A New Awakening

Evaluation of The Mooka'am Program

APPENDICES

Frank Maidman, Ph.D
June 1992
Table of Contents

Appendix "A"The Mooka'am Program Model

Appendix "B"Participants in Community and Cultural Consultation

Appendix "C"Mooka'am Program Development: Literature Review

Appendix "D"The Client Study

Appendix "E"The Healing Circle

Appendix "A"

The Mooka'am Program Model

NATIVE CHILD AND FAMILY SERVICES OF TORONTO

THE MOOKA'AM SEXUAL ABUSE PROJECT

A Developing Program Model

Frank Maidman, Ph.D

November 4, 1991

TABLE OF CONTENTS

1.INTRODUCTION

This document provides a program description of the Mooka'am Sexual Abuse Program. The program, offered by Native Child and Family Services of Toronto, is an innovative experimental approach for responding to the needs of Native adult and child sexual abuse victims and their families. The aim is to evolve a comprehensive program which is culturally appropriate and sensitive to the needs of Native people.

The ideas in this document summarize a model in the process of development. They are preliminary ideas, to be revised as the project unfolds and the program is evaluated. The elements of the draft model are based on early treatment experiences, literature reviews, consultations with Native elders, staff discussions, consultations with other programs in Toronto, and on-going evaluation.

These ideas will be assessed, refined and elaborated throughout the remaining months of the program impact phase of evaluation.

The following sections include a problem definition, target persons, treatment issues, program goals and objectives, general program principles, program format, the helping situation, and techniques. Finally, preliminary thoughts are presented on the appropriate organizational support.

2. PROBLEM DEFINITION

Mooka'am's program philosophy and specific treatment model responds to the general limitations of present mainstream service agencies in their efforts to serve Native clients, as well as the specific difficulties of treating Native sexual abuse victims.

The Mooka'am Program originally began in response to three problems:

.the increase in the number of known sexual abuse cases from the Native community; consultations with other local Native programs indicate that 80% of case load clients have experienced sexual abuse.

.the impact of sexual abuse on the victims and their families

.the lack of Native sexual abuse programs

Numerous cases were referred to Native Child and Family Services involving incidence of sexual abuse for both children and adult women. Native people were not using mainstream agencies for treatment because of cultural differences, insensitivity, the historical relationships with social workers, and a lack of trust.

Sexual Abuse: Definition and Assumed Causes

In the Mooka'am Program, sexual abuse is regarded as a sexual activity imposed upon a victim by an adult or older adolescent who has violated a position of trust, authority, or a care-taker role. The authority and power enable the offender, implicitly or directly, to coerce the victim into sexual compliance and secrecy.

The activities of sexual abuse may be successful and unsuccessful attempts at: exposure; genital fondling; breast fondling; oral genital contact; digital penetration; masturbation; inappropriate kissing; and/or vaginal or anal intercourse as perceived by the victims. Other forms of sexual abuse may include: child pornography; verbal threats of abuse; inappropriate observation of adult sexual activity and inappropriate observation of the victim.

Sexual abuse is regarded as a form of violence, including physical, emotional, psychological, and spiritual abuse. Prior to contact with European society, Native communities were largely abuse-free. The major cause of Native sexual

abuse is seen as colonization, and all the repercussions that followed. Some of these repercussions were:

.the breakdown in cultural norms, roles, rules, and responsibilities (eg. breakdown of clan system)

.residential schools which ran rampant with sexual abuse by those in authority, leaving at least two generations without proper role modelling in parenting

.various governmental policies, such as the Indian Act which often robbed Native people of their pride and dignity

.the foster care system which placed many Native children in white homes which were culturally different, and which provided opportunities for abuse

.Native adoptions in which Native children were adopted out all over the world

.urbanization which has led to isolation, lack of extended family support, and further breakdown of cultural values and norms

.the penal system with its extraordinary high percentage of Native people

These historical and structural factors have led to internalized anger, loss of control and the erosion of dignity and self-esteem. Alcohol and drug abuse are used as ways of dulling the pain. Lacking control over their lives, some people seek control by misusing power and authority over those in a weaker position. Such is the situation for sexual abuse.

The adult victim treatment component of the program aims to reduce the risk of future cases by giving parents or future parents the emotional capacity to parent and protect their children. Research and clinical experience has shown that many sexual abuse victims abuse their own children.

Treatment for children aims to assess the existence of sexual abuse and to help children cope with the resulting trauma.

3.TARGET PERSONS

Direct targets are persons who are involved in the program, and are directly exposed to program services, activities, and techniques. In the Mooka'am Program, the adult and child victims of sexual abuse are the direct targets.

Indirect targets are those receiving benefit indirectly through the client's treatment and growth. Children of victims, for example, will benefit from their parent's new self-esteem, parenting abilities, and capacities to relate to others. This helps reduce the risk of an intergenerational cycle of abuse.

Where children are victims, parents will indirectly benefit from their treatment.

The perpetrators of sexual abuse are not treated in the Mooka'am Program at this stage of program development. Because of the infancy of the program, and the highly specialized treatment needs of perpetrators, the latter will be referred to other programs. Appropriate liaisons will be maintained with these programs.

The primary interventions in the program are directed to individuals and families, and not organizations or whole communities. However, a secondary aim of the program has been and will continue to be the education of Native and non-Native communities concerning the needs of Native sexual abuse victims and the special character of the Mooka'am Program.

4.CLIENT ISSUES AND IMPLICATIONS FOR TREATMENT

Experience thus far in the Mooka'am Program suggests that the issues and needs of Native sexual abuse victims must be assessed on a person-by-person basis. This is confirmed by research which suggests that the specific treatment needs of victims will be affected by the kinds of physical, emotional, and relationship dynamics surrounding the abuse.

Depending on the specific dynamics, then,

.victims may be traumatically sexualized, that is, their sexual feelings and attitudes may have developed in an inappropriate and dysfunctional fashion

.they may feel betrayed by a trusted person

.they may experience powerlessness, a process in which the victim's will, desires, and sense of efficiency are continually undermined

.they are stigmatized by negative self images of badness, shame and guilt.

The specific needs of the victims and treatment issues discussed in the clinical literature and the fact of being Native combine to isolate the following specific treatment issues guiding the Mooka'am Program:

The Second Class Citizen Syndrome

This refers to individuals who have not only been sexually abused and feel damaged, dirty and soiled, but to all Native people who have been abused by the total society. Mooka'am clients feel doubly different, stigmatized, and outcastes within their families and society. They carry the shame of their abuse and the shame imposed on them through years of colonization.

For these reasons, victims need to assemble in a healing circle so that they know they are not alone, and so they can begin to feel proud of their rich culture, heritage and identity. In individual therapy, they need reassurance that they are not permanently damaged and soiled because of sexual abuse. Victims, through their involvement in therapy, need to establish hope for light at the end of the tunnel. Mothers of abused children need to know that their children will be normal.

Self-Blame

Victims of sexual abuse often blame themselves for the abuse, believing that they are somehow responsible. They blame themselves for taking part in the abuse. As well, they blame themselves for what follows a disclosure, such as family break-up or the perpetrator's incarceration.

What is needed are healing techniques which remove self-blame.
Mooka'am techniques help clients identify, talk about, and sort out the self-blaming feelings. As well they convey to the victim that she is not responsible for the abuse. Only the abuser is responsible for sexual abuse.

Fear

Another large issue for Mooka'am clients is fear. Adult victims fear for the future, they fear relationships, they fear for their children and they fear intimacy. Victimized children fear losing the family and losing love; they may even fear losing their life.

Fear is rooted in the fact of keeping secret the abuse for so many years. It is a strong immobilizing force, which is expressed in a number of different ways: anxiety attacks, phobias, illness, over-eating, or under-eating.

Helping clients deal with their fears requires a safe, trusting relationship in which they can express their fears, reinterpret their experiences, and anticipate a more positive future. Through play, children need to express their fears, and become empowered.

Depression

Nearly all sexual abuse victims experience depression after they have been abused and again after disclosure. Victims may be sad, subdued, withdrawn or apathetic. As well, depression may manifest itself through physical ailments, such as headaches and stomach aches. Suicidal tendencies are also common.

To support healing, victims are encouraged to express their pain, through such methods as talking, drawing, or playing. Suicidal feelings are noted and monitored.

Low Self-Esteem

As a result of their previous victimization, subsequent experiences, and their general status as second class citizens, Native sexual abuse victims present themselves for treatment with extremely low self-esteem. This is manifest in such feelings as:

.being unworthy, unloved and undeserving

.low confidence

.unrealistically high or non-existent goals

Behaviorally, victims with low self-esteem often seek out abusive relationships which revictimize and reinforce low self-esteem. Substance abuse gives false courage and pride.

Children with low self-esteem generally lack social skills, and become aggressive or hostile towards other children. Or, they may become withdrawn, shy, forlorn or timid. Concentration is lacking, and school work suffers. With both adults and children, jealousy prevails, creating more isolation, bad feelings and poor peer relationships.

Repressed Anger

Another client issue is repressed anger. Anger which is buried deep within the clients may manifest itself in either passive or aggressive tendencies. Aggressiveness may even lead to violence.

Clients with such tendencies need to be encouraged in a number of different ways to get in touch with, and ventilate, their anger.

Lack of Trust or Superficial Trust

Sexual abuse typically involves the violation of a trusting relationship. Accordingly, victims have difficulties trusting other people, including their therapists. This can take the form of either overly trusting or having no trust whatsoever.

In therapy, the inability to trust often results in anger and frequent testing of limits, from both adults and children. This necessitates understanding, pacing, and encouragement from the therapist.

~

Blurred Role Boundaries and Confusion

Sexual abuse within the family is accompanied by the blurring of appropriate family roles. The victimized child is cast into developmentally inappropriate sexual activities and other adult roles. When this is intermingled with children's roles, the result is a confusion in personal identity and behavior. Adult victims are often observed to carry this confusion into adult life.

The therapists task is to resolve the role and identity confusion. For example, family therapists help family members restructure their activities in ways which are appropriate both for child development and family functioning.

Inability to meet developmental tasks

Because of the dysfunctional arrangements within sexually abusive families, victims have not accomplished age-appropriate developmental tasks during childhood and adolescence. This often results in victims taking on a mature appearance and behavior while remaining emotionally very young, immature and needy. A child may regress in play to a much younger age. Adult women, although mature in appearance, may be unable to meet simple life demands.

Therapists help victims to become well-rounded human beings, whether this involves having fun, taking responsibility for serious life decisions and activities, or casting off inappropriate false images.

Control

Control is another issue for sexual abuse victims. Sexual abuse involves a violation of a person's body, privacy and rights. Within the family, sexual abuse is maintained over time by complex behavior controls by the powerful over the weak. All of these dynamics have lasting effects. Victims may be over-controlling or out of control.

Ambivalent Feelings

Those who have been abused by a trusted adult will experience considerable ambivalent feelings. They have feelings ranging from love to hate, anger to sadness, rejection to desire. Such feelings are projected onto significant people in the victim's adult life, thereby complicating the development and stability of intimate relationships.

Therapists in the program help clients work towards more normal intimate relationships by helping with the clarification and normalization of ambivalent feelings. As well, they help clients avoid miscommunications based on past relationships.

