SEXUAL ABUSE VICTIMIZATION AND NATIVE HEALING

A Review of The Literature

A Working Paper for the Mook'am Project,
Native Child and Family Services

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INTRODUCTION

This paper results from a selective literature review on Native treatment programs. As well, a summary of recent reviews of the impacts of sexual abuse victimization is presented.

The purpose in writing the paper is to develop a series of practical principles to aid the design and evaluation of the Mook'am Sexual Abuse Program, at Native Child and Family Services of Toronto.

Although several references surfaced through a computerized library search, many were difficult to access. They appeared in small (sometimes Native) journals in distant parts of North America. In some cases, unpublished program descriptions were reviewed.

A wide net on the topic of "healing" was cast, including information on the larger social, cultural and organizational context of healing programs and relationships. We felt this was necessary for three reasons. First, we believe that the success of healing depends on factors beyond the actual direct healing process, including the respective roles of healer and client, the available resources and the working relationships with other helping agencies. Secondly, the broad healing perspective reflects the holistic perspective endorsed by Native people themselves, and is consistent with the "ecological" and "system" perspectives in social work and other helping practices.

A third reason for not allowing a narrow conceptual approach limit the literature review has to do with the early development stage of Native services. Given the thrust towards Native self-sufficiency in services, there is a need for broad and thorough documentation of relevant material.

This paper is organized into two broad sections. Part A examines literature on Native healing and healing programs. Part B reviews literature on sexual abuse victimization. In Part A the literature findings are organized into six broad categories: assumptions about illness, the context of Native healing, establishing a helping relationship, assessment, techniques, and implementing Native healing methods.

PART A: NATIVE HEALING

BASIC ASSUMPTIONS ABOUT ILLNESS

All healing or helping methods reflect the social and cultural setting in which they are developed and applied. Part of this setting or context is the set of beliefs concerning health, well-being and illness. Unlike European and most North American scientific medicine which separates mind and body, Native and traditional medicine make these distinctions less sharply, viewing physical illness as "misbehaviour of the body". Illness may be an appropriate reaction to the conditions of life. The person in his/her total milieu is assessed and helped.

Lesley Malloch, a Native women, examines the differences between Indian and non-Indian illness (1989). She first identifies several fundamental Native beliefs about health and sickness:

Good health is a gift from the Creator

Good health is a balance of physical, mental, emotional,
and spiritual elements

All elements interact to form a strong healthy person

When we become sick, it is usually because we are out of balance in some way...either physically, emotionally, spiritually, or mentally

Sickness can also be the result of something that someone has done to us

Clearly, these beliefs place Native healing close to what is termed today as "holistic medicine". Malloch's other ideas about Native beliefs concerning sickness and healing are reviewed in a later section.

Mental Health and The Conditions Facing Native People: Ethnostress, Anomic Depression, and Implications for Healing

Native and non-Native clinicians working closely with Native people take the position that problems such as alcohol abuse, sexual abuse victimization, and other forms of family violence should not be treated in isolation from general quality of life difficulties. This suggests that treatment for specific clinical problems will benefit from a thorough knowledge of societal conditions facing Natives in general and their impact on well-being. Again this reflects a holistic perspective.

Native people and specialists in Native well-being and illness link many Native clinical physical and mental health problems to their place in North American society. Words like "oppression" and "cultural disintegration" are used frequently to describe the plight of Natives. Efforts are made to link these socio-cultural states to individual symptoms.

Two concepts, "ethnostress" and "anomic depression" have been used in recent literature, both of which describe societal conditions affecting Native people and their effects.

Ethnostress

Ethnostress is a core concept in a book entitled Power Within People, written by three Native people. The book is primarily a community development handbook, but is useful for its lengthy discussion of ethnostress. This concept has strong implications for the place of cultural components in the Native healing process. It is a perspective that addresses needs which are related to the general situation of Native people.

The authors argue that the suicide, alcohol abuse, family breakdown and other abuses of aboriginal people in North America are symptomatic of the underlying problem of ethnostress. The characteristics of ethnostress all refer to the Native person's self-image and sense of place in the world. It is the disruption of the cultural beliefs and joyful identity of a people, and includes feelings of powerlessness and hopelessness that can affect the life of the individual, family, community and even a nation.
The oppression of Native people in North American society exists through several institutions and practices. The reserve system robbed Native people of their independence and self-determination. Indian residential schools punished children for using their language and culture, took them away from their families and communities, and in some instances subjected them to physical and sexual abuse.

These institutional arrangements for Native people, combined with forced involvement in non-Native ways of life, as well as negative messages about Indians in the media, all produced disastrous consequences for individuals, families, and whole communities. To name a few:

.Community conditions, to this day, do not promote an identification with a valued social network

.Many Native communities have not developed a community consciousness, based on shared values and beliefs; this has undermined the development of activities and acceptable practices for meeting such basic needs as the psychological sense of safety and belonging.

.Many Native families have been ravaged and disorganized by unemployment, alcohol abuse, violence and neglect. It is instructive that a recent study in six Native communities in York Region and Simcoe County identified "rebuilding the family unit" as the number one priority.

.Native people have limited choices for meeting their needs and realizing a life of quality

.Many Native people have been confused about their selves and their existence

As a result of these, and other conditions, in the past many Native people have expressed a negative self-identity as Native people, and have lost faith in their own values and institutions. As well, as a result of inappropriate socialization experiences within the family, peer group and community at large, many have developed inappropriate survival or coping patterns, such as alcohol or drug abuse. Out of hurtful experiences, many have developed beliefs or behaviors which continue the victimization of themselves and others.

The implications of this discussion for Native victims of sexual or physical abuse, or indeed for the perpetrators, is that healing must address the larger context of oppression. This acknowledges that abuse and its effects are part and parcel of larger issues affecting the thinking, attitudes and behavior of the victim. To quote Native writers on the elements of the healing process:

."We need to seriously focus our attention... on how we mimic and internalize oppressive behaviors"

."We need to learn how to distinguish the oppressive patterns from the supportive ones. We need to understand how we oppress ourselves and others. We need to re-evaluate our currently held beliefs and behaviors"

."As a major part of the healing process we need to re-evaluate our thinking and feelings about the cultures we were born to. We must break the narrow pattern th----------eople, 1986, Pg.52)

Anomic Depression

Certain types of Native mental illness have been referred to as anomic depression (Topper and Curtis, 1987; Jilek, 1982). Like "ethnostress", this illness emerges from the particular conditions faced by Natives, and requires unique healing approaches which are sensitive to these conditions. Also like ethnostress, anomic depression is a relatively new idea which requires more research to understand it fully.

