NATIVE ILLNESS MEANINGS: DEPRESSION AND SUICIDE

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Education
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Depression and suicide rates are prevalent amongst Native people living on reservations in North America. The literature indicates that the emotional difficulty termed "depression" is common among Native people (O'Neill, 1993). However, Western understandings of the term "depression" may not always be applicable in Native contexts. Studies indicate that in some Native communities the particular impact of social circumstances on mood is related to Native peoples' experiences of depressive illness. It is important to understand the meanings Native people give to the term "depression", their experience of it, and the sources they ascribe to it, both social and individual.

It was the purpose of this study to assess from the Native participants' understanding, whether depression and suicide does affect those living on a reserve in Northwestern Ontario. This study's aim was to explore whether both depression and suicide, as the terms are understood in Western culture, are a problem for these Native peoples. Also, it was the aim to understand what the illness experience of depression and suicide means for these Native people, both at the social level, the contextual level and the personal one. It was intended that from this research, knowledge would be gleaned about what these Native peoples' explanatory models were regarding the sources of low mood and suicide.

This exploratory narrative investigation revealed the participants' themes or meanings that they gave to their illness experience. These themes spoke to psychosocial sources for which these Native individuals attributed their experiences of psychological distress. In their understanding, both female and
male participants experienced episodes of depressive mood and certain symptoms. Participants also had experienced suicidal thoughts and intentions. Importantly, participants sourced their mood difficulties to social causes and not to their own biologically-based predispositions or diseases as posited by Western medicalized perspectives as sources for mood problems. Rather, the occurrences of psychosocial stressors that began in early life and continued into adulthood were described as major contributors to the illness experience of mood difficulties by participants in this study.
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INTRODUCTION

The People and Their Home

The Norwesters are located in rugged land in Northwestern Ontario. These mountains are strong and resilient, steel blue against the high background of the sky. The landscape is jagged, craggy, helped to appear so by the outline of the trees; firs, pine, mountain ash, poplar and birch. This is not gentle geography. The land is situated on the north shore of Lake Superior in the centre of nowhere. Driving to the reserve from the city, I cross a rickety swing-bridge where a dilapidated, no longer used grain elevator is situated. A ship sits at dry-dock beside it, its rusted black bulk high in the air. The road leads straight to the mountain. At the corner, the highway marks the end of the road. The highway stretches left and right. To the right is the paper mill with its smoke stacks puffing upward. Ski trails can be seen forming rivulets down the mountain. Gas bars and confectionery stores line one side of the highway and a railroad track lines the other. Native people own these pumps where gas and cigarettes are cheap, even if you are a non-Native customer. This annoys the non-Native vendors on the other side of the track enormously. Turning left and driving down the highway past more gas bars and heading toward the lake, half-ton trucks and muddy cars roll past. A police cruiser usually sits along side the highway waiting for speeders. About a quarter of kilometer down the road, on the right-hand side, a large, beaten up white painted sign attached to a pole is half hidden in the brush. It reads, "NABSS" with a painted circle beside it split into quarters, in one quarter a feather, another a rising sun, then a round white circle surrounded in green, and in the fourth quarter a stalk with three leaves. "Fort William Indian Band" is written
underneath this with a picture of the Sleeping Giant, which is a local landmark and part of the mountain range. Under this is written, "Administration Office". Then, another long narrow sign underneath reads, "Nishnawbe-Aski". Below that yet another sign reads, "Nishnawbe-Aski Development Fund". Beside this sign is an oval sign with a red sun on the left shining over a teepee and reeds in water. And, beside this a sign with the words "Nation" with a bear-rug like painting on it. Underneath this, another sign says, "Development Fund Unity Strength Success".

Turning right onto a non-paved curving road, the band offices eventually appear. They are a hodgepodge arrangement of huge trailer offices. Thirty to forty cars are parked by each trailer but people are rarely seen around. A few big dogs usually sit in the sun outside the trailer doors. Opposite the trailers are homes, modern versions of log cabins, some are beautifully architectured. A few stucco homes of the mid-sixties style are intermingled between. The yards are big and scrubby. Some have lawns but most have no landscaping. Curiously, this juxtaposition seems metaphoric of the mix between the presence of acculturation and tradition on this reserve. Unpaved roads traverse the reserve land with homes built side by side along the roadsides. A main dirt road slices the reserve in half and meanders up the mountain. Part way up it splits into a fork with one side leading to a bay on the lake and the other heading up to the mountain's top.