Out of Balance

Because of their victimization, Native sexual abuse victims have a difficult time living according to the traditional Native values of respect, kindness, harmony, caring, balance, honesty and sharing.

Workers need to help their clients begin to live according to these values. This is best accomplished by treating them in the way they should have been treated.

Compounding the feelings and behaviors associated with sexual abuse, are difficulties with alcohol, drug dependency, and other poor coping behaviors. For treatment purposes, one cannot separate sexual abuse symptoms from other serious problems.

Although Native men are frequently the victims of sexual abuse, compared to female victims they are less likely to talk about their experiences, and therefore experience serious emotional trauma. With the revelations concerning residential school abuse, more and more Native men are expected to disclose.

From clinical experience, it appears that sexual abuse of Native women may have been accompanied by physical abuse, moreso than non-Native sexual abuse. This has important implications for treatment.
The context of the abuse, then, is important assessment information.

4.PROGRAM GOALS AND TREATMENT OBJECTIVES

This section presents a first documentation of the Mooka'am program goals and treatment objectives. Goals and objectives refer to the anticipated client changes from participating in the program.

Program goals refer to ultimate or long range client changes (or states) after the program. An example of a Mooka'am program goal is that clients would engage in healthy non-victimizing relationships.

Treatment objectives are more specific anticipated client changes resulting from specific treatments or program elements. These changes should contribute to the realization of program goals. For example, counselling in the Mooka'am program will enhance the client's self-esteem (objective), which in turn contributes to developing healthy, non-victimizing relationships (program goal).

Perhaps another way of distinguishing program goals from treatment objectives is that goals refer to states of improved or ideal functioning outside of the helping relationship. Treatment objectives are the treatment-related changes that would contribute to that ultimate state of improved functioning.

Mooka'am Program Goals

.Program participants to develop healthy and enduring relationships with peers and members of the opposite sex, based on non-victimization.

.Program participants to develop healthy coping behaviors, for dealing with life's demands, rather than using self-destructive behaviors, such as drug and alcohol abuse

.Program participants to improve their physical health

.Program participants to increase their self-help potential, including the ability to participate in a healing community

.Program participants to appropriately parent

Treatment Objectives

A system of treatment, healing and program activities will help clients move towards the above levels of functioning. For individual victims, these activities aim to accomplish specific objectives, including:

.the enhancement of self-esteem

.removal of self-blame for victimization

.removal of negative stigmas related to the abuse

.acceptance of the body

.understanding and valuing Native identity and culture as a step towards enhanced self-esteem

.the capacity to express, and generally get in touch with feelings

.the learning of interpersonal and social skills

.the learning and accessing of medical and other healing resources, including Native traditional healing

.relaxation

.a stronger capacity to trust others

.the expression of pent-up feelings related to victimization

.the realization that feelings and ideas about themselves, given their past experiences with abuse, are normal and are shared with other people from similar circumstances (normalization and validation)

The above treatment objectives will be accomplished by one or more program activities, some quite distinctive to a Native treatment approach. The link between objectives and program activities (eg. treatment) will be made in a later section. Other treatment objectives relevant to traditional Native healing and family therapy will also be presented in later sections.

6.PROGRAM PRINCIPLES

Experience so far with Native sexual abuse victims suggests the following important program principles:

.The program must respond both to the symptoms of sexual abuse and the problems associated with poor coping behaviors.

.Client' concerns must be addressed before the sensitive and painful area of sexual abuse can be broached.

.Flexible program rules (eg. treatment schedules, discontinuation of treatment, etc.) should be followed, so as to accommodate the often unpredictable emotional reaction to sexual abuse treatment.

.Recognizing that client needs vary and that some methods may not work for all people, the program should be highly individualized. For example, although everyone is exposed to cultural teachings, immediate participation in healing circles may not be suitable for those who are highly acculturated to non-Native urban living.

.The program must be compatible with the cultural and situational background of Native people. To help actualize this principle, program development opportunities, such as on-going consultation with elders or cultural teachers, must be built into the program.

7.PROGRAM FORMAT

The following description of program format gives a snap-shot of the structure of Mooka'am's treatment, including:

.the range of target areas for change (scope)

.the number and variety of treatment modalities

.the sequencing of treatments

.the strength of intervention (frequency and total numbers)

.the control of client participation

.arrangements for client termination

.maintenance and generalization

Scope of Treatment and Support

Following the Native cultural principle of holism, the Mooka'am program focuses on several different parts of the person:

.psychological needs (such as the need for emotional catharsis, building self esteem, self awareness and validation) are attended through individual counselling, the healing circle, and private activities such as writing.

.the spiritual aspects of the person are addressed through the healing circle and the sweat lodge.

.cultural awareness is provided primarily within the physical environment and healing circle, but may also happen in individual counselling

.life skills learning (decision-making, problem-solving, stress management) is encouraged within individual counselling

.learning parental roles is facilitated within counselling sessions, and to some extent at summer camp

.physical needs are addressed in counselling (relaxation), healing circles (meditation) and within the sweat lodge.

.material needs and family support (housing, financial, baby-sitting) are addressed through individual counselling and linking the person to other resources (home care, respite care)

Number of interventions

As indicated above, several different treatment modalities are used. As well, each modality may address more than one area of need.

Sequence

The needs of sexual abuse victims are varied. The circumstances of the abuse traumatize victims in different ways. As well, victims differ in their capacity to share details and deal with the emotional pain. Finally, their present environmental circumstances are often overwhelming and unpredictable.

For these reasons, an individualized treatment policy is followed in the Mooka'am program. Individual treatment goals are set for each client after intake and assessment. Direct response to the sexual abuse victimization may occur well along in the clients treatment, when readiness is assured and other needs are addressed. Some clients, children for example, may not regard past sexual abuse as their most serious problem.

Strength of intervention

At this stage of program development, no assumptions are made concerning how much assistance is required to meet the needs of sexual abuse clients. No specific numbers of treatment are specified. Because of the complexity of needs, a more or less open-ended process is currently in place.

Structure

In terms of the structure of treatment, a program may be "tightly" or "loosely" structured in terms of (a) explicitness of agreement with the client (b) specificity of program directives and instructions concerning what must be done (c) closeness of monitoring the individual implementation of the program, and (d) consequences for client compliance and non-compliance. On these dimensions, the Mooka'am Program is best described as loosely structured. Clients are presented with options (eg. participation in traditional activities) and are treated with flexibility concerning attendance and participation. All clients participate in individual counselling.

Termination

Concerning the arrangements made for ending the treatment process, no policy has been developed.

Maintenance and generalization methods

Concerning what arrangements are made to assure that the client changes persist after the program, again no policy is in place.

8.GENERAL TREATMENT PRINCIPLES

Helping sexual abuse victims work towards changes in their lives, requires a set of guiding helping ideas, otherwise known as treatment or practice principles. So far, the following tentative ideas have evolved:

.Understanding the victim's needs and responding appropriately will require a holistic perspective. In this, the person's spiritual, psychological (thinking and knowing), emotional (feeling) and physical selves will be taken into account. Responding to the person's spiritual needs represents a major difference from mainstream healing.

.The client will participate in decision-making concerning the appropriate treatment approach. Methods which make clients feel "studied" or which treat them as objects will be avoided. Treatment is part of a relationship in which the person being helped is a co-participant with the helper.

.The appropriate boundaries of relationships are important issues for sexual abuse victims, since they themselves have been violated in this regard. With this in mind, the relationship between client and helper will nevertheless be more personal than in the usual "professionally distant" healing relationship. For example, topics for discussion may be more flexible. Similarly, more flexibility will be allowed concerning how much can be disclosed between client and staff.

.A major assumption is that the healing of sexual abuse is likely a life-long process. Events, like the birth of a child or the death of a parent, may conjure up memories and feelings associated with the abuse. This means that victims must be given the tools to respond appropriately and work through such events throughout their lives. Their potential for self-healing, and engaging in a "healing community" must be addressed.

.Victims in the Mooka'am program will be helped by a process of describing the abuse, and reliving the pain. The healing comes from (i) emotional release (ii) a non-judgemental therapeutic attitude and response, and (iii) therapeutic re-labelling of past events, such that victims no longer feel responsible. These processes help normalize the victim's experience, and validate her as a worthy human being.

.The victim will be helped to establish relationships with the Native social and cultural community, thus building ties with trusted persons. This involves an introduction to traditional healing, such as smudging with sweet-grass, sweat lodges, and talking to Elders.

9.HELPERS AND HELPING ROLES

The primary helping persons in this program are the staff of the Mooka'am Project. The emphasis is on "helping" rather than "expertise". Staff see themselves as guides, educators, and helpers of clients through the healing process.

Unlike other program models, Mooka'am staff believe that the helping process is aided by personal involvement and sharing. An equal relationship with clients is the ideal. Thus staff participate in healing circles, sharing their problems and pain with the clients.

Following the above general principles, program staff will assume the following helping roles:

.educator

.coach

.enabler of trust

.relationship builder

.facilitator for reliving the pain

.reflective, active listener

.role model for sharing experiences and feelings; this builds on the Native cultural practice of learning through observation

.story teller to facilitate communication; story-telling is another Native cultural practice

.a linkage person to (i) traditional healing and cultural activities in the Native community, and (ii) other referral agencies, as needed

In addition to the above helping roles, staff will also participate in research and evaluation activities during this early development stage of the program. As part of an evaluation team, they will work with an external evaluation consultant to monitor and assess the early implementation phase. As well, based on these experiences, they will refine the program model, and help plan an evaluation of program impact.

As needed, other potential helpers will be Elders, cultural or spiritual teachers, and natural helpers, such as friends, relatives and other victims.

Clients will learn how to participate in a Native community of healers. This will begin in the program through the healing circles, but will extend beyond the program into the natural helping community. This notion builds on the traditional practice of natural helping within the clan system.

A distinctive part of the program is the participation of Native Elders and cultural teachers. An important assumption is that victim self-esteem will be enhanced through experiences of cultural learning and the development of pride as a Native person. Ideally,
Elders and teachers are involved as resource people for both clients and staff. They lead the healing circles, provide cultural teachings and ceremonies, and are available for individual counselling and fasting.

Because of the sensitivity of sexual abuse, the possible relevance of Native identity issues, and the importance of cultural experiences in the program, it is assumed that staff should be ...

.Native people, or non-Natives with extensive clinical experience with Native people and the Native community

.knowledgeable of Native culture

.supportive of traditional healing approaches and their complementarity with contemporary social work techniques

10.THE HELPING SITUATION: PHYSICAL ENVIRONMENTS AND RESOURCES

The Mooka'am Program is currently offered in the building presently occupied by Native Child and Family Services of Toronto. Located in downtown Toronto, the offices house the NCFST management and staff. The program has separate rooms for Mooka'am staff and for working with adult clients and children.

Because the program will attend to the physical needs of participants, providing an appropriate physical environment for treatment will be important. The physical surroundings will ...

.enhance and complement treatment goals and activities

.assure comfort for all program participants

.help build the relationship between program staff and participants

.provide cultural learning opportunities

Specifically, the physical setting will provide...