"Anomie" is a sociological concept referring to a societal situation in which groups of people are blocked from achieving goals which are held out for all people in a particular society.
Native people, for example, may seek economic success, but are blocked because of insufficient economic development or culturally appropriate training opportunities. Achieving traditional economic goals may be blocked by laws limiting traditional hunting and fishing activities.

Sociologists say that anomic conditions foster certain adaptive behaviors, including illegitimate ways of achieving these goals, other forms of deviance such as alcohol abuse, and passive withdrawal through mental illness.

Jilek may have been the first person to use the anomic depression concept for describing Indian mental illness (1982). It is characterized by existential frustration, discouragement, feelings of defeat, low self-esteem, and sometimes moral disorientation.

Linking anomic depression to the place of Native people in society, the author proposes that the following psychodynamics produce this condition:

.acculturation attempts through western education

.attempts at white identification

.experience of rejection, discrimination, and deprivation in white society

.cultural identity confusion

.moral disorientation, often resulting in acting out behavior

.guilt and depression over the denial of Indianness

(Jilek, 1982, pg.55)

Topper and Curtis, in a later study of Native mental illness, added new ideas to the concept (1987). For them, anomic depression is a form of depression which grows out of an inability to achieve success within Native or non-Native society. The frustration due to this inability leads to depression and deviant behavior. Those experiencing anomic depression are angry about their deprivation and economic helplessness. As well, they develop adaptive patterns which perpetuate dependency on others, and anger towards self, household members and the community for allowing this dependency.

The primary clinical diagnostic characteristics include depression, hostility, accompanied by feelings of inadequacy and hopelessness. Periods of depression may also be accompanied by drinking and/or violent sexual acting out. Thus patients may appear in severe intoxication or alcohol/drug withdrawal, medical complications accompanying suicide attempts, and deep depression. Also, patients in treatment may display hostility and resistance to treatment which is manifest in anger towards adults, rejection of authority, and suspiciousness towards the therapist. Therapeutic efforts to confront the dependency patterns in the relationship may result in the patient leaving therapy.

* * *

There are several implications for this discussion of the healing process. First, in all likelihood, the difficulties presented by Native people seeking help for such things as sexual abuse victimization may be interrelated with larger issues related to "being Native". Healing success will be more likely when the therapist keeps an open mind concerning past events and current forces impinging on the lives of victims.

A second related implication is that treatment success for matters such as sexual abuse will be affected by other forces in the victim's life. A comprehensive treatment program, perhaps including skill development opportunities, is likely indicated. Evaluation of treatment success must take these into account. Even so, problem-specific treatment may not produce dramatic results. Matters such as low self esteem and depression are likely the

result of a hodge-podge of factors.

Thirdly, the discussions of anomic depression and ethnostress both suggest that troubled Native people have in all likelihood developed dysfunctional adaptive or coping behaviors. Since these are typically not the kinds of responses that build and sustain relationships, it is likely that Native clients may lack natural support relationships during and after the healing process. This suggests that healing must build the natural skills and attitudes for creating these natural supports.

THE SOCIO-CULTURAL AND ORGANIZATIONAL CONTEXT OF NATIVE HEALING

Beliefs concerning health and illness

Current Native healing programs and practices are legitimized by a system of traditional beliefs which contrast with western medical beliefs. In modern society, these contrasts are not as sharp, particularly in the growing field of holistic medicine. Nevertheless, they are useful to note, since many traditional beliefs are the foundation of Native healing.

Malloch summarizes the differences (1989):

.Traditional Indian medicine emphasizes an integrated, holistic approach to health: body, mind and spirit interact to form a person. Western medicine takes an analytical approach, separating body, mind and spirit. There is a total split between religion and medicine.

.Indian medicine places emphasis on sickness prevention, whereas western medical practitioners emphasize disease and treatment.

.Traditional Indian culture emphasizes personal responsibility for health and sickness; western medicine takes an impersonal, scientific approach.

.Indian culture understands health and sickness in terms of the laws of nature; western culture understands health and sickness in terms of quantifiable scientific data.

.Indian culture emphasizes that people should live in balance with nature. Therefore traditional medicine is governed by the laws of Creation, such that everything needed comes from the Earth: food, medicine, water, education, religion, and laws. Western culture adopts the view that people should control nature for their interests and benefits.

.Traditional medicine men are accountable to the Creator, the people, and to the Elders of their medicine societies. Western doctors are accountable to the government and to their medical associations.

.Indian people believe that medicine is not for sale, that it is a gift to be shared. In comparison, western medicine (socialized medicine notwithstanding) is a business. Patients are consumers.

.In traditional Indian culture, the land and the people support the medical healer. In comparison, the government, the taxpayer, and the consumer support western medical practice.

Many Native people hold that their beliefs concerning health, illness and healing encourage self-sufficiency, self-care, responsibility and control.

Community Context: Legitimation

The healing process often depends on the smooth co-ordination and co-operation of many programs or agencies. This becomes particularly challenging in cases of innovative programs with techniques which may at best be unknown to the professional community at large, and at worst may be received with some scepticism.

The status and credibility of culturally sensitive programs to outside agencies and professionals affects their ultimate success. This may particularly hold true in the case of acceptance of assessments and evaluations in referral circumstances (Khan,1988).

Current research on innovative Native social service organizations suggest that, by and large, main stream agencies accept the philosophy and concept of Native self-determination in the service field. However, one case study revealed that working relationships were strained when specific details of programs were unknown, and when follow-up arrangements were not followed (Maidman, 1988). Such stresses tended to weaken the credibility of the Native organization.

The Physical Setting

Because Native clients may have grown up on reserves, outdoor or other natural settings may promote more verbal and responsive participation (Edwards and Edwards, 1980). This reflects a familiarity and comfort with such settings. As well, the natural environment, according to Native traditional thinking, is a source of care and healing.

Participants in Treatment

Native traditional treatments may involve more persons than the patient, including the family and the whole community (Haycox, 1980). In some cases the issue of confidentiality may not be important. Native clients have been known to bring friends or relatives along to treatment meetings without previous arrangements with the therapist.