Locating the band office is not difficult if one knows who drives what car. Entering the band office I hear the sound of telephones, intercoms, fax machines, printers and all the noises of a busy office. There are many offices in this place and long narrow corridors lead off in various directions created by add-ons to the main trailers. I know the secretaries from previous visits to the reserve and we chat and I am usually told to go to the back and make
myself a coffee. No one is surprised to see me, even if I have not been there for months. I was told a long time ago that concerning band members, "everyone knows where everybody is all the time". I have never asked how. I am comfortable here, the attitudes of others toward me are very relaxed. Perhaps because the city and its surrounding geography were my birthplace and home for many years and the reserve looks the way the city appeared years ago when I was growing up. The air is clear, clean and energizing. I have visited the reserve more than once a year for almost twelve years now, whenever I come to the city. I have a close friend who works in the band office whom I enjoy reconnecting with when I have the chance to go home.

Until recently, upon appearance, it seemed the band was run by a matriarchy of women. The chief was female and several other women were in positions of authority. While interviewing for this study, it was my impression that local government was controlled by women. I felt this to be an enlightened political situation and since women are both more verbal and helper-orientated by nature, I believe it assisted me in negotiating the process for this study to be realized. All the women I spoke with were encouraging of my educational pursuits and enthusiastic about this type of study. I did not meet with the resistance to outside researchers so often described in the literature (Darou, Hum & Kurntness, 1993). Over the summer of 1995, two women, Bev and Evelyn, emerged as my companions in this endeavour and it was their friendship and assistance that helped me to negotiate the territory among people I had not yet come to personally know. Initially, I would not have been able to contact interviewees without their assistance. My closeness with these two women developed during the data collection and I had a difficult time emotionally separating from them at the end of the summer. When transcribing the tapes after leaving the reserve, it was sometimes hard to
distinguish my voice from theirs. I had not known before that our accents were so similar, even the tenor of our voices was alike. I felt such a keen sense of sisterhood with them that it was easy to forget that our lives had been so different. They were Native and I was not and because of this, we had experienced two very different worlds.

The treatment centre was located at the base of the mountain beside a bay. I took the second fork in the road to get there. It was necessary to drive through the reserve to get to this road leading to the centre. The sheer cliff of the mountain rose high over the pine and cedar building. Long before I began visiting the reserve itself on a regular basis, I was asked to come as a volunteer to the centre so that a woman could "do her fifth". It seemed like I drove for miles along a dusty road before I reached the bay. There were no signs, no people, no houses. Just a long road in the middle of tall timber on either side. The road suddenly ended directly at the shore of the bay. To the right, a muddy track by the water's edge eventually led up to the building. A sweat-lodge was erected to the right of it. I parked and entered the building. I was greeted by no one but a few people were seated in a canteen to my right. The place was very quiet and I stood in the foyer waiting. Eventually, a small Native man approached me and we exchanged names. I was instructed to have a coffee in the canteen while the man went to find the woman who wished to do her "fifth". I had no idea what "a fifth" was. My brother volunteered me to do this and I understood from him that all I had to do was listen. A shy Native woman came with the man and we greeted each other. She led the way into the centre's meeting room. It was a large, circular, wooden meeting room with skylights, it smelled strongly of cedar wood and sweetgrass. On the floor in the centre of the room was a rug with the four directions, north, west, south and east in different colours. We sat side by
side on a bench that encircled the room and the woman began to talk and I listened. Five hours later I have learned that "a fifth" is a confession of past sins and guilt. It is a part of the Twelve Step program used in drug and alcohol treatment. Basically, my role required non-judgmental, Rogerian-style reflective listening (Rogers, 1951). My impression, from hearing this woman's story was that she had far less to confess than those who had perpetrated actions against her. Once a "fifth" is completed, the person in treatment can "graduate" from the program. After hearing many "fifths", I have become quite learned in the victimization of Native woman. One woman horrified me when she showed me older and newer scars on her arms and stomach from knife wounds she had experienced at the hands of an abusive non-Native husband. She worked for him dragging logs in a more Northern remote community. Another young beautiful Native girl told me she prostituted in the city to pay for groceries because if the city's social worker visited her mother's house and found no groceries in the cupboards, C.A.S. would take her siblings away. Central to every woman's story were incidents of experiencing abuse and violence. All had used alcohol or drugs but whether they were alcoholics or addicts was unknown to me. My impression was that most were not. It seemed to me that substances accompanied the troubled lives they led. I was glad for the treatment lodge in that from my perspective, it provided them with some rest. I held little hope that things would change much for them when they left treatment. My sense was that a drastic change in the environment in which they lived would need to first occur. To me, their life situations seemed to be products of the social world that they interacted with.