.A place of safety in a comfortable welcoming environment. For example, coffee, herbal teas and cookies, etc. (i) provide a homey atmosphere (ii) help clients handle nervousness, and (iii) provide nurturance: food can be offered as a treat or nurturance; this avoids distractions and "stuffing their feelings down" (iv) cedar tea could be offered after a particular hard session.

.Soft lights that are conducive to healing (eg. lamps rather than florescent lights).

.A quiet room for relaxation and re-energizing after particularly trying sessions. Dim blue or green lights are very soothing.

.Plants, pillows

.Punching bag for the release of anger and other pent-up feelings

The physical environment will include many features of Native material culture. This is deemed important for relationship-building as well as cultural learning:

.Rooms will contain sweet-grass, matches, and other useable cultural objects. Even though not used by everyone, these items make a statement about what is being done in the program. Clients accustomed to seeing these items may ask about, or try cultural activities.

.Women's sage will be important material for the program. This is a traditional medicine for women during their moon time (menses). Having the sage will open the door for explaining particular aspects of traditional culture.

.This may also provide cultural education in the sense of providing information about Indian culture "naturally", making clients feel less awkward about not knowing their own culture. These opportunities will be provided at the beginning, and continue throughout the client's stay in the program.

For both adults and children, it is extremely important that the room for therapy is experienced as safe, secure and private. Without such a setting, it is unlikely that sexual abuse victims can express their pain.

The natural environment is also regarded as an important context for healing. The importance of the environment builds on Native holistic beliefs and spirituality, particularly the notion of mother earth as worthy of respect and as a source of healing (eg. medicinal herbs). For these reasons, some treatment sessions will be held outside in pleasant outside settings. Summer camps and other outings will be held.

11.PROGRAM ACTIVITIES AND TECHNIQUES

This section summarizes the main techniques used in the Mooka'am Program.

Engaging the Client

Engaging the client in a helping relationship requires specific techniques for (a) developing the relationship (eg. primarily trust), and (b) maintaining the relationship throughout the process.

The first meeting with the client is a "getting to know you" session which should be non-threatening and informal. It can be used for showing the person around, orienting them to activities that go on in the program, and private rooms for treatment.

First meetings are also used for acquainting new clients with staff, sharing experiences and credentials, and reviewing the style of work.

The first session will also be used to obtain preliminary information about clients: where they are from, where they are living now, and how they came to the agency.

Unless the person is particularly needy, and perhaps breaks down, this session may be only one-half to one hour in duration.

First sessions can be tense, so holding a rock may relax the person for conversation. A basket of rocks will be available from which clients choose their own.

Finding out the client's support system is also important during a first contact. They will be advised of the possible painfulness of the work, and that at times they may leave in an uncomfortable state. It is important to make sure that clients have special friends or relatives with whom they can confide and receive support.

An important question concerns the appropriateness of healing. Is this a suitable time in their life for this kind of work? Or is another crisis being added to their life?

Assessment: The Integration of Understanding and Help

The typical assessment techniques will be avoided for Native clients. Usually, structured question-asking is used to establish a beginning point for conversation and relationship-building, as well as an important information-gathering device. However, experience shows that these assessment check lists are presented in a linear, intrusive fashion, a style inimical to Native culture. This approach is not relaxing and is questionable as a way of gathering information.

Replacing this approach will be a process of offering immediate help, starting with a few brief questions eliciting the clients needs and determining the best beginning point. After that, assessment information will be gathered throughout the helping process.

From the clients responses to intervention, assessments will help to understand the main issues and the most appropriate treatments. For example, clients from non-traditional backgrounds may not respond immediately to traditional Native treatments, even though the initial steps towards Native culture were taken by seeking Mooka'am services. Assessment information will also include details on the circumstances surrounding the abuse.

The assessment will be used to determine who will be the most appropriate staff person to be involved with the case. For example, those abusing alcohol would require a specialized person.

Finally, the assessment would generate potentially useful base-line information for assessing change (eg. level of self-esteem). Such information will also be useful for program evaluation.

Assessments will likely be done over an extended period, perhaps longer than those in main-stream agencies.

Helping the sexual abuse victim think better of themselves is an important Mooka'am program objective. Therefore, the assessment process will gather information on each participant's level of self-esteem in various areas of living. This will be important base-line information for treatment planning and evaluation.

Healing Techniques

The following healing and educational techniques are Mooka'am's core program activities:

.Healing circles

.Sweat lodges

.Traditional medicines: sweet grass, cedar,

.Individual counselling

.Relaxation techniques

.Cultural awareness

.Non-directive creative methods such as keeping diaries, writing, art work, poetry-writing, etc.

.Family therapy

.Play therapy

A summary of the above techniques is presented in the following pages.

The Healing Circle

Perhaps the most innovative part of the Mooka'am program is the combination of contemporary social work practice with traditional Native healing. A large part of traditional healing takes place in a healing circle.

The healing circle is a form of group discussion in which staff, clients and a cultural teacher sit as co-equals, sharing painful issues in their lives as well as learning cultural values, traditional healing practices, and traditional teachings.

A "cultural teacher", "traditional teacher" or "Elder" is a person who is recognized in the Native community as someone who carries a great deal of knowledge about Native people's spirituality and is able to communicate this knowledge to others. In addition, such a person also acts as a confidant and advisor to those who are having personal difficulties of whatever nature. In summary, the role of traditional teacher is a combination of teacher, spiritual advisor, doctor and therapist.

The Mooka'am Program's healing circle is made up women only, although mixed circles are common within the Native community. The fact that the staff participate in the circles has had a positive impact on the clients. Some clients have remarked that this, perhaps more than anything else, has helped them to establish trust with the staff.

Confidentiality is a major component of every circle. A common phrase "what is said in the circle, stays in the circle" is usually mentioned near the beginning of each evening. The signing of confidentiality forms has never been necessary.

Although the traditional teacher leads the circle, a sense of equality pervades. The teacher will often invite the women present to conduct tasks throughout the evening. This is a way for the traditional teacher to pass on "how things are done" which is one of her major responsibilities, but it is also a way of developing positive self-esteem within the women.

The circle is always opened with a prayer by the traditional teacher, thanking the Creator for bringing the group together, asking for guidance in passing on the teachings, assisting the women with any problems they may bring out, and for help with their healing.

Always present are the "four gifts of life":

.Fire (through a lighted candle)

.Sweetgrass/sage/cedar/tobacco for smudging which eliminates any negative energy

.Water which cleanses or purifies

.Berries which are a healing food

The traditional teacher usually sings a song while drumming on a hand drum. The song is sung in her language, but she also explains the meaning of it in English.

The teacher then goes on to talk about a specific traditional teaching. The themes of these teachings all have to do with healing and growth, the earth and environment as sources of healing, personal and community responsibility and relationships.

Throughout the traditional teaching, core Native values are passed on, including those of kindness, caring, sharing, honesty and strength.

The rest of the circle involves the participants in a process of sharing their pain. A sacred object, such as an eagle feather, rock or talking stick, is passed from person to person. Upon receiving the sacred object, each person talks about what she is struggling with.

"...what is bothering them, what concerns them, anything at all, whether it be their family, themselves, their community, ... whatever."

Each person may take as long as she needs to speak. However, there is never any pressure on anyone to speak if she does not wish to.

Since the Mooka'am Program is a sexual abuse treatment program, this is a topic that arises at times because the pain the women are currently experiencing is inevitably tied into their past abuse.

If a woman disclose something which causes her to break down and cry, the teacher will smudge her with sweetgrass and then hold her until she "is cried out" and able to start again. This is extremely powerful because of its comforting effect.

Some of the sources of healing in the healing circle are sharing the pain, purification through exposure to the four gifts of life, the teaching of core Native values and a supportive non-judgemental atmosphere.

Probably the most visible and describable impact of the healing circle is the emotional release, sometimes from long-standing pain, which occurs.

"That burden you carry around you is lifted a bit. I can tell you that when you come away from those healing circles, you definitely have had some weight lifted off you, whether its guilt, grief, indecision....you come away with some measure of healing.

In addition, healing circles have a strong spiritual component which is created through the teacher's talks and the symbolism of cultural materials and activities. Foe example, smudging with sweetgrass not only cleanses, but it also mediates the events of the circle and the spirit world. Each person's prayer, thoughts and feelings are going out to the Creator through the smoke. There is no doubt that the strength of healing circles comes, at least partially, through the spirit world.

The circle is closed with another prayer and hugs all around. Troubled faces are now smiling and a distinct feeling of exhilaration which will last for days, has filled the group.

The Sweat Lodge

The sweat lodge is an integral part of the healing process in the Mooka'am Program. With its physical and spiritual aspects, the sweat lodge is a source of spiritual and bodily cleansing. It combines sweating and relaxation, prayer, cultural learning, closeness with others, and reflection. Participants smoke the Sacred Pipe and drink cedar water.

Victims of sexual abuse have experienced 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.)

In summary, for sexual abuse victims in the Mooka'am Program, the sweat lodge contributes to:

.relaxation and physical health

.cultural awareness and spiritual learning

.the development of social and emotional ties with others

.revitalization

Adult Therapy

Individual counselling is an important component of the program. All program participants will take part in individual counselling at the outset. Some clients will be uncomfortable in group sessions when they first enter the program, and will benefit from a one-to-one relationship. This approach will help clients to develop the strength to enter group or healing circles. Individual counselling will act as an adjunct to other program methods. For example, unique individual needs may become apparent in group which can only be addressed in counselling.

Because it mirrors outside normal relationships, the staff-client relationship will be an important tool in the healing process. Some therapeutic objectives of this relationship include:

.the enhancement of trust in others

.the development of social skills

.ventilation of feelings in a safe relationship

.exposure to traditional healing (such as smudging with sweet-grass) and cultural teaching

.learning specific sources of on-going healing within the Native community in Toronto

.normalization of feelings, attitudes and relationships

To achieve these objectives, the relationship must be open, honest, unconditionally accepting, and non-judgemental. The therapist will role model appropriate behavior, and coach the client in new interpersonal skills.

Therapy with adults in the Mooka'am Program is mostly talking. The clients share their stories, and the staff help them to focus on their feelings around the abuse. More than anything, staff deal with feelings...helping the women to express, then let go of their feelings.

With adults, the therapist helps them to re-live the abuse in the therapeutic setting. In this way they can look back and come to the realization that as children they were not responsible for causing the abuse; nor could they do anything to stop it.

To enhance self-esteem, staff use the following healing techniques:

.encouragement

.focusing on positives

.helping set realistic goals

.activities that enhance self-esteem

.visualization

.cultural activities and ceremonies

Because sexual abuse victims may not have developed appropriately, therapists can...

.help them go back and grieve what they missed as children

.renurture their "inner child"

.help them to learn ways to give to themselves and take off false roles

Many of these therapeutic objectives are equally true of other components in the Mooka'am program. Individual counselling, then, involves the twin processes of helping the client (a) prepare for, and realize objectives in, other parts of the program, and (b) learn appropriate interpersonal skills and self-attitudes for normal functioning.

Healing techniques for the ventilation of repressed anger are talking, drawing and abreactive work. The latter involves such things as screaming or punching pillows.

Individual counselling also helps client strike a more appropriate balance of controlling behavior. For those who believe they have no control over anything, healing techniques will help empower the victim, giving her the opportunities to make choices and decisions. For clients who believe they must control everything, therapists need to help them realize what they can and cannot control. The worker then helps clients let go of what they cannot control.