Resource persons other than the "healer" may also be involved, such as singers of special songs (Haycox, 1980) and cultural teachers.

The Client Role

The Native client should assume as much responsibility as possible for the activities, discussions, and decision-making in the helping relationship. The history of Native-white relationships has created severe mistrust of those in authority, particularly whites. Also, as indicated earlier, Native people traditionally expect to take more responsibility for their well-being.

"Social workers should move slowly, identify problems and procedures clearly, make commitments regarding situations in which they have control, follow through consistently, and use client strengths appropriately in order to establish feelings of trust and establish professional relationships" (Edwards and Edwards, 1980).

The Structure of Healing Services

The organization of service should take into account the culturally appropriate behavior of the client group. This may mean, for example, that therapy scheduling could be more flexible than those in non-Native treatment settings.

Examples of flexible therapy schedules

.Therapy starts when the patient turns up.

.Therapy accommodates additional persons who unexpectedly show up. (eg. extended family members).

.Therapy ends when the client has a sense of completion.

The challenge here is to distinguish between culturally appropriate behavior and behavior which is symptomatic or perhaps adaptive to the oppressive conditions of Native people. Also, some imagination will be required to adapt helping techniques to Native ways. For example, there may be difficulties in adapting group therapy methods to the flexibility of Native ways.

Socio-cultural expectations

Indian people are being taught to value themselves, their families, clans and tribes, and to adhere to distinctive values. Social workers should consider the values of each specific tribe (Edwards and Edwards, 1980), and be prepared to discuss matters of cultural concern.

In rather subtle ways, non-Native techniques may not be culturally appropriate for Native healing.For example, introspection and self-evaluations may be difficult for some. Some may find it difficult to talk about themselves. Some traditions dictate that exaggeration should be avoided, use of name, "I", etc. Indian clients may expect

to be understood without having to discuss their concerns in detail (Edwards and Edwards, 1980). Native clients may block or show discomfort when the demands of treatment directly conflict with cultural norms or behaviors. The worker should try to help the client verbalize these conflicts, thus freeing the client to participate in counselling. Also, the client may welcome feedback on the ways he/she is behaving according to cultural values (eg. independent self-help) (Edwards and Edwards, 1980).

Certain values (eg. individuality) may inhibit the discussion of the problems of other family members during sessions. Social workers can help by discussing their understanding, and the conflict caused (Edwards and Edwards, 1980).

ESTABLISHING A HELPING RELATIONSHIP

Establishing a relationship with a client is an important task in the professional helping process, and has been given wide coverage in the social work literature. The main assumption is that factors other than the main treatment approach may affect progress with the client. For example, clients and therapists may come from different socio-economic or cultural backgrounds, or the client may not know what to expect in treatment, or indeed may have different ideas about seeking help. For whatever reason, clients may distrust helpers, may experience stress, or may resist help.

Because of the mistrust of non-Natives, a substantial time commitment may be required to establish a professional relationship between a Native client and non-Indian staff. Helping Indian clients obtain services desired, as they see it, helps the development of a relationship. (Edwards and Edwards, 1980)

As indicated earlier, non-Native staff must acknowledge that client/staff perception of reality, based on different belief systems, may be at odds. One study showed how one young patient's behavior, encouraged by his grand-father (eg. day-dreaming, telling wild stories), was not accepted by clinical staff.

Staff should also recognize that socio-linguistic differences may exist between staff and clients, affecting verbal and non-verbal communication. For some Native cultural groups, the area around the eyes is a behaviorally expressive region. Talk is modified by widening or crinkling of the skin around the eyes.

Eye contact may sometimes cause uneasiness. Staff should develop a technique of looking elsewhere, or developing an activity or game where talking does not require eye contact (Edwards and Edwards).

The expectation for participation may be different for different cultural groups. This may create difficulties for securing attention within group therapy. Certain behaviors may falsely be taken as inattention.

The technical aspects of treatment may be based on behavioral expectations which are at odds with Native culture. Talk therapy and psychoanalytical models of ----------omote interaction with Native clients, particularly if the worker can make fun of his/her own actions and work. (Edwards and Edwards, 1980).

The social worker can help build the relationship by assuming a role which is appropriate to the cultural values and beliefs concerning the helping process (Edwards and Edwards). For example, should the culture emphasize individuality and self-help, the worker should identify his/her role as "sounding board", while helping the client develop his own plans for working through the conflicts involved.

The assumptions behind the healing process, and the accompanying expectations for the healer may be different for the Native client and the non-Native therapist. The influence of the tradition healer derives from his/her membership in the community, "a connectedness between a spiritual healing power, the healer, and the community". Healing involves the healers struggle to channel healing to the community, an effort that does not remove the healer from everyday life. What this means for the healer/client role relationship is that the client may try to involve the healer in his/her daily life.

ASSESSMENT

Assessment instruments should be selected to reflect how the cultural group actually thinks about symptoms. Instruments need to select highly valued areas of function. Various types of mental illness have surfaced in studies of how people themselves describe their illnesses, eg. "deep worry", "loss of mind", "spiritual death", "drunken-like craziness in the absence of alcohol". (McShane, 1987)

Cause of illness may be attributed in different ways. One study showed that the Ojibway notion of sickness emerged out of the person's or the parent's "bad conduct". (McShane, 1987;
Johnson et al, 1988). Service plans should be negotiated which address the patients concerns. (Johnson, 1988)

When the therapist concludes that the problem is experienced by the patient in cultural terms, and when the patient agrees to a traditional approach, the assistance of a traditional healer may be arranged. (Kahn, 1988)

Behavior taken as clinical evidence of symptomatic behavior
may be quite normal within Native culture. For example, the soft hand-shake ("passing hands") was taken as symptomatic of psychomotor retardation by a non-Native Psychiatrist. Firm hand-shakes are taken as aggression by Ojibways.

Information-gathering for assessment purposes might learn from the guidelines established for culturally-sensitive research (Rogler, 1989). For example, extreme sensitivity is required to the possible inappropriateness of concepts to the Native culture. What are the meanings to Native clients of terms like "abuse", "self-esteem",
"protect", etc. Avoid what has been termed the "category fallacy", the application of terms developed in one cultural context, without checking out its validity for another cultural group.

Also, it may be useful to incorporate terms and concepts in the assessment process which are cultural in reference (eg. "acculturation").

Language differences are known to present difficulties in the assessment and treatment process.Where relevant, Native language
speaking persons could be used for assessment interviewing.