Doing this research touched at an array of feelings within me. Because this study's approach was based in grounded theory, I have not included my emotional experiences in this study. As Glaser and Strauss (1967) describe,
"The field worker who has observed closely in this social world had, in a profound sense, to lived there" (p.226). Yet, as these authors explain as required, I had to be sufficiently immersed in this world to know it, and at the same time retain enough detachment to think theoretically about what I saw and lived through (p.226). As these authors comment, this detachment serves to protect the researcher from "going native" while still passing as a native to a large extent (p.226). My sojourn with these people was a time of warmth and acceptance. However, their stories pained me and I spent many evenings sitting in a boat at the water's edge wondering how I could emotionally regroup after each day of interviewing.

**My Personal Interest in the Academic Study of Depression**

Research that explores the illness experience of depression has interested me since I began studies for my second career goal - that of becoming a clinical psychologist. My first experience of thesis writing was in my undergraduate psychology studies in 1993 and this research explored depression amongst survivors of cancer. What type of psychological help cancer survivors, particularly those who reported experiencing depression, regarded as most helpful to them in their physical illness experience was the topic of interest in that study.

Since 1993, I have chosen internship training in psychiatric settings at both the Master's level and the Doctoral level of my studies. Throughout the seven years I have been involved in the academic process of studying to become a psychologist I have focused my interests on training and working in psychiatric settings. For the past four years, I have been working with the population of schizophrenic clients whose mental illness experience is both severe and chronic.
However, it has been the presence of mood difficulties in all clients' or patients' illness experiences that continues to most capture my interest. Training and now, employment as a clinician in psychiatric settings has afforded me the learning opportunity to work with individuals suffering from varied psychological difficulties. Currently I work with a population where chronic schizophrenia is the predominant illness experience of my clients or patients; however, a good proportion of this population suffer from a mood dysregulation difficulty that has come to be termed as "schizoaffective disorder". This mood disorder includes the presence of psychotic features and is a severe illness that often first presents as Bipolar Disorder.

As a clinician, I find working with individuals experiencing mood difficulties to be most rewarding because treatment strategies for the several forms of mood illnesses, particularly depressive illness, offers more hopeful treatment resolutions to relieve the mental distress. There are many therapies available to control the symptoms. Because my training occurred in psychiatric hospital settings, I have been educated in both counselling and pharmacological treatment modalities. I feel that I cannot make a general comment on whether any particular treatment strategy or a combination of them is most effective because results often depend on the individual, their circumstances and what life experience variables preceded the illness and may contribute to perpetuating it. It is in this life experience arena, or what issues surround the illness experience, particularly causal factors, that I find most intriguing.

Addressing causal factors for both depression and suicide have been of great research interest perhaps because it is assumed that the manipulation of the factors related to etiology, be they biological, psychosocial or sociocultural, may work towards developing better treatment outcomes.
Importantly, designing interventions where factors have been identified through research activity to contribute to depressive illness may prevent its onset, shorten its duration or prevent reoccurrence.

**Personal Interest in the Native Population**

During my elementary and high school years, I lived in Thunder Bay but spent considerable time in Winnipeg, Manitoba. Both cities have large Native populations. I grew up surrounded by Native people in my environment but I did not intermingle with them socially until I was in my early teens when I developed a relationship with a boy who was half Native. We continued our relationship into young adulthood and although I knew his Native mother well, my friend and I never discussed the topic of his Native background. Some form of silent agreement existed where I knew it was a topic he did not wish to discuss. My friend did not inherit his mother's Native physical characteristics and so, in the early stages of our relationship, before I met his family, I was not aware of his Native ancestry. If I had been, I do not know whether a relationship between us would have developed. Racism was quite prevalent in our geographical area and I do not know if I could have withstood societal pressure at the time.

After finishing university, I married a man who was half Native also. Through this marriage, I gained what is called "Indian Status" and became a band member, in both my married and single name, of Fort William First Nations Indian Reservation. I had very little contact with the reservation and knew virtually no one who lived there but my husband told me stories of the years he had spent as a child on the reservation before his mother left both his Native father and the reservation. My husband was one of the three children his mother was forced to "give away" by the insistence of her new non-Native city-dwelling husband to C.A.S. for adoption. My husband did inherit his
Native physical characteristics. The stories I heard from him about his life on and off the reserve were upsetting to me and much of what he described is similar to that presented in the data for this study. The marriage did not last but my name has remained listed on the band membership.

