

Culture Stress – According to the Special Report on Suicide Among Aboriginal People (1995):

> Culture stress is a category of risk that applies to those whose societies have undergone massive, imposed or uncontrollable change. It is studied primarily in relation to immigrant and indigenous populations, but research on the aftermath of natural disasters such as floods and earthquakes, and social disasters such as wars, reports similar symptoms of social breakdown. (p. 25).

According to the authors:

> In cultures under stress, the smooth operation of society and the sense life makes to its members can be seriously impaired. Culturally transmitted norms that once provided meaning and guided individual behaviour becomes ineffectual as rules for living or sustaining relationships, and the rules themselves fall into disrepute. People lose confidence in what they know and in their own value as human beings. They may feel abandoned and bewildered and unsure about whether their lives have any real meaning or purpose. (p. 25).

Interconnectedness – According to Favel-King (1993):

> Throughout the history of First Nations people, the definition of health evolved around the whole being of each person – the physical, emotional, mental and spiritual aspects of a person being in balance and harmony with each other as well as with the environment and other beings. This has clashed with the Western medical model which, until very recently, has perpetuated the concept of health as being "the absence of disease". (p. 125).

McCormick (1995) quotes Ross (1992) who wrote:

> ...that we are not alone, nor can we go it alone. We are here not to assert our dominion or to rise above the rest, but to make a contribution to the rest. The successful man is the one who understands his role as the conduit of sustenance for all components of creation and who dedicates his efforts towards maintaining harmony and balance within all creation. (p. 182).

According to McCormick (1995), "...connectedness can be viewed as the individual's connection to the world outside the self. Practically, this means to become connected or reconnected to friends, family, community, and culture" (p. 260).

Self-esteem – Bopp et al (1988) define self-esteem as how one feels about her/himself and her/his ability to grow and change (p. 19).

Branden (1994) defines self-esteem as being "...the disposition to experience oneself as competent to cope with the basic challenges of life and as worthy of happiness.

The definitions as presented above serve as the base of the main terms within the practicum report. The next section of the report consists of the

background, rationale for the practicum, practicum objectives, and outline of the practicum report.

BACKGROUND

The decision to undertake this task was motivated by my experience of working as a First Nation clinical social worker (providing therapist/counseling services) in Northern Manitoba First Nation communities during the past 5½ years. It was evident from the many stories shared by First Nation Cree women in these communities that their disrupted childhood backgrounds have affected and continue to affect their lives. I was not aware of the extent of alcohol/drug abuse, family violence, and sexual abuse prior to working in the communities. It is evident from the stories shared by these First Nation Cree women that these are predominant issues in their lives. Many of them feel alone, that they have nowhere to turn – they have been betrayed time and again by family members, partners, and other community members. Their life experiences have negatively impacted their feelings of self-worth. These women's stories are very powerful. By doing this research, it allows them to speak to social work practitioners and researchers and this can be a powerful way of getting the information out. It is apparent that there is a need for techniques that deal specifically with the healing of self-esteem impacted by culture stress. The fact that I am a First Nation Ojibwe woman who comes from a background similar to many of these women has instilled in me a great desire to work towards implementing a healing

technique that focuses on their experiences. While I recognize that these findings cannot be generated beyond this case, it is my hope that the exploration of these techniques will address the needs of not only the woman who has participated in this practicum but will be of use to other Aboriginal women as well. This practicum examines the usefulness of this approach in promoting positive self-esteem in this First Nation Cree woman.

RATIONALE FOR THE PRACTICUM

There is a great need to implement approaches to healing that are culturally relevant and effective for Aboriginal women. According to LeCroy (1992), "Practitioners need to select...interventions that have the best fit with the client situation" (p.2). The author further purposes the theories used should be valid, should be empirically demonstrated to be effective. Some mental health researchers (Lafromboise, 1988; York, 1990) recommend practitioners familiarize themselves with mental health healing processes that are more appropriate for Aboriginal people. In order for therapists to offer culturally appropriate mental health services, they need to understand the cultural values of Aboriginal peoples that relate to healing (Everett and Proctor, 1983; Collier, 1993; Longclaws, 1994; McCormick, 1995).

Many approaches to facilitate healing for Aboriginal peoples have been tried. Aboriginal writers (Longclaws, 1994; McCormick, 1995; Nabigon & Mawhiney, 1995; Hart, 1999) state the importance of holistic healing – the

healing of body, mind and spirit. According to Bopp et al (1988), "All tribes teach that human beings have spiritual, physical, mental, and emotional, and volitional aspects to their being" (p. 38). The authors write that the volitional aspect of our being helps us develop the many aspects of our nature. This is the force that helps us make decisions and then act to carry out those decisions". (p. 16). Aboriginal writers (Longclaws, 1994; McCormick, 1995; Nabigon & Mawhiney, 1995; Hart, 1999) stress the importance of interconnectedness in the healing process. What better approach can there be than to implement techniques that Aboriginal peoples indicate have facilitated healing among Aboriginal people?

The decision to focus on applying culturally appropriate healing techniques with a First Nation Cree woman from a Northern Manitoba First Nation Cree community in this practicum stems from the realization that there is lack of literature that addresses the area of interventive strategies and techniques for working with First Nation women in Northern Manitoba First Nation communities. This woman's story embodies common struggles I hear among women in the First Nation communities in which I provide mental health services.

PRACTICUM OBJECTIVES

The purpose of this practicum was the implementation and evaluation of a six-session intervention which would provide the participant with an opportunity to begin to heal in the areas of her life impacted by culture stress. This would be

accomplished by using an Aboriginal approach to healing integrated with ecological and cognitive theories.

The primary focus of this practicum was to:

(i) Increase the participant's awareness of the factors that contributed to her childhood abuse and the resulting current problems;

(ii) Give permission and encouragement to the participant for self-care; and,

(iii) Provide the participant with the opportunity for personal growth and development through an educational process.

The main goal of this practicum was to provide an opportunity for the participant – a survivor of culture stress – to begin to understand the concept of culture stress and its impact on her life and through this begin to work toward increasing her self-esteem. It is the hope that this will promote healing from the effects of culture stress. Due to the "gossip" problem in the community and the magnitude of the issues, it was essential that therapy take place in a warm, safe, nurturing environment if the proposed goal was to be achieved, a place where the participant could share her experiences with acceptance and support from the therapist.

To increase self-esteem, the participant had to be educated about Aboriginal history prior to and after European contact and culture stress and its impact on the lives of Aboriginal peoples.

It was hoped that through the therapy process, the participant would let go of self-destructive and self-defeating behaviours such as substance abuse and develop new and healthy coping strategies so that she may model a healthy lifestyle for her children as per her desire.

My personal learning goals for the practicum included:

i) To learn how to do case study research;
ii) To learn about culturally appropriate clinical social work practice methods;
iii) To develop my own framework for culturally appropriate social work practice;
iv) To identify themes that emerge as useful practice with First Nation Cree women in Northern Manitoba First Nation communities;
v) Obtain information which I can share with others living and working with First Nation women in Northern Manitoba First Nation communities;
vi) Establish questions for future research;
vii) To learn how to carry dual roles of social work researcher and social work practitioner in a way that maintains integrity and ethics of both roles; and,
viii) To clarify my own thoughts/experiences as a First Nation woman working as a social worker in a system historically discriminating to First Nation women.

OUTLINE OF THE PRACTICUM REPORT

This practicum report is set up in chapter format. Chapter one provides an introduction to the practicum – background, rationale for the practicum, practicum objectives, and outline of the practicum report. Chapter two provides a review and discussion of the relevant literature including the Aboriginal way of life prior to and after European contact, the impact of the colonization experience on Aboriginal women, generational perpetration of abuse, and culture stress and its

impact on self-esteem. Also included will be an Aboriginal approach to healing integrated with ecological and cognitive theories. Chapter three outlines the practicum procedures, describing the setting, the practicum committee, selection of participant, the case description, and the intervention model. Chapter four consists of the intervention process. It provides an overview of the sessions with the woman who participated in this practicum and a summary of the intervention process. Chapter five summarizes the results of the practicum and discusses implications of the intervention. In the last chapter, the overall practicum experience is evaluated. There is a summarization of the major learning themes and recommendations for future work with First Nation women.

CHAPTER TWO

LITERATURE REVIEW

This chapter provides a review of the literature relevant to the development of positive self-esteem in the First Nation Cree woman who participated in this study, an individual who has been impacted by culture stress. There is a lack of literature that addresses the area of interventive strategies and techniques for working with First Nation women in Northern Manitoba First Nation communities. Included is a review of the Aboriginal way of life prior to and after European contact, the colonization process and its impact on Aboriginal women. The literature review also includes the definition of self-esteem, the necessity of having good self-esteem, and how Aboriginal women's self-esteem has been impacted by culture stress. As well, the literature review will include concepts that are consistent with Aboriginal theory that will be utilized in the intervention.

A. THE ABORIGINAL WAY OF LIFE PRIOR TO AND AFTER EUROPEAN CONTACT

1. Pre-European Contact

Authors who have written about Aboriginal history (Adams, 1989; Dickason, 1993; Ross, 1992; Ross, 1994; Royal Commission on Aboriginal Peoples Report, 1995; Grant, 1996) support the viewpoint that Aboriginal cultures possessed all aspects of successful societies prior to European contact. Collier (1947, pp. 97-98) writes that Columbus described the "Indians" as "gentle

beings, souls of hospitality, curious and merry, truthful and faithful, walking in beauty, and possessors of a spiritual religion." Rosenfelt (1973) quotes George Caitlin who lived for eight years among North American Plains Indian tribes as follows:

> All history of the subject goes to prove that when first visited by civilized people, the American Indians have been found friendly and hospitable – from the days of Christopher Columbus to the Lewis and Clark Expedition...and so also have a great many other travelers, including myself. Nowhere, to my knowledge, have they stolen a six-pence worth of my property, though in their countries there are no laws to punish for theft. I have visited 48 different tribes, and I feel authorized to say that the North American Indian in his own native state is honest, hospitable, faithful, brave...and an honorable and religious being. (p. 66).

I feel it necessary to include these writings to substantiate that Native people, contrary to the belief some people may have, treated others with respect and lived by their beliefs. I believe it is important for Aboriginal people to know that they come from a strong, proud, and respectful race of people. This can contribute to elevated self-esteem.

They had a way of living that enabled them to live in harmony with their environment. They lived by four great commandments: respect for Mother Earth, respect for the Great Spirit, respect for others, and respect for individual freedom. It is necessary to expand on these four areas of respect in order to provide a better understanding of how the economy and welfare of the people were influenced by these belief systems.

i) Respect for Great Spirit

According to authors who have written about Aboriginal history (Johnston, 1988; AJI Report, 1991; Longclaws, 1994; Nabigon and Mawhiney, 1995; Grant, 1996; Hart, 1999), our ancestors believed that someone all-powerful – Kitchi Manitou or the Great Spirit - placed Mother Earth in the universe. These authors write that Aboriginal people were a spiritual people and they lived faithfully by this belief. It was this belief that held them together in an organized way of life. They found peace and satisfaction through their spirituality. According to these authors, their belief was that Kitchi Manitou created the universe and everything in it. It was their belief that creation was an act of generosity and they in turn shared with others what Kitchi Manitou had given them. They had great respect for benevolent Kitchi Manitou, the one who had created them, and as a result they had a good opinion of themselves as worthy individuals. They believed in the goodness of human beings and treated one another accordingly.

ii) Respect for Mother Earth

According to Aboriginal teachings (Sinclair, 1994; Grant, 1996), our ancestors took from the earth only enough for their needs on the basis of mutual sharing. They attempted to live in harmony and balance with the earth and sky, taking care of both, each in their own way, for the well being of their people and those who would follow them.

iii) Respect for One Another

According to writings by Aboriginal authors (Mercredi and Turpel, 1993; McCormick, 1995; Grant, 1996), in traditional Aboriginal society, families and relatives were very close. The authors suggest that extended family members were all loved and respected and in times of need, they would assist one another. They write, also that sharing was their way of life. For example, when there was only a little food, it was given first to the very old and the very young and the rest would go without. Anyone who was homeless or in need would be taken in by other families and provided for. "Assistance, protection, and support were given not only as part of their economic system, but as part of their spiritual beliefs. Serving family and community instilled in them a sense of worth and pride." (Adams, 1989, p. 22). Their Creator was generous and kind to them and so, because of this, they, too treated one another accordingly.

Theirs was an egalitarian way of life (Johnston, 1984; McCormick, 1995; Sinclair, 1994; Grant, 1996; Ross, 1996). No one was inferior to any other. There were no poor or needy, wealthy or privileged. According to Morrison and Wilson (1986, p. 148), each member had a role, however, if a situation called for it, both women and men could do the basic work of the other. The authors further state that each community member was responsible for contributing to the tribe's welfare when required. As well, the authors write that there was a strong belief that each person should to work towards self-reliance in virtually all things. The authors write that no individual was considered superior to anyone else even

if they possessed special skills and that leaders whose influence rested on their wisdom and ability had no formal authority. Adams (1989) writes that prior to European contact, "Indian society was governed without police, without kings and governors, without judges, and without a ruling class.... Indian government was neither extensive nor complicated, and positions were created only to ensure effective administration for a given period of time" (p. 22). The author further goes on to say that matters that were a problem were discussed at council meetings, where both women and men present, and all took part in discussions. And so everyone had something to contribute to the community and they were respected for their contribution. Every person was worth something, not only to themselves, but also to the community.

iv) Respect for Individual Freedom

Aboriginal authors (Sinclair, 1994; McCormick, 1995; Grant, 1996;) allude to the fact that Aboriginal people believed strongly in individual freedom as long as it did not threaten to harm the people or Mother Earth. Dickason (1993) writes that, "Power was not the prerogative of a class or individual; it existed in the society itself, and each man was his own man master" (p.46).

The principle of non-interference as described in several writings (AJI Report, 1991; Ross, 1992), has been one of the most pervasive of all the ethics by which Aboriginal people live. According to these authors, this means that an Aboriginal person will not interfere in any way with the rights, privileges, and

activities of another person. The authors write that an Aboriginal person believes in freedom, in minding her/his own business, and in the right of others to make up their own minds. They go on to say that this ethic also applied to children. They were permitted to make their own choices in all aspects of life and they were responsible for observing and learning on their own. According to the authors, there was no praise, punishment, withholding of privileges, nor promise of reward and the fact that they were not criticized, not given advice, and not coerced resulted in children being very loyal to their parents and extended family members.

Respect, then, was given to all – from the youngest to the oldest. According to some authors (AJI Report, 1991; Ross, 1992), in the eyes of an Aboriginal person, arriving at an attitude of respect is honoring God, the Creator, for the gift of life, and with respect comes the desire to serve other members in the tribe. It would appear that this respect Aboriginal people had also extended to others as indicated by Collier (1947) and Rosenfelt (1973).

Historical accounts indicate that this is what Aboriginal societies were like at the time of European contact. According to Rosenfelt (1973), "Native people had a world view and a self view that no society before or since has surpassed, that it was an art to be ranked supreme among the arts known to mankind" (p. 23).

I believe it is important that Aboriginal people learn about their history prior to colonization so that they may know that they come from a proud, strong, respectful and free nation, so as to understand and appreciate the richness of their culture, to work toward letting go of the shame that is associated with being an Aboriginal person. It is also important for Aboriginal people to look at the process of colonization and its impact on their lives.

2. European Contact

> ...no adverse impact visited on the Indians by the 1492 voyage of 'discovery' was more profound in its consequences in every nook and cranny of the Americas than Columbus's introduction of Western European ethnocentricity to the Indians' worlds. (Josephy, 1991, p.5).

It would appear that Europeans observed and judged Aboriginal peoples from their own self-centered point of view and, as such, failed to comprehend the complexity and richness of Aboriginal cultures.

According to Rosenfelt (1973), "The white conqueror, for military, economic, and religious reasons, pronounced the death sentence on First Nations people many years ago and that through slavery, forced dispersal, elimination of food supply, forced migration, and attempted religious conversion, they were driven to the brink of oblivion" (p. 21).

History shows that Aboriginal people attempted to exist peacefully with the newcomers (Rosenfelt, 1973; Kellough, 1980; Adams, 1989; Grant; 1996). According to Rosenfelt (1973), Native people shared their knowledge and

whatever they had with the newcomers and in return, they were exterminated by the white man's diseases, tricked by the white man's treaties, and saw their values destroyed by a society that did not understand them nor wanted to understand them" (p. 22). According to the author, "They were looked upon as being savage, barbaric, and inferior. They were considered to be hostile because their leaders tried to defend their land and their culture" (p. 22). Rosenfelt (1973) states that, "Their leadership was destroyed through killing of the body and through killing of the soul. Their leaders were bribed, replaced, and manipulated to conform to the views of the white race" (p. 22). Numerous writings show that this culture was almost totally wiped off the earth (Rosenfelt, 1973; Kellough, 1980; Adams, 1989; Josephy, 1991; Kuyek, 1992; Grant, 1996).

According to Josephy (1991, p.5), "...from Canada and the United States to Guatemala and Brazil...genocide against Indians is still widely practiced." The author further adds that, "White ethnocentricity and ignorance have insulted, demeaned, and crushed out the self-esteem of Native peoples. At their worst, they have fostered violent hatred and racism, massacres, and the plundering and dispossession of Native peoples" (p. 5).

Dosman (1982, p.7) further confirms this treatment of Canada's Native people by stating that at the United Nations, Canada is regularly reminded that the treatment of its Native population leaves something to be desired – that this treatment has been a national disaster. The author suggests that, "Native sub-

culture is not merely low in status and income; it is not merely at the bottom of the trash pile; its situation is becoming increasingly worse" (p. 7).

Kuyek (1992) substantiates the atrocious treatment of Aboriginal people:

> For years, indigenous people have found themselves overwhelmed by powerlessness and despair in their attempts to bring change to their own communities. Their subjugation had been brought about by the police and army intervention, by the removal of their children to residential schools, by the forced removal of peoples in the creations of villages and reserves, by the imposition of regulations and laws outlawing traditional sources of income, by the plunder of their lands and resources by corporate interests, and by the outlawing of their traditional language, religion, and way of life. (pp.64 - 65).

I believe the messages behind these actions are quite clear – that Aboriginal people are incapable of managing their own affairs, that their needs are unimportant, that they are not important, that they are unthinking and unfeeling beings. Recent census data (CCSD, 2000; CCSD, 2002) shows that Aboriginal people are poor; they hold the most poorly paid jobs and suffer high unemployment rates; they are relatively poorly educated; they are subject to discrimination; and many are dependent on some kind of social assistance. According to Dosman (1982, p.7), it was decided by those in authority in the dominant society that Aboriginal people be taken care of as part of a welfare state. Walsh (1971, p. 67) quotes Cardinal (1969) who said that the government made a mistake when they gave native people welfare, that they did not think of the consequences, and that this decision has made Aboriginal people dependent

on the welfare system and was a disservice to them. As Dosman (1982) points out, "Native people live as strangers in the land that was owned entirely by their ancestors before the white man came. They have been robbed of their heritage" (p. 7). Consequently, the disempowerment caused by the ethnocentric attitude of the dominant race has left its mark. It is reflected in the Aboriginal community – alcohol abuse, child abuse, child neglect, and suicide – violence in every sense of the word. According to York (1990):

> Hundreds of native communities are still enduring the malignant effects of institutions that seem benign to non-native Canadians: the churches, religious boarding schools, provincial and federal schools, child welfare agencies, courts, government departments, hydro corporations, and resource developers. The social conditions on modern day reserves are a 'legacy' of the decisions and policies of the most powerful institutions of the nineteenth and twentieth centuries. Many of those policies – and the attitudes that shaped them – still exist today. (p. xiii).

Thus, we have a majority of Aboriginal people who are apathetic and without hope and this has been passed on from generation to generation.

This once proud, strong, and free nation has had its four great commandments taken away from them and broken against them – respect for Mother Earth, respect for the Great Spirit, respect for others, and respect for individual freedom. We find a culture whose traditional ways of life have been disrupted and fragmented by the white man and his culture. They have not only lost their land and their traditional ways, but also their independence and their identity (AJI Report, 1991; Adams, 1995; Grant, 1996). In a society where

racism occurs, Aboriginal people may be stereotyped as immoral, lazy, drunkards, and lacking ambition. These beliefs have been passed on from generation to generation since European contact.

These are symptoms of an oppressed people – a culture under stress.