To assure meaning equivalence between languages, a method called "back-tracking" could be used. A bilingual person could translate from the source language of assessment questions to the client's language. Another bilingual person then translates back to the source language. The comparisons are made between the original material and the back-translated material. Any discrepancies are used as the focal point for changes and adaptations in the two languages.

The assessment interviewer must also be sensitive to possible cultural factors affecting the way people answer assessment questions, or the way people behave in assessment situations. For example, Native people may find the behavior or experiences implied in certain questions to be more or less socially desirable, (Rogler,1989, Pg.299), in ways unrelated to mental health. In other words, clients may answer in certain ways because they think they should.

One way of developing a culturally appropriate assessment instrument is to ask a group of Native people what could go wrong in Native minds or spirits after sexual abuse. Following a reply, one question after another could determine the behavioral, affective and cognitive dimensions of the illness; the perceived causation of the illness; the differences between the different types of illnesses, and the reasons for these differences. (For other details on how this process was used to develop an American Indian Depression Schedule, see Rogler, 1989, pg. 300; and Manson, "The Depressive Experience in American Indian Communities: A Challenge for Psychiatric Theory and Diagnosis", in A. Kleinman, Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder , 1985.)

Assessment questions should also ask about the degree of affiliation and identification with Indian culture, and any conflicts between minority and majority cultural values. (Edwards and Edwards; Topper and Curtis, 1987). For example, the concept of dual means-goals disjunction refers to the anomic situation where Natives may be exposed to differing cultural goals, based on exposure to traditional and industrialized values and goals, coupled with blocked means to achieve these goals. This concept draws from Merton's formulation and is advanced by Jileck, and Topper and Curtis. The clinical presentation of "synergistic dual anomic depression" involves depressed mood, hostility, feelings of inadequacy and hopelessness. Depressed moods may be accompanied by drinking and/or violent sexual acting out. (Topper and Curtis)

TECHNIQUES

The Sweat Lodge

The sweat lodge is a frequently used traditional method for assuring well-being in Native communities and Native service organizations. With its physical and spiritual aspects, it is a source of both spiritual and bodily cleansing. The sweat lodge combines sweating and relaxation, prayer, cultural learning, closeness with others, and reflection. Participants smoke the Sacred Pipe and drink cedar water. It is usually organized and provided by a Native healer or cultural teacher.

Troubled, unhappy or abused Native people experience a disturbance in their harmonious selves. How the sweat lodge helps to restore this harmony, is best conveyed in the following quotation from a Native elder:

"We seek to return to wholeness by our purification of body, mind, heart, and spirit. We seek to restore healing to our brokenness. This is accomplished by restoring our relationships with our Creator, ourselves, our fellow human beings and all of creation. We do this with prayer, song, and spirit power within the lodge. Finally, by crawling out of the lodge we experience a newness of life. Washing with cold water invigorates us and invites us to begin to live again in a new way."

(Eva Solomon, "The Sweat Lodge: Purification Ritual", M'Nowa Djimowin, Winter, 1988.)

To promote health and well-being, the sweat lodge functions as both an illness prevention and therapeutic activity. Participation in the sweat lodge contributes to:

.relaxation and physical health

.cultural awareness and spiritual learning

.the development of social and emotional ties with others

.revitalization

Group Methods

Group influence is an important traditional approach for solving problems. For this reason, serious consideration should be given to the therapeutic potential of using group methods. These should incorporate traditional culture as a clinical variable, including such things as role modelling, apprenticeship training, and group consensus re: dealing with stresses of life and the dominant culture (Edwards, E. and M. Edwards, 1980; LaFromboise and Rowe, 1983)

Concrete, skills-oriented, self-help approaches have been found to be useful in therapy (Ashby et al, 1987), and in training (Maidman, 1989). Those working with groups should be sensitive to the potential for divisions between Indian cultural groups. This may be a factor working against group cohesiveness.

Intervention strategies and skills with groups

Group leaders working with Native clients should provide positive reinforcement on an individual basis at first, thus avoiding the embarrassment of praise in front of the group (Edwards and Edwards, 1980). Alcoholism-related treatment should be task-centred, and proceed with extreme sensitivity (Edwards and Edwards, 1980).

Groups should focus on increasing positive feelings about being Indian, such as discussions and activities related to traditional and modern day life; historical, cultural, and present day concerns (Edwards and Edwards, 1980)

Multi-Component Treatment Models

Many Native treatment programs use multi-component treatment models, perhaps reflecting the holistic perspective on understanding and healing. Native alcohol programs like Pedahbun Lodge in Toronto provide alcohol counselling, life skills training, cultural awareness, and groups. Many have strong Native medicine components such as the use of sweet grass, pipe ceremonies, sweat lodges and the like.

Ashby and her colleagues (1987) describe such a group treatment approach for working with Native sexual abuse victims. This program is described in detail because of its richness of therapeutic elements, and its incorporation of cultural components.

The program begins with a pre-treatment ethnographic interview designed to gain information about respondents perceptions concerning difficulties in their lives and how they have coped. The

interview builds trust and empathy between interviewer and interviewee, and creates motivation to attend and participate.

Participation in traditional arts and free art expression is another important part of this program. These are included to promote identification with the Native cultural heritage. Therapeutic objectives aim to (i) increase pride in culture (ii) remove reticence about group participation, and (iii) enhance self-esteem through completed tasks (Ashby,1987).

Program participants also share a meal, an important traditional gesture of acceptance and solidarity among individuals.

Didactic exercises such as values clarification, information giving (eg. a film about incest) and skills building (giving compliments, eliminating self-criticism) are also included.

The Talking Circle

Finally, the talking circle is an important Native group therapy technique used in many Native communities across North America. It is structured to allow participants an opportunity for free expression of opinions and feelings affecting themselves and others. The authors describe the circle:

" Participants gather and begin the circle with ritual greetings. An eagle feather is used as a strong spiritual and therapeutic means to aid identification with traditional culture. The feather signifies strength and truth and is a powerful agent of healing. A participant leader is designated to begin the circle by picking up the eagle feather and disclosing feelings and concerns that set the topic for the rest of the group. When she so chooses, the designated leader passes the feather in a clockwise manner to the participant next to her who may speak or choose to remain silent and pass the feather on. When the feather has been passed to all participants, it is laid in the centre of the circle to be picked up in turn by those wishing to speak further. When all who want to speak are finished, the circle is ended with a ritual closing. Disclosures made in the closed circle are held in strictest confidence." (Ashby et al, 1987, Pgs.27-28)

This program is a good example of how a Native treatment program focuses on the four traditional elements of the person: the spiritual, the psychological (cognitive), feelings, and physical.
Further, the program blends traditional and non-Native helping technologies, and demonstrates once again how community ceremony is an important emotional component.