Mooka'am therapists help clients deal with their ambivalent feelings towards others which have arisen in past abusive situations. Therapy will help the client identify the ambivalent feelings, and learn that it is normal to have both positive and negative feelings. Clients are helped to sort what aspects of their present relationships are triggering feelings from the past. Clients are also helped to sort out the myths about the family, what was real and what was not.

Native Elders will also be available to work with staff or clients on a one-to-one basis. For example, after a healing circle, participants may request to see an Elder individually for counselling, or the administration of traditional healing (eg. cedar bath)

Concerning counselling of sexual abuse perpetrators, only abusers from outside the family will be treated in the Mooka'am Program. Reasons for not treating family members who have committed intrafamilial abuse are given in the "family therapy" section.

Cultural Learning

The Mooka'am program assumes that self-esteem enhancement for Native sexual victims will occur partially through developing pride as a Native person. This pride will grow as clients participate in a living Native culture.

The learning of Native culture will happen in two important ways. First, clients will learn Native values, spirituality, and practices through direct participation in sweat lodges, healing circles, and smudging. On one level these are therapeutic activities. On another, they are opportunities for learning, through the Native learning style of observing and doing.

The second source of cultural learning is the direct teaching of Elders and Native staff members. As well, clients are referred to community cultural events.

These processes of cultural learning should have the important by-product of socializing the client into a Native community. By sharing common experiences based on traditional values, socially isolated individuals will become part of "community". The mental health and illness prevention consequences of this are well known.

Creative Methods

The healing process is described by many as a process of self-realization and creativity. This is particularly important with sexual abuse victims, who have become estranged from their selves through a processes of control and violence.

For some, the low self-esteem and poor social skills are major impediments to healing through interaction with others in groups or healing circles. What is needed are creative activities like drawing, poetry and diaries. These are private, reflective and undemanding in a social sense.

Staff suggest or loan out books on sexual abuse, for women to read. Each person is given a journal to document their thoughts and feelings. They may be asked to write letters to their abusers, non-offending parents, or others...and talk about the abuse and its effects. They may or may not send those letters.

Some women draw pictures, punch a punching bag, do visualizations, scream and cry. They are encouraged to do whatever is comfortable, for whatever they need.

These individualized creative methods should have immediate healing affects through their impact on self-esteem and emotional release. In some cases, they function as important tools for recovering deeply buried memories and feelings, and therefore are an aid to assessment. Like counselling, these methods supplement or prepare clients for participation in other program activities.

Substance Abuse Counselling

As a way of dealing with pain or meeting other needs, sexual abuse victims often develop inappropriate coping methods, such as alcohol or drug abuse. The Mooka'am Program recognizes this and is prepared to suggest appropriate services and referrals. Basic substance abuse counselling will be offered by staff. Extreme cases will be referred to Native treatment agencies and health clinics, such as Pedahbun Lodge or Anishnawbe Health.

Family Therapy

Mooka'am services are also available to the sexual abuse victim's family. Therapy with sexually abusive families assumes that family pathology may be both cause and consequence of sexual abuse. Families, for example, are known to collude in keeping the abuse a secret or unwittingly perpetuate the abuse in other ways. As well, the adult victim's behavior and self concept are known to hamper normal relationships with their partners. For these reasons, family therapy will be an important treatment modality.
The development of family therapy as treatment is still at an early stage in the Mooka'am project. Initial planning anticipates that family therapy will be provided sequentially, following victim counselling, non-perpetrator counselling, and non-perpetrator/victim dyad counselling.

In the case of intrafamilial sexual abuse, the perpetrators of sexual abuse who are family members will not be treated within the Mooka'am Program. The main reason for this is that the same sexual abuse therapist should not provide therapy to both victim and perpetrator. The difficulties of maintaining trust with the victim, and the complexity of family alignments within the family system, argues against one therapist for all members. Perpetrators will be referred, and close liaison will be maintained with a referral agency.

The immediate treatment objectives of family therapy are as follows:

.To prevent re-victimization

.To restore a sense of security and safety within the family

.To surface and deal with any other family issues

.To respond to the feelings about the abuse

.To help restructure family relationships so that appropriate interpersonal boundaries are restored between adults, and between adults and children.

Working with Children

Most of the above discussion is relevant to the treatment of adult sexual abuse victims. The Mooka'am Program, as indicated, is also available to Native children who have been victimized.

Working constructively with children requires entering the child's world, the "world of play". Professional play therapy is the main treatment modality, the main ingredients of which are:

(i)A relationship between the therapist and the child which allows the child to feel safe, secure and protected.

(ii)Therapists who honour the play therapy process and believe that child knows where they need to go. Children are given the power to do this; staff must be patient to follow.

(iii)Therapist who learn and use the language of play, since children explain through association and metaphor.

(iv)Play as a circular process, with reoccurring themes. This is a slow process which needs to be honoured. Children cannot be pushed faster than they need to go.

For children it is especially important for them to feel particularly special for the therapist, in a relationship based on support and encouragement.

Following the lead of main-stream sexual abuse programs, play therapy will be used for assessment purposes. Young children, particularly those traumatized by abuse, are best able to express thoughts and feelings indirectly through play. Therapeutically, play therapy will be used primarily to help young victims release the emotional trauma associated with the abuse and the violence.

In principle, for both assessment and therapy, the style of relating to the child will be determined by the child's needs and behavior. Two styles of play therapy are used in the Mooka'am Program: non-directive and directive.

Non-directive play therapy does not focus on the abuse, and allows the children the freedom to play and talk as they please. This is particularly useful for establishing a relationship with the child, and for working with very young children.

Also, non-directive play therapy is useful for assessing children with unidentified traumas. For example, a parent who suspects that a child has been abused, requires assistance to possibly discover the truth. Although play therapy helps surface certain traumatic themes in the child's experience, it is not an iron-clad technique for proving sexual abuse.

Non-directive play therapy may also be used with children who are traumatized because of sexual abuse. Children, at an early development stage, experience difficulty verbalizing their feelings. Play therapy helps to surface themes which are interpreted by the therapist, then communicated to the child as a way of stimulating expression of feelings.

Directive play therapy is much more planned and structured. It could include such activities as: sketching a picture of the family, representing an animal for each family member, or drawing the perfect family. Directive work should include activities where children can feel good about their accomplishments, whether making mobiles or winning at games.

Directive play therapy will also be used when sexual abuse has been acknowledged and can be discussed more openly with the child. For example, some children will be involved in the court system and need assistance to express their fears before attending court.

Adaptations in play therapy practices and principles for Native children will be documented in future revisions of the

model. For now, anatomically correct Native dolls are used. Smudging with sweet-grass has also been introduced as a way of purifying play situations which symbolically have been identified by the child as harmful.

Play therapy will also be used with children who are clearly upset about other things in their lives. Like adults, they too have concerns (eg. parents fighting) which need to be surfaced and perhaps take priority to the sexual abuse.

Children in the Mooka'am Program will also be involved in summer camp along with other NCFST children. As well, they will be involved in story-telling activities.

12.ORGANIZATIONAL SUPPORT FOR THE PROGRAM

Consultation with Elders

Elders are important sources of consultation and support for the program. Consultation may address such issues as the meaning of sexual abuse, its prevalence in Native communities, traditional community methods for responding to abuse, assumptions and beliefs about why sexual abuse exists, and principles for helping clients.

Elders are also expected to have specific helping roles within the program. They may be used to support both clients and staff.

Links with other agencies

The Mooka'am Program will have strong working relationships with other Native and non-Native programs. Already, staff have consulted broadly with a number of agencies, including: Pedahbun Lodge, Native Women's Resource Centre, Thistletown Safety Program, Children's Aid Society, Native Community Crisis Team, Barbara Schlieffer Clinic, and West End Creche.

These links are important because:

.appropriate referrals will be necessary for Native clients

.sexual abuse victims often have other needs, sometimes requiring specialized resources

.other programs will require on-going education about Mooka'am's innovative program

Team Support within Native Child and Family Services

Unlike many other agencies, strong ties will be maintained between this program and other NCFST programs. Program staff wish to draw upon the expertise in the agency, and keep others informed about sexual abuse and it's treatment. The entire staff were consulted at the early stages of development, drawing on their advise for program design and treatment principles.

Discussion has also taken place on the desirability of staff being available for support. Group level process can...

.surface staff interpersonal problems which are hampering the work

.help staff members when they are affected by the clients (eg. staff becoming dissociative because that is what they work with all the time; feelings of unworthiness; clients may raise issues which creates negative feelings and problems for the staff)

.help staff deal with anger from unknown sources

Privacy would be respected. There would be no expectation to delve into issues that are private and from the past. It would be a safe place for staff growth. The facilitator should be an outside person such as an elder.

13.FUTURE DEVELOPMENT OF THE MODEL

The Medicine Wheel: A Symbol of Holistic Thinking and Practice

The final draft of the model will organize the material into the Native Medicine Wheel symbolism. Assumptions about problems, needs and treatment are based on holistic thinking. Briefly, the clients' problems will be shown as the interaction of physical, psychological, spiritual, and emotional factors. In Native culture, this perspective can be summarized by the Medicine Wheel.

All Mooka'am Program techniques will be summarized within the medicine wheel drawing, showing the relationship between techniques and changes in client functioning. The medicine wheel will summarize how each technique in the program is designed to bring about many changes in client functioning. Participating in a sweat lodge, for example, contributes to emotional and spiritual strength, cultural awareness and the strengthening of Native identity, and physical health.

As a teaching tool, The Medicine Wheel will assist presentations to professional audiences and readers. Movable parts of the drawing will be used to show how various techniques bring about changes in the various parts of client functioning. This will depict visually what the program wants to achieve in a holistic way.

As an assessment and treatment tool, the Medicine Wheel may be used with the client to illustrate discussions of treatment and progress.

Appendix "B"

Participants in Community and Cultural Consultation

Community Consultations

The following agencies participated in consultation interviews early in the development of Mooka'am services.

Native Women's Resource Centre

Thistletown Safety Program

Pedahbun Lodge

Native Community Crisis Team

The Barbara Schlieffer Clinic

The Children's Aid Society of Metropolitan Toronto
(Sexual Abuse Treatment Program)

West End Creche Child and Family Services

Cultural Consultations

The following persons were consulted for advice and information on the cultural components of the Mooka'am Program.

Edna Manitowabi

Lily Bourgeois

Ann Jock

Rebecca Martel

Janice Longboat

Appendix "C"

Mooka'am Program Development:
Literature Review

SEXUAL ABUSE VICTIMIZATION AND NATIVE HEALING

A Review of The Literature

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

Frank Maidman, Ph.D.
In Association With Charlene Avolos, M.S.W.

March 24,1991

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 Mooka'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."
(The Power Within People)

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 require certain behaviors which are at odds with Native culture. Talk therapy and psychoanalysis, for example, may not be suitable for some cultures.
Humour, an indication of acceptance and comfort, can promote 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 parents.

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 in the initiation of the novice into spirit dancing: depatterning, physical training, and indoctrination.

Depatterning occurs through an alternating pattern of sensory overload and deprivation. 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 inappropriate way, and in a manner which is interpersonally dysfunctional.