B. CULTURE STRESS

According to the writers of the Special Report on Suicide Among Aboriginal People (1995):

> Culture stress is a category of risk that applies to those whose societies have been subjected to massive, imposed or uncontrollable change – it is the transformations that result from these oppressive experiences. It is studied primarily in relation to immigrant and indigenous populations, but research on the aftermath of natural disasters such as floods and earthquakes, and social disasters such as wars, reports similar systems of social breakdown (p.25).

The Report (1995) further goes on to say that:

> In cultures under stress, the smooth operation of society and the sense life makes to its members can be seriously impaired. Culturally transmitted norms that once provided meaning and guided individual behaviour become ineffectual as rules for living or sustaining relationships, and the rules themselves fall into disrepute. People lose confidence in what they know and in their own value as human beings. They may feel abandoned and bewildered and unsure about whether their lives have any real meaning or purpose (p.25).

The Report (1995) further points out that Indigenous cultures around the world have been subjected to forces of change that are strikingly similar to the disruptions suffered by victims of war. The list of similarities is as follows:

> ~Loss of land, loss of control over living conditions and restricted economic opportunity;

> ~Suppression of belief systems and spirituality;
> ~Weakening of social institutions;
> ~Displacement of political institutions;
> ~Pervasive breakdown of cultural rules and values and diminished self-esteem;
> ~Discrimination and institutional racism and their internalized effects; and,
> ~Voluntary or involuntary adoption of elements of an external culture and loss of identity (p.25).

According to the writers of this same Report (1995), "The transformations that result from the oppressive experiences are gathered together in the term 'culture stress', which has a central role in predisposing Aboriginal people to suicide, self-injury and other self-destructive behaviours" (pp. 25-26).

According to the authors of the Report (1995):

> The related parts of culture such as relationships, knowledge, languages, social systems, beliefs, values, and rules of ethic hold a people together and give the society and its individual members a sense of who they are and where they belong. Culture is something that is introduced within families and later reinforced and developed in the community. If this is done from one generation to another, the children learn their culture. Individuals learn about what is culturally acceptable or non-acceptable behaviour. Their own conscience and what others expect of them keep them in line. (p. 25).

There is considerable literature that supports that Aboriginal people, through the colonization process, have undergone massive, imposed, or uncontrollable change (Adams, 1989; Ross; 1992; Morrissette et al, 1993; Sinclair, 1994; Green, 1995; Grant, 1996) and has disrupted this process. It is evident that the damage with respect to self-esteem, family attachments, and

trust in and respect for others, which human beings need in order to build loving relationships and healthy communities, is great.

Culture stress, as it pertains to Aboriginal people was brought about by human beings, and not natural disasters. People come together when natural disasters occur – they are there to assist one another. The disruptions suffered by Aboriginal people are not looked upon in the same manner but rather they are blamed for their circumstances. There is no "coming together" to assist them in their losses. Rather, they are looked down on because of the many problems that exist in their communities – there is blaming of the victim. As Kellough (1980) points out, "For the oppressor, violence in Indian communities is seen as further evidence of the barbaric, uncivilized nature of Indians" (p. 367). The author quotes Friere (1968, p. 41) who wrote that, "What is not seen is that 'violence is initiated by those who oppress, who exploit, who fail to recognize others as persons." Kellough (1980) further writes that, "Violent behaviour by Indians is a reaction to the violence of the oppressors, however misdirected such behaviour might be" (p. 369).

Although the colonization experience has negatively impacted all members of the Aboriginal culture, for the purpose of this paper, emphasis will be on the impact it has had on First Nation Cree women.

C. THE COLONIZATION PROCESS AND ITS IMPACT ON ABORIGINAL WOMEN

1. The Role of Aboriginal Women Prior to Colonial Contact

Literature (AJI Report, 1991; Sinclair, 1994; Grant, 1996) and teachings from elders suggest that women occupied a central role within the family, within government, and in spiritual activities. Women, along with the men, performed functions fundamental to the survival of their communities. According to Aboriginal oral history, women were seen as life-givers and caretakers of life. They were responsible for the socialization of their children.

According to these Aboriginal authors, family breakdowns were rare, if any, as it was expected that spouses respect and honour one another and to treat each other with honesty and kindness. There is much literature to substantiate that women and men were equal in power and each had personal freedom.

With European contact, the role of Aboriginal women changed.

2. The Role of Aboriginal Women after Colonial Contact

The total destruction of Aboriginal societies and their traditions is well documented (Rosenfelt, 1973; Kellough, 1980; AJI Report, 1991; Josephy, 1991; Adams, 1989; Grant, 1996). According to these writings, the colonizers forced new values and cultural standards that brought about social and cultural changes, which have been destructive to Aboriginal communities.

In the AJI Report (1991), Hamilton & Sinclair suggest that, "Economic factors served as the initial catalyst for change within Aboriginal societies" (p.

477). The authors write that Aboriginal people were removed from their traditional lands and they were no longer able to access lands that provided their means of sustenance and they were placed into settlements with a welfare economy. According to Adams (1995):

> The Europeans set up a quasi-legal system allowing them to commit atrocities against Aboriginal peoples with impunity.... The Aboriginals had no legal recourse to protect their land or their homes from European plunderers. According to the Europeans, Aboriginals were subhuman, so indigenous occupancy did not constitute human residence. The Europeans claimed they had 'discovered' vacant land that they were free to claim as their own.... The political structure was designed to place all authority, privileges, and even the most basic human rights exclusively within the colonizer's domain. Short on warfare, the Aboriginals had no options.... (p. 28).

Some writers (Douglas, 1961; Kellough, 1980; Adams, 1995) support that if Native people challenged such a white view of their ownership and economies, white laws, customs and courts existed to prove them wrong and decide the matters of emptiness and title in favour of the invaders.

Hamilton and Sinclair (AJI Report, 1991, p. 477) write that because of the economic changes that took place, the traditional male and female roles were greatly altered. They point out that, "Males who were once responsible for providing for their families were now reduced to a state of powerlessness and vulnerability which their culture deemed highly inappropriate" and they "came to experience severe role strain" (p. 477). The authors further write that, "These

cultural changes were destructive to Aboriginal women in that their value as equal partners in their society was completely undermined" (p. 477).

Another factor that came into play was the residential school system. This system accelerated the victimization of women (AJI Report, 1991; Grant, 1996). According to Grant (1996), "Total power corrupts and nowhere has this power been greater than in residential schools. With the full force of the law behind them, government and especially churches held the power of life and death over Native people" (p. 23). The damaging role of the residential school system with respect to Aboriginal societies is well known (Kellough, 1980; York, 1990; AJI Report, 1991; Grant, 1996). Many children were taken away from warm, nurturing environments and taken to an environment that was totally different.

The cultivation of parenting skills, which was a fundamental aspect of training as children in Aboriginal families, and which was modeled on a daily basis, was no longer in place due to the forced removal of children from families and communities and placement into environments where parenting skills were not observed or taught (AJI Report, 1991; Special Report on Suicide Among Aboriginal People, 1995; Grant, 1996). The authors suggest that several generations of Aboriginal people were denied this very significant training. At the time of the writing of her book, Grant (1996) commented that, "The correlation between emotional trauma, unnatural upbringing, devaluing of Indian language and culture, and lost parenting skills is only now being examined" (p. 23).

The abuse inflicted upon the children at these schools leaves much to be desired. As Grant (1996) points out, "There was no one to love, coddle, spoil, and cherish the little Indian children when they arrived at the residential school" (p. 27). Instead, "They were forced to give up all aspects of their culture and were severely punished if they did not obey the rules imposed upon them" (p. 27). They were taught that they were pagans, inferior beings, and were forbidden to speak their languages and worship according to their cultural traditions (AJI Report, 1991; Sinclair, 1994; Adams, 1995; Grant, 1996).

How does a child respond when forced to stop speaking a language that is familiar and forced to stop worshiping as taught by loved ones? How does a child respond when being told that their parents are no good, their cultural practices are not good? How does this suppression affect a child?

In addition to the disintegration of cultural values, there was physical, sexual, and emotional abuse. How does a human being respond to this type of treatment?

It is hard to imagine a child developing normally when forced to suppress normal feelings. How does this affect their functioning in adult life?

And what about the children's families? Children were the central aspect of their lives (AJI Report, 1991; Report of the First Nation Child and Family Task Force, 1993; Grant, 1996). How does one cope with the painful experience of having their children taken away? How does one feel when they are powerless

to prevent this from happening? How does one feel each day waking up to a home without children? How does a community function when its people are in pain, when its people are feeling powerless?

In the AJI Report (1991), Hamilton and Sinclair suggest that, "The roles of First Nation women were further undermined by the Canadian government when they introduced the concept of disenfranchisement in 1869 whereby Indian people would lose their treaty status and be treated the same as other Canadians" (p. 479). The authors state that this resulted in devastating consequences for First Nation women. They further write that:

> The role assigned to First Nation women was that of inferiority and subjugation to the male. Native women lost their status upon marriage to a non-status man whereas non-native women marry native males gained status. Bill C-31, which was set up in 1985, created problems in terms of differential treatment of male and female children. Children of a status Indian woman can pass on status to their children only if they married registered Indians, whereas the grandchildren of a status male will have full status, despite the fact that one of the parents does not have status. (p. 479).

According to some authors (AJI Report, 1991; Grant, 1996), traditionally, First Nation women played a prominent role in the consensual decision-making process of their communities. The Indian Act created the chief and council system of government with the local Indian agent having power over this system. Women were not allowed to vote in this new system and had no involvement in the political system.

Hamilton and Sinclair (AJI Report, 1991) write that, "...The breakdown of Aboriginal cultural values and the abuse suffered by Aboriginal people at residential schools contributed to family breakdown.... This began a cycle of abuse in Aboriginal communities, with women and children being the primary victims" (p. 478).

D. GENERATIONAL PERPETRATION OF ABUSE

While I am talking about adults, I am hearing that the violation of many of the women I see began in early childhood. It would appear it is almost inherited, that it has been incorporated into the lifestyles of many individuals and could be referred to as generational toxicity. For the purpose of this practicum the definition to be used for the word toxicity as it pertains to abuse is that it is like a poison, it is corrupt, and has a harmful influence. Hamilton and Sinclair, in the AJI Report (1991), support the concept of generational perpetration of abuse as follows:

> Many Aboriginal grandparents and parents today are products of the residential school system. The development of parenting skills, normally a significant aspect of their training as children within Aboriginal families, was denied to them by the fact that they were removed from their families and communities, and by the lack of attention paid to the issue by residential schools. Parenting skills neither were observed nor taught in those institutions. Aboriginal children traditionally learned their parenting skills from their parents through example and daily direction. That learning process was denied to several generations of Aboriginal parents. In addition to the physical and sexual abuse that Canadians are now hearing took place in residential schools, emotional abuse was the most prevalent and the most severe. (p. 478).

The authors further write that:

> Not only did residential schools not support the development of traditional parental roles among the children, but they taught the children that they were 'pagan' – an inferior state of being – and should never use their language or honour their religious beliefs. These messages were imparted to Aboriginal children in a sometimes-brutal manner (p. 478).

The writers further indicate that, "...some of the presenters pointed out to them that residential schools not only removed children from their families, but they also prevented any closeness, even contact, from occurring between siblings and relatives at the same school" (p. 478).

1. Violence and Abuse Against Women

Hamilton and Sinclair (AJI Report, 1991, p. 479), write that, "For Aboriginal women, European economic and cultural expansion was especially destructive women" in that, "Their value as equal partners in tribal society was undermined completely (p. 477). The authors further add that, "...while their role within Aboriginal society remained relatively stable for some time after contact, all that changed completely with the advent of the residential school system" (p. 477). They further write that, "In addition to this, Aboriginal women, over the years, have been given a demeaning image, that of being ill-treated by Aboriginal males, and have been referred to as 'beasts of burden'. " According to the authors, "These images of women are more than symbolic as they have helped to facilitate the physical and sexual abuse of First Nation women in contemporary

society" (p. 479). It is a fact that even today Aboriginal women are believed to be sexually promiscuous.

For as long as I can remember, the term "squaw" has been used to refer to Aboriginal women. LaRoque (1994, p. 74) points out that a direct relationship between racist/sexist stereotypes and violence can be seen in the dehumanizing portrayal of Aboriginal women as 'squaws'. In the AJI Report (1991), this same author states that, "The portrayal of the squaw is the most degraded, most despised and most dehumanized throughout the world." The author further states that this is "the female counterpart of the Indian male 'savage' and as such she has no human face; she is lustful, immoral, unfeeling, and dirty. Such grotesque dehumanization has rendered all Native women and girls vulnerable to gross physical, psychological and sexual violence." The writer believes "there is a direct relationship between horrible racist/sexist stereotypes and violence against Native women and girls" (p. 479). Hamilton and Sinclair (AJI Report, 1991,) further contend that, "In addition to causing hurtful feelings and affecting self-esteem, racist/sexist stereotypes encourage abuse not only by Aboriginal men but by others as well" (p. 480). According to the writers of this report, "Native men, over the centuries, have assumed the same attitude towards Aboriginal women as the European. There are indications that violence was perpetuated against Aboriginal women prior to contact with the Europeans and these were met with quick justice. However, this increased with European contact" (p. 480).

Violence and abuse in Aboriginal communities is rampant and the victims are usually women and children (AJI Report, 1991). The authors refer to a study presented to their Inquiry which states that "...while one in 10 women in Canada is abused by her partner, for Aboriginal women the figure is closer to one in three" (p. 482).

The Thompson Crisis Centre reports (AJI Report, 1991) that:

> In general, women are abused at least twenty times prior to seeking help. As confirmed by the Crisis Shelter workers, in terms of reporting abuse, women are often reluctant for a number of reasons: long response time on part of law enforcement officials, insensitive response of law enforcement officers to spousal abuse, humiliating questioning, failure of law enforcement officials to protect victims, failure of law enforcement officials to take spousal abuse as a serious crime, difficulties obtaining peace bonds, and difficulties obtaining protection or getting away from abusive partners in small communities" (p. 483).

It would appear that the justice system fails to be the answer to these women's problems.

Another concern I am hearing in Northern Manitoba First Nation communities, that makes it more difficult for the abused woman, is the lack of privacy. Many First Nation women express concerns regarding gossip. This quite often results in silence on the woman's part due to feelings of shame and fear of ridicule and shunning. Another factor that silences women is their fear that the offender's family or friends may attempt to hurt them.

Secondly, there is lack of housing and no safe houses are available for women and children trying to escape from an abusive situation. Quite often they

have to leave the community to attend a crisis shelter. The problem is currently dealt with by women remaining in their communities and putting up with the abuse or leaving their communities to live elsewhere. I am hearing that most women would prefer to stay in their home communities, if protected, and they believe they should not have to leave their communities in order to feel safe.

It would appear that women would feel disempowered in these situations. Inevitably, this disempowerment affects children. Children who live in environments where there is violence are not safe.

2. Violence and Abuse Against Children

Children are vulnerable targets for adults when it comes to abuse in any form. It is hard for them to prevent physical attacks or sexual advances from parents, relatives, or other adults.

Incest and sexual interference with children is taboo in all cultural groups including the Aboriginal community, where, according to our elders, the abuse of women and children was unthinkable. As Josephy (1968) wrote, "Most of the bands on the plains observed strict codes of rules that regulated behaviour between people who were related to each other" (p. 121). Adams (1989) writes that, "Order and discipline were maintained in various ways. In the first place, the individual had a strong sense of his or her responsibility to the clan and to the tribe. Also, public shaming and ostracism were effective in deterring

unsanctioned behaviour" (p. 21). It would appear these rules have broken down not only in mainstream society but in Aboriginal society as well.

The First Nations Child and Family Task Force Report (1993) indicates that, "Physical and sexual abuse is widespread in many First Nations communities and that this abuse is perpetrated by young people, parents, siblings, leaders, elders, and professionals in the field of child care. The victims are infants, toddlers, children, and teenagers" (p. 37).

According to an assessment team working with sexual abuse and family violence in the community of Hollow Water, upwards of 85% of their community members had been buried in alcoholism, sexual abuse, family violence, and a wide variety of dysfunctional thinking and behaviour (CHCH, 1993, p. 1). According to Ross (1996), "...abuse occurred most often at the hands of extended family members and usually for long periods of time. The assessment team estimates that a full 50% of the community's population, again both male and female, has at one time or another, sexually abused someone else (p. 39). According to Hamilton and Sinclair (AJI Report, 1991), the Hollow Water Resource group informed them that in a community workshop they held in which approximately sixty people attended, "Two-thirds said that they had been [abused]. A startling one-third admitted that they had victimized someone else" (p. 493-494).

The prevalence of sexual and physical violence in many Aboriginal communities across Canada is confirmed by other sources (Maracle, 1993; Report of the First Nations Child and Family Task Force, 1993; Special Report on Suicide Among Aboriginal People, 1994; Grant, 1996).

Hamilton & Sinclair (AJI Report, 1991) include a statement made in the Child Advocacy Project report:

> Children are suffering from trauma, physical injury, and psychological devastation that result from sexual abuse. The injuries to self-esteem, trust and emotional functioning last a lifetime. The incidence of sniffing, alcohol [drug] abuse, eating disorders, suicide, depression, and sexual acting out among Indian children suggest that the problem of child sexual abuse has reached epidemic proportions. (p. 489).

Ross (1996) shares a story of sexual abuse to illustrate that as long as sexual abuse is hidden, it spreads from generation to generation and multiplies as it goes, engulfing entire communities (p. 43). The author writes that the health care workers he spoke to estimate that sexual abuse spans three or four generations. The director of an Aboriginal treatment program for substance abuse informed him that 100% of the people going to the center had been victims of sexual abuse (p.39).

Hamilton and Sinclair (AJI Report, 1991) indicate that:

> It was generally Aboriginal women who spoke to us of the effect of alcohol on crime in general and on family violence in particular. It is a fact established by a long line of studies that Aboriginal involvement in crime includes as a factor the abuse of alcohol. It is also the case that the consumption of alcohol contributes to the incidents of domestic violence and child abuse which occurs on Indian reserves. (p.497).

Women at God's Lake Narrows (a dry reserve) told Hamilton and Sinclair (AJI Report, 1991, p. 497) that, in their opinion, 95% of crime in their communities is related to the consumption of alcohol. Most of the many inmates and former inmates who spoke to these writers attribute their offence to the over-consumption of alcohol. The writers point out that, "A substantial number of those involved in causing the death of another did not even remember the event, due to alcohol consumption" (p.497).

Glennis Smith of the Zeebeequa Society (a group of Aboriginal women who seek to protect women and children at Roseau River) stated to Hamilton and Sinclair (AJI Report, 1991) that, "Abuse in general, and violence, it is a disease and it can be treated. We cannot forget, even our offenders have one time been victims of these types of abuses" (p.492).

The Canadian Council on Social Development (1996), in their report entitled *The Progress of Canada's Children,* a self-assessment inspired by the United Nations' efforts to focus attention on children's health and well-being, include a foreword by Stephen Lewis, Deputy Executive Director of UNICEF:

> *The Progress of Canada's Children 1996* sheds light on three of the four pillars that uphold the Convention of the Rights of the Child. One is the principle of non-discrimination. The Convention establishes that rights are never to be compromised by race, sex, ethnicity, religion or any other invidious subdivision, but the statistics gathered here on First Nations peoples lead us to conclude that there is a class system of haves and have-nots in Canada's children....The rights to survive, to grow and develop are organized under a third principle. Again, Canada's

> government falls short of its responsibility, administering a nation where indigenous children are less likely to survive or to grow and develop fully; and in which adolescent suicide and instances of family violence are no longer seen as remarkable events. (p. 4).

The multiple factors, especially environmental risk factors, affect the healthy development of Aboriginal children and indicate that they have a less than optimal chance of developing their full potential to enable them to meet the demands of a "complex society and a volatile economy" (Canadian Council on Social Development, 1996, p. 5) and become healthy, self-reliant adults. This same report points out that:

> "...indicators of healthy child development include good physical health; the ability to make effective social connections with others; competence in culturally valuable skills and the opportunity to use them; good coping skills, including handling stress; control over one's life choices; a sense of psychological well-being; and, good self-esteem. (p. 5).

The report further states that, "A child's ability to develop to their full potential depends upon the love and nurturing they receive in their families and the support provided by caring communities" (p. 5). This is alarming when one looks at the factors present in Aboriginal communities that affect the healthy development of children and youth.