The Use of Culture-Specific Techniques

Efforts should be made to help clients understand the social intervention process, and, based on cultural differences, modify procedures when beneficial to the client (Edwards and Edwards, 1980).

The behavioral norms of the Native culture should be learned and introduced into communications as needed. For example, in one tribe it was forbidden to speak a dead relative's name. This tradition could be followed in therapy. Where such behaviors are not known, cultural teachers should be consulted (Edwards and Edwards, 1980).

Some traditional techniques, such as the singing of special songs, are quite specialized in their focus, often responding to changes in the patient's life (Haycox, 1980).

Increasing Indian adolescent girls involvement in cultural activities enhances self-esteem. Many studies show the desirability of incorporating traditional Indian activities in treatment approaches. (Edwards and Edwards, 1978; Edwards, Edwards, Gain and Eddy, 1978)

Extended Family Participation in Treatment

Following traditional helping practices, the participation of the extended family in the healing process is widely supported by Native organizations across Canada and the United States. For example, building on the principle of strengthening the natural sources of community support, Ojibway Tribal Family Services' family support model requires staff to involve relatives in child care, crisis support, and teaching young parents (Maidman, 1988).

The Urban Indian Child Resource Centre in Oakland California provides a unique and effective approach to the treatment of child abuse and neglect in Native American communities (Metcalf, 1979). The model views the problems of abuse and neglect as resulting from social processes originating outside the individual, and occurring because of institutional pressures from Anglo society on Native cultural systems. The solution follows traditions and tribal patterns, that of reconstituting families. Treatment goals are linked to interdependency, that of pulling people together into mutually reinforcing social networks. The agency works in an urban setting providing services to strengthen extended families, and create surrogate ----------
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---The traditional Navajo healing approach saw the medicine man treating the individual in a ceremonial context in which extended family members were secondary patients. The healing process was quite direct and authoritative, with the medicine man providing specific directives to the wider family for changing behavior and affective relationships. Culturally, the Navaho people were reluctant to express feelings in group situations, except in ceremonial situations with close friends and relatives.

The authors' extended family therapy approach builds on this pattern. The therapist focuses on the individual patient primarily, either in regular one-to-one sessions or in larger family meetings. Whereas individual meetings are regularly structured, extended family sessions are episodic, following the traditional ceremonial pattern. The therapists' style models the medicine man's authoritative role in the sense of providing directives for changing relationships, such that support for individual growth in therapy is provided. The therapist tries to respond to the existential and development needs of the individual and the family, as defined by them.

A second extended family approach is well detailed in an unpublished paper entitled "Dealing With Sexual Abuse in a Traditional Manner". Written by an Indian Psychologist (Oates, 1988) as a discussion paper, this is a step-by-step approach building on traditional community support methods.

The method is grounded in several assumptions which are clearly delineated. For example, it is assumed that the damage caused by sexual victimization of children can be minimized if handled by the community in a caring and healing, rather than punitive manner. As well, the author states that sexual abuse combines a disorder of power, a need for dominance, an expression of aggression, and inappropriate sexual arousal. There is a suggested association between sexual abuse and the systematic denial of power and responsibility of the native male through European contact.

The method aims to deal with the problem of sexual abuse in a culturally appropriate manner, and in the process heals the entire community. Although the primary focus is shifted from the victim and the spouse to the offender, all family members receive support and healing.

Eighteen steps are described. These are summarized as follows:

1.Disclosure to a trained sexual abuse co-ordinator who assumes responsibility for the remaining steps.

2.Confronting the offender concerning (i) the disclosure by the victim (ii) that the victim has been relocated to a place of safety, and (iii) alerting the offender to the next steps. A support person is assigned to the alleged perpetrator.

3.Protecting the child, through quick removal by the Co-ordinator or an Elder, to a safe place. Depending on family and community dynamics, this is preferably within the extended family or the clan.

4.Aiding the Non-Perpetrating Spouse. A respected person is assigned as a supportive ally to guard against suicide, and violence, and provide non-threatening, non-judgemental support.

5.Adult Ally For the Victim. A sympathetic, non-offending relative that will provide a place to stay, protection and psychological support.

6.Validation Process in which community representatives (eg. Co-ordinator, Elders, adult ally) verify the allegation and begin to establish an appropriate context for healing.

7.Decision to Proceed or Not to Proceed in which three possibilities are considered: (i) no reasonable grounds for the alleged abuse (ii) charges are valid, and should be dealt with by the Native community, or (iii) the charges are true and so serious that they must be dealt with by the non-Native, off-reserve authorities

8.Preparation of the Offender in which the offender is informed of the community's decision, requested to admit the offence and to accept treatment, and informed/prepared for the next steps in the community treatment process.

9.Extended Family Gathering in which relatives, clan members or other community representatives meet with the perpetrator. Steps #10-13 occur in one meeting, #14-17 in another.

10.Ceremonial Opening in which the event is signified as important in a distinctly Native way, including drum, song and prayer.

11. The Declaration of Purpose and Explanation of Offence, in which the Sexual Abuse Co-ordinator or community leader explains the purpose of the meeting, giving emphasis to such things as (i) details of offence (ii) planning a community-based healing process (iii) showing support to all parties (iv) affirming that the behavior is unacceptable (v) learning about sexual abuse in general (v) establishing arrangements for monitoring treatment plans.

12. Offender Accepts Procedure and Validity of Charges in which the offender hears and agrees to the charges, and expresses willingness to participate in the proceedings. If not, the matter is turned over to off-reserve authorities.

13. Educational Process in which a Native staff worker educates the parties involved and the all community participants on the nature, dynamics and dangers of sexual abuse.

14. Offender Verbally Accepts Full Responsibility for His/Her Actions in which the perpetrator openly admits to the offence
without rationalizations, justifications, or reservations.

15. Extended Family Speaks to the Accused, the heart of the traditional process. All people speak openly about such things as their feelings about the offence, suggestions for dealing with the problem, encouragement to accept responsibility, the non-perpetrating spouses responsibility in the offence and in healing, non-responsibility of the victim, community support, and their own personal experiences with sexual abuse.