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.

BIBLIOGRAPHY

Antone, R.A., D.L.Miller, B.A. Myers, The Power Within People, Vision Press, Southwold, Ont., 1986.

Ashby, M.R., L. Gilchrist, A. Miramontez, " Group Treatment for Sexually Abused American Indian Adolescents", Social Work with Groups, Vol.10, 4, Winter, 1987.

Edwards, D. and M. Edwards, "American Indians: Working with Individuals and Groups", Social Casework, 61 (8): 498-506, 1980.

Finkelhor, D.A Sourcebook on Child Sexual Abuse, Sage Publications, Beverly Hills, 1986.

Hampton, M., E. Hampton, G. Kinunwa, L. Kinunwa, Sr., "Alaska Recovery Camps: Experiential Counselling Model for Treating Alcoholism". University of Alaska, Fairbanks. No date.

Haycox, J.A."Native Therapies for Behavioral Disorders", Current Psychiatric Therapies, 1980.

Jilek, W.G.Native Healing, Hancock House Publishers, 1982.

Johnson, T., B. Fenton, B. Kracht, M. Weiner, and F, Guggenheim, "Providing Culturally Sensitive Care: Intervention by a Consultation-Liaison Team", Hospital and Community Psychiatry, Vol. 39, 2, Feb. 1988

Kahn, M.W.,"An Indigenous Community Mental Health Service On The Tohono O'odham (Papago) Indian Reservation: Seventeen Years Later", American Journal of Community Psychology, Vol. 16, No. 3, 1988

Maidman, F.,The Experience of Growth: An Organizational Review of Ojibway Tribal Family Services, 1988.

Maidman, F."The Pow Wow Island Learning Centre", Unpublished Planning Paper, 1990.

Malloch, L."Indian Medicine, Indian Health", Canadian Women Studies, V.10 (2/3), summer/fall, 1989.

Oates, M.,"Dealing with Sexual Abuse in a Traditional Manner",
Unpublished Document, Prince Rupert, B.C., 1988.

McShane, D."Mental Health and North American Indian/Native Communities: Cultural Transactions, Education, and Regulation", American Journal of Community Psychology, Vol.15, No.1, 1987

Metcalf, A."Family Reunion: Networking in a Native American Community", Group Psychotherapy: Psychodrama and Sociometry, 1979, Vol.32, pgs. 179-189.

Rogler, L.H."The Meaning of Culturally Sensitive Research in Mental Health", American Journal of Psychiatry, Vol. 146, 3, March, 1989.

Solomon, E."The Sweat Lodge", M'nowa Djimowin, Winter, 1988, Pg.5.

Topper, M. and Curtis, J., "Extended Family Therapy: A Clinical
Approach to the Treatment of Synergistic Dual Anomic Depression Among Navajo Agency-Town Adolescents",
Journal of Community Psychology, Vol.15, July 1987

Weibel-Orlando, J., "Hooked on Healing: Anthropologists, Alcohol and Intervention", Human Organization, Vol.48, No.2, Summer, 1989.

Appendix "D"

The Client Study

Learning to Trust

A Summary of Client Experiences
of the Mooka'am Program

Frank Maidman, Ph.D
April 10, 1992

"The circle brought us together. Learning to trust with our own secrets, and trusting your secrets with others. This is the most significant part of healing. Knowing that others are experiencing too. Building the support system is good too. Being in the circle and showing the different parts of healing. Being supportive of people who are dealing with something that you have already dealt with. The effort that you put into the relationship makes it all worthwhile."

(Mooka'am client)

Acknowledgements

I wish to extend my personal thanks and gratitude to Merle Beedie for her involvement in this stage of the Mooka'am Program evaluation. It takes a special person to encourage people to talk about their lives and personal experiences in an interview. I knew that Merle was the person for that job, and she didn't let me down.

Thanks also to Dianna Nason, Charlene Avalos, and Cindy Baskin, for their assistance in planning this part of the evaluation, commenting on the draft interview questions, and identifying suitable clients for interviews. Their flexibility in taking time away from their daily work is much appreciated.

The nature of program evaluation sometimes makes it difficult work. Often we are treated as necessary evils. This has not been the case in this project...at least not so far! Thanks to Kenn Richard and all the staff for making me feel welcome during the various stages of the over-all project.

But most of all, a very special thanks to the six women who agreed to be interviewed. They shared insights into the program, and at times personal reactions to very important events in their lives. We thank them for their trust, and for their contributions to Mooka'am.

Frank Maidman

Table of Contents

Introduction

This document summarizes client experience with the Mooka'am Program. The information is one of many sources for a formative evaluation of the program. Formative evaluation aims to assist program development by documenting activities, ideas, responses and implementation issues during the early phases. Other components of the over-all evaluation project include (i) the development of a program model, and (ii) the identification of program implementation issues. All results will be incorporated into a general program evaluation report.

As an important part of the project, six clients agreed to participate in intensive interviews concerning their participation in the program. Each interview lasted from two to four hours.

Interviews probed the clients' experiences with the program. Assessments are made of client reactions to traditional and contemporary healing methods, including unanticipated negative effects. Interviews also assessed whether clients' principle issues were being addressed, and whether they are comfortable with the program, the staff, and the physical environment.

This study also makes a first step towards documenting the impact of the program on the clients' functioning. As well, questions were asked to tap recommendations for program improvement, from a client perspective. The paper ends with a series of issues for discussion.

The paper will be used as a tool to stimulate discussion about the program, and possible fine-tuning and improvements.

Finally, this component of the project tested the feasibility of using in-depth interviews with Native clients. A similar technique is under consideration for a program impact study during 1993. Interviews were quite lengthy and probing. They were conducted by a Native woman with nursing and research experience.

The Mooka'am Program: A Brief Review

The Mooka'am Program is a highly innovative program, combining traditional Native healing principles and practices with social work techniques. The program aims to assist Native sexual abuse victims towards psychological well-being, and halt the intergenerational transmission of child abuse. As well, the program provides play therapy to Native children suspected of being sexually abused.

The core therapeutic or healing activities of Mooka'am include individual counselling, healing circles, traditional Native medicines, sweat lodges, creative methods (eg. diaries, art), family therapy, and play therapy.

Client Background

Native Identity

All sample clients had Native heritage. However, in terms of their Native self-concept, there were obvious differences. Asked to describe themselves in terms of being Native, the sample clients used different descriptions. These ranged from very traditional to non-traditional. No client wanted to distance herself from being Native, although one expressed some on-going discomfort.

Those with more traditional leanings know, participate, and are committed to Native culture (singing, dancing, language use).
But even those viewing themselves as "an urban Indian", "contemporary", or simply "not a traditional Indian" are all in the process of becoming exposed to Native culture and friends.

Several seem somewhat uncomfortable with city life.

" I'm not a city person. I hate the city. I feel like I'm stuck here and shouldn't be here."

" If I wasn't living in T.O. I would be living back home and going to the Longhouse."

Family Participation

With the exception of two women, all sample clients participated in the program with other family members. Two are involved with a daughter or son. One has her children involved and her husband.
One client's boyfriend is involved.

Two clients wanted to encourage the participation of other significant people in their lives.

Previous Agency Experiences and Program Expectations

Nearly all sample clients had previously participated in main-stream helping agencies, and all reported very negative experiences. One person had been previously involved with NCFST, and had negative experiences which left her not trusting. On a friend's advice she gave the Mooka'am program a chance.

Alienation and negativity towards main-stream agencies was expressed in different ways:

"[In Mooka'am] I was able to work at my own pace. In the past, someone else made my decisions for me and that is why I withdrew."

" I expected things to be different. I didn't have to prove myself. I could come with all my baggage and not be judged. I went to a non-native agency and had experienced that prejudice. I expected to be accepted."

"Previous efforts to seek counselling from CAS, etc. hadn't worked out because I was drinking and taking drugs...honesty and commitment won me over... Recognizing the downfall before it happens. The C.A.S. did not recognize any of the signs. I went to C.A.S. and through all that, they weren't helping at all."

"I was so down and fed up with therapy and counselling, I did not know what to expect really."

These negative experiences helped shape their expectations for NCFST and the Mooka'am program. People were looking for the comfort of being in the company of Native people. As well, they sought support and freedom of self-expression, acceptance and an opportunity to work at a comfortable pace.

What Did Clients Hope to Get Out of the Program?

Clients were asked to recall their initial hopes and expectations for the program. These hopes were expressed in different ways. Some described the help they expected for their children. Others looked no farther than the healing process itself (eg. "a chance to grieve", opportunity for self expression), and did not think in terms of concrete changes.

There were some, however, who expressed fairly specific hopes for personal change. These were expressed primarily in terms of feeling better, functioning independently, or achieving their potential.

If there is a discernable pattern, it is that clients focused on emotional growth or their "inner life". They were less likely to talk about anticipated changes in behavior, relationships, social or job functioning, and more likely to talk about feelings. They wanted a chance to grieve, to feel happier, to understand their feelings, and remove the torment.

For some, personal betterment would ultimately come from self-understanding or insight into themselves, their problems and their feelings.

Client Access to the Program

Mooka'am clients live the kinds of lives that could potentially create barriers to easy access and on-going participation in the program. Some live out of town in near-by cities, or are distant from the city's central core. Others have families. Still others are financially strapped, making transportation and baby-sitting costs seem formidable. Others have demanding jobs.

Apart from material conditions, the emotional reality also poses threats to steady participation. At times sexual abuse victims become withdrawn or have flash-backs. Family or interpersonal crises also occur.

The distance from home to office was mentioned, but otherwise no serious complaints were registered about accessing the program or staff as needed. Clients spoke warmly about receiving help for baby-sitting and transportation, and were particularly impressed with staff flexibility:

"If my counsellor hasn't heard from me, we have an understanding. She really takes time to understand that I need time and doesn't judge me if I miss an appointment"

"My counsellor has changed her hours to accommodate me and my daughters; I really appreciate that."

Clients talked of how staff created an atmosphere of accessibility and responsiveness, such that they feel free to call at any time.

"They tell us that if anything happens, to call, and I have called. Even the receptionist will listen to me."

"The staff always return my calls whenever I need them. Everyone is good at returning calls."

For some, accessibility to staff was a problem during staff holidays and after-hours family crises.

"The only bad thing was when I was ...having flashbacks and two of the workers were on vacation and I couldn't get anyone to talk to. Although the hospital psychiatrist helped a

little."

"When the crisis happened...I think there should be an answering service so I could call somebody".

6

General Reactions

Reactions to Space and Facilities

" There is Indian stuff all over the place. I liked that. You have your own privacy while you're in therapy. There are jobs posted on the wall..information about other things going on...Useful information, I liked that."

" I felt really weird at the beginning, sitting on a hard chair and staring at the empty wall opposite, with office staff walking in and out of their offices"

An important Mooka'am assumption is that sexual abuse victims need a sense of safety and comfort from their surroundings. In early planning, considerable attention was given to spacial, environmental, and material aspects of the program. As well, attention was given to creating an environment which is distinctively Native in aesthetics and utility.

This section summarizes client responses to the physical environment of Mooka'am. This includes reactions to the general NCFST office space, since clients are exposed to this as they enter and await their appointments.