Where did all the violence and abuse in Aboriginal communities begin? What has occurred to change this culture's viewpoint with respect to children, the viewpoint that children were precious and a sacred gift from the Creator and as such were loved and protected and the center of a strong and caring society?

Sinclair (1994) writes that many times he has heard many non-Aboriginal people ask the question, 'What is it about Aboriginal people that causes them to behave like that?" (p. 25).

E. THE IMPACT OF OPPRESSION/DISEMPOWERMENT

It is my opinion that:

- Severe damage to an individual's self-esteem occurs when they are convinced that nothing about their culture has any value – their languages, medicines, spiritual practices, social patterns, political practices, family values;
- Severe damage to an individual's self-esteem occurs when economic independence is stripped away and they are unable to adequately provide for their families;
- Severe damage to an individual's self-esteem occurs when they lose their stewardship over the land and have no choice as to where they live;
- Severe damage to the self-esteem occurs when a family's children are taken from them without their consent; and,
- Severe damage occurs to the self-esteem when people have no control over their lives and destinies.

According to Germain (1991):

> The concepts of power, oppression, and pollution derive from the concept of dominance. Dominant groups in society may withhold power from others and/or may abuse their political and economic powers to exploit others resulting in oppression (disempowerment of vulnerable groups). Disempowerment and social pollution (e.g., poverty, structural

> unemployment, inadequate systems of housing, education, health care, and income distribution threaten the health and well-being of individuals and they impose enormous adaptive burdens on the affected individuals and collectives over the life course. (p. 67).

Kuyek (1992) points out, "Aboriginal people found that their disempowerment was reflected in their lifestyles and social relations of their communities. Dependence on alcohol, horizontal violence and suicide were the most prevalent symptoms" (p. 65). The rise of alcohol abuse has coincided with cultural breakdown and a growing dependence on government programs (York, 1992; Maracle, 1993). Adams (1995) writes:

> Welfare assistance is one of the most effective ways of controlling the oppressed, who represent a threat to society's order. However, once people are forced to live on welfare for a while, they develop a dependency that soon encompasses their entire lives. (p. 19).

The author further points out that, "The structure for maintaining Aboriginals under the welfare system extends through numerous state institutions..." resulting in "a highly sophisticated and efficient mechanism for making the poor fearful, intimidated and, most importantly, subservient" (p. 19). The author suggests that there are alternatives the state could use to care for its unemployed and indigenous people, but they would not have the same controlling force as welfare (p. 19).

Hamilton & Sinclair (AJI Report, 1991) write that, "The causes of sexual abuse are difficult to determine" (p. 490). They suggest "It may be partly due to feelings of anger and frustration and the need for a feeling of power or

dominance over another" (p.490). As well, the authors attribute the use of alcohol to abusive behaviours as "many people do things that they would not ordinarily do when under the influence of alcohol" (p. 490). The authors point out that in saying this, they "are not making excuses, as this behaviour is not acceptable" (p. 490). According to several authors, (Yoder, 1990; AJI Report, 1991; Special Report on Suicide Among Aboriginal People, 1995), children of alcoholics are frequently victims of incest, child neglect, and other forms of violence or exploitation. Many leaders regard alcohol abuse as their number one problem (Shkilnyk, 1985; Anderson, 1992; York, 1992; Maracle, 1993). I would suggest that gaining an understanding of where the problem stems from makes it possible to work towards making changes in the individual's behaviour.

Glennis Smith of the Zeebeequa Society is quoted (AJI Report, 1991) as saying that, "Abuse in general, and violence, it is a disease and it can be treated" (p. 492).

According to some writers (Kellough, 1980; Mercredi & Turpel, 1993), the devaluation of the Aboriginal way of life has devalued the Aboriginal people, not only in the eyes of non-Aboriginal people, but also in their own.

According to several authors (Kellough, 1980; Sachs, 1991), oppressed people usually come to believe the negative things that are said about them and that this is referred to as internalized oppression. According to the authors,

people who are oppressed may identify with their oppressors and attack others, who like themselves, are weak and vulnerable.

Roy Fabian, a Dene, is quoted in the Special Report on Suicide Among Aboriginal People (1995) in which he describes how external oppression becomes internalized and generates a vicious cycle of violence:

> When you are talking about oppression, there is a process that goes on. [First] there is a process that demeans us, that belittles us and makes us believe that we are not worthy, and the oppressed begin to develop what they call cultural shame and cultural self-hate, which results in a lot of frustration and a lot of anger. At the same time this is going on, because our ways are put down as Native people, because our cultural values and things are put down, we begin to adopt our oppressors' values and, in a way, we become oppressors [of] ourselves...Because of the resulting self-hate and self-shame we begin to [sic] start hurting our own people [ourselves].
> When you talk about things like addiction and family abuse, elder abuse, sexual abuse, gossip, suicide and all the different abuses we seem to be experiencing, it's all based on [the original] violences. It's all a form of [internalized] violence. [Churches and governments] made us believe that the way we are today is the Dene way. It isn't. That is not the Dene culture...(pp. 27-28).

Ross (1996) writes:

> No one can bear considering himself or herself worthless, essentially invisible. People who have been disempowered will eventually stand up and demand to be noticed. The easiest way to assert power, to prove that you exist, is to demonstrate power over people who are weaker still, primarily by making them do things they do not want to do. The more those things shame and diminish that weaker person, the more the abuser feels, within the twisted logic of victimization, that they have been empowered and restored themselves. Further, nothing is more attractive to those who need to feed off the denigration of others than the road of sexual abuse, and the safest and easiest sexual abuse is of children (p. 48).

Josie Hill, director of the Native Women's Transition Centre stated to Hamilton and Sinclair (1991) that:

> [It] is no less than the absolute disrespect of a human being...? Our own...grandmothers...state that when a child is sexually abused, 'the spirit leaves; the spirit can hide; the spirit can die', as a result of the great shock...the ultimate effect is that people become unable to function in home and community. (p.482).

Hamilton and Sinclair (1991) refer to a portion of the Child Advocacy Project that states:

> The social cost of child sexual abuse is higher than we can imagine. These child victims continue to be victimized throughout their lives. The burden of this victimization is preventing many Indian children from becoming the healthy, functioning adults they might otherwise be. The failure of the social, medical, and legal systems to provide a safe environment for the normal development of these children perpetuates the existence of future generations of victims. It is time to break the cycle of victimization. It is time to break the long-standing pattern of non-action on reserve-based child sexual abuse. (p.490).

Ross (1995) relates the story of an Aboriginal woman who shared her story at a sexual abuse workshop.

> This woman, at age 16 yrs, was released from residential school and returned to her community where she began to be sexually abused by first an uncle, then older cousins. This woman was also abused at school in that they tried to take the 'Indian' out of her – her language, spirituality, culture, and worldview. The First Nation woman shared how she handled these abusive behaviours – alcohol/drug use, living on the streets and abusing herself in virtually every way. She advises how she did a complete turnaround – stopped using alcohol and drugs, went back to school, graduated from university, got married and had children. According to her, it appeared everything was fine. She relates an incident when one of her daughters returned from school with a straight-A report card. She asked her daughter why there was no A-plus marks to which her daughter tearfully questioned why they had to be better than everyone else in everything they did. This woman realized then that they was still hiding from her sexual abuse and recognized she had traded alcohol and

> drugs for perfectionism and that she had not come to terms with being a victim of sexual abuse – the pain, the guilt, the 'dirtiness'. Her own peoples' abuse of her did not help. She sought guidance from elders. She wanted to face up to realities, put the pain behind her, and undertake healing for both herself and her community. The result of seeking help from the elders is that they helped her understand why it was her own people; her own family had sexually abused her. She learned from the elders that the people she left at age six were not the same people she came back to when she was 16 yrs of age. According to this First Nations woman, 'The change began on the day we [the children] were taken from them.' This woman realized that 'her abusers...did not abuse because they were Aboriginal people, but because they were changed Aboriginal people. (pp. 45-46).

The author continues:

> If that was so, then there was something they could do to reverse the downward spiral that had everyone so firmly in its grip: they could look back to see when the changes began, what they were, how they touched people – and how they might be reversed. In other words, there was a chance that they could rescue themselves. (p. 46).

Many Aboriginal people have been transformed by their oppressive experiences; their self-esteem has been severely damaged.

F. SELF-ESTEEM

Branden (1994), in reflecting on stories he heard from his clients, found "...that whatever an individual's particular complaint, there was always a deeper issue: a sense of inadequacy, of not being 'enough,' a feeling of guilt or shame or inferiority, a clear lack of self-acceptance, self-trust, and self-love" – "...a problem of self-esteem" (p. xiv).

Branden (1994, p.xv) also writes that:

> Apart from disturbances whose roots are biological, he cannot think of a single psychological problem – from anxiety to depression, to underachievement at school or at work, to fear of intimacy, happiness, or success, to alcohol or drug abuse, to spouse battering or child molestation, to co-dependency and sexual disorders, to passivity and chronic aimlessness, to suicide and crimes of violence – that is not traceable, at least in part, to the problem of deficient self-esteem. (p. xv).

The author further suggests that, "Of all the judgments we pass in life, none is as important as the one we pass on ourselves" (p. xv).

Webster's Ninth New Collegiate Dictionary (1987, p. 1066) defines self-esteem as, "a confidence and satisfaction in oneself; self-respect." This same edition defines self-worth as self-esteem.

According to Waitley (1979), "The word 'esteem' literally means to appreciate the value of" (p.39). The author states that, "Positive self-esteem is one of the most important and basic qualities of a winning human being. It is that deep down, inside the self, feeling of your own worth" (p.36).

Branden (1994) writes, "By 'self-esteem' I mean much more than the innate sense of self-worth that presumably is our human birthright" and which is "only the anteroom to self-esteem" (p. 4).

The author defines self-esteem as:

> ...confidence in our ability to think, confidence in our ability to cope with the basic challenges in life; and confidence in our right to be successful and happy, the feeling of being worthy, deserving, entitled to assert our needs and wants, achieve our values, and enjoy the fruits of our efforts. (p.4).

Sanford and Donovan (1984) write that, "The term self-esteem is used interchangeably with self-respect, self-love and a sense of self-worth and also with the term 'self-concept' and that these terms are not all interchangeable" (p.7). The authors go on to say that, "...self-concept or self-image is the set of beliefs and images we all have and hold to be true of ourselves" and that, "By contrast, our level of self-esteem (or self-respect, self-love, or self-worth) is the measure of how much we like and approve of our self-concept" (p.7).

Branden states, "...self-esteem is a fundamental human need" (p.3), and that:

> The level of our self-esteem has profound consequences for every aspect of our existence: how we operate in the workplace, how we deal with people, how high we are likely to rise, how much we are likely to achieve – and, in the personal realm, with whom we are likely to fall in love, how we interact with our spouse, children, and friends, what level of personal happiness we attain. (p.5).

According to Sanford and Donovan (1984), "We need self-esteem because nothing is as important to psychological well-being" (p. 3). The authors further state that, "Our level of self-esteem affects virtually everything we think, say, and do". The authors suggest that:

> It plays a part in how we see the world and our place in it, how others in the world see and treat us, the choices we make such as what we will do with our lives and with whom we get involved, our ability to give and receive love, and our ability to take action to change things that need to be changed. The authors suggest that, "If a woman has an insufficient amount of self-esteem, she will not be able to act in her own best interest. (p. 3).

Sanford and Donovan (1984) write that, "Self-esteem is a product of the life experiences that a person is subjected to throughout the lifespan" (p. 8). According to the authors, there are, "...two main sources acquired prior to adulthood from which we have many of the basic ideas about ourselves and these are how others treated us and what they told us about ourselves" (p.8). In support of this, Rosenberg (1979) writes that, "People, as social animals, are deeply influenced by the attitudes of others toward the self," and over the course of time, begin to view themselves essentially as they are viewed by others" (p. 63).

Branden (1994) writes that, "We are impaired in our ability to function if our self-esteem is lacking to a serious degree" (p.17). According to the author:

> An inadequate self-esteem may reveal itself in a bad choice of mate, a marriage that brings only frustration, a career that never goes anywhere, aspirations that are somehow always sabotaged, promising ideas that die stillborn, a mysterious inability to enjoy successes, destructive eating and living habits, dreams that are never fulfilled, chronic anxiety or depression, persistently low resistance to illness, over dependence on drugs, an insatiable hunger for love and approval, children who learn nothing of self-respect or the joy of being. (p.17).

The author further points out that, "...sometimes lack of self-esteem does eventuate in death in fairly direct ways – for example by a drug overdose, defiantly reckless driving of an automobile, remaining with a murderously abusive spouse, participating in gang wars, or suicide" (p.17).

In the case of Aboriginal people, Aboriginal females, the attitudes, the views, of others from generation to generation has played a major role in how they view themselves. Their self-esteem is lacking to a serious degree. There is a definite need to increase the self-esteem of Aboriginal women so that they will, as Brandon (1994) states, "feel better" and "live better", and "be able to respond to challenges and opportunities more resourcefully and more appropriately" (p. 5). With increased self-esteem, they will be able to act in their own best interests.

G. CASE STUDY RESEARCH

Employment of the case study approach has been chosen so as to enable study of the "particularity and complexity of the case, and through this come to understand its activity within important circumstances" (Stake, 1995, p. xi). The author writes that in case study research, the emphasis is on "sequentiality of happenings in context, the wholeness of the individual". The author further writes that, the case study method involves "...commitment to interpretation, an organization around issues, the use of stories,...the need for validation, the aim toward naturalistic generalization" (p. xi).

In this particular case, case study is instrumental to accomplishing something other than understanding this particular woman. The goal is to intervene in such a way as to facilitate healing. Although group intervention is a preferred method for many survivors of childhood abuse, many clients are

reluctant, at least initially, to share their stories in a group setting. My client also has the additional issue of living in a small community where gossip is a serious problem and contributes to lack of trust; hence another reason for seeing her in individual sessions.

According to Kazdin (1992), "...research design refers broadly to an approach toward evaluating phenomena and establishing valid inferences....Indeed evaluation and valid inferences can be readily accomplished with the individual subject or single case" (p. 151).

Kazdin (1992) points out that:

> ... the unique feature of single-case designs is the capacity to conduct experimental investigations with one subject and that the special feature that distinguishes the methodology is the provision of some means of rigorously evaluating the effects of interventions with the individual case. (p. 152).

Another feature of the case study, as mentioned by the author, is that, "...it usually consists of uncontrolled observations of the individual client in situations where concrete and immediate concerns of the person must be given high priority" (p. 152).

As Kazdin (1992, p. 156) points out, "The case study is limited as a research tool and even though it has special value that stands on its own, as a basis for establishing knowledge, it has limitations:

> Firstly, many alternative explanations usually are available to account for the current status of the individual other than those provided by the

> clinician. Retrospective accounts try to reconstruct early events and show how they invariably led to contemporary functioning. Although these accounts are frequently persuasive, they are scientifically questionable. There are many events in the individual's past that might have accounted for current functioning other than those focused on by the clinician or client. As well, there is no way to test a hypothesis with the usual case report to assess the causal events in the past. As the author points out, in many cases, one cannot even be assured that the events in the past believed to account for behaviour actually occurred because the reports of an individual are not necessarily reliable and cannot, without independent corroboration, be accepted uncritically.

A second limitation, according to Kazdin (1992, p. 156) is:

> The heavy reliance of cases on anecdotal information that provides for the possibility of quite biased presentation because clinical judgment and interpretation play a major role in making sense out of the client's predicament. Therefore, conclusions cannot be accorded scientific status in the absence of objective measures. As the author points out, many inferences are based on reports of the client and these reports are the 'data' on which interpretations are made. The possibility exists that the client's reconstructions of the past and remembered events are likely to be distorted and highly selective, particularly those laden with emotion. The reports may have little bearing on what actually happened to the client in the past. They could be completely unreliable unless subjective accounts are independently corroborated. Many case reports give the appearance of literary descriptions of stories rather than scientific investigations because of the type of information made available. (p. 156).

A third major concern about the information derived from a case study, Kazdin (1992 writes is, "...the generalizability to other individuals or situations. Attempts are made to establish relations between independent and dependent variables in scientific research" (p. 156). According to the author:

> Although such relations may be demonstration for an individual case, the assumed purpose of science is to develop general 'laws' of behaviour that hold without respect to the identity of any individual. It is possible that the

> individual case will reflect marked or unique characteristics and not provide widely generalizable findings. The absence of objective procedures to evaluate the case makes replication of the study often difficult. Hence, knowledge about several potentially similar cases is difficult to achieve. (p.157).

Kazdin (1992 does point out, however, "That the naturalistic and uncontrolled characteristics also have made the case a unique source of information that complements and contributes to experimental research" and that, "...case studies often have served as the basis for developing specific therapeutic techniques" (p. 154).

Although the case selected is typical or representative of other cases, this in no way suggests that this case is a strong representation of others. This case has been pre-selected and my obligation is to come to understand this case in such a way as to be able to assist this woman in facilitating her own healing.

H. AN ABORIGINAL APPROACH TO HEALING

It is evident that there are multiple issues related to self-esteem that need to be resolved when working with Aboriginal people, and in particular, for the purposes of this practicum, First Nation Cree women. There is a need to implement approaches that are culturally relevant and effective for Aboriginal individuals (Morrissette et al, 1993; Longclaws, 1994; McCormick, 1995; Nabigon & Mawhiney, 1995; Hart, 1999)

It is well documented that practitioners need to select theory and interventions that have the best fit with the client situation. In working with clients from other cultures, a practitioner must choose approaches or methods that match the cultural background of that individual.

According to Aboriginal teachers and writers (Longclaws, 1994; McCormick, 1995; Grant, 1996; Hart, 1999), Aboriginal people have been practicing their own methods of healing for years and did so prior to European contact. In reviewing the literature on Aboriginal healing practices, the concepts of interconnectedness, spirituality, and balance are emphasized as being important goals in counseling (Morrissette et al, 1993; Longclaws, 1994; McCormick, 1995; Nabigon & Mawhiney, 1995; Hart, 1999). These authors write that an effective healing program for Aboriginal people would involve empowerment, cleansing, balance, discipline, and belonging.

According to these same authors, the role of healing in traditional times was to consider the individual in the context of the community. Dealing with one's problems with the help of others provides an individual with acceptance and the support they need. What I am hearing is that many people come to the belief that they are alone, that they don't matter, that they have nothing to offer, and that they have no significance beyond themselves. I believe that when an individual comes to these kinds of conclusions the possibility exists that they may

be feeling lonely and desperate and they may end up abusing themselves and abusing others.

According to Nabigon and Mawhiney (1995):

> The First Nations philosophy of life helps people understand the relationship among all things. Understanding necessitates acceptance and putting into practice a way of life that promotes healing. Healing reconnects us with our innermost self and our surroundings. This, in turn, shapes our surroundings. All aspects of life may be improved, whether we are seeking help because of dysfunction, change, or a desire for a greater awareness of life and self. (p. 21).

According to McCormick (1995):

> A key factor in the facilitation of healing for First Nations people is the process of dealing with problems with the assistance of others and not by oneself. Assistance can be obtained from friends, the family, the community...and that this can be done "on a social basis. (p. 266).

The author cites Katz and Rolde (1981, p.266) who wrote "...therapy for First Nation people should encourage the client to transcend himself or herself by conceptualizing the self as being embedded in and expressive of community." The author further supports the concept of interconnectedness by making reference to Epes-Brown (1989): "Interconnectedness is considered a dominant theme in all First Nations cultures" (p. 266). McCormick (1995) also cites Torrey (1972) that, "Some Native people see improving interpersonal and social relationships as one of the goals of traditional therapy" (p.266). The author, who conducted a study of Aboriginal people, writes that the individuals who had a tendency to withdraw from people saw their behaviour as being problematic in

that they experienced feelings of "loneliness, anxiety, feeling left out, and of not being accepted" (p.169).

McCormick (1995) refers to a study conducted by First Nations where the development of a culturally sensitive framework for counseling was examined. In this study it was found that the healing process combined with spirituality was a recurrent focus (p. 262). The author states that, "Spirituality is seen as the essence of healing for many First Nations people" (p. 267). The author cites Hammerschlag (1988) that, "For First Nation people spirit plays a major role in wellness and sickness as does the mind and body" (p. 267).

Morrissette et al (1993) write that, "...spiritual healing requires special attention because it is the spiritual aspect of Aboriginal identity that has suffered most from the effects of cultural colonialism" (p. 99).