16. The Family Reaches Solutions Through a Consensus Process
in which the community considers a broad variety of solutions having at least three components: punishment which builds self-esteem, protection against further abuse, and treatment for all members of affected family. The treatment plan is selected by consensus. The community is involved in the treatment process.

17. The Accused Publically Apologizes to the Extended Family and to the Victim, and Agrees to the Group's Solution

18. Ceremonial Closure in which ceremonial activities (eg. drum, song, traditional prayer, Christian prayer) is determined by group leadership.

19. Cleansing Ceremony after the treatment process, which varies from tribe to tribe. May include public cleansing, feast, or sharing of gifts. Of particular importance is that the offender label is removed from the perpetrator for life, thus breaking the stereotyping process.

Learning Lodges and Spirit Camps

Native healing programs often take place in natural outdoor settings, combining healing activities with traditional economic, cultural and recreational activities. In many instances, troubled Native children and youth are given the opportunity to interact on a daily basis with Elders and other community members. These programs have been variously referred to as Learning Centres or Lodges, and Spirit Camps.

One such program which is currently under development is the Pow Wow Island Learning Centre. This is a youth/elder traditional learning centre to be located on Pow Wow Island (Lake of the Woods), Rat Portage Reserve. Addressing the problems of Native youth (eg. gas sniffing), the proposed centre will function primarily as a meeting place where Elders will share their wisdom concerning Native cultural heritage, environmental skills and knowledge, preparing for work, and health. As well, the location, facilities and atmosphere will be used for recreation, reflection and healing.

The proposed learning centre will have a secondary purpose. It is deemed an ideal location for a family retreat for family education and rebuilding family strengths, both of which are important for the learning and development of youth.

Finally, the centre will be available to social service and other community groups for the purpose of reflection, learning and mutual support. All of these processes are deemed important to Native helpers who face the challenges and stress of supporting youth and families on a daily basis.

The healing emphasis in the centre is one of building health and well-being through positive learning experiences around culture, life skills and knowledge, and Native rights. It is anticipated that the experiences, the atmosphere and relationships will provide an important context for healing. Those with problems will benefit from such things as...

.learning a positive identity based on Native culture

.being treated as normal individuals rather than "clients" with problems

.learning from, and helping to teach others, in an atmosphere of caring, acceptance and strength

.living, playing and learning in a semi-isolated relaxed atmosphere which is conducive to growth

Any specific problems requiring individual or group counselling will be handled by Elders in their traditional helping roles, or by the staff members of Ojibway Tribal Family Services (Kenora/Dryden).

Further details on the needs, philosophy and activities of this centre can be found, with permission of the planning group, in the planning paper "Pow Wow Island Learning Centre" (Maidman, 1990).

The concept of blending traditional learning and healing in an outdoor setting has also been used to help recovering alcoholics. One model is the Alaska Recovery Camp (Hampton, and others, n.d.). This program stresses that the alcoholism recovery process requires incorporating traditional activities and subsistence with treatment activities. This model is deemed particularly useful in rural communities where contemporary forms of alcohol abuse treatment have not worked.

The program model assumes that alcohol addiction is a process which separates individuals from their "true" selves. This concept of alcoholism is best conveyed through the words of another author. Reflecting about the "alcoholic self", Norman Denzin writes:

> "Every alcoholic I observed drank to escape an inner emptiness of self...The self-other experiences, the self-ideals, and the ideal selves that the alcoholic pursues are largely imaginary and out of touch with the world of the real. Alcohol sustains these imaginary ideals ... Intense preoccupations with self shut the alcoholic off from the world of normal interaction with others (The Alcoholic Self, 1987, Pg.21)"

Through a lengthy spirit camp experience Native alcoholics learn who they are and where they came from. As well, they learn to hope and trust, persist and not give up. Of particular importance, the recovery camp activities can be replicated in the community context.

Program activities include traditional subsistence activities (eg. building a dog sled, drying meat), cultural activities such as bead-work, recreation (story-telling, swimming), and healing. The program's central healing activities are talking circles, sweat lodges, and experiential counselling.

The healing goal of helping individuals get in touch with their true selves is achieved through both program activities and counselling. The structure and expectations surrounding camp activities reinforce Native spirituality by encouraging individuals to be responsible to their true selves, others in the program, Nature, and the Higher Power.

In experiential counselling, the major healing ingredient is the basic human connection between people through an open honest sharing of experiences. Counsellors, too, are encouraged to adopt unique counselling styles which are consistent within their inner selves.

Finally, the spirit camp embodies an important social process which promotes collective healing and a sense of community. This socio-therapeutic emphasis on the "system as a whole" helps to create relationships and sensitivities which are transferable to the home community.

Spirit Dancing

The final traditional healing practice reviewed is spirit dancing. Spirit dancing is a shamanistic ceremony practised by the Coast Salish Indians of Western Canada. It was recently documented and analyzed for its therapeutic dynamics and effects by Wolfgang Jilek, a Psychiatrist (1982).

The practice of spirit dancing is associated with the Salish belief that one's health and well-being are sustained by Guardian Spirits. This belief is typical of the general acceptance of a connection between spirituality and physical or mental health. Further, the beliefs concerning guardian spirits are linked to the roles and practices of Shamans in Salish culture. With the help of Shamans, the winter spirit dance helps participants acquire spirits, and therefore power, vitality and strength for the winter season.

In addition to its "preventative" use, spirit dancing is also used therapeutically for the cure of "spirit illness" or, in the authors terminology, "anomic depression" (see above section). Anomic depression is described as resembling neurotic depression in western cultures, and is characterized by such symptoms as melancholia, singing and hollering during sleep, hallucinatory or delusional perceptions, and a perceived lack of air. The psychodynamics producing this physical and mental state are related to the stresses of being Native in North American society; these are described in the earlier section on anomic depression.

Full details on the Native beliefs concerning the therapeutic affects of spirit dancing (sya'wan theory of death and rebirth) and the accompanying ceremonials will not be described fully. A core part of the beliefs is the myth of death and re-birth, in which the ill person or the spirit dancing initiate, symbolically dies and is reborn to a new life. The healers' activities (eg. simulated clubbing) remove the vestiges of the dancer's "old self" (including ailments and conflicts), and help him move towards a new potential for change, towards the path to Indian traditions through the teachings of the Elders.