The general reaction to the over-all physical environment was positive, mixed with some noteworthy critical comments. The positive reactions conveyed how people respond differently. Some reactions are sensory and nothing else...smells, bodily comfort, physical relaxation. For others, the space and its contents produce a deeper psychological response, like memories of home or trust. Still others are helped, through visual cues, to structure their experience, and their expectations from the program.

Reactions to the general NCFST offices were favourable to mixed. Although appreciative of the proximity to transportation, some clients find the offices small, crowded and cluttered. One client, critical of the waiting room's proximity to the staff room, expressed discomfort at hearing her counsellor's voice. Another perceived "no place to sit and wait". Still another longed for a more bush-like environment.

Reactions to the separate Mooka'am space was more uniformally positive and enthusiastic. People reacted to different items in space, all positively. Of interest is that different items provided program messages and helped the client know what to expect:

.the doll house and figurines meant that a son was going to helped

."Kleenex on the table told me they were not going to freak out if I cried"

For one, the ticking clock was an annoying reminder of passing time in therapy.

The signs and symbols of Native culture ... sweetgrass, pictures, magazines...all were noted and appreciated as a positive part of the Mooka'am environment.

Reviewing the negatives, the dim lighting in the Mooka'am area is not for everyone, although for some it produced the intended relaxation.

The Mooka'am environment produces different response in terms of privacy and confidentiality. Those lacking a sense of privacy, spoke of the close proximity of interviewing rooms, and poor sound-proofing. Positive responses centred on the absence of interruptions or people walking through, and the locked door.

First Responses to the Program

"My problems are so big. How can this little place help me?"

Typically, new clients enter new personal development experiences with apprehension and fears. Successful programs find ways of acknowledging and normalizing these feelings.

Mooka'am client comments suggest that some early apprehensions and negative feelings intermingled with their early experiences with the program...

.... having to wait for a worker, particularly during a crisis

.... bad experiences with previous therapy

.... fear of losing kids

.... possible staff response to client's loss of control

.... the doubts about being helped by a new program

.... how they will be involved in their child's therapy

How did clients react when they were first introduced to the program? With few exceptions, the early experiences produced positive, hopeful responses.
Some entered with positive "pre-program" attitudes and expectations, having been exposed to the program in a workshop or reading, or as a result of having heard favourable comments about the staff.

The initial positive responses resulted primarily from staff actions.

"My counsellor's honesty and commitment won me over"

"Just call them up and they will understand what you are going through. They were not going to take your kid away. I was told that"

"My family worker is qualified. My concern was that people be qualified"

"I do recall that I felt safe and comfortable right away. I felt I found a place that I could do what I wanted to do. They gave me suggestions, for instance, they encouraged me to write and draw."

"They don't treat you like a client. They treat you like a person, and they don't make a big deal about you either."

"What I did like was when my counsellor first started to burn the sage. Overall my first visit wasn't bad"

The responses to Mooka'am's physical surroundings were almost as important in creating a sense of safety and relaxation.

Sustaining Hope and Commitment

Therapeutic and counselling programs are continually challenged to sustain client hopefulness and on-going participation in the program. Mortality rates are high in many programs, especially those dealing with sexual abuse.

> "I felt I was going to get help. With those two there was a never-ending support, and the honesty...they didn't try to spare my feelings. They didn't fib. If [staff] cried and shared her feelings I felt good to have her feelings shared...They ask me first before they do something for me. They are up front with me"

Assuming that the anticipation of being helped is an important dynamic in sustaining commitment, Mooka'am clients were asked whether, once they started, they felt that they would be helped by the program. As well, we asked whether these feelings changed throughout the program.

All six clients communicated a sense of optimism about being helped by the program. However, whereas three of these women were steadfast in this optimism, three admitted to wavering to the point of considering withdrawal. What insights can we glean from their comments?

First, their descriptions of what sustained their hopefulness emphasized such things as ...

.their personal comfort in disclosing

.the honesty of staff concerning the potential for change and their own expertise

.staff sharing their own feelings

.opportunities for involvement in decision-making

.the sense of staff competence

It was clearly difficult for clients to reflect on when and why their hopefulness wavered, and why they considered dropping out. Isolated comments suggest that...

.mood changes, such as depression, were taken as signs of potential failure in the program

.some clients had lofty expectations of their counsellors

Those who wavered were remotivated through a process of reflecting about their problems, and concluding that program success was very much dependent on their personal efforts in their own healing.

This suggests that an important program feature is the capacity to overcome the client's dependency on the program, and engender an early sense of the importance of self-healing.

Client Participation in Healing Activities

In this section we examine client participation in the core healing activities of the program. The aim is to document their emotional responses, and learn from their interpretations of various events. This includes their involvements and responses to staff as helpers.

Participation in Core Program Activities

In principle, Mooka'am clients are not required to participate in all core activities. Services are individualized depending on client needs and cultural inclinations.

This principle was reflected in the experiences of the six sample clients. Although all clients participated in one-to-one counselling, two of these had not participated in healing circles and four had not experienced a sweat lodge. Four clients received smudging.

Those who were uninvolved in traditional Native healing activities were either not Ojibway or were generally uninvolved in traditional Native culture. Even so, one person who had been raised in a white family and had found the healing circle a "culture shock", nevertheless attended the circle and participated in smudging. A Mohawk woman who had been raised in the Longhouse tradition chose not to participate in Ojibway-oriented traditions.

Other activities experienced by some, though not all, clients are reading self-help books, journal-keeping, camping, and letter-writing.

Participation in the Healing Circle

"I always find it hard to talk about myself. At the healing circle I can cry and I know what is going to happen. I sort of know that things are going to come out sooner or later. Sometimes this stops me from going, but I also know that it is part of healing so I keep going"

Healing circles are not mandatory for Mooka'am clients. Two of the four women interviewed had not yet participated. As an explanation, one spoke of her different cultural background:

"I don't think I'm ready to go to these activities...All of these are from different teachings, although I know a little about them. We do not use them in the Longhouse where I go. All the activities are Ojibway and I don't know much about them...Our ceremonies are very different."

Another expressed discomfort with her Nativeness.

Client participation in the healing circle produced generally positive feelings towards the process, but not without some mixed
reactions. The negative responses were directed against the symbolism of the activities or the requirements to speak about oneself in front of others. For one client, the fear of openness was a significant factor in her spotty attendance.

The temporary discontinuation of the healing circle produced disappointment and confusion. One woman was very disappointed at the discontinuation of the circle, and sensed that clients may have been blamed for this. Her comments reflected anger and confusion over why the circle had been discontinued.

On the positive side, clients felt that, within the context of the circle, they were able to raise their personal issues. One said that specific issues were not necessarily resolved in the circle, but that she was generally helped in her

relationships with other people. Another said:

"I'm identifying feelings that I had hidden for so long. Now I'm totally different. I'm more assertive. Yes, very much so. I've learned a lot. I've gained a lot of respect for myself and I've earned it. I'm not saying that I'm conceited"

Clients were asked to talk about those particularly helpful processes within the circle, and speculate on the reasons for their helpfulness. Their comments indicate how the format produced both common and unique experiences.

For most, sharing issues and problems within the circle produced a sense of trust, emotional release, and the comfort of not being alone with certain problems. References were also made to the concrete ideas and suggestions received for specific problems.

Two women drew attention to specific cultural activities, such as the singing of traditional songs and the passing of the feather. Interestingly, the feather was important to one woman who found particular comfort in knowing that she could talk for as long or as little as she wanted. And finally: "Hugging is always good!".

A unique feature of the healing circle is the participation of staff in the circle and sharing of their own issues. For one woman, this participation was helpful: "It helped me change my feelings about them". For another, knowing about their problems and issues made her temporarily "lose faith" in staff. Clearly, people have different responses to this aspect of the program.

I conclude this section with a lengthy quotation which is extremely reflective and powerful.

"The circle brought us together. Learning to trust with our own secrets, and trusting your secrets with others. This is the most significant part of healing. Knowing that others are experiencing too. Building the support system is good too. Being in the circle and showing the different parts of healing. Being supportive of people who are dealing with something that you have already dealt with. The effort that you put into the relationship makes it all worthwhile."

This quotation and other comments throughout all six interviews draws attention to an important element of the healing process. This has to do with the capacity and perhaps the joy of helping others. People are no longer passive objects for others, but are "subjects" who act upon and contribute to a reciprocal relationship. Perhaps this is what is meant by the "community of healers". It may be particularly important for sexual abuse victims.

Participation in Counselling

Every Mooka'am client participates in a one-to-one counselling relationship with a staff member. Interviews surfaced strong and consistent positive response to counselling. This applies to both staff members.

The interviews also surfaced a number of conditions and processes which, for clients, were significant parts of counselling. On the positive side, three of the six clients mentioned the helpful and calming effects of cultural activities and materials, such as burning sweet-grass and sage. Others commented on..

.the lack of barriers or structure, which encouraged a recognition of being able to solve one's own problems

.comfortable furniture

.counsellor's timely questions, friendliness, acceptance and "being on my side".

Several clients emphasized the usefulness of counselling in making a bridge to other healing program activities, such as the healing circle, writing, drawing, reading, and other support groups.

Clients were also asked to reflect on the uncomfortable aspects of counselling, and the things that sometimes made it difficult to participate. Some comments reflect the inevitable anxiety associated with the process of personal growth. Others may be related to cultural differences in the behaviors expected within a helping relationship.

Some talked about the difficulty of talking, particularly about their own problems, including taking the first steps towards independent problem-solving. Another talked about the difficulty of sustaining eye contact. Finally, one person talked about her expectation for closer physical proximity to the counsellor and emotional comforting.

Interaction with Other Clients

Clients in the Mooka'am program interact with others during the healing circle. At summer camp, they mix with women and children from Mooka'am and other NCFST programs.

Three of the six people interviewed were acquainted with other program clients before starting the program. A positive indication of the quality of the relationships is that four women felt that they had made new friends during the program, people with whom they could share troublesome issues.

Most spoke positively about their involvements with the other women. They emphasized such processes as sharing, offering support, and knowing that others had similar problems.

One women commented on how the different growth levels may sometimes inhibit stronger bonding with others.

Another client commented on what she saw as marked differences in her responses within the healing circle and at summer camp:

" I loved sharing in the healing circle. Camping was different. I found all my fears about people were there. I didn't know how to act. I stayed by myself or stayed with the children."

This comment raises important questions about the differences in organization and interaction in these two settings, and how these differences can be utilized for assessment and healing. The structure of camp likely brings people together in closer, more frequent interaction, which partly requires some completion of tasks. As well, those with children are publically involved in parenting their own, and possibly other children.

The healing circle in a sense minimizes two-way interaction, with focus on the leader or each client addressing the group as a whole. The camp setting has a broader scope of interactions with more people around various tasks. It appears that each setting calls forth different sets of personal resources, attitudes, and areas of self-esteem or doubt. (For other comments on this, see last section, entitled "Issues for Discussion").

More will be said on the roles of fellow clients in the section entitled "Program Impact".

Perceptions of Staff

Within healing programs generally, the interaction between clients and staff is an important vehicle for personal change. Research on the "helping process" has consistently shown that success derives from many factors, well beyond professional "techniques".