Nabigon and Mawhiney (1995) write:

> Traditionally, First Nations teachings suggest that all human beings need healing and that the means to grow and that the means to grow spiritually are incorporated into every aspect of life. Healing is a lifelong journey and individuals strive constantly to create and recreate balance and harmony. Spiritual life is not separate from everyday life. Every aspect of existence is spiritual....Our traditional teachings tell us that all things are related. There is no sense of object and subject, all is one. Mind, body, emotions, and spirit are not separate, and humans are not separate from the earth and everything on and in it. (p.21).

The authors further go on to say that, "The goal of treatment is to promote balance and harmony within individuals and groups of people, including

communities, and to assist in taking action to relieve pain in the communities and nations of the world" (p.28).

In conjunction with interconnectedness and spirituality, focus must be on maintaining balance. McCormick (1995) writes that, "One important aim for First Nation people is attaining and maintaining balance among the mental, physical, emotional, and spiritual dimensions of the person....First Nations elders say that living life in an unbalanced way leads to illness" (p. 174).

To support the importance of balance in one's life, Bopp et al (1988) write that, "...a person who does not achieve balance will not be able to develop their full potential" (p. 93).

According to Favel-King (1993, p. 123), First Nations history defined health by taking into account all aspects of a person – the spiritual, emotional, physical, and mental - and these dimensions being in balance and harmony with each other as well as with the environment and other persons.

According to Bopp et al (1988):

> In addition to these four aspects of the self, there is also volition (will). The five steps to be carried out when learning to use volition are attention and concentration, goal setting, taking action, sticking to the action (not giving up), and finishing the action. It is a force that helps people make decisions and then to carry out those decisions. It is the primary force in the development of human potential. This volition can be used to help individuals develop the other aspects – spiritual, mental, emotional, and physical. Each of these areas must be developed equally in a healthy, well-balance person through the use of will power. (p. 16).

The fact that all aspects of the Aboriginal person has been impacted – the body, mind, and spirit – the spiritual, physical, emotional, and mental components – necessitates a holistic approach to healing.

1. The Spiritual Component

Based on writings by Aboriginal authors (Morrissette et al, 1993; Longclaws, 1994; Nabigon & Mawhiney, 1995; Hart, 1999), one of the greatest losses suffered by Aboriginal people is that of their spirituality.

As previously indicated, Aboriginal people were a spiritual people and their belief in Kitchi Manitou or Great Spirit is what governed their actions and was a strong force that held them together in a highly organized way of life. The respect they had for their Creator provided them with respect for themselves and others. They turned to the Great Spirit in times of need.

Bopp et al (1988) point out that:

> The Great Spirit is the center pole of creation for balancing and understanding ourselves as human beings....The fruits of this tree are the good things the Creator has given to the people: love, caring for others, generosity, patience, wisdom, fairness, courage, justice, respect, humility. To wander too far from the safety of the Tree will result in great sadness for First Nations people – many will become sick at heart and lose their power, their lives will become filled with sadness and anger and little by little they will poison themselves and everything they touch. (p. 9).

Aboriginal teachings strongly emphasize the spiritual aspect of healing; they stress the need for reconnection with one's spirituality. McCormick (1995, p.

262) quotes Medicine Eagle (1989) who said that spirituality or holiness is seen as the essence of healing for Aboriginal people.

Longclaws (1994, pp. 32-33) states that, "A major area that requires further examination is the area of spiritual versus secular." The author further adds that "...the healing of a person occurs primarily from the inside out (spiritual) and not outside in (environment)." Russell (1998, p. 26) quotes Sanford (1990) who wrote that, "Spirituality has been found to be a powerful tool in helping survivors make sense of painful early life experiences and may also play a role in propelling them into the healing professions".

Torrey (1972) as quoted by McCormick (1995, p. 262) indicates that there exists a close association between illness and the spirit for most indigenous people around the world. According to Hammerschlag (1988, p. 67), spirit plays a major role in sickness.

Carroll (1998) quotes Canda (1998) in that:

> Spirituality has been described as a relationship or interconnectedness with self, others and God – with all that exists in the universe. When spirituality is one dimension equal with the other dimensions (biological, psychological, and social) it apparently refers only to the relationship with God [or Kitchi Manitou]. (p. 5).

Carroll (1998) further quotes Canda (1998) as stating that:

> One way in which the spirit-as-dimension is manifest is in the caring and commitment that people have toward each other. In this sense, spirituality, as one dimension (namely the relationship with God or the transcendent) is reflected in the extent and quality of interconnectedness between self and others. (p. 5).

According to Canda (1998):

> People who wish to explore the transpersonal reaches of their potential could also be assisted by social workers who are in an especially appropriate position to help clients reflect on the interplay between inner spiritual growth and responsibility to society and nature, given our person-in-environment focus. Plans to assist and advocate for clients then would take into account the impact of any changes on other people, including people who may be in conflict with the client.
> In summary, a spiritually sensitive understanding of human fulfillment links personal growth, social justice and ecojustice. This presents a tremendous opportunity for professional theories and practice strategies to go beyond a goal of egoistic self-actualization to a goal of mutual benefit for all beings. (p. 100).

Based on traditional teachings, it is evident that spirituality played an important role in the everyday life of Aboriginal people. In the present time, many of our people are facing their struggles without a spiritual connection. In the past, this was a strong source of strength and support that unified the tribes – it is needed in Aboriginal communities today, to unify the people so they can be there for one another. As helping professionals, we must work with clients toward making this possible. Due to the tremendous loss with respect to spirituality and in keeping with Aboriginal theory, the spiritual aspect must be taken into account when working with Aboriginal people. Participants in McCormick's study (1995) indicated it was necessary to develop the spiritual aspects of themselves to attain the necessary balance with the mental, emotional and physical components.

2. <u>The Mental Component</u>

It is safe to say that the many problems being faced by Aboriginal people today – the destructive coping mechanisms such as alcohol and drug abuse, violence directed towards oneself and others, high unemployment rates, inadequate/substandard housing – stem from the colonization process. Not all Aboriginal people are aware that their many problems stem from the colonization process, that they did not always have these problems and that they come from a rich heritage.

Quite often people feel helpless because they blame themselves for problems they did not cause. Blaming themselves for circumstances they did not cause makes many people feel helpless because they cannot respond constructively until they understand that someone or something else it at fault.

The knowledge of what they possessed and then lost will require focus on the emotional component. Aboriginal people have endured and continue to endure much suffering as a result of their lost culture. As part of their healing, it will be necessary to grieve these losses.

3. The Emotional Component

The expression of feelings and emotions through talking, crying, and screaming is important in developing the emotional aspect of oneself and can be helpful in gaining strength and balance in this area (McCormick, 1995, p. 278). For some individuals, this may be difficult. Grant (1996) writes that:

> In the [residential] schools there was no means of talking out disagreements and frustrations; problems had to be borne in silence or dealt with in a secretive way. Most children were much too frightened of supervisory staff to react in an open fashion; usually they simply repressed their feelings or they took frustrations out on those weaker and more timid than themselves. Nothing could be 'talked out' or questioned until they could do so in English; by then most of the students had lost their inherent spontaneity and had learned to retreat into themselves. (p. 196).

McCormick (1995) writes that many Aboriginal people use techniques such as screaming and crying to cleanse themselves of bad emotions. This is included in the traditional teachings of the Medicine Wheel (p. 278). The need for both awareness and the expression of feelings for improved self-esteem and interpersonal relationships has long been recognized by mental health professionals and by the medical profession and society in general.

Another important component in healing is focusing on the physical aspect of the self.

4. The Physical Component

This aspect of healing focuses on physical exercise in any form (i.e., walking, running, cycling) and proper diet and rest.

According to Grant (1996, p. 31), "Aboriginals were healthier than Europeans, taller, and had better teeth" and that their "strenuous outdoor lifestyle ensured physical stamina".

Copeland (1998) quotes Bourne (1990) with respect to the benefits of regular exercise. According to the author, the physiological benefits of regular

exercise include discharge of pent-up frustration, increased production of endorphins (which increase one's sense of well being), increased energy level, improved circulation, improved digestion, decreased cholesterol levels, decreased blood pressure, improved regulation of blood sugar, suppressed appetite and consequent weight loss. The psychological benefits of exercise are increased feeling of well-being, reduced dependence on alcohol and drugs, reduced insomnia, improved concentration and memory, alleviation of depression symptoms, greater control over feelings of anxiety, and increased self-esteem (pp. 251-252). Copeland (1998) stresses the importance of making exercise part of one's daily routine so as to ensure consistency and reap the benefits (p. 252).

In addition to exercise, attention must be paid to the diet. A protein-rich diet free of salt and sugar enhanced the physical well being of Aboriginal people (Grant, 1996, p. 34). What we eat affects the way we feel. Sugar, for example, can make one feel lethargic, foggy, bloated, and uncomfortable. It has been shown that salt is not recommended as part of a healthy diet. It is also very important that meals are not skipped. Education in the area of proper eating habits can only be beneficial.

In many Aboriginal communities, a proper diet is difficult to maintain. High unemployment rates result in many people being on social assistance, a source of income which is grossly inadequate. The high cost of food is also evident in many First Nation communities. "Junk" food, which is high in sugar, salt, or fat

has been shown to increase depression and contributes to excess weight that affects self-esteem. This type of food is not as costly and is consumed on a much larger scale than it should be; hence, the increasing numbers (according to Nursing Station staff) of individuals with Type 2 diabetes.

Exercise, rest, and proper diet are essential to healing the body, mind, and spirit.

In addition to healing techniques that focus on the above-mentioned four components of the self, it is important to work with Aboriginal people toward improving interpersonal and social relationships.

5. Interconnectedness

According to Aboriginal teachers and writers (AJI Report, 1991; Morrissette et al, 1993; Longclaws, 1994; McCormick, 1997; Nabigon and Mawhiney, 1995; Hart, 1999), connecting or reconnecting means an individual connecting to the world outside the self – with family, friends, community, culture, and the universe. This belief is held throughout most of the Aboriginal culture. Some Aboriginal people believe that isolation contributes to poor mental health and that interpersonal relationships are essential to their well-being. Part of the healing process thus requires connecting or reconnecting individuals to family, friends, community, culture, and the universe. They need to connect to the world outside themselves.

I. CONCLUDING SUMMARY

I believe the literature on the impact of culture stress on the Aboriginal individual provides evidence that damage with respect to self-esteem is immense. People do lose confidence in what they know and in their own value as human beings. The long-term impact of culture stress on self-esteem is evident. Individuals whose level of self-esteem has been negatively impacted by culture stress will find it difficult to act in their own best interests because their level of self-esteem affects everything they think, say, and do, and an insufficient amount of self-esteem limits their ability to act in their own best interests. A review of case study research supports the use of this method in this particular study. An advantage of case study research and one-to-one intervention over group work is that it allows the client to share her stories, her experiences, in a safe environment, and focus on her healing. As previously indicated, the client resides in a small community where gossip is a very real and serious problem. This is very important when it is taken into consideration that there have been instances where confidential information has been divulged. This contributes to lack of trust and prevents many individuals from beginning to do their healing work and accessing a much-needed local support system. Case study research enables the clinician to focus on one particular client. It consists of uncontrolled observations of the client in situations where concrete and immediate concerns of the client must be given high priority. This client does, after all, have a life that exists beyond this study.

To summarize, culture stress has done great damage to the self-esteem of Aboriginal people. There is a need to intervene in such a way as to facilitate healing so that those Aboriginal people who have been impacted can take charge of their lives once again.

CHAPTER THREE

THE PRACTICUM PROCEDURES

This chapter provides a description of the setting where the study and intervention took place, a description of the practicum committee, a discussion on participant selection, the case description, and description of the intervention model.

A. THE SETTING

The First Nation and Inuit Health Branch Mental Health Unit sponsor my position as a mental health service provider in northern Manitoba First Nation communities. I am contracted to provide group, family, and individual therapy and crisis intervention services. I must ensure that the work carried out is done so in a manner that shows understanding of, and respect for, unique First Nation cultural and social realities.

Services are provided without fee to clients. The cost is covered by First Nation and Inuit Health Branch non-insured health benefits. Clients are either self-referred or are referred through Nursing Station medical staff and community resource workers.

The setting for this practicum was in my office that is located in the Nursing Station in one of the four First Nation communities in which I provide

mental health services. Meetings with the participant took place after work hours.

B. THE PRACTICUM COMMITTEE

Eveline Milliken from the Inner City Social Work Program, Faculty of Social Work, was my practicum committee chair and principle supervisor in this practicum. She provided much guidance and direction. She was available for consultation in the form of discussion and constructive feedback throughout the practicum process. Shirley Grosser from the Faculty of Social Work provided further consultation. She provided input and much needed support on an as-needed basis. Barbara Lavallee, of the Aboriginal Focus Program was the external committee member and provided, on an as-needed basis, her valuable input and support.

All three committee members have their graduate degrees and experience in working with women and First Nation peoples.

C. SELECTION OF PARTICIPANT

I selected a First Nation Cree woman from a Northern Manitoba First Nation Cree community whose life experiences embodies common struggles I hear among women in the First Nation communities which I serve – those who come from backgrounds of parental alcohol abuse, violence, and sexual abuse – an individual impacted by culture stress.

The participant selected was given basic information about the study and intervention. The participant had voluntarily agreed to participate in the practicum and was willing to meet with me on an ongoing basis. The stability of the client was taken into consideration.

The session dates and times were determined by the client and the student from session to session, the reason being that unexpected incidents arose (i.e., medical and other appointments outside the community, family illness) which necessitated changes in our scheduled appointments. There were six sessions in total.

The student and primary advisor met to discuss the pre-selected case for this practicum. The student contacted the pre-selected participant during a scheduled visit to the community and a meeting was arranged to discuss the purpose of the practicum study. The participant was given time to read the "Informed Consent" (Appendix A) and given the opportunity to ask questions or discuss any possible concerns about the form. The form provides information with respect to the title of the project, the researcher's name, the purpose of the research, and the procedures involved. It informs the participant that she is free to withdraw from the study at any time and still receive mental health services, and/or refrain from answering any questions without prejudice or consequence, and to feel free to ask for clarification or new information throughout their participation in the practicum. The participant was made aware that the student

would be submitting a written report to the University of Manitoba and that no identifying information would be included in any of the reports or in the discussions with the practicum committee. Assurance was given that all information received would be kept confidential. The participant was agreeable to taking part in this study and agreed to attend all sessions except in cases of emergency (i.e., illness of self or child, medical appointments out of the community). The participant did not have any questions or concerns and signed the form.

The client was asked to complete three quantitative measurement tools: Burns Depression Checklist (Appendix B), Burns Anxiety Test (Appendix C), and the Relationship Satisfaction Scale (Appendix D) for the purpose of pre-testing. The client was given assignments to complete at home: "Personal Goals for Self-Esteem Intervention" (Appendix E), Personal History Form (Appendix F), and an assignment (Appendix G) with the question, "What are you expecting from participating in this study? This latter question was assigned to enable the client to articulate her personal goals. She was directed to bring the completed assignments to the next meeting.

D. CASE DESCRIPTION – MRS. ROBERTS

I have chosen to name the family in this study the Roberts family to protect their identities. The case study of Mrs. Roberts reflects the integration of cognitive restructuring and ecological theory with Aboriginal theory. The case

study was selected for this practicum report due to a determined effort on the part of the client to attend regularly scheduled sessions and a further expressed commitment to accomplishing positive changes for herself and her family.

The Roberts family consists of Mrs. Roberts and her four children ranging in age from three to ten years. Mrs. Roberts and her spouse were married for approximately five years then separated 4 ½ years ago due to her spouse's substance abuse and infidelity which began during the first year of their marriage. Mrs. Roberts quit school when she was in grade ten. She was fifteen years of age and was pregnant. Mrs. Roberts miscarried at that time. She got pregnant again when she was 17 years of age. This baby was healthy and well. She got married shortly after the birth of her son.

Mrs. Roberts has attended school to further her education beyond grade ten. Currently, she is employed full-time. She is the sole provider for her children. The father maintains sporadic and minimal contact with the children.

Mrs. Roberts' parents are both alive and reside in the same community as she does. She is the eldest child in a sibline of six. In the development section of the personal history form, the participant indicates there were circumstances that affected her development and describes these as: (a) being responsible for the care of her siblings; and, (b) incidents of sexual abuse. She reports a history of child abuse – sexual, physical, and verbal – both as a victim and a perpetrator. Another childhood issue the client reports is that of neglect. Mrs. Roberts reports

a history of alcohol abuse on the paternal side of her family. According to Mrs. Roberts, her mother would accompany her father when he went out drinking and that the incidents of neglect occurred at these times.

Like many Aboriginal individuals, Mrs. Roberts, too, has been impacted by culture stress, which in turn, has impacted her self-esteem.

E. THE INTERVENTION MODEL – AN ABORIGINAL APPROACH TO HEALING

This section presents an overview of the model of intervention to be used in this practicum. As previously indicated, there is a need to implement approaches that are culturally relevant and effective for Aboriginal people.

This model was structured to focus on the damage done by culture stress to the self-esteem of the participant. Concepts that are emphasized in the review of the literature as being important goals in counselling will be utilized, these being spirituality, balance and interconnectedness. As suggested by Aboriginal authors, (Longclaws, 1994; McCormick; 1995) an effective healing program for Aboriginal people would involve empowerment, balance, discipline, and belonging.

BALANCE

An important aim for Aboriginal people is attaining and maintaining balance among the spiritual, physical, emotional, and mental components of the self. Our elders teach that living life in an unbalanced way leads to illness. As

well, an individual will not be able to develop her or his potential without a balanced life.

1. The Spiritual Component

Spirituality is seen as the essence of healing for many Aboriginal people and healing this aspect of the self requires special attention because it is the spiritual aspect of the Aboriginal identity that has suffered most from the effects of colonization.

Based on my own experience in working with Aboriginal people, one of the greatest losses suffered by Aboriginal people is that of their spirituality. Many clients have expressed a desire to have God, the Creator, in their lives.

Due to the tremendous loss with respect to spirituality and in keeping with Aboriginal theory, the spiritual aspect must be taken into account when working with Aboriginal people as well as focus on the mental aspect of the individual.

2. The Mental Component

I believe that a knowledge of their history as a colonized people will serve the function of helping Aboriginal people combat their feelings of helplessness, the feeling that they face problems alone, and that will serve as a reminder that they are not to blame for their problems. By acknowledging where the problems stem from, they can begin to take steps to make changes. As written by Sanford and Donovan (1984), "...as women we cannot understand ourselves and our attitudes toward ourselves unless we understand...the culture and society in

which we interact; and we cannot understand either our individual upbringing and experience or the larger culture and society without some understanding of history...". (p.xvi).

It is also important to learn about one's culture. The participants in McCormick's study (1994) indicated that activities that strengthened cultural identity were healing. Aboriginal people will come to see that prior to the colonization process, their ancestors possessed a way of life that was, according to Grant (1996), "as rich and cultured as any in Europe" (p. 31). They will learn that their ancestors had central life principles that determined behaviours due to their strong faith in Kitchi Manitou – respect, kindness, caring, sharing, honor, the attainment of wisdom, strength, and truth. They will learn what their ancestors did not approve of, that they were discouraged from adopting values such as materialism, greed, jealousy and dishonesty and the use of alcohol (Longclaws, 1994, p. 28).

The knowledge of what they possessed and then lost will require focus on the emotional component. It will be necessary to grieve these losses, as much was lost.

3. The Emotional Component

In the healing process, it is necessary, if one is to heal, to be able to express feelings and emotions. Aboriginal people who went through the residential school experience were not allowed to express their emotions. Many

of them, in turn, passed this on to their own children. The expression of feelings and emotions through different methods such as talking, crying, and screaming is important in developing the emotional aspect of one's self. It can be helpful in gaining strength and balance in this area.

Individuals can learn how to identify and express their emotions and in so doing develop an awareness of a problem. They can learn to identify, clarify and make sense of their problem. An understanding of a problem is empowering – once understood, a problem can be dealt with. In view of the fact that failure to express feelings could result in physical and emotional illness, this is a very important component in healing. Focusing on the physical aspect of the self is also a necessary step in the healing process.

4. The Physical Component

In keeping with the concepts of balance and holistic healing, it is necessary to take care of one's self through physical exercise in any form (i.e., walking, running, cycling), proper rest, and proper diet.

In addition to exercise, special attention must be paid to the diet. What we eat affects the way we feel. Education in the area of proper eating habits can only be beneficial.

Exercise, proper diet and rest are essential to healing the body, mind, and spirit.

The participant will be provided with information on another aspect of the self – that of volition or willpower.

5. Volition

The participant will be informed that this is a force that helps people to make decisions and helps them carry out those decisions. She will be told that it is the main force in the development of human potential and can be used to help her develop the other aspects of herself - that each of these areas can be developed through the use of willpower. She will be informed of the five steps to be carried out when learning to use volition: attention and concentration, goal setting, taking action, sticking to the action, and finishing the action.

In addition to healing techniques that focus on the spiritual, mental, emotional, and physical aspects of the individual, we must work toward improving the individual's interpersonal and social relationships.

6. Interconnectedness

Gossip has done much damage with respect to the healing process. It is one of the major concerns reported by individuals in Northern Manitoba First Nation communities when social workers attempt to connect them with local support systems. Many First Nation people have been betrayed by other community members time and again; hence the reluctance to discuss their problems and concerns with community members; and hence, the lack of connection with family, friends, and community.

The concept of interconnectedness was introduced to the participant as a key factor in the facilitation of healing for Aboriginal people, that this is the process of dealing with problems with the assistance of others and not by oneself and that this assistance can be obtained from family, friends, and community. The goal is toward improving interpersonal and social relationships and providing the participant with a support system in the community. As previously indicated, people who isolate themselves may experience feelings of loneliness, anxiety, feeling left out, and not being accepted. As Nabigon and Mawhiney (1995) point out, "The goal of treatment is to promote balance and harmony within individuals and groups of people, including communities, and to assist in taking action to relieve pain in the communities and nations of the world" (p.28).

As the situation now stands, clients meet with a therapist and are able to discuss their problems. However, the therapist is in the community only several times a month and this is not adequate. An essential goal then, is to work towards connecting Aboriginal clients to family, friends, community, and culture.

This model of intervention will utilize concepts that are considered to be important when working with Aboriginal people with the focus being on the damage done by self-esteem.

CHAPTER FOUR

THE INTERVENTION PROCESS

This chapter provides an overview and discussion of each session of the intervention process. In each session held with the client, it was necessary to focus on and deal with current happenings that were creating stress in the client's life.

A. THE SESSIONS

SESSION ONE:

In this session, there was discussion around goals and commitment. I informed the client that my objectives for the practicum were to learn how to do case study research and to work toward developing my own framework for working with our people and that the main focus of the intervention would be on the impact of culture stress on self-esteem.

The participant brought her assignments from the previous meeting to this session – the completed personal history form, completed "Personal Goals for Self-Esteem Intervention", and her expectations for participating in this project. The wording on the personal goals for self-esteem intervention is as follows:

> Now that we have evaluated your moods and personal relationship satisfaction, let us define some of your goals. If you had a way that you could solve all of your problems, what would be on your wish list? How would your life change? Would you overcome depression? Would you develop greater self-esteem? Would you feel closer to other people? Would you become more productive and successful? Please list at least

three personal goals you would like to accomplish as you participate in this intervention. (Burns, 1993).

The client's personal goals for the self-esteem intervention are as follows:

1. To realize my husband doesn't want to communicate and resolve problems from past and present situations.
2. Go on with my life with my kids and be there for them by staying away from alcohol.
3. Find someone to settle down with and be happy and get a job somewhere.

Her response to the question, "What are your expecting from participating in this project?" was: "I am expecting to learn how to address my obstacles in my life positively without turning to alcohol or drugs; to learn to live in a healthy way for my children and I so that my children will learn a healthy lifestyle from me".

In this session, there was discussion around tasks. The utilization of logs was discussed – daily record of activities (Appendix H) in the area of self care (exercise, sleeping/eating patterns, spiritual activities) and daily mood logs (Appendix I). The concepts of balance, interconnectedness and volition were introduced. As a reminder to the client, the definitions to these terms were included at the bottom of the daily record of activities form.

In this session, the client was asked to complete a three-item questionnaire as follows:

Q. How do you feel about taking part in this study and intervention?

A. I feel confident in this study and proud that the student believes in me.

Q. Do you have supports in the community?

A. Yes. [Listed eight individuals].

Q. Are you able to make a commitment to attend the sessions and participate in this intervention?

A. Yes.

The purpose of this questionnaire was to ensure the client was still interested in participating in the project and to ensure there were supports in place in the community. She understood that I would continue to provide services to her without prejudice if she decided not to participate in this project.

The client was provided with blank copies of the daily record of activities, daily mood logs, sample prayer (Appendix J), relaxation techniques and visualization techniques (Appendix K), and self-care for intense feelings (Appendix L). She was instructed to do the logs daily and to bring them to the next session.

In this session as well, the client was given an assignment with respect to circumstances that affected her development (Appendix P). These questions were based on the information obtained from the personal history form.

SESSION TWO

This session began with the client bringing forth current events that were causing stress in her life. After doing the required work around these issues, we discussed the assignments from the previous session. In this session, the client brought completed daily record of activities and completed daily mood logs as well as the assignment on circumstances that affected her development. There was discussion around these assignments. The client found them to be beneficial in that she was able to take better care of herself and feel better. Through utilizing the daily record of activities form, her eating patterns changed for the better. She "did not eat a lot like before". She reports doing a lot of thinking when performing this activity. According to the client, she felt a need to exercise and this was helpful in motivating her. She indicates she was able to see how her moods changed and learned to deal with them in a better way. The relaxation and visualization techniques were helpful in terms of calming herself. The sample prayer provided was helpful initially. She advises this prayer would be helpful to individuals who are not familiar with praying.

As per the client's request, she was given additional blank copies of the daily record of activities and daily mood log forms. It was discussed with the client that these activities are to be done on an ongoing basis throughout the duration of this study.

For the next session, the client was given the following assignments:

1. Circumstances that affected the client's development (Appendix M).

2. Racism (Appendix N). As an Aboriginal person, have you ever experienced racism? Please give an example(s) and how it made you feel.

3. An experience from the client's childhood/adolescence that strongly impacted her life (Appendix O).

4. Questionnaire around usefulness of assignments (Appendix P).

The client was asked to bring completed assignments to the next session.

SESSION THREE

In this session, we first went over the four assignments given to the client in our last session.

Based on information obtained from the personal history form, I asked Mrs. Roberts to respond to questions pertaining to the various issues she experienced as a child. The question and answer format was used with the client. The following are questions and responses (verbatim) to the questionnaire:

1. Under the section "Development" in the Personal History Form, you indicate that there were special, unusual, or traumatic circumstances that affected your development. You describe these as "having to keep your siblings" and "sexual abuse". You indicate that there has been a history of child abuse – sexual, physical, and verbal – both as a victim and a perpetrator. Another childhood issue is that of neglect. Please share your story of the sexual abuse

(form of sexual abuse – fondling, anal/oral sex, sexual intercourse, etc.). At what age did the sexual abuse begin and end? How old was the perpetrator? What was the gender of the perpetrator? How did the abuse impact your life? How did it impact your self-esteem? You may add other comments.

My experience of sexual abuse was mostly fondling and me touching and kissing them. I was about six years old – [up until] nine years. They were between the ages of 14 – 17 years old. They were of both genders. I think due to the sexual abuse, I more or less liked to lead boys on until I met [my husband]. He was the one I thought would never leave me and always love me. I got pregnant at age 15, miscarried. Got pregnant again at age 17, had a baby at 18 years of age, a son. I got married shortly after that. I thought life couldn't be better. I was wrong though.

2. You indicate that there is a history of being a sexual perpetrator when you were 10 years of age. Please share your story. What form of sexual abuse? In looking back at this, why do you think you performed the sexual acts? How did this impact your life? Your self-esteem? You may add other comments.

My parents had foster kids. Quiet kids who kept to themselves. My parents spoiled them, loved them. I was jealous. So I started touching them and telling them not to tell. I guess I wanted to hurt them because they were getting attention from my mom. Also my cousins stopped bothering me and I thought that the fondling was normal, after going through it for a long time. I felt like a rapist for years. Dirty. Disgusting! When I met [my husband] and lost my virginity, I tried any kind of sexual acts – oral, anal, basically anything that was gross or hurt! Kinda like a payback for what I did.

3. Please share your story about having to take care of your siblings. How old were you when you began taking care of them and up until what age? Why were you responsible for taking care of them? Where were your parents? How

did this impact your life? How has it impacted your role as a parent today? How did it affect your self-esteem? You may add other comments.

I was about seven or eight years old when I started taking care of my sisters. My mom always followed my dad around when he was drinking. Our babysitter always stayed in the room with a boyfriend. I always felt I could be a good mother. It made me want to have babies right away. I feel bad when I leave my kids with a sitter or my sister. I don't like leaving my kids unless I have to. But I do go out when I'm overwhelmed with my personal stuff. I'm scared they will hate me if I do leave them. I want my kids to love and respect me.

4. Please share your story about the physical abuse. When did it begin and end, who inflicted the abuse? How did this impact your life? How did it affect your self-esteem? You may add other comments.

Well, my boyfriend started to hit me after our son was born. I think it was the pressure of being young, married, and being parents. We didn't understand anything. I felt as long as he didn't leave me it was okay. Like it really was my fault. I loved him too much to acknowledge that it was wrong.

5. Please share your story about the verbal abuse. When did it begin and end? Who inflicted this form of abuse on you? How did this impact your life? How has it affected your self-esteem? You may add other comments.

My parents made me feel no good, useless, and helpless. I wanted someone to take me away from them. I did anything to show them they were right. I tried to live my own life. Be my own boss. I wanted to prove to them that I didn't need them anyway. My husband made me feel ugly because he was committing adultery and wanted to blame me.

6. Please share your story about neglect – give some examples of instances when you felt you were neglected. How did this impact your life, your self-esteem? You may add other comments.

When my sisters and I slept in a closet while there was a party downstairs. Later in life I didn't want to leave my sisters. I always wanted to sleep with them. So my mom made one big room out of two rooms. I was scared that someone would hurt or molest my sisters. I still constantly worry about my sisters. I get angry when they're hurting. I try to comfort them in any way I can.

7. How did the forms of abuse inflicted upon you affect your role as a wife?

Your role as a mother?

I started to lust after other men. I didn't want my children at one point in my life. I felt it wasn't fair to them that their dad wasn't there. I blamed myself for everything that was going on in our lives.

8. What role, if any, has the abuse had on your use of alcohol?

A lot of my use of alcohol ties to the abuse I faced in my life. Because when I was a teenager I rarely used alcohol - until I left my husband. Mainly, I used alcohol to fill the emptiness I felt.

In response to the question on racism, the client responded as follows:

Yes. My sister and I were shopping in Winnipeg at Polo Park. I couldn't find a certain size of clothing and I was trying to get help from the sales clerk. She ignored me and went to a white woman on the other side of the shop. So my sister and I left. As I was walking out, I told her she was rude. She made me feel like I couldn't afford anything in that shop. I was very angry and upset.

The following is an experience the client shared from her youth that strongly impacted her life:

Well, I think the thing that affected me more than anything else in my life is when my grandfather died. I felt so alone and helpless. He was my dad, the only father I ever knew until I was four. That's when my mom got married. Anyway, I remember when I was three years old and wanted to follow the older kids around and couldn't. He (grandpa) always showed me an even better time. Like when

they went swimming in the lake, he put water in a barrel for me to splash in. Also, once he baked me potatoes that tasted like real chips. Oh, how much I miss him. I love him so much. Maybe when I was 15 when I met my husband he showed me so much attention That I fell in love with him. The thing is, though, I still love him a lot. My dear lost husband. Oh, how I wish he'd come home to stay.

We then discussed the questionnaire about the usefulness of the assignments. The client was asked if she considered the concepts of balance, interconnectedness, and volition – concepts that are considered to be important aspects of healing by our people – to be important components in healing. The client responded that these were important components in healing. When asked how these were important in her own healing, she responded as follows:

1) Physical component: "I started to walk a lot and I didn't feel tired all the time."

2) Spiritual component: "I looked to Christians and began to pray a lot. Also listening to gospel music and singing gospel too. I enjoy that a lot. Reading my Bible too!"

3) Mental component: "I look to what I could be in my future and try my best at new things."

4) Emotional component: "I now can cry when I'm overwhelmed because it helps. I don't stay angry at anyone or about anything for a long time anymore. I am able to talk about my anger."

5) Interconnectedness: "I talk with elders in the Christian community regarding my husband and my job. They share of their experiences and encourage me to keep going, not to give up."

6) Volition (will): I know now that I can do anything and be anything as long as I put my mind to it."

The following statement was made to the client: "Our ancestors believed strongly in a great spirit which they referred to as Kitchi Manitou. They were a spiritual people. The importance of spirituality in healing is strongly emphasized by healing professionals in the Aboriginal community today." I then asked the client if this was an important component in her own healing. Her response was, "Yes. I took the Lord as my Savior and healer. He gives me strength and guidance in my life. I fall at times but I always take Him back. Without God, I am lost. I love Him."

The client was asked if it helped in her healing to write about her painful life experiences and share of these painful life experiences and how this helped. Her response was, "Yes, because by talking about my pain I saw where my own faults were and there will always be trials in my life. By doing the assignment on circumstances that affected my development, I came to the realization that my parents loved me and were strict with me not because they were mean but because they cared about my future. It helps me understand my husband and myself. He's also got undealt things that he needs to talk about. It made me

realize we have to recognize ourselves in order to change our lives. The questions asked around my childhood abuse issues helped me to see my experiences in a different light and I was able to release my emotions. I no longer blame myself for everything."

In this session, the following assignments were given to the client who was directed to bring completed assignments to session four:

1. Readings: The lives of Aboriginal people prior to and after European contact; Culture Stress.
2. Questionnaire on Culture Stress (Appendix Q).

SESSION FOUR

In this session, the client advises she has not been consistent with self-care activities and logging due to current stressors related to her spouse. She advises she feels better when performing these activities and will work toward resuming these activities.

The client read the material on the lives of our people prior to and after European contact and culture stress. The questionnaire on this topic was done in question and answer format as follows:

1. Based on what you've learned about culture stress, do you think it has affected your life as a First Nation person?

A. Yes. The abuse I went through with older cousins, it wasn't their true beings. It was a learned behaviour and act. It's like a cycle that has to stop somewhere.

2. Does it change the way you feel toward your family members? Please explain.

A. No. Things like that happen and can't be changed. We just have to forgive and try to understand their upbringing. Forgiveness and love is what needs to be taught.

3. Does it change the way you feel toward members of your community? Please explain.

A. No. We as parents now have to come to terms to what happened to us. To make better lives for our children so that it doesn't happen to them too.

4. Does it change the way you see yourself, the way you feel about yourself? Please explain.

A. No. As long as I keep praying and have faith. Good things will come my way. God hears us and answers prayers.

5. Is this information on culture stress useful to you? Please explain.

A. I felt angry when reading the information on how our people lived before colonization. Things would have been better, easier if there had been no contact. We would have our way of life and our languages. The participant was able to get a better understanding of what our people have been through and

why things are the way they are today through reading the material on culture stress. The participant is able to see the strength of our people and feels proud that, "We never give up. We always get back up, back on our feet."

In this session, the client was given assignments to bring to the next session:

1. Reading: Think Indian (Appendix R) and feelings/thoughts when reading this article.
2. Reading: George Caitlin's Creed (Appendix S) and feelings/thoughts when reading this article.

SESSION FIVE

The readings assigned in the previous session were discussed. These readings were assigned with the intent of instilling pride in the client.

The client's response to the article "Think Indian" is, "This article sounds too prejudiced/racist for me. Like a native person talking highly, but everyone is equal – white, black, native, or oriental. We're all the same."

The client's response to George Caitlin's Creed is, "It makes me feel good about where I come from. And that believing in God is a strong belief and that I don't have to be part of a religion."

The client was assigned the following for the next session:

1. Questionnaire: Old Lifestyle vs. New Lifestyle (Appendix T).

2. Reading: Be Who You Are (Appendix U) and feelings/thoughts when reading.

3. Reading: Personal Bill of Rights (Appendix V) and feelings thoughts when reading.

SESSION SIX

The client attended this session and brought completed assignments. We went through the assignment on "Old Lifestyle vs. New Lifestyle" first. This, too, was done in question and answer format as follows:

Q. What are the benefits to you of using alcohol?

A. Well, nothing really. Everything that happens when I'm using alcohol is only short term.

Q. How would your life change if you stopped using alcohol?

A. My life would be easier and more fulfilling. Maybe my husband would come home.

Q. How would your life change if you exercised daily, got adequate rest, and ate a balanced diet?

A. I probably would get a lot done in a day and I would be healthy.

Q. How would your life change if you spent time daily with non-drinking friends?

A. I probably would have a lot of friends and have more goals in life.

Q. How would your life change if you practiced spiritual activities on a daily basis?

A. I think that things would definitely change in my life and people would see the change.

Q. How would these changes affect your self-esteem?

A. I would have a positive outlook on life and wouldn't be afraid of changes.

Q. How do you think these changes would impact the lives of your children?

A. They would learn a healthy lifestyle and believe in themselves and others. Also learn that meditation is also healthy.

Q. Are the methods used in this intervention in keeping with your desire to develop a healthier lifestyle that will better the lives of your children? Please explain.

A. Yes. I always remember that if I keep using alcohol, my children will learn it too so I try not to use alcohol a lot when I run into trouble. But yes, at times I am weak and go back to using alcohol.

The client's thoughts/feelings when reading "Be who you are":

> It makes me realize that whatever happened to us, we didn't bring it upon ourselves. They just happened so that we may see our inner strengths. Also that we are who we are and no one can change us. They may judge us but they'll never know who we really are. Also, we must accept the things that happen because we cannot go back and change them even though we would like to. It's just a part of life and to understand it.

With respect to the "Personal Bill of Rights", the client was asked if she felt comfortable applying these rights to herself. Her response was, "Yes. Things have happened in my life but I still have to love/respect myself."

In this session, the client was asked to complete the "Client Satisfaction Questionnaire" (Appendix W). In this questionnaire, the client was informed that her opinion about the service she received is important in helping the student and therapist provide the best possible service to clients. The response to this questionnaire is as follows:

1. Was the therapy helpful in providing ways for you to understand your problems better?

(a) always (b) usually (c) sometimes (d) rarely

A. (a) always

2. What has changed since you participated in this intervention?

A. I don't feel doubtful about anything, that I'm not the only one with problems.

3. What was the most helpful to you?

A. When I hated my husband. I realized that I still loved him and that I do miss him and want him home again. I learned to express myself and was able to forgive through insight gained.

4. What was the least helpful to you?

A. Not applicable.

5. Do you feel this work we have been doing has changed your level of self-esteem? Please explain.

A. Yes. My self-esteem has increased. I had a tendency to give up easily – no longer. I have more confidence. I no longer blame myself.

6. Are you interested in continuing on with the activities that were used in this intervention?

A. Yes.

7. Additional comments: The therapist is wonderful and without her help and belief in me, I can't even imagine where I'd be right now.

In this session, another meeting was scheduled in order for the client to complete the post-intervention measure.

B. SUMMARY OF THE INTERVENTION PROCESS

This method of intervention appears to be an appropriate approach in working toward increasing the self-esteem of this particular client. The sessions included a variety of information and assignments that facilitated the participant's understanding of the events that have impacted the lives of our ancestors and which, in turn, has impacted her life. As well, the client was given information on the importance of holistic healing, an Aboriginal approach to healing, and was provided with exercises/activities that motivated her to focus on all aspects of the self.

Through the utilization of questionnaires, the client was able to see the changes that she had made throughout the period of the project.

Although the project was terminated, the client will continue to attend counseling sessions with the therapist.

According to the client's feedback, this intervention was useful for her in terms of increasing her self-esteem.

CHAPTER FIVE

RESULTS AND IMPLICATIONS

This chapter discusses the evaluation process and a description of the measures utilized in this practicum. Also presented are the results of the intervention, a discussion of the findings, and implications of the intervention.

Both quantitative and qualitative evaluation procedures were completed by the participant.

A. MEASUREMENT TOOLS

Both quantitative and qualitative methods were used to measure the process and outcome of this practicum. The practicum intervention was evaluated through self-assessment tests (Burns Depression Checklist, Burns Anxiety Inventory, Burns Relationship Satisfaction Scale), reviewing of daily mood logs, daily record of activities, client-prepared work, the participant's life stories, and a client satisfaction rating scale.

A single system design was utilized to measure the progress toward treatment. A single system design permits one to draw valid inferences about factors that influence performance. The design focuses on individuals who are studied over time. According to Kazdin (1995):

> The most fundamental design requirement of single-case experimentation is the reliance on repeated observations of performance over time – on several occasions, usually before the intervention is applied, and continuously over the period while the intervention is in effect. Continuous

assessment is a basic requirement because single-case designs examine the effects of interventions on performance over time. (p. 159).

The author points out that:

The investigator is allowed to examine the pattern and stability of performance before treatment is applied and that this information, over an extended period, provides a picture of what performance is like without the intervention. When the intervention eventually is implemented, the observations are continued and the investigator can examine whether behaviour changes coincide with the intervention. The effects of a particular intervention on performance are examined. (p. 158).

Kazdin (1995) writes that:

One or two observations (e.g., pre- and post treatment assessment) are obtained. In single-case research, the effects of the intervention are examined by observing the influence of treatment and no treatment on the performance of the individual. Instead of one or two observations of several individuals, several observations are obtained for one person. Continuous assessment provides several observations over time to allow the comparisons of interest within the individual subject. (p. 159).

According to the author:

Observation of behaviour for several days before the intervention is implemented takes place in a single-case experimental design. This initial period of observation, called the baseline phase, provides information about the level of behaviour before the intervention begins. Data collected during this phase describes the existing level of performance. The descriptive function of baseline provides information about the extent of the client's problem. As well, this data serves as the basis for predicting the level of performance for the immediate future if the intervention is not provided. (p. 159).

According to Kazdin (1995), "Although the descriptive function of the baseline phase is important with respect to indicating the extent of the client's problem, from the standpoint of single-case designs, the predictive function is central" (p.159).

Kazdin (1995) further writes that, "It is important to have an idea of what performance would be like in the future without the intervention to evaluate the impact of an intervention in single-case research" (p. 159). He further points out that:

> A description of present performance does not necessarily provide a statement of what performance would be like in the future because it is possible that performance might change even without treatment and the only way to be certain of future performance without the intervention would be to continue baseline observations without implementing the intervention but that the purpose is to implement and evaluate the intervention to see if behaviour improves in some way" (p.159).

As the author points out, "The projected level of performance for baseline is toward improvement. A very strong intervention effect of treatment would be required to show clearly that treatment surpassed this projected level from baseline" (p.161). The author writes that, "It is presumed that when the intervention is implemented, a trend toward improvement in behaviour will be evident" (p. 161).

As previously indicated, the quantitative measures used in this study are the Burns Depression Checklist (BDC), the Burns Anxiety Inventory (BAI), and the Relationship Satisfaction Scale (RSAT). Given the impact of culture stress on the self-esteem of the adult survivor, these three tests were chosen as they are extremely accurate tests and can measure very small fluctuations in moods and they appear to be suitable for any population as they are in simple language and can be easily administered. This is substantiated by Burns (1993, p. 3), in

his introduction in which he writes that between 1988 and 1996, when he was acting chief for the Psychiatry Division at the Presbyterian/University of Pennsylvania Medical Centre in Philadelphia, they treated over three thousand patients. According to the author, "Most of these individuals had multiple psychiatric problems including severe depression, anxiety and personality disorders". The author states that approximately half of them were also substance abusers, many were suicidal or hallucinating at the time of admission. As well, most of them had severe social and economic problems, including unemployment, limited education, and few or no financial resources. (p. 8).

Burns (1993, p. 8) goes on to say that, "The average scores on the Burns Depression Checklist (BDC) at the time of admission were in the mid- to upper 20s. The intake scores indicated that the typical patient in our program was moderately to severely depressed, as one might expect. The author further goes on to state that "In contrast, the average depression scores for all the patients at the time of discharge ten days later were 11 or 12. Scores below 10 on the BDC are considered normal, so most patients had improved substantially and many were free of depression by the time of discharge" (p. 8).

The author admits that, "Although the patients were clearly not 'cured' in the short period of time they were in the program, the "strong burst of improvement in patients with such profound psychiatric and social difficulties was encouraging" (p. 8).

These tests were administered one week prior to the first session and one week after the final session.

1. QUANTITATIVE MEASURES

i) Burns Depression Checklist (BDC)

This self-assessment test measures feelings of sadness, discouragement, and inferiority. It was administered both pre and post therapy. This is a 15-item instrument developed by David Burns (1993). People who are depressed have a tendency to think about things negatively and this results in self-defeating behaviour. The individual experiences disengagement with or disinterest in normally enjoyable activities in life, social withdrawal, feelings of guilt, and lack of desire to live. This negative thinking impacts self-esteem. Low self-esteem and feelings of hopelessness are the worst aspects of depression.

The scoring on the BDC can range between 0 (if 0 is answered on all fifteen questions) and 45 (if 3 is answered on all fifteen questions). Higher scores indicate more severe depression. Scores between 0 and 4 are optimum. Most people in this range are quite happy and have no symptoms of depression at all. Scores from 5 to 10 are normal but could stand improvement. An individual scoring in this range is not clinically depressed but is not as happy as they would like to be. Scores above 10 indicate increasingly severe depression and may indicate the need for treatment.

ii) Burns Anxiety Inventory (BAI)

This self-assessment evaluates the symptoms of anxiety, such as worry, nervousness or feelings of panic, fears of dying, or a racing heart. This is a 33-item instrument divided into three categories: anxious feelings (items 1-6), anxious thoughts (items 7-17), and physical symptoms (items 18-33). For each symptom, it is to be indicated how strongly the feelings have been in the past few days on a scale from 'not at all' (scored 0) to 'a lot' (scored 3). Once completed, the total score is added up. The total score can range between 0 (indicating no anxiety) and 99 (the most intense anxiety). As with the BDC, low scores are the best while higher scores indicate more severe levels of anxiety.

iii) Relationship Satisfaction Scale (RSAT)

This self-assessment measures how close you feel to others. It evaluates how satisfied you feel about your relationships, in general. It can be used to evaluate a relationship with a friend, family member, or colleague. Troubled marriages, tensions in the family or with friends, and work relationships may contribute to depression and low self-esteem. As human beings, many of us base our self-esteem on being cared about and valued by others.

This is a 7-item instrument that asks about communication and openness, resolving conflicts and arguments, and the degree of affection and caring. Each item on the scale requires indicating how satisfied one has recently been feeling between 'very dissatisfied (scored 0) and 'very satisfied' (scored 6). Once completed, the total score is added up. The score will be between 0 (if answered

'very dissatisfied' for all seven relationship areas) and 42 (if answered 'very satisfied' for all seven relationship areas). A scoring key is included to interpret the score. This key is based on a statistical analysis of data Dr. Burns obtained from asking over eleven hundred individuals to take the RSAT. The RSAT does not measure how 'good' or 'adequate' any marriage or relationship is, but measures how satisfied or dissatisfied one feels in a relationship.

The above-mentioned instruments were used to keep track of changes in the participant before and after intervention.

2. QUALITATIVE MEASURES

i) Self-Report Questionnaires

These questionnaires were used throughout the study. A brief description is provided for each questionnaire.

a) Personal Goals for the Self-Esteem Intervention (Appendix E).

One of the most important keys to recovery is the willingness to help oneself (Burns, 1993, p. 29). The objective of this exercise is to possibly assist the participant in being proactive in her healing journey. It will assist her in assuming personal responsibility for taking steps to change her life.

b) Personal History Form (Appendix F).

This form asks the participant to provide background information in several areas of her life such as information about the participant's family, development, education, and employment, legal, and other medical history.

c) Questionnaire on Expectations from Participating in this Practicum (Appendix G).

This was used to keep the participant involved and focused on her goals for this practicum.

d) Questionnaire on Circumstances that Affected Participant's Development (Appendix M).

This questionnaire was based on information obtained from the personal history form. The purpose of this questionnaire was to provide an opportunity for the client to discuss how these experiences impacted her life, to share her feelings around these experiences, and to become aware that she was not to blame for the abuse that was inflicted upon her, and to come to the knowledge of how abuse is passed on from generation to generation.

e) Questionnaire on Racism (Appendix N).

The purpose of presenting this question to the participant was to allow her to express her thoughts and feelings around the issue of racism. Additionally, it was put forth to the participant to make her aware that she is not alone in this experience.

f) Experience from childhood that had a strong impact on participant's life (Appendix O).

This assignment was given so as to provide an opportunity for the participant to bring forth an experience from her past that has not been resolved and that is continuing to affect her life today.

g) Questionnaire on usefulness of assignments (Appendix P).

This self-report questionnaire was assigned in order to gain feedback on the usefulness of the material used in this intervention as well as to provide an opportunity for the participant to reflect on the assignments and determine whether they were, in fact, helpful/useful in her healing work.

h) Questionnaire on Culture Stress (Appendix Q).

This questionnaire was intended to educate the participant on the concept of culture stress in an attempt to help her gain an understanding of where the many problems our people are experiencing stem from and through this come to the realization that she, as an Aboriginal person, comes from a strong, proud race of people who have encountered and overcome numerous obstacles. It is my hope that she will take pride in who she is as an Aboriginal person and share this with her family so they too will take pride in who they are and not allow obstacles to stand in the way of their goals.

i) Questionnaire on Old Lifestyle versus New Lifestyle (Appendix T).

The purpose of this questionnaire was to provide an opportunity for the participant to reflect on her current lifestyle and compare it to a different lifestyle, now that she has implemented the techniques in this intervention. As well, to

assist the participant in determining for her own self, how these techniques would affect her self-esteem and how these changes would impact the lives of her children. The final question was put forth for the purpose of getting the client to look at this approach to see if it is in line with her goal to develop a better lifestyle that will better her life and the lives of her children.

j) Client Satisfaction Questionnaire (Appendix W)

In the final session with the participant, I administered a qualitative client satisfaction questionnaire (Appendix W). The purpose of utilizing this scale was to obtain the participant's perceptions with respect to her progress in therapy, and to provide feedback to the student/therapist as to what she found the most helpful about the therapeutic process.

ii) Daily Mood Logs

Bad feelings like depression, anxiety, guilt, hopelessness, frustration, and anger are often caused by distorted thoughts. The mood log consists of three columns with the headings: Negative Thoughts (write down upsetting thoughts), Distortions (all-or-nothing thinking, overgeneralization, mental filter, discounting the positives, magnification, emotional reasoning, "should" statements, labeling, blame), and Positive Thoughts (substitute other thoughts that are more positive and realistic).

The use of the mood log will enable the participant to become aware of negative thought patterns that may be contributing to bad feelings, to feelings of

low self-esteem. The idea is to change illogical, self-critical thoughts so as to change the way the participant feels.

iii) Daily Record of Activities

This chart records the date, eating patterns, exercise, spiritual activities, and rest patterns. At the bottom of this form is information on balance, interconnectedness, and volition that have been included to assist the participant in remembering the important aspects of healing. This form was intended to assist the participant in focusing on all aspects of her healing. This form was also intended to educate the client with respect to holistic healing and information on volition was to remind her that this is an important aspect of the self and is needed to achieve her potential.

B. QUANTITATIVE FINDINGS AND DISCUSSION

In this section, the results of the quantitative evaluation tools used in this project are presented. These findings include the results of the Burns Depression Checklist (BDC), Burns Anxiety Inventory (BAI), and Relationship Satisfaction Scale (RSAT).

The Burns Depression Checklist measures feelings of sadness, discouragement, and inferiority. A higher score indicates more severe depression. The scoring key for this scale is as follows:

Total Score	Degree of Depression
0 – 4	Minimal or no depression
5 – 10	Normal but unhappy
11 – 20	Borderline to mild depression

21 – 30	Moderate depression
31 – 45	Severe depression

The thirty-three items on the Burns Anxiety Inventory (BAI) evaluate the symptoms of anxiety, such as worry, nervousness, or feelings of panic, fears of dying, or a racing heart. Higher scores indicate more severe levels of anxiety. The scoring key for this scale is as follows:

Total Score	**Degree of anxiety**
0 – 4	Minimal or no anxiety
5 – 10	Borderline anxiety
11 – 20	Mild anxiety
21 – 30	Moderate anxiety
31 – 50	Severe anxiety
51 – 99	Extreme anxiety or panic

The 7-items on the Relationship Satisfaction Scale (RSAT) evaluates how one feels about her or his most intimate relationship. According to Burns (1993, p. 25), troubled marriages, tensions in the family, and professional relationships may contribute to feelings of low self-esteem. The scoring key for this scale is as follows:

Total Score	Level of Satisfaction	Percentage of People With Troubled Relationships Who score higher	Percentage of People With successful relationships Who score higher
0 – 10	Extremely dissatisfied	75%	100%
11 – 20	Very dissatisfied	35%	95%
21 – 25	Moderately dissatisfied	25%	90%
26 – 30	Somewhat dissatisfied	15%	75%
31 – 35	Somewhat satisfied	5%	50%
36 – 40	Moderately satisfied	1%	10%
41 – 42	Very satisfied	Less than 1%	Less than 1%

Burns (1993, pp. 25-26) provides instructions on how to use this scoring key. You use the "Total Score" figure to arrive at the results. You look in the second column entitled "Level of Satisfaction" to determine the level of satisfaction. As an example, if the total score is in the 0-10 range, the second column of the key indicates that one probably feels extremely dissatisfied with her or his relationship. The third column of the scoring key indicates that at least 75% of people with troubled marriages will score higher than this. This means that most of them feel more satisfied with their partners than the respondent. The fourth column indicates that 100% of the people with successful relationships will score higher than the respondent. The bottom line, writes the author, is that one is extremely unhappy with her or his partner. The author cautions, however, that this does not mean one necessarily has a bad relationship and the test does not say who is to blame for the difficulties. It simply means that one is exceedingly dissatisfied and that there is much room for improvement. If, on the other hand, the total score was in the 31-35 range, the second column indicates that one probably feels somewhat satisfied with her or his relationship. The third column indicates that only about 5% of people with troubled relationships will score higher. This means one feels better about her or

his relationship than 95% of the people with troubled ones. According to the author, this is good. The fourth column indicates that 50% of people with successful relationships will score higher. This means one is doing reasonably well, but there is considerable room for improvement to make one's relationship even better. The author emphasizes that the RSAT does not measure how "good" or "adequate" any marriage or relationship is. It simply measures how satisfied or dissatisfied one feels.

The participant completed the above tests one week prior to the first session and one week after the last session.

The following lists the categories and the pre and post-test responses to the Burns Depression Checklist (BDC):

CATEGORY	PRE-TEST SCORES	POST-TEST SCORES
1. **Sadness**: Do you feel sad or down in the dumps?	(3) A lot	(1) Somewhat
2. Discouragement: Does the future look hopeless?	(1) Somewhat	(1) Somewhat
3. Low self-esteem: Do you feel worthless?	(1) Somewhat	(1) Somewhat
4. Inferiority: Do you feel inadequate or inferior to others?	(1) Somewhat	(1) Somewhat
5. Guilt: Do you get self-critical and blame yourself?	(1) Somewhat	(1) Somewhat
6. Indecisiveness: Is it hard to make decisions?	(2) Moderately	(1) Somewhat
7. Irritability: Do you frequently feel angry or resentful?	(2) Moderately	(1) Somewhat
8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends?	(1) Somewhat	(0) Not at all
9. Loss of motivation: Do you have to push yourself hard to do things:	(1) Somewhat	(0) Not at all

10. Poor self-image: Do you feel old or unattractive?	(3) A lot	(2) Moderately
11. Appetite changes: Have you lost your appetite? Do you overeat or binge compulsively?	(2) Moderately	(2) Moderately
12. Sleep changes: Is it hard to get a good night's sleep? Are you excessively tired and sleeping too much?	(2) Moderately	(2) Moderately
13. Loss of sex drive: Have you lost your interest in sex?	(1) Somewhat	(1) Somewhat
14. Concerns about health: Do you worry excessively about your health?	(3) A lot	(2) Moderately
15. Suicidal impulses: Do you have thoughts that life is not worth living or think you'd be better off dead?	(1) Somewhat	(1) Somewhat

The following lists the categories and pre and post-test responses to the Burns Anxiety Inventory (BAI):

CATEGORY	PRE-TEST SCORE	POST-TEST SCORE
CATEGORY 1: ANXIOUS FEELINGS		
1. Anxiety, nervousness, worry, or fear	(3) A lot	(1) Somewhat
2. Feeling that things around you are strange or unreal	(1) Somewhat	(0) Not at all
3. Feeling detached from all or part of your body	(1) Somewhat	(0) Not at all
4. Sudden unexpected panic spells	(2) Moderately	(0) Not at all
5. Apprehension or a sense of impending doom	(2) Moderately	(1) Somewhat
6. Feeling tense, stressed, "uptight" or on edge	(3) A lot	(0) Not at all
CATEGORY 2: ANXIOUS THOUGHTS		
7. Difficulty concentrating	(1) Somewhat	(1) Somewhat
8. Racing thoughts	(2) Moderately	(1) Somewhat
9. Frightening fantasies or daydreams	(3) A lot	(1) Somewhat

10. Feeling that you're on the verge of losing control	(3) A lot	(1) Somewhat
11. Fears of cracking up or going crazy	(3) A lot	(1) Somewhat
12. Fears of fainting or passing out	(0) Not at all	(0) Not at all
13. Fears of physical illnesses/heart attacks or dying	(1) Somewhat	(1) Somewhat
14. Concerns about looking foolish or inadequate	(2) Moderately	(1) Somewhat
15. Fears of being alone, isolated, or abandoned	(3) A lot	(1) Somewhat
16. Fears of criticism or disapproval	(3) A lot	(2) Moderately
17. Fears that something terrible is about to happen	(3) A lot	(1) Somewhat
CATEGORY 3: PHYSICAL SYMPTOMS		
18. Skipping, racing, or pounding of the heart (palpitations)	(2) Moderately	(0) Not at all
19. Pain, pressure, or tightness in the chest	(2) Moderately	(0) Not at all
20. Tingling or numbness in the toes or fingers	(0) Not at all	(0) Not at all
21. Butterflies or discomfort in the stomach	(1) Somewhat	(0) Not at all
22. Constipation or diarrhea	(0) Not at all	(1) Somewhat
23. Restlessness or jumpiness	(1) Somewhat	(1) Somewhat
24. Tight, tense muscles	(2) Moderately	(1) Somewhat
25. Sweating not brought on by heat	(1) Somewhat	(0) Not at all
26. A lump in the throat	(1) Somewhat	(1) Somewhat
27. Trembling or shaking	(0) Not at all	(0) Not at all
28. Rubbery or "jelly" legs	(1) Somewhat	(0) Not at all
29. Feeling dizzy, lightheaded, or off balance	(1) Somewhat	(1) Somewhat
30. Choking or smothering sensations or difficulty breathing	(0) Not at all	(0) Not at all
31. Headaches or pains in the neck or back	(3) A lot	(1) Somewhat
32. Hot flashes or chills	(1) Somewhat	(0) Not at all

33. Feeling tired, weak, or easily exhausted	(2) Moderately	(1) Somewhat

The following lists the categories and pre and post-test responses to the Relationship Satisfaction Scale (RSAT):

CATEGORY	PRE-TEST SCORE	POST-TEST SCORE
1. Communication and openness	(0) Very dissatisfied	(1) Moderately dissatisfied
2. Resolving conflicts and arguments	(0) Very dissatisfied	(0) Very dissatisfied
3. Degree of affection and caring	(0) Very dissatisfied	(0) Very dissatisfied
4. Intimacy and closeness	(0) Very dissatisfied	(0) Very dissatisfied
5. Satisfaction with your role in the relationship	(0) Very dissatisfied	(1) Moderately dissatisfied
6. Satisfaction with the other person's role	(0) Very dissatisfied	(0) Very dissatisfied
7. Overall satisfaction with your relationship	(0) Very dissatisfied	(1) Moderately dissatisfied

The following shows the scores of the pre and post -test measures:

Measurement Scale	Pre-Test Score	Post-Test Score	Change in Score
BDC	25	17	-8
BAI	54	20	-34
RSAT	0	3	+3

The BDC pretest score of 25 indicates the participant has moderate depression. The post-test score of 17 indicates borderline to mild depression.

The BAI pre-test score of 54 indicates extreme anxiety or panic. The post-test score of 20 indicates mild anxiety.

The RSAT pre-test score of 0 indicates the participant is extremely dissatisfied in her relationship with her spouse. According to the scoring key, there are 75% of people with troubled relationships who score higher and 100% of people with successful relationships who score higher. The post-test score of 3 suggests the participant is still dissatisfied in the martial relationship but that there have been some positive changes in this relationship or perhaps that the participant has gained awareness that the problems in the marital relationship are not all of her doing.

C. QUALITATIVE FINDINGS AND DISCUSSION

In this section, the results of the qualitative evaluation tools that were used in the intervention are presented after which the findings will be discussed.

The qualitative findings of the practicum study include the results of the self-report questionnaires, readings to enhance self-esteem, readings, the daily record of activities, sharing of stories, and daily mood logs.

1. Questionnaire – Culture Stress

This questionnaire was useful to the client who was not familiar with the term "culture stress". She was able to look at herself, her community, her family, in a different light in view of their experiences. According to the participant, it gives her a sense of pride knowing she comes from a strong nation. She gained insight into the causes of her own experiences as victim and perpetrator. She was able to let go of the self-blame.

2. Questionnaire – Circumstances from childhood that affected development.

In this questionnaire, the client reports "feeling good" after completing the exercise. Although painful, it "felt good to let go of the secrets". The manner in which the questions were presented in this questionnaire helped her to understand she was not entirely to blame for the abuse that occurred in her life.

3. Questionnaire – Old Lifestyle vs. New Lifestyle

According to the client, this assignment was useful in that it helped her to see that she has a desire to quit doing those things that interfere with her desire to be a good role model for her children.

4. Questionnaire – Client Satisfaction

I was able to gather from the responses to these questions that the client benefited from the intervention. For example, the participant indicates that the therapy was "always" helpful with respect to helping her understand her problems better. The participant states that since participating in the intervention, she no longer feels "doubtful about anything" and realizes she is "not the only one with problems". According to the participant, the work done throughout the intervention period has resulted in increased self-esteem as prior to the intervention, she had a tendency to give up easily and no longer does. As well, she indicates she has more confidence and no longer blames herself for everything that happened to her. The fact that the participant wishes to continue with activities used in the intervention suggests she finds the activities helpful.

5. Readings to enhance self-esteem: Personal Bill of Rights, George Caitlin's Creed, Be Who You Are, Think Indian

All the articles provided to the client were beneficial with the exception of "Think Indian". The client indicates she felt good about herself as a First Nation person when reading the article by George Caitlin.

6. Daily Record of Activities

The client found this to be a very useful activity in that she was able to keep a record of food intake, rest period, exercise, spiritual activities. It was also motivational in that she began to walk and was eating less. Participation in these activities reduced her stress level and made her feel better about herself.

7. Daily mood logs

The client found this to be a useful activity. Being focused on her moods made a difference in her reaction to others.

8. Sharing of stories – Consisted of a childhood experience that strongly impacted the client's life and an incident on racism. These were helpful to the client in that she was able to write about these incidents and then discuss them. She was not aware that these incidents still affected her and reports she felt "better" after writing about the incidents and discussing them.

All of these assignments were intended to assist the participant in doing her healing work and thereby increasing her level of self-esteem.

Several themes identified in the literature emerged in the participant's response to the self-report questionnaires – self-blame, shame, and the need for connections.

D. IMPLICATIONS

A number of techniques were utilized in the intervention to increase the level of self-esteem of this participant. Due to this, it is difficult to focus on any particular aspect of the intervention that would have contributed to this client's increased self-esteem. It is safe to say, based on the results, that the intervention approach used in this practicum was fairly successful. This is based on the quantitative and qualitative findings.

The literature suggests that the damaging effects of culture stress to an individual's self-esteem are extensive. As the authors of the Special Report on Suicide Among Aboriginal People indicate, "People lose confidence in what they know and in their own value as human beings" (p. 25). When an individual's self-esteem is damaged in this way, it is difficult to act in her or his own best interests much less the best interests of their children. As self-esteem is increased, an individual is able to, according to Branden (1994), feel better and live better and "respond to challenges and opportunities more resourcefully and more appropriately" (p. 5).

The implications as derived from this study are as follows:

1) It is possible for survivors of culture stress to increase their level of self-esteem;

2) Increased self-esteem is essential in healing from culture stress;

3) It is possible that survivors of culture stress can increase their level of self-esteem in adulthood;

4) Community support (interconnectedness) plays an important role in the healing process;

5) A knowledge of one's culture and colonization history aids in the healing process and contributes to an increase in self-esteem;

6) The concepts of balance, interconnectedness, and volition are important components in the healing of Aboriginal people;

To summarize, self-esteem problems in Aboriginal people can be attributed to culture stress. The numerous unresolved losses incurred by Aboriginal people have resulted in the current apathetic state of many people in Aboriginal communities today.

In the following chapter, the personal learning benefits and recommendations for future intervention are discussed.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

This chapter will summarize the intervention experience and the personal learning goals, and conclude with recommendations for future intervention.

The main goal of intervention in this practicum was to apply a healing approach that would benefit the First Nation Cree woman who agreed to be a participant in this study. The focus of this intervention was on healing the damage that had been done to the self-esteem of this young woman. This young woman was able to gain awareness as to the root cause of her issues and also gained insight with respect to her role in conflictual relationships.

Although group work would have been a more appropriate form of intervention in dealing with these issues, the purpose in doing a single case study and intervention stemmed from my own awareness of trust issues in many of our communities. The participant chosen was a willing participant who is eager to do her healing work in an effort to be a positive role model for her children.

The results of the intervention indicate change and increase in self-esteem, although it is difficult to measure the amount of change. The findings in this study indicate the participant did benefit from the intervention with respect to insight, awareness, confidence, decreased shame, and pride in her culture. The participant, at the beginning of the study, was not aware of the term "culture

stress" and was not aware of the impact this has had on our people. This knowledge, alone, has instilled in the participant, a sense of pride in being an Aboriginal person, in being a member of a race of people who have undergone massive losses and have survived these experiences and many are taking steps to make changes in their lives.

Branden's (1994, p. xv) suggestion that other than disturbances whose roots are biological, many of the psychological problems such as anxiety; depression; underachievement at school or work; fear of intimacy, happiness, or success; alcohol and drug abuse; spouse battering; child molestation, co-dependency and sexual disorders, passivity and chronic aimlessness; suicide and crimes of violence are traceable, at least in part, to the problem of deficient self-esteem. In my capacity as a clinical social worker in Northern Manitoba First Nation communities, I encounter individuals with the above-mentioned problems.

The literature on self-esteem and culture stress indicates that there is a strong connection between the two. Although the intervention consisted of a single case and it worked for the purpose of this study, the group session approach would have reached many more women who are struggling with issues similar to those of the participant in this study.

A. LEARNING BENEFITS

My personal learning goals in this practicum were to examine this case in-depth and in this process learn how to do case study research. As well, I wanted

to apply healing concepts to solidify my own framework for direct practice with First Nation Cree women in First Nation Cree communities and evaluate the effectiveness of concepts that are consistent with tenets of Aboriginal theory such as understanding colonization history and the resulting culture stress, balance, interconnectedness, and volition. I wanted to obtain information which I could share with others living and working with First Nation women in Northern Manitoba First Nation communities. I believe I was able to obtain some information that could be shared with others living and working with the women in these communities. Perhaps, through provision of the information on the Aboriginal way of life prior to and after Western contact and culture stress and its impact on Aboriginal people, this will help with respect to others gaining an understanding of why things are the way they are in many Aboriginal communities. As well, it may work toward changing the negative attitude and treatment of Aboriginal people. Perhaps, instead, there will be respect.

The opportunity to work with a young Cree woman from a Northern Manitoba First Nation community was an honour for me. I admire her for her strength and her courage, for the determination to go on even when it appears there is no hope. She has been a great inspiration to me. It was a wonderful experience for me to work with a young woman who is doing her healing work so that she can break the cycle of violence in her own family. It has been an eye-opener for me, working in a small community, to see the impact of betrayal and

the resulting lack of trust and how this prevents individuals from dealing with these issues and doing their healing work and thereby perpetuating abuse in our communities.

The exercises and assignments used in this project to educate the participant in the area of culture stress and the lives of our people prior to colonialism were quite useful and provided insight and awareness to the client. The concepts of balance, interconnectedness, and volition as used in this intervention were helpful according to the participant. The exercises and assignments for the purpose of this practicum were selected after much research on material written by Aboriginal writers. As well, I took into account what assisted me in my own healing.

My hope was that the exercises and assignments would assist the participant in her healing journey and in the process elevate her self-esteem. The work assigned the client could only work toward moving her forward in her healing journey as the assignments were set up in such a way as to promote her healing in all aspects of herself. The participant could work on them at home by herself. They were tools she could use herself and this could be empowering. I gained knowledge on how to select exercises and how to score by going through this process.

A review of the literature has given me a greater knowledge and understanding of Aboriginal culture. Prior to this practicum, I had some

knowledge but not to the degree that I now have after doing the research. Researching material on the Aboriginal way of life prior to contact with the Western world not only served the purpose of providing material for this practicum but also played a part in my own healing. Research shows that Aboriginal culture had great value, that it was distinct. The positive description of our ancestors and their way of life at the time of contact instilled in me a sense of pride. I wanted to share this information with other Aboriginal people to help them to see that we have reason to take pride in our culture, that we have nothing to feel ashamed of. I wanted to share this information with non-Aboriginal people as well so as to let them know that we come from a rich heritage. This information, however, made me want to find out what happened to change this race of peoples' way of life, what happened to have created all the problems that exist in many Aboriginal communities today.

My research on colonialism and its impact on Aboriginal people – culture stress – helped me to gain knowledge and understanding in this respect. And again, I wanted to share this information with other Aboriginal people, as again, the information obtained was helpful in my own healing. My intention in sharing this information with other Aboriginal people was to help them recognize just how strong, how resilient, they are in having survived the colonization experience. In addition to this, Aboriginal people will come to the realization, the awareness, that there is a reason for the way things are today and that they are not to blame.

It is the hope that through the sharing of information on the colonization experience and culture stress that this will elevate somewhat the damaged self-esteem of those impacted by culture stress and inspire them to make changes in their lives. It is evident from the research that there is a connection between self-esteem and culture stress, that culture stress did, in fact, do extensive damage to the self-esteem of many Aboriginal people.

The literature on self-esteem shows the importance of having good self-esteem. The research indicates that self-esteem is a product of the life experiences that an individual is subjected to throughout the lifespan. It is evident from the oppressive experiences suffered by Aboriginal people that there was extensive damage done in this regard. I was able to use material from sections such as "The Aboriginal Way of Life Prior to and After European Contact", "Culture Stress", and "Generational Perpetration of Abuse" to educate the participant in these areas and based on her reaction, I will use this with other clients.

The type of intervention utilized in this study requires the participant helping themselves to heal and thereby empowering them. This particular participant was chosen due to her own desire to commit to carrying through with this project. She had shown commitment in previous endeavors. One example is when the client made the decision to further her education after being out of

school for a number of years and following through until the completion of the program.

B. RECOMMENDATIONS

There are several suggestions for future intervention using this type of approach. First of all, the number of sessions could be increased to allow more time for the participant to do assignments as due to time constraints some of the assignments were done in a rush. In spite of this, however, the participant showed her commitment to this project and toward her healing by completing all of the required assignments. I am truly amazed by this young woman. There were six sessions in total and she was able to accomplish a considerable amount of difficult work. Evidently, she is very committed to doing her healing work. Secondly, I believe that the material used in this intervention is non-threatening in that it focuses on an outside source that has contributed to the problems facing many communities. I believe it would make it easier for individuals to disclose if they are able to connect their current behaviour to their past experiences. This is not to say that the behaviours are acceptable or that they should not be accountable for their behaviours, but rather to come to the realization of where the problems stem from and take steps to make changes in their lives. Due to the magnitude of the problems in some Aboriginal communities, I believe it is necessary for this approach to be used. This intervention could, therefore, be utilized in a group setting.

There is a need for community education around the issue of culture stress. The effects are long lasting and far-reaching. This is a major factor contributing to the ongoing abuse/violence in many of our communities.

Many leaders are not ready to deal with the issues of sexual abuse and because of this, many women and children continue to suffer. Intervening with an individual who has been impacted by culture stress and seeing her growth gives me hope that healing can take place when an individual is ready to take charge of their lives.

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APPENDICES

A – W

INFORMED CONSENT

Research Project Title: Culture Stress and Its Impact on Self-Esteem

Researcher(s): Barbara J. Veilleux

Sponsor (if applicable):

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

1. A brief description of the purpose of the research:

   In the case of First Nations' people, First Nations' women, the attitudes and views of others from generation to generation has played a major role in how they view themselves. Their self-esteem is lacking to a serious degree. There is a definite need to increase the self-esteem of First Nations women so that they will be able to act in their own and their children's best interests. My intention is to engage in case study research with a First Nation Cree woman who resides in a northern Manitoba First Nation community and who comes from a background of familial alcohol abuse, violence, and sexual abuse. The proposed practicum is intended to examine this case in-depth and apply healing concepts to solidify my own framework for direct practice with First Nation women in northern Manitoba First Nation communities. This case has been pre-selected and my obligation is to come to understand this case in such a way as to be able to assist this woman in facilitating her own healing.

2. A description of the procedures involving the subject, including their nature, frequency and duration.
   There will be a total of six sessions. Each session will be 1.5 – 2.0 hours in duration. Concepts that are consistent with Aboriginal theory will be utilized in the intervention – understanding colonization history and the resulting culture stress; knowledge of culture; spiritual connection; expressing oneself; exercise, self-care; and interconnectedness. Written exercises in the form of self-assessment tests, questionnaires, daily mood logs, daily record of activities, participant's life stories, and questionnaires will be utilized.

   Provision for follow-up following termination of the project should treatment not be complete:
   I will continue to be available to work with this client in my role as a mental health

service provider for First Nations and Inuit Health Branch should treatment not be complete at the end of the project.

3. Neither the participant's name nor any identifying information will be disclosed in any written reports that result from the sessions. Records may be accessed only by the facilitator's practicum committee. All written records will be kept in a locked file and will be destroyed upon successful completion of this practicum.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

Principal researcher: Barbara J. Veilleux
Telephone: (204)669-7899
Supervisor: Eveline Milliken
Telephone: (204)668-8160

This research has been approved by the Joint-Faculty Research Ethics Board. **If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.**

_____

Participant's Signature Date

_____

Researcher and/or Delegate's Signature Date

THE BURNS DEPRESSION CHECKLIST*

Place a check ($\surd$) in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

	0 Not at All	1 Somewhat	2 Moderately	3 A Lot
1. **Sadness:** Do you feel sad or down in the dumps?				
2. **Discouragement:** Does the future look hopeless?				
3. **Low self-esteem:** Do you feel worthless?				
4. **Inferiority:** Do you feel inadequate or inferior to others?				
5. **Guilt:** Do you get self-critical and blame yourself?				
6. **Indecisiveness:** Is it hard to make decisions?				
7. **Irritability:** Do you frequently feel angry or resentful?				
8. **Loss of interest in life:** Have you lost interest in your career, hobbies, family, or friends?				
9. **Loss of motivation:** Do you have to push yourself hard to do things?				
10. **Poor self-image:** Do you feel old or unattractive?				
11. **Appetite changes:** Have you lost your appetite? Do you overeat or binge compulsively?				
12. **Sleep changes:** Is it hard to get a good night's sleep? Are you excessively tired and sleeping too much?				
13. **Loss of sex drive:** Have you lost your interest in sex?				
14. **Concerns about health:** Do you worry excessively about your health?				
15. **Suicidal impulses:** Do you have thoughts that life is not worth living or think you'd be better off dead?†				
Total score on items 1–15 $\rightarrow$				

†Anyone with suicidal urges should seek immediate help from a mental health professional.

THE BURNS ANXIETY INVENTORY*

Place a check ($\surd$) in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

Category I: Anxious Feelings	**0 Not at All**	**1 Somewhat**	**2 Moderately**	**3 A Lot**
1. Anxiety, nervousness, worry, or fear				
2. Feeling that things around you are strange or unreal				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight," or on edge				
Category II: Anxious Thoughts	**0 Not at All**	**1 Somewhat**	**2 Moderately**	**3 A Lot**
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening fantasies or daydreams				
10. Feeling that you're on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illnesses or heart attacks or dying				
14. Concerns about looking foolish or inadequate				
15. Fears of being alone, isolated, or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				

THE BURNS ANXIETY INVENTORY (Continued)

Category III: Physical Symptoms	0 Not at All	1 Somewhat	2 Moderately	3 A Lot
18. Skipping, racing, or pounding of the heart (palpitations)				
19. Pain, pressure, or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded, or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak, or easily exhausted				
Total score on items 1–33 →				

RELATIONSHIP SATISFACTION SCALE*

Place a check ($\surd$) in the box to the right of each category that best describes the amount of satisfaction you feel in your closest relationship.

	0 Very Dissatisfied	1 Moderately Dissatisfied	2 Slightly Dissatisfied	3 Neutral	4 Slightly Satisfied	5 Moderately Satisfied	6 Very Satisfied
1. Communication and openness							
2. Resolving conflicts and arguments							
3. Degree of affection and caring							
4. Intimacy and closeness							
5. Satisfaction with your role in the relationship							
6. Satisfaction with the other person's role							
7. Overall satisfaction with your relationship							
Total score on items 1–7 →							

Note: Although this test assesses your marriage or most intimate relationship, you can also use it to evaluate your relationship with a friend, family member, or colleague. If you do not have any intimate relationships at this time, you can simply think of people in general when you take the test.

PERSONAL GOALS
FOR
THE SELF-ESTEEM INTERVENTION
(David D. Burns)

Now that we have evaluated your moods and personal relationship satisfaction, let us define some of your goals. If you had a way that you could solve all of your problems, what would be on your wish list? How would your life change? Would you overcome depression? Would you develop greater self-esteem? Would you feel closer to other people? Would you become more productive and successful? Please list at least three personal goals you would like to accomplish as you participate in this intervention:

1.

_____

_____

_____.

2.

_____

_____

_____.

3.

_____

_____

_____.

Personal History Form

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns

___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs

___ Other mental health concerns (specify): _____

Family Information

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother			—	—	—	—
Father			—	—	—	—
Spouse			—	—	—	—
Children			—	—	—	—
			—	—	—	—
			—	—	—	—

Significant others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
			—	—	—	—
			—	—	—	—
			—	—	—	—
			—	—	—	—
			—	—	—	—
			—	—	—	—

Source: D.E. Wiger, "The Clinical Documentation Sourcebook", John Wiley & Sons, Inc., Toronto, 1999, pp. 267-274.

Marital Status (more than one answer may apply)

___ Single

___ Divorce in process
Length of time: _____

___ Unmarried, living together
Length of time: _____

___ Legally married
Length of time: _____

___ Separated
Length of time: _____

___ Divorced
Length of time: _____

___ Widowed
Length of time: _____

___ Annulment
Length of time: _____

Total number of marriages: ___

Assessment of current relationship (if applicable): ___ Good ___ Fair ___ Poor

Parental Information

___ Parents legally married

___ Parents have been separated

___ Parents ever divorced

___ Mother remarried: Number of times: _____

___ Father remarried: Number of times: _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? ___ Yes ___ No

If Yes, please describe: _____

Has there been history of child abuse? ___ Yes ___ No

If Yes, which type(s)? ___ Sexual ___ Physical ___Verbal

If Yes, the abuse was as a: ___ Victim ___ Perpetrator

Other childhood issues: ___ Neglect ___ Inadequate nutrition ___ Other (please specify): _____

Comments re: childhood development: _____

_____

Social Relationships

Check how you generally get along with other people: (check all that apply)

___ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often ___ Follower

___ Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn ___ Submissive

___ Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? ___ Yes ___ No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? ___ Yes ___ No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ___ Yes ___ No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ___ Moderate ___ Much

Are you affiliated with a spiritual or religious group? ___ Yes ___ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ___ Yes ___ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ___ Yes ___ No

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? ___ Yes ___ No

If Yes, please describe: _____

Past History

Traffic violations: ___ Yes ___ No DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement: ___ Yes ___ No Civil involvement: ___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: _____ Currently enrolled in school? ___ Yes ___ No

___ High school grad/GED

___ Vocational: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

___ College: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

___ Graduate: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ___ FT ___ PT ___ Temp ___ Laid-off ___ Disabled ___ Retired
___ Social Security ___ Student ___ Other (describe): _____

Military

Military experience? ___ Yes ___ No Combat experience? ___ Yes ___ No
Where: _____
Branch: _____ Discharge date: _____
Date drafted: _____ Type of discharge: _____
Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

___ AIDS
___ Alcoholism
___ Abdominal pain
___ Abortion
___ Allergies
___ Anemia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bronchitis
___ Bed wetting
___ Cancer
___ Chest pain
___ Chronic pain
___ Colds/Coughs
___ Constipation
___ Chicken Pox
___ Dental problems
___ Diabetes
___ Diarrhea
___ Dizziness
___ Drug abuse
___ Epilepsy
___ Ear infections
___ Eating problems
___ Fainting
___ Fatigue
___ Frequent urination
___ Headaches
___ Hearing problems
___ Hepatitis
___ High blood pressure
___ Kidney problems
___ Measles
___ Mononucleosis
___ Mumps
___ Menstrual pain
___ Miscarriages
___ Neurological disorders
___ Nausea
___ Nose bleeds
___ Pneumonia
___ Rheumatic Fever
___ Sexually transmitted diseases
___ Sleeping disorders
___ Sore throat
___ Scarlet Fever
___ Sinusitis
___ Small Pox
___ Stroke
___ Sexual problems
___ Tonsillitis
___ Tuberculosis
___ Toothache
___ Thyroid problems
___ Vision problems
___ Vomiting
___ Whooping cough
___ Other (describe): _____
_____

List any current health concerns: _____
List any recent health or physical changes: _____
_____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	___ / week	_____	___ No ___ Low ___ Med ___ High
Lunch	___ / week	_____	___ No ___ Low ___ Med ___ High
Dinner	___ / week	_____	___ No ___ Low ___ Med ___ High
Snacks	___ / week	_____	___ No ___ Low ___ Med ___ High

Comments: *Some days I have no appetite.*

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ___ Yes ___ No

If Yes, describe: _____

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

Family history of medical problems: _____

Pleases check if there have been any recent changes in the following:

___ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level

___ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically uses substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:

___ Addicted ___ Build confidence ___ Escape ___ Self-medication

___ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes ___ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes ___ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Does your body temperature change when you drink? ___ Yes ___ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? ___ Yes ___ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Panic attacks
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? ___ Yes ___ No

If Yes, explain: _____

What are you expecting from participating in this project?

DAILY RECORD OF ACTIVITIES

For the Period _____

Date	Eating Patterns Incl. Snacks	Exercise	Spiritual Activities	Rest Patterns (Indicate Times)

BALANCE: A focus on the physical, spiritual, mental, and emotional aspects of the self. A person who does not achieve balance will not be able to develop their full potential. Leading life in an unbalanced way leads to illness. The physical component may consist of regular exercise (daily), healthy eating patterns, and proper rest. The spiritual component may consist of prayer, spiritual music, getting in touch with nature. The mental component may consist of applying what you are learning through active effort and practice to change your life. The emotional component is allowing yourself to express your thoughts/feelings during sessions and with others.

INTERCONNECTEDNESS: We heal better with supportive people around us. Dealing with one's problems with the help of others provides an individual with acceptance and the support they need.

VOLITION/WILL: The five steps to be carried out when learning to use volition are attention and concentration, goal setting, taking action, sticking to the action (not giving up), and finishing the action. It is a force that helps people make decisions and then to carry out those decisions. It is the primary force in the development of human potential. This volition can be used to help you develop the other aspects – spiritual, mental, emotional, and physical. Each of these areas must be developed equally in a healthy, well-balanced person through the use of will power. (Sacred Tree, 1988).

Source: Barbara Veilleux, 2003

HOW TO USE THE DAILY MOOD LOG

The purpose of the Daily Mood Log is to help you overcome painful emotions such as loneliness, depression, anger, shyness, guilt, frustration, worry, and fear. There are three basic steps:

Step One: Describe the Upsetting Event. At the top of the sheet, write a brief description of the situation or problem that's bothering you. It might involve coming home to an empty house after work or having an argument with a friend.

Step Two: Record Your Negative Feelings. Identify your negative emotions and rate how intense they are, on a scale from 0% (for the least upset) to 100% (for the most upset).

Step Three: Use the Triple-Column Technique. Write down the Negative Thoughts associated with your feelings in the left-hand column. Number them consecutively. Indicate how much you believe each thought, from 0% (not at all) to 100% (completely). In the middle column identify the distortions in these thoughts, using the Distorted Thinking chart on the second page of the Daily Mood Log. In the Positive Thoughts column, substitute other thoughts that are more affirmative and realistic. Indicate how much you believe each of them, from % to 100%. Now reevaluate how much you believe each of your Negative Thoughts, from % to 100%. Finally, indicate how much better you feel by crossing out your original estimates (0% to 100%) for each negative emotion and writing new estimates.

Source: D.D. Burns, "Ten Days to Self-esteem", Harper Collins Publishers Inc., New York, 1993.

DAILY MOOD LOG*

Step One: Describe the Upsetting Event _____

_____

Step Two: Record Your Negative Feelings—and rate them from 0% (the least) to 100% (the most). Use words like *sad, anxious, angry, guilty, lonely, hopeless, frustrated,* etc.

Emotion	Rating (0%–100%)	Emotion	Rating (0%–100%)	Emotion	Rating (0%–100%)

Step Three: The Triple-Column Technique

Negative Thoughts Write down the thoughts that make you upset and estimate your belief in each one (0%–100%).	**Distortions** Use the Distorted Thinking chart on the next page.	**Positive Thoughts** Substitute more realistic thoughts and estimate your belief in each one (0%–100%).

(Continued on next page)

DAILY MOOD LOG (Continued)

Negative Thoughts	Distortions	Positive Thoughts

DISTORTED THINKING*

1. **All-or-nothing thinking:** You look at things in absolute, black-and-white categories.
2. **Overgeneralization:** You view a negative event as a never-ending pattern of defeat.
3. **Mental filter:** You dwell on the negatives and ignore the positives.
4. **Discounting the positives:** You insist that your accomplishments or positive qualities don't count.
5. **Jumping to conclusions:** You conclude things are bad without any definite evidence.
   (a) **Mind reading:** You assume people are reacting negatively to you.
   (b) **Fortune-telling:** You predict that things will turn out badly.
6. **Magnification or minimization:** You blow things way out of proportion or you shrink their importance.
7. **Emotional reasoning:** You reason from how you feel: "I feel like an idiot, so I must be one."
8. **"Should" statements:** You criticize yourself or other people with "shoulds," "shouldn'ts," "musts," "oughts," and "have-tos."
9. **Labeling:** Instead of saying, "I made a mistake," you tell yourself, "I'm a jerk" or "a loser."
10. **Blame:** You blame yourself for something you weren't entirely responsible for, or you blame other people and overlook ways that you contributed to a problem.

Each morning when you wake up, and each evening before sleeping, give thanks for the life within you, for all life, for the good things God, our Creator, has given you and others, and for the chance to grow a little more each day. Give thanks for yesterday's thoughts and actions (what you did) and for the courage (to be brave, not scared), and strength (to be strong), to be a better person. Ask for the things that will help everyone.

Source: J. Bopp, M. Bopp, M. Brown, P. Lane, *The Sacred Tree,* Four Worlds Development Project, Lethbridge, AB, 1988, p. 77.

RELAXATION TECHNIQUES

1. Close your eyes and take a few deep breaths. Hold for a few seconds and then slowly exhale.
2. Try to imagine a pleasant scene such a beach, a place in nature you go to, or to a place that exists only in your imagination – a place where you feel safe, warm, and comfortable.
3. Inhale slowly, clench your fists and count to five. Exhale and think of the world "Relax".
4. Inhale slowly, shrug your shoulders and count to five. Exhale and relax.
5. Inhale slowly, point your toes, tighten your calves, and count to five. Exhale and relax.
6. Inhale slowly, tighten your upper thigh muscles, and count to five. Exhale and relax.
7. Inhale slowly, squeeze your buttocks together and count to five. Exhale and relax.
8. Once you have completed this simple exercise, spend a few moments imagining the pleasant scene again, and gradually open your eyes.

VISUALIZATION – A PLACE OF RELAXATION, TRANQUILITY, AND SAFETY

Close your eyes and relax in a comfortable position. Imagine yourself in some beautiful natural environment. It can be anyplace that appeals to you...on an empty beach, on a mountaintop, or in the forest. It could be anywhere. Wherever it is, it should feel comfortable, pleasant, and peaceful to you. Explore your environment, noticing the visual details, the sounds and smells, any particular feelings or impressions you get about it.

Now do anything you would like to do to make the place more homelike and comfortable. You might want to build some type of house or shelter there. Perhaps just surround the whole area with a golden light of protection and safety. Create and arrange things there for your convenience and enjoyment.

From now on, this is your own personal inner sanctuary to which you can return anytime just be closing your eyes and desiring to be there. You will always find it healing and relaxing to be there.

You may find that your sanctuary spontaneously changes from time to time, or that you want to make changes and additions to it. You can be very creative in your sanctuary and have a lot of fun there. Just remember to retain the primary qualities of peacefulness, tranquility, and a feeling of absolute safety.

Source: S. Gawain, *Creative Visualization: Use the power of your imagination to create what you want in your life*, New World Library, San Rafael, CA, 1995.

SELF-CARE FOR INTENSE FEELINGS

Doing the exercises/assignments requested for the purpose of this practicum report may bring up strong feelings. When you are not used to experiencing your feelings, you may feel overwhelmed when this occurs. You may find it difficult to think at such times. The following is a sample list of things you may do to comfort yourself, to calm down.

1. Take a few long, slow, deep breaths.
2. Make a cup of herbal tea for yourself.
3. Curl up in a warm, cozy blanket.
4. Take a warm bath.
5. Put a cool washcloth on your face or forehead.
6. Listen to music (spiritual/classical/relaxation tape/CD).
7. Hold a soft cushion or stuffed animal such as a teddy bear.
8. Exercise.
9. Call someone you can trust.
10. Pray – Talk to God, our Creator, about how you are feeling.

Source: L. Davis, *The Courage to Heal Workbook: For Women and Men Survivors of Child Sexual Abuse,* Harper and Row, Publishers Inc., New York, 1990, p. 67.

Questionnaire – Circumstances That Affected Development

1. Under the section "Development" in the Personal History Form, you indicate that there were special, unusual, or traumatic circumstances that affected your development. You describe these as "having to keep your siblings" and "sexual abuse". You indicate that there has been a history of child abuse – sexual, physical, and verbal – both as a victim and a perpetrator. Another childhood issue is that of neglect. Please share your story of the sexual abuse (form of sexual abuse – fondling, anal/oral sex, sexual intercourse, etc.). At what age did the sexual abuse begin and end? How old was the perpetrator? What was the gender of the perpetrator? How did the abuse impact your life? How did it impact your self-esteem? You may add other comments.

2. You indicate that there is a history of being a sexual perpetrator when you were 10 years of age. Please share your story. What form of sexual abuse? In looking back at this, why do you think you performed the sexual acts? How did this impact your life? Your self-esteem? You may add other comments.

3. Please share your story about having to take care of your siblings. How old were you when you began taking care of them and up until what age? Why were you responsible for taking care of them? Where were your parents? How did this impact your life? How has it impacted your role as a parent today? How did it affect your self-esteem? You may add other comments.

4. Please share your story about the physical abuse. When did it begin and end, who inflicted the abuse? How did this impact your life? How did it affect your self-esteem? You may add other comments.

5. Please share your story about the verbal abuse. When did it begin and end? Who inflicted this form of abuse on you? How did this impact your life? How has it affected your self-esteem? You may add other comments.

6. Please share your story about neglect – give some examples of instances when you felt you were neglected. How did this impact your life, your self-esteem. You may add other comments.

7. How did the forms of abuse inflicted upon you affect your role as a wife? Your role as a mother?

8. What role, if any, has the abuse had on your use of alcohol?

Source: Barbara Veilleux, 2003

As an Aboriginal person, have you ever experienced racism? Please give an example(s) and how it made you feel.

Source: Barbara Veilleux, 2003

Please share an experience from childhood/adolescence that has strongly impacted your life:

Source: Barbara Veilleux, 2003

QUESTIONNAIRE ASSIGNMENTS

1. Please indicate if the following home assignments were helpful to you:

Daily Record of Activities ___ Yes ___ No

Please explain:

_____

_____

_____

_____.

Daily Mood Log ___ Yes ___ No

Please explain:

_____

_____

_____

_____.

Relaxation techniques ___ Yes ___ No

Please explain:

_____

_____

_____

_____.

2. The concepts of balance (physical, spiritual, emotional, mental aspects of the self), interconnectedness (connecting with supportive people in your community), and volition are considered to be important aspects of healing by our people. Do you agree that these are important components in healing?
___ Yes ___ No

3. How are these important in your own healing?

Physical component:

_____

_____

Spiritual component:

Mental component:

Emotional component:

Interconnectedness (connecting with supportive people in your community):

Volition (will):

4. Our ancestors believed strongly in a great spirit that they referred to as Kitchi Manitou. They were a spiritual people. The importance of spirituality in healing is strongly emphasized by healing professionals in the First Nation community today. Is this an important component in your own healing? Please explain.

5. Has it helped you in your healing to share of your painful life experiences? Please explain how this has helped.

Source: Barbara Veilleux, 2003

1. Based on what you've learned about culture stress, do you think it has affected your life as a First Nation person? ___ Yes ___ No
If yes, how has it affected your life?

_____

_____

_____

_____

_____.

2. Does it change the way you feel toward your family members? Please explain.

_____

_____

_____

_____.

3. Does it change the way you feel toward members of your community? Please explain.

_____

_____

_____

_____.

4. Does it change the way you see yourself, the way you feel about yourself? Please explain.

_____

_____

_____

_____

_____.

5. Is this information on culture stress useful to you? Please explain.

_____

_____

_____

_____

_____.

Source: Barbara Veilleux, 2003

THINK INDIAN

by Big White Owl

1. "Think Indian," and you will always be respectful, courteous, friendly, helpful, to your fellow man.
2. "Think Indian," and you will always be grateful and proud of your [Native] ancestry.
3. "Think Indian," and you will never be wasteful; you will never pollute and destroy.
4. "Think Indian," and you will never take part in thoughtless, indiscriminate, senseless vandalism.
5. "Think Indian," and you will learn how to respect, and how to love, our mother, the good earth.
6. "Think Indian," and you will always be a good conservationist.
7. "Think Indian," and you will never need to use the White Man's mind-destroying drugs.
8. "Think Indian," and you will better understand what our forefathers meant, when they said: "Drink not too excessively of the white man's fire-water for it can turn a good man into a whimpering fool."
9. "Think Indian," and you will realize that life is good and beautiful; that there is life even in the rocks and stones; that there is life in the earth, around the earth, and beyond the earth; that the Creator of All Life is "Kitchi Manitou" - The Great Spirit.
10. "Think Indian," and you will help to preserve, and to retain, our own native religion and heritage.
11. "Think Indian," and you will revitalize your inner spirit, and you will learn how to walk on your own, and how to do things for yourself.
12. "Think Indian," and you will be better able to commune with nature, and nature will commune with you in return.
13. "Think Indian," and you will be helping to build a new kind of unity, brotherhood, progress, peace, among our people - the Native people of Canada.

I HAVE SPOKEN!

(Big White Owl (Jasper Hill) lives in Keswick, Ontario. He is a Delaware (Lenni Lenape) Indian.)

GEORGE CAITLIN'S CREED ABOUT INDIANS:

~I love a people who have always made me welcome to the best they had.
~I love a people who are honest without laws, who have no jails and no poorhouses.
~I love a people who keep the commandments without ever having read them or heard them preached from a pulpit.
~I love a people who never swear, who never take the name of God in vain.
~I love a people who love their neighbours as they love themselves.
~I love a people who worship God without a Bible, for I believe that God loves them also.
~I love a people whose religion is all the same, and who are free from religious animosities [do not fight over religion].
~I love a people who never raised a hand against me, or stolen my property, where there was no law to punish for either.
~I love a people who never fought a battle with white men, except on their own ground.
~I love and do not fear mankind where God has made and left them, for they are His children.
~I love a people who live and keep what is their own without locks and keys.
~I love a people who do the best they can.
~And oh, how I love a people who do not live for the love of money.

Source: W.E. Rosenfelt, *The Last Buffalo*, T. S. Denison & Company Inc., Minneapolis, 1973, p. 66.

[OUR ANCESTORS LIVED BY THEIR SPIRITUAL BELIEFS. THEY RESPECTED THEMSELVES AND, IN TURN, RESPECTED OTHERS.]

Questionnaire – Old Lifestyle vs. New Lifestyle

1. What are the benefits to you of using alcohol?

2. How would your life change if you stopped using alcohol?

3. How would your life change if you exercised daily, got adequate rest, ate a balanced diet?

4. How would your life change if you spent time daily with non-drinking friends?

5. How would your life change if you practiced spiritual activities on a daily basis?

6. How would these changes affect your self-esteem?

7. How do you think these changes would impact the lives of your children?

8. Are the methods used in this intervention in keeping with your desire to develop a healthier lifestyle that will better the lives of your children?
___ Yes ___ No

Please explain:

Source: Barbara Veilleux, 2003

BE WHO YOU ARE

When I meet people or get in a new relationship, I start putting all these repressive restrictions on myself. I can't have my feelings, can't have my wants and needs, can't have my history, can't do the things I want, feel the feelings I'm feeling or say what I need to say. I turn into this repressed, perfectionistic robot, instead of being who I am - ME.

--Annonymous

Sometimes, our instinctive reaction to being in a new situation is: DON't BE YOURSELF.

Who else can we be? Who else would you want to be? We don't need to be anyone else.

The greatest gift we can bring to any relationship wherever we go is being who we are.

We may think others won't like us. We may be afraid that if we just relax and be ourselves, the other person will go away or shame us. We may worry about what the other person will think.

But when we relax and accept ourselves, people often feel much better being around us than when we are rigig and repressed. We're fun to be around.

If others don't appreciate us, do we really want to be around them? Do we need to let the opinions of others control us and our behaviour?

Giving ourselves permission to be who we are can have a healing influence on our relationships. The tone relaxes. We relax. The other person relaxes. Then everybody feels a little less shame, because they have learned the truth. Who we are is all we can be, all we're meant to be, and it's enough. It's fine. Our opinion of ourselves is truly all that matters. And we can give ourselves all the approval we want and need.

Today, I will relax and be who I am in my relationships. I will do this not in a demeaning or inappropriate way, but in a way that shows I accept myself and value who I am. Help me, God, let go of my fears about being myself.

Source: UnKnown

PERSONAL BILL OF RIGHTS

As we begin to feel better about ourselves, as our self-esteem increases, we begin to understand that as human beings, we have certain rights. When an individual's self-esteem has been impacted by childhood abuse, it may be difficult for that individual to believe she has rights. It is important for us to acknowledge that we have these rights.

1. I have the right to peace, love, and joy in my life.
2. I have the right to make choices, to make decisions.
3. I have the right to dignity and respect.
4. I have the right to say "no" without feeling guilty.
5. I have the right to make mistakes.
6. I have the right to change my mind.
7. I have the right to relax and take care of myself.
8. I have the right to my feelings (fear, guilt, shame) and then to let go of these feelings.
9. I have the right to disagree with others and not feel guilty.
10. I have the right to withhold personal information.
11. I have the right to grieve my losses.
12. I have the right to feel anger and express it in an appropriate manner.
13. I have a right to give and receive unconditional love.
14. I have the right to develop and to grow in all aspects – spiritually, physically, emotionally, and mentally.

Source: L. Loewen, MSW Practicum, 1997.

CLIENT SATISFACTION QUESTIONNAIRE

Your opinion about the service you received is important in helping the student and therapist provide the best possible service to clients. Please comment in the space provided or circle the answer that best describes your opinion.

1. Was the therapy helpful in providing ways for you to understand your problems better?

   (a) always (b) usually (c) sometimes (d) rarely

2. What has changed since you participated in this intervention?

   _____
   _____
   _____
   _____.

3. What was the most helpful to you?

   _____
   _____
   _____
   _____.

4. What was the least helpful to you?

   _____
   _____
   _____
   _____.

5. Do you feel this work we have been doing has changed your level of self-esteem. Please explain.

   _____
   _____
   _____
   _____.

6. Are you interested in continuing on with the activities used in this intervention? ___ Yes ___ No

7. Any additional comments:

   _____
   _____
   _____
   _____.

Source: Barbara Veilleux, 2003