As a youngster, I watched Native people come in from the reservation to grocery shop in my father's store. They used "chits" or food vouchers to purchase their food. My father let them into the store to shop at 5:55 p.m. "just before we were ready to close" when the store was not open to regular customers. I recall my father telling me that these Native customers were not allowed to purchase the "higher grades of meat". They could not buy anything more than what was indicated on the "chit's. My father said "They were only allowed to buy from a specified list of groceries". He also said "But we, for instance they like maple syrup, but I'd tell them they could take it and we doctored things after. We had to send this list in to the city in three copies and they [the city] never questioned it as long as we were within the amount they [the Native customers] were allowed to have."

My father said that in 1947 until the mid-sixties, not many Indian people were ever seen in the city of Thunder Bay. Because they had their own school on the reserve until the mid-sixties, no Native children attended school in town. I remember seeing signs on the city's main street on bar-room doors stating, "No Indians Allowed" in the early 1970's.

In grade school, I was often bored with the dry content offered to us in reading and writing classes but I particularly recall being enchanted when our grade four class studied a poem by Native poet and writer E. Pauline Johnson entitled The Song My Paddle Sings. Throughout my childhood, my maternal grandmother told my sister, brother, and I stories about her life growing up on the prairies. She told colourful and descriptive tales about seeing Indians
riding bare-back on horses and being terrified of them. She too was proud of her own ability to ride bare-back.

My grandmother was a very good story-teller even though we knew most of the "scary" content was made up. In later years, my mother told me that this grandmother's father had been nicknamed "Wandering Spirit" because instead of running his large farm in Manitoba, he left that work to his sons and went off for long periods of time to do "business" with Indian people. I was never told what this business was. At some point in my early teens, my grandmother gave me a buckskin covered book written by E. Pauline Johnson (1913) entitled *Legends of Vancouver*. On the front cover, Ms. Johnson had hand-painted her self-portrait in full Native head-dress. I do not recall how my grandmother explained that she received this book but it is inscribed to her by Ms. Johnson.

In my undergraduate studies as an English major in the mid-seventies, my plan was to enter the Master's Program in Literature and do my thesis on the works of E. Pauline Johnson. Near the end of my undergraduate program, I travelled to Brantford, Ontario to visit the site of the Johnson home and learn more about what her life had been like. I made a special effort to take courses that would focus one-quarter of my English degree on Canadian Literature studies. The poetry and stories written by Canadian poets and authors about Native people were of most interest to me. Unfortunately, pragmatism intervened and the finances required were unavailable to me for further long-term studies at the Master's level. After swallowing my disappointment and some weeping in the university washroom, I trudged across campus to register for the one year Faculty of Education degree.

I taught high school in both Northwestern Ontario and Manitoba for fifteen years. Throughout these years I encountered Native children in my
classrooms and later, in my Guidance Counselling office. With rare exception, these students did not fare well in our education system and by Grade 11, almost all had dropped out along with the large number of students as a whole who drop out at this grade level. I was concerned about this and was perplexed as to why these students needs could not be met in school? I was puzzled as to why the school system was not much interested in the poor school performance of Native students. Even a weak-hearted attempt by the last board I taught for to introduce a course in Native studies was a complete failure. I was aware of racism in the schools on the part of both students and faculty. I sensed that the home lives of Native students were different from those of students in general. Native students' values regarding education did not seem to be similar to those of the predominant school culture either.

I did not take a "leave of absence" from teaching to further my studies in counselling because of a particular concern on how to better help Native students but the desire to know more about what to do in general for students experiencing psychological distress strongly motivated me to become better trained. Many Native students I encountered while teaching fit into this group.

At the time I began my teaching career my brother, whom I was close to, had completed his Master of Divinity degree and became a parish minister serving on Native reservations in Saskatchewan. He married a Cree woman and he himself was becoming learned in traditional Native healing practices. He incorporated these into his theology praxis and honed his skills in Native counselling. He would eventually practice this role in a hospital in Thunder Bay. On vacations, we would encounter each other in Thunder Bay and it was he who introduced me into Native counselling as a volunteer at a Native treatment centre nearby. It was this experience that helped me learn and
better understand the experiences of psychological distress amongst Native people and its prevalence.

**Academic Interest in Native Peoples' Interacts with Personal Interest**

Over the following years, I came to know Native people and their life circumstances quite well. I also realized that most of the non-Native population I interacted with was not aware of what I had come to learn.

In 1994, I joined the Native Psychological Association when I began my doctoral studies. Their regular newsletters kept me abreast of research by Native people for Native people. Movements in all areas of life for Native people were being addressed and advanced because of