A number of specific questions were asked about the clients perceptions of staff and their own relationships with staff.

Over-all, comments about staff were overwhelming positive in their tone and descriptions. The isolated critical comments were lost among the many statements of praise and respect. Critical comments were directed to the early stages of the staff-client relationship, and in most cases did not hold true as the relationship evolved. Details are provided in the following sections.

Sense of Staff Competence

All six clients were **consistent and lavish in their perceptions of staff competence**. Each described competence in slightly different ways. The most frequently mentioned attributes creating a sense of competence were the classical qualities for a good helping relationship:

.good listening skills

.interpersonal perceptiveness and understanding (empathy)

.skills for drawing out the client without seeming manipulative

Both staff members were seen as competent, yet as one client remarked, "they showed their individuality". Although interviews did not delve into the perceived competence of other staff, the Program Supervisor was seen as competent, particularly in her mediation skills.

Qualities of a Helping Relationship

Clients were asked a series of specific questions designed to tap the qualities of helping relationships. The results:

.Most clients felt comfortable with staff

.All but one felt the opportunity to raise and deal with their own issues

.Everyone felt respected by staff

.For the most part, all felt free to say and do anything without being judged or criticised.

.Most felt that confidentiality was respected

A few qualifying observations are noteworthy:

(i)One client felt slightly uncomfortable upon first starting counselling. However, this discomfort quickly dissipated as the relationship grew and the client began to appreciate her counsellor's qualities.

(ii)Non-core members of the program received mixed reviews. One client felt uncomfortable with both male NCFST staff during support services. Another was quite critical of the woman organizing the fast. Others were critical of the camp organizer. An exception to this were very positive statements made about the intake worker and the receptionist.

(iii)For some, the early phase of counselling was most difficult. For example, in the beginning it was difficult to talk freely, and address issues of most concern.

(iv)One person, when discussing confidentiality, mentioned her apprehension concerning the camping experience.

(v)The physical aspects of the helping relationship was mentioned by four clients. Eye contact was difficult and uncomfortable. Physical closeness in the counselling room was valued. Timely hugging was welcomed. Staff's physical expression of feelings were noted and were beneficial to the relationship.

A Profile of Valued Healing Responses

During the course of each interview, clients made a number of evaluative comments which provided insight to important qualities of staff and the helping relationship. Clients were also asked about what would constitute ideal staff in a program such as Mooka'am.

The patterns in these comments are useful for understanding client's expectations and their sense of what contributes to the healing process.

Valued staff and helping qualities may be summarized as follows:

.Staff who enjoys their job and loves to help

.Honesty in the expressions of feelings and opinions, limitations of skills, and perceptions of the client.

.A counselling pace which is unhurried and patient.

.Non-judgemental and accepting responses.

.A sense of safety and trust, particularly about losing the children.

.Staff willingness to share their own personal issues.

.Staff who have worked on their own issues

.A relationship which encourages the expression of affect, both positive and negative feelings

.A relationship which is broad in scope such that clients feel that they and the staff are relating as total persons, rather than staff and clients ("to be a friend ...available").

.Empathy and sensitivity

.Warmth and kindness
.A sense of staff skill

.An elder on staff

Program Impact

Technically, this phase of the evaluation project was not designed to assess the specific effects of the program on clients. This is planned for 1992. However, some attention was given to an exploration of the personal effects perceived by clients, without specifically measuring the various kinds of changes anticipated by the program. In effect, this section discusses the clients' "sense of change" emanating from various program experiences.

In this section I assume that the language used by clients to describe their own personal changes is a "window" to their various healing selves. For this reason, this language is retained throughout the section.

The Impact of Counselling

All clients sensed that the counselling process made them think differently about themselves. The descriptive language clearly indicates that the differences were positive and highly valued by each person.

Some expressed their changes abstractly and metaphorically:

" I just blossomed. I could compare it to a seed being frozen...and gradually thawing out and feeling."

Most were quite specific in their language of personal change:

" I thought of myself as a better person. I found out I wasn't bad. I don't let people walk all over me, not any more."

" I think about myself differently. I know now that I'm a deserving human being. I can really see myself in a positive light. More self-esteem."

" Only eight months of therapy. I've come a long way. This kind of counselling is not a kind of dependency. Its helping me solve my own problems. Talking it out, talking it all out. Coming to a conclusion myself."

" Yes.[The counselling made me think of myself differently]. At first, I felt really helpless."

Clients were also asked if, and how, counselling may have made a difference to how they lead their life. All agreed that it did, but in different ways. Those with family felt better able to parent or relate to their partners. Others spoke of a growing independence in their behavior, such as problem solving, having an "inner strength" and natural creativity, and the ability to speak up for herself. Still others spoke of being able to change harmful behavior (eg. alcohol, drugs) and relationships.

The impact of healing circles

"Learning about Native things helped me identify myself...Get in touch with myself"

All four participating clients, expressed a clear sense that healing circles made a difference, either in the ways they lead their lives or think of themselves. How do clients express this sense of change?

Depending on who speaks, their words are highly abstract or indeed indicative of specific and concrete experiences or behaviors. Three themes emerge from comments about how they think of themselves differently. Again, client words and phrases are used to convey these themes:

.becoming "unblocked" or "soft inside" in the sense of getting in touch with feelings.

.self respect

.being able, and wanting to share feelings

This last distinction between "being able" and "wanting" to share feelings is important. Each represents a slightly different component of self. One conveys a sense of a new capacity, the other a sense of the desirability of a new way of relating.

Clients were also asked if, in their opinion, the experience of the healing circles helped them make some changes in the

way they were living their lives. All four said yes.

" They changed my life. I was flying high when I came out. Brought a lot more out of my life. Learned how I missed my own culture."

In addition to changes in cultural involvement, clients talked about new...

.inner changes: "getting softer"

.assertiveness

.abilities to talk and not take things for granted

.ways of taking care of oneself

The impact of relationships with other clients

Two of the four clients who had involvements with other clients felt that these relationships helped to make changes in the way they think of themselves, as well as how they lead their lives.

Clients developed a fresh sense of their own abilities to support and help others. As well, they became more aware of their negative feelings and attitudes towards themselves, and how these inhibit relating to others.

Comments also highlight growing capacities for assertiveness, recognizing strengths and weaknesses in others, avoiding judgements, and relating to the feelings of others.

For some, interaction with others produced new self-insights and an emerging curiosity about life. One talked of learning about personal fears and "running and hiding" in the presence of others. Yet another spoke of her desire to...

"...learn about life: human behavior, concrete houses versus life at the reserve ..... understanding all things around me."

Still another spoke of "building relationships that matter" and associating with people who care.

Changes in other family members

Those with other family members in the program spoke optimistically about positive changes in family behavior, and the positive implications for them personally.

" Yes. He is much easier to deal with, talk to. He's a better person. Isn't drinking any more. Much happier with himself. I can talk to him much easier now."

Those with children conveyed a sense of being better parents, but not without some struggle:

" I'm more concerned for him now. Recognizing his changes. I'm a better parent now. He was unhappy after one particular session. Sometimes he's protective of me."

"Yes [there were changes resulting from the program]. More acting out. My oldest daughter is physically abusive to me. I had to really take the time to sit and listen to her. I have to be more self-disciplined in disciplining her."

Those with husbands or boyfriends talked about sharing the problem-solving and better communications.

Descriptions of self... then and now

To glean an overall sense of Mooka'am's contribution to personal change, each client was asked two questions towards the end of the interview:

Think back to when you first started in the Mooka'am program, what words would you use to describe yourself at that point?

What words would you use to describe yourself now?

The answers are reproduced in detail on the following page.

When I first started the program	**Now, I am....**
"I was making a step to get my family life together and better.	"Still in the process of doing that, and am further ahead in the process of doing that."
"I was still drinking. Its like I was a child. I grew up more now in this program than I have in the past with other programs. I'm drug-free now. I've totally cut off those people..."	"More aware, mature, more conscious about my problem. I'm functional now. I'm trusting, more assertive, and a better parent. The inner me is more accepting of stuff, accepting my physical me because my adoptive parents used to use it against me."
"I was a mess, angry, confused, disoriented, disillusioned, and plain fed-up."	"I feel good about myself. I am actually going to be me. I am starting to like me."
"Desperate. Helpless"	"I'm hopeful. There's hope...Feeling more self confident at this stage."
"A bratty little teen-ager who thought she knew everything. That was two years ago.."	"More mature. It took a long time. I'm happier now."
"Frozen, stunted creatively. Extremely terrified. Determined to find a way out of this. Very ill.	"Struggling. Not as terrified. I'm feeling now...learning to identify my feelings. Convalescing."

The over-all pattern is clear. Each and every client indeed expresses a sense of change since beginning the program. Maturity, healthiness, trust, in touch with feelings....these, and other themes prevail as clients compare then and now.

To be sure, very little new information is added to experiences reported earlier in this report. The value of this data is one of verification and summary.

Clients Recommend Program Change

The thrust of these program experiences is one of movement. By and large, the program provides, and is seen to provide, opportunities for clients to experience novelty. They experience new messages, think about (and offer) themselves in new ways, and act rather than being acted upon.

Humanistic research must also provide these opportunities. To this end, our interviews treated clients as experts with valuable knowledge for program growth. To do otherwise risks unnecessary discordance between self-experience in two realms. Like the program, we said "your experience counts!".

At several points throughout the interview, clients were essentially asked: "how could things be done differently... and better?"

Most recommendations were idiosyncratic in the sense that each client made a different set of recommendations. Recommendations covered several areas of the program: techniques, organizational features, physical environment, programs and services.

Three recommendations were mentioned by three people. These were:

.Improvements in the summer camp: better organized, better food, and more healing circles.

.Outreach to the Native community: hot-line; community education about the program;

.Increase in counselling staff

The next three recommendations were mentioned by two persons each:

.More frequent healing circles

.Elders

.Modifications in physical facilities: larger rooms, natural light, wheelchair accessibility, and a room apart from staff for client (cigarette) breaks.

Finally, the remaining ideas were offered by one individual each:

.healing circles for children

.better planning of in-home program

.healthier food at Xmas party

.long term care program

.art therapy for adults who find it difficult to talk about problems

.more opportunities for fasting

.counselling techniques for releasing rage

Issues for Discussion

1.Would those choosing not to participate in healing circles benefit from another kind of group experience? Client data highlights the benefits of the group process within the healing circle.

2.What proportion of clients are Mohawk or some other culture? How can they benefit from Native healing? Are there generic healing activities suitable for all cultures?

3.What are the anticipated therapeutic benefits of summer camp?
Could these be identified and added to the description of the model?

4.Stresses were noted as Mooka'am clients came into contact with personnel and program activities which are outside of the program core. How is Mooka'am helped to interface with the agency at large and other programs?

5.How should future organizational "growing pains" be handled so that clients are not left confused and angry?

Appendix "E"

The Healing Circle

THE HEALING CIRCLE

A Research Working Paper
for the Mooka'am Program Evaluation Project

Frank Maidman, Ph.D.
November, 1991

Introduction

Perhaps the most innovative part of the Mooka'am Program is the combination of contemporary social work practice with traditional Native healing. A large part of traditional healing takes place in a healing circle.