The author's analysis is that three major therapeutic processes of change are at work i---------- An altered state of consciousness is induced through physical means (eg. bodily seizure, grabbing, physical restraint, tickling, kinetic stimulation, mock clubbing to death, acoustic stimulation through drumming). All of these activities are administered by two teams of eight workers, supervised by a senior "ritualist".

Through all of this the individual is expected to show signs (eg. a song) of an altered state of consciousness, and will experience a vision which is typically associated with the presence or acquisition of a guardian spirit.

The physical training goes hand-in-hand with indoctrination, and aims to strengthen the new self ("baby"). Physical training typically consists of running, swimming, and dancing to the fast rhythms of drums. Total exhaustion and an altered state of consciousness is frequently induced. Neurophysiological research confirms the altered states of consciousness effects of rhythmic drumming.

The final therapeutic component, indoctrination, occurs throughout the process. This basically is a didactic socialization process in which the initiate learns traditional culture and appropriate rules for living. The learning process includes verbal direct teachings from ceremonial speakers and senior ritualists, and non-verbal observation. Appropriate rules of conduct are reinforced and socially controlled by other participants in a dramatic communal atmosphere.

The content of this indoctrination process includes rules and sanctions of the sacred lore and beliefs of sya'wan. Appropriate rules of behavior are also taught, including rules for menstruating women, ways of talking, eating and drinking, and the sense of personal responsibility towards Elders and others. The prohibition of drugs and alcohol is taught and reinforced. The potential results of breaking the rules (eg. illness) are also taught.

The entire process ends with a disrobing process in which the "new-born baby" is given a first bath by spirit dance participants.

RESOURCES

The use of natural human resources (eg.relatives, friends, and elders) has generally been found useful in some Native communities. Many innovative Native programs are designed to strengthen these resources. However, certain forces (eg. alcohol abuse, death, migration/acculturation, lure of foster care payments, etc.) have resulted in deterioration of positive family and social support systems.

Culturally-sanctioned healers (eg. medicine men) can be encouraged to relate to clients in more or less traditional ways. However, a few factors should be taken into account:

.Few such persons may be available; they may have to be recruited from outside the community

.Some acculturated clients may not believe in such traditional healers, making traditional healing difficult in group situations.

.Traditional healing dynamics may be difficult to document and evaluate, and/or documentation may be resisted by the healers as non-traditional. The worth of traditional healing is based on customary acceptance or faith, not on rational scientific evidence.

"When you do believe, you will be cured. I feel that how well the medicine man's treatment works depends on how much belief you have" (Khan, 1988)

.The legitimacy of traditional healing may not be accepted by dominant health system. Traditional healers have a different approach to reality, believing in subjective rather than objective knowledge. (McShane, 1987)

The use of Native staff is assumed to help Native clients cope with a potentially alienating non-Native setting. A number of difficulties have been experienced, though:

.Native staff who are acceptable to "professional authorities" may be well-educated and acculturated, and inappropriate to Native clients, and may become isolated from their own communities.

.Native-oriented programs often take place in larger non-Native contexts. Adjustments to non-Native contexts may be painful to Native staff.

IMPLEMENTING NATIVE HEALING METHODS

Joan Weibel-Orlando (1989) wrote a useful article which, although generally critical of an unquestioned support of indigenous healing, nevertheless provides useful implementation advise for developers of traditional healing programs.

She argues that traditional methods are effective only in groups which adhere to traditional social and cultural life. Success will be determined by the match between the level of acculturation of the individual and the level of traditionalism of the strategy. (Dozier, 1966)

One longitudinal study found that those who initially benefitted from indigenous healing, whether from medicine men, herbs or peyote, nevertheless regressed to their alcoholic ways at later times (Weibel-Orlando, 1889).

Thorough follow-up or evaluation has rarely been done after program involvement. Imaginative post-treatment social supports, particular for the abusers of alcohol and drugs, have rarely been implemented after program participation.

The author emphasizes the importance of understanding the personal and motivational, interpersonal and dynamic, socio-cultural and psychosocial dimensions of the relationship between the healer and the healed, and his/her context, which either promote or inhibit program goals. Her comments concerning successful programs are useful. Of 50 Indian substance abuse programs observed since 1978, the viable ones had the following characteristics:

.the programs were self-generated rather than imposed from without

.there were officiating or orienting charismatic role model initiators, including shamans, tribal leaders who had experienced alcoholism

.all involved the recovering clients in on-going therapy with the group as clients and healers

.all saw themselves as a social entity, a community structure alternative to the drinking culture

The notion of the healing community is a good place to start. Those who heal were once themselves being healed. Continuous healing service to the community keeps oneself balanced, healthy and healed. This is a contemporary version of village medicine sodalities.

PART B: SEXUAL ABUSE IMPACT ON VICTIMS

Sexual Abuse Impact on Victims: Recent Literature

Browne and Finkelhor completed an extensive review of research literature on the effects of sexual abuse (1986). Using two criteria for sexual abuse, (i) forced sexual behavior that is imposed on a child, or (ii) sexual behavior between a child and a much older person or a person in a care-taking role, they distinguished between "initial" (within two years of abuse termination) and "long-term effects".

Unfortunately, Finkelhor's review does not highlight differences in impact in various ethnic, minority or cultural groups. Therefore, we have no way of knowing whether these findings hold true for Native victims.

Short-term effects

The authors general appraisal of the research literature is that although some support for clinical observations does exist, the lack of standardized measurements and comparison groups make most conclusions quite sketchy.

Emotional reactions and self-perceptions

In general, empirical studies support clinical observations that sexually abused children suffer negative emotional effects. However, most studies lack standardized measures for comparing results to the general population or other clinical populations.

In summary, the emotional effects are:

.fear.anger and hostility

.guilt and shame, including guilt over the disclosure

.low self-esteem, although reported in clinical observations and some research, has not been confirmed in reputable studies with standardized measures.

Physical consequences and somatic complaints

Anxiety-related physical symptoms are noted in both clinical and research literature. These include...