The healing circle is a form of group discussion in which staff, clients, and a cultural teacher sit as co-equals, sharing painful issues in their lives, and learning cultural values and traditional healing practices. Spirituality is also an important part.

The details of this practice were acquired through an intensive interview with the program's cultural teacher. As well, the consultant himself was a participant in a healing circle during another project. The project Research Assistant has also participated in several healing circles, and shared her experiences and reflections. Later elaborations will incorporate the experiences of clients.

Process

The healing circle process is as follows: The cultural teacher arrives slightly before the circle begins. This allows her to meet with any participants individually for the purpose of dealing with private matters which are not comfortably shared within the circle. This also has the benefit of building trust.

In some cases the circle begins with a short period of exercise, for the purpose of releasing negative energy. This is usually followed by an opening prayer in the teacher's own language.

Next follows a period of cultural teaching and perhaps singing, again in the Ojibway language. The teacher may also drum on a hand drum. The stories and songs, which are explained, speak to themes of healing and growth. The earth and environment ("grandmother moon", water) as sources of healing, are frequent themes. Some language teaching may also occur.

Throughout the cultural teachings, core Native values are taught, including the values of kindness, caring and sharing, honesty, and strength.

The first session is deemed a "getting to know you" period. As well, the first three sessions or so, are generally thought of as important for trust-building. Throughout the healing circle, participants share in the "four gifts of life"...

.sweet grass through smudging

.water

.strawberries
.fire, through a lighted candle
The next stages involve all participants in a process of sharing their pain around a talking circle. A feather, rock or stick is passed from person to person. Upon receiving the feather, each person talks about her life experiences. They may speak on any topic:

"... what is bothering them, what concerns them...anything at all, whether it be their family, themselves their community, their city ....whatever."

If they disclose something which causes them to break down and cry, then the Medicine Woman, cultural teacher, (or an Assistant) will smudge that person until she regains her composure and she starts again.

This whole process continues, each person talking about whatever is on their mind. The feather goes around and around the circle. The particular cultural teacher or medicine woman is able to tell if the group needs more healing, and she may pass it around the second time. Usually the person who is really bothered by something will eventually disclose, no matter how shy, or how long it takes.

The leader seems to know which person in the room has a very serious problem which they want to talk about, but can't.

> " So that much patience...the feather would be coming, would get around until each person has disclosed what it is that is bothering them. And through this passing around of the feather or the talking rock or whatever ... in fact I've seen a stone passed around, and it starts off grey and comes back red. The medicine woman said that it showed that the grandmothers were in the room and that it was their way of saying that they were in the room to help us. And you could feel the presence in the air, you could feel...and too, when you are passing the feather around, um, some people pass it on without saying anything."

One observation about Native people is a tendency towards emotional control. This has been attributed to a fundamental cultural code against emotional release and spontaneity. Possibly for this reason, emotional blocks are frequent during healing circles, but these are handled routinely through the practice of smudging.

Should an emotional block occur, the leader will approach the person and smudge her with sweet-grass. Other things may also happen. For example:

"the Medicine Woman.. because the person had blocked off, or almost reaches the point where they don't want to
blurt out what it is that they've been carrying around .. she'll say "let it out, let it all out". Its more or less what we say to our children when they have a hurt. "It's O.K., you know..", that kind of thing. And um, with a bit of coaxing usually the person needs to be drawn out... gently. Then once she's on her way to blurting out what ... has been hurting her for so long, it's exhausting for that person, physically exhausting too."

No time pressures are imposed. Sometimes the guidelines leave open the choice of topics; sometimes a structure is given. For example, participants may be asked to talk about their abuse. In other circles, this will not happen.

Healing Circles and Teaching

Although this varies from circle to circle, and from leader to leader, healing circles are a source of specific teachings. All circles have a cultural learning component. The first Mooka'am teacher spoke of teaching cultural practices, healing customs, and the meanings of events and materials in the healing circle. Many of these talks provided the tools for self-healing.

Other teachings give specific advise on how to respond to life events and transitions in a culturally appropriate way. To quote:

"I even got instructions what to do at the funeral...to put my medicine bag in the coffin with [husband], even though he was not an Indian, even though he did not know a thing about sweet grass. Just the very physical act of putting it away in there knowing that he's going to go into the spirit world. So my whole medicine bag and everything went in there with him."

Many life transitions create confusion and emotional upheaval. Building on one's connections to others, society has its ways of providing the support and ideas for handling these transitions, allowing one to get on with one's life in a reasonably orderly way. The following quotes illustrate how healing circles assist major life crises:

"There's instructions, too, that they give you. During the month that [husband] was sick in the hospital before he died I went twice to two healing circles to get the support I needed to be able to get through that month. I knew I could not find it anywhere else, that strength I needed anywhere else. I would not have gotten that emotional, spiritual, and total support, I guess that you get from the healing circle. In the course of the instructions I got in that healing circle, they told me how to help him die, to make it easier for him and also to make it easier for me to go on living. And it was so helpful..."

"the Medicine Woman told me to talk with [husband] and to ask forgiveness for him for all the times that I failed him, and wasn't there for him when he needed me. And also I forgave him for all the times he wasn't there for me, when I needed him. And forgive him for all the times he hurt the kids, and to name specific events that especially hurt me...and to name specific events that I thought were especially hurting to the kids. When I talked to [husband] I first talked to him about the kids and asked him to...First of all, I asked forgiveness for me, because it would be easier to talk to him, and tears were running down [husband's] face. Had I not gone to the circle I probably would not have gotten this instruction nor would I have had the courage nor the strength to tell him to do it. And it was exhausting for both of us, but also very healing for both of us to go through this whole thing. And I had my sweet grass and my sage on me, close to me when I was telling him all this in the hospital, and we both fell asleep. I had my head down on the bed; it was terribly exhausting for both

of us, and we both fell asleep. Most of the Nurses on the floor were my work mates; oddly enough he died on the floor where I worked. That even added to the difficulty of .. because I had to deal with them on a daily basis too. So anyway, this whole healing process helped both of us; it helped him settle."

The Roles of Staff

Other than the distinctive Ojibway teachings and practices, a highly unique aspect of healing circles is the relationship between staff and clients. Both are co-equal participants in the healing process. Staff and clients share previous and current pains in their lives. In contrast to non-Native therapy, the boundaries between the "healers" and "the healed" are dissolved into a "community of healers" in which all participants are cleansed.

Healing and Impact

According to Mooka'am's first cultural teacher, the sources of healing in the healing circle derives from...

.sharing the pain

.purification through exposure to the four gifts of life

.the teachings of core Ojibway values

.contact with cedar, through sitting on cedar chips, drinking cedar tea, or through taking a cedar bath

On the close link between physical materials and healing.

"quite often the person who is very hurt feels a terrible weight when they get that feather. Its like the "weight of the feather", which makes them know that it is they that has to talk. I guess the medicine lady knows exactly how...she must be trained to see who is needing it as it goes around the first time. I don't quite know how the process goes, but I certainly know the benefits of it."
(Interview with Research Assistant)

One of the most visible and describable impacts of the healing circle is the emotional catharsis or release. In many cases, perhaps because of a cultural code of emotional control, emotion is released for long-standing pain.

"That burden you carry around with you is lifted a bit. I can tell you that when you come away from those healing circles you definitely have had some....weight lifted off you whether its guilt, grief, indecision,....you come away with some measure of..healing. You feel you have had a ...its hard to describe the feeling..."

Emotional release is accompanied by physical contacts and connecting at a basic physical level:

"I've seen people fall apart and not.. and think that they are not going to come together again, but usually through almost like a "laying on of hands", almost, where people just hug them and cry with them... the physical contact of spontaneous feelings you share with them of caring...they come out of it, and they walk away from that whole healing process and have a cup of tea (laughs). And you just marvel at how..something so simple can bring about such change."

The intervention of the leader may represent another way in which healing circles differ. Some leaders of the circle may not be as active as others in drawing people out. Circles have been observed where that intervention did not happen. If there is a block and some tears, and clearly the person is holding it back, the leader may not intervene.

The intensity of the experience and the open-ended structure of the circle produces, for some, a changed perception of time. Circles often break up very late at night. There are no restrictions on how long they can last.

"Most people who want to be healed...you're not even aware of time. It was only my own physical discomfort that took me out of the circle, because I had to sleep. Even people find it difficult to leave the room and go to the bathroom once the circle is underway.

... there's no rule. It's almost a sense of... for me, anyway that you don't want to break that circle...that power".

Spirituality

Healing circles have a strong spiritual component:

"There is almost a spirituality type of thing that comes with it too. You come away with almost a new reverence, a new feeling of ... a certain reverence for the whole feeling."

The spiritual references and feelings are created through the leader's talks, and the symbolism of cultural materials and activities.

Visions have been reported:

"I've actually been present in the room where other... I don't know .. like Grandmother has materialized. Somebody is sitting in an empty chair, what was an empty chair, somebody is sitting in it. We have been in a room where there has been a fancy dancer while the healing circle is going on ... and this person dressed in the fancy outfit has been there. I didn't think it was possible. They didn't stay for long, but we knew that there was something special happening, and it was not frightening. We just realized that something very special was happening to us all."

Visions are described as a component of healing:

"These are spirits who materialized while we were there in the healing circle and they added to whole healing. You've never heard of it? We don't talk too much to non-Natives about it. We had one non-Native person there, and she didn't see anything, but some of us did see a fancy dancer. Two of the young girls that were there saw the fancy dancer... I didn't, but I saw the Grand-mother sitting there. And you feel the presence of other spirits in the room too, so it ...you know there's something extraordinary going on. And you feel confident knowing that your Grandmother is there watching over you."

"I...haven't talked to the Medicine Woman about that presence yet, but both of us who were there and saw her felt comforted, and were in no way...It just seemed like a natural thing to have there, almost a natural part of that healing... I have always had a strong belief in powers like that because my Grandfather was also a medicine man. He talked a great deal about spirits."

~

Sweet grass and smudging also is believed to mediate the events of the circle and the spirit world.

"I guess ...from my personal point of view... I actually believe that smudging has that cleansing feeling. But also, you know that your thoughts and your prayers are going up to the Creator through the smoke. Whatever you are feeling, whatever is happening to you is being almost being elevated up to ...wherever."

Some participants believe that the strength of healing circles at least partially comes from the spirit world. Talking about the death of her husband:

"...before that circle ended we also set a date for another circle for after [husband] died, for me to go through another healing circle so that we could deal with [husband's] death, and my feelings about it. And the grief that I felt. So the whole thing was very useful for me to be able to continue working, to be able to help my family who were all around me that did not go to any of these healing circles, and are not even aware that such a thing exists. My own children don't know...So they wondered where I got the strength from...it comes from the Creator and also goes through that healing circle."

Healing Circles and Group Therapy

The importance of spirituality clearly distinguishes traditional healing circles from group therapy. There are other differences as well. In contrast to group therapy, participants rarely talk to each other during the healing circle:

"There's no communication. It's almost like a .. each one telling a story, a chapter in their life. It's like another chapter in this healing process. Once you leave the circle, you never talk about it again. I have never had the curiosity to ask a person who almost fell apart anything that happened that day. I just saw with my own eyes what happened, and it seemed like a natural turn of events."

(Interview with Project Research Assistant)