.sleep disturbances

.changes in eating habits

.adolescent pregnancy (inconclusive)

Effects on sexuality

.two studies confirm inappropriate sexual behavior such as having had sexual relations at an early age, public masturbation, excessive sexual curiosity, frequent exposure of genitals

Social functioning

.difficulties at school and truancy

.running away from home

.early marriages by adolescents

Long-Term Effects Of Sexual Abuse

Emotional reactions and self-perceptions

The empirical research literature, including excellent community surveys, is consistent with clinical observations that sexually abused victims will show the long-term effect of depression, often with hospitalization. As well, depressed victims are more likely to have attempted suicide or have suicidal thoughts or want to hurt themselves. In at least one study, this depressive reaction held true even when other family stresses were not present.

Somatic disturbances and dissociation

The presence of anxiety in sexual abuse victims has been widely confirmed in studies of adults abused as children. Such symptoms include anxiety attacks, nightmares, sleeping difficulties, nervousness and eating disorder (anorexia and bulimia). These studies include college studies as well as community random samples.

One study reports that adult victims are more likely to report feelings of dissociation, spaciousness, out of body experiences and the feeling that things seem unreal. Dissociation is an hypothesized strategy for initially escaping the abuse experience which later becomes a regular part of everyday experience.

Self-esteem

Sexual abuse victims continue to feel isolated and stigmatized as adults. Also, the widespread clinical observation of low self-esteem is confirmed in empirical research. Such feelings of low self-esteem appear to grow over time, since studies of immediate consequences are inclusive on this matter.

Impact on interpersonal relating

Women who have been sexually abused as children report a variety of interpersonal problems, including:

.difficulty in relating to both men and women

.conflicts with their parents, including hostile feelings towards their mothers

.hostility towards the abuser

.contemptuous feelings towards all women, including themselves

.difficulty trusting others: fear, hostility, sense of betrayal, fear of men and women, difficulty in close relationships (incest victims), conflict with or fears of husbands or sex partners, never having married.

.vulnerability to being revictimized: rape, abuse by husbands or other adult partners.

Parenting difficulties

Mothers in child abusing families report previous sexual abuse. One explanation is that such mothers sexualize closeness and affection and maintain distance. Such an environment is conducive to abuse, but should not be considered a primary cause.

Effects on sexuality

Only clinically-based studies are available. The findings are that...

.incest victims report problems with sexual adjustment (eg. sexually anxious, sexual guilt, dissatisfaction, decreased sexual drive, inability to enjoy, avoidance, compulsive desire).

.inconsistent evidence of differences in sexual self-esteem

.victims seeking therapy report fewer orgasms, are less sexually responsive, less sexually satisfied, less satisfied with quality of relationships with men, and report more sex partners.

.victims describe themselves as promiscuous (possibly resulting from low self-esteem), but do not show significantly different behavior.

.no observed effect on homosexual preferences

Social functioning

Studies of special populations show a connection between sexual abuse and prostitution. One study found that although this pattern was not true, prostitutes' previous victimization started earlier, and was more likely to involve physical force.

Studies also show a connection to substance abuse. Those in college populations showed no such pattern.

Effects of Different Types of Abuse

Clinicians argue that certain other factors will increase the severity of the trauma associated with sexual abuse: length of time, penetration, non-supportive reaction by parents, accompanying aggression, age of victim/awareness of cultural taboos, participation by child, and close relationship of perpetrator.
Few empirical studies have delved into these.

Impact of Sexual Abuse: Assessment

Contrary to those arguing that the traumatic impact of sexual abuse has been overstated, the authors conclude that...

.as evidence accumulates, there is a clear suggestion that sexual abuse is a serious mental health problem

.findings of long-term impact are particularly persuasive, showing that although impairments are not necessarily severe, all but one study has documented some impact.

.all four studies employing multivariate analysis, found impairment after other background factors were controlled

The Trauma of Sexual Abuse

Recent writings on the impact of sexual abuse draw attention to the factors "surrounding" the abusive events and their contributions to clinical problems (Finkelhor, 1986). These factors (eg. transmission of confused messages about sexuality) point to family processes, but perhaps also could describe other surrounding contexts, like the community or residential school. The following scheme for understanding traumagenic factors is presented in considerable detail since it has enormous implications for assessment and treatment.

Finkelhor argues that the dynamics surrounding sexual abuse can be analyzed in four broad categories: traumatic sexualization, stigmatization, betrayal, powerlessness. Each of these are described below.

Traumatic sexualization is the process of shaping the child's sexuality, both feelings and attitudes, in a developmentally inap----------
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----------nsmission of confusion and misconceptions about sexual behavior and morality

.frightening memories and events are associated in the victim's mind with sexual activity

Traumatic sexualization may vary according to whether the child is actively or passively involved in sexual responses, is enticed or brutally forced to comply, is made fearful or not. As well, traumatic sexualization may vary according to the child's level of understanding sexuality.

If traumatically sexualizing dynamics are present, the child may develop inappropriate kinds of sexual behavior, confusions and misconceptions about sexual self concepts, and unusual emotional associations with sexual behavior.

The victim's sense of betrayal emerges from the discovery that someone on whom the child is dependent, and perhaps trusts, has caused harm. The harm comes from...

.lies or misrepresentations about moral standards

.treatment with callous disregard

.receiving no protection from a non-perpetrating family member

The victim's sense of betrayal may depend on how tricked the child feels, and the family's response upon disclosure.

Victims may develop a pervading sense of powerlessness when their will, desires, and feelings of efficacy are continually undermined or opposed. This happens ...

.when a child's territory or body space are invaded against the child's will

.through the use of coercion and manipulation

.when the victim is frustrated in his or her efforts to halt the abuse

.when the child feels fear, but cannot make adults understand

.when victims feel trapped in a state of dependency

It is proposed that a sense of powerlessness is brought about in situations where the perpetrator is authoritarian and is threatening serious harm.

Finally, processes of stigmatization result in the victim incorporating self images of badness, shame and guilt. These negative ideas about self are communicated through...

.abusers who denigrate, blame and shame

.pressures for secrecy, leading to a sense of guilt

.attitudes expressed in the community, and messages about the victim

.people's reaction after disclosure

These processes may be affected by the victim's prior knowledge and understanding of sexual deviance and sexual taboos.

Each of the above traumatizing dynamics....traumatic sexualization, stigmatization, betrayal, and powerlessness.... have different types of psychological impact and behavioral impact. These are discussed and summarized in Finkelhor's book (Chapter 6).

One last word. The above traumatizing dynamics occur in other types of victimization and interpersonal violence, other than sexual abuse. However, Finkelhor proposes that they appear to cluster together in instances of sexual abuse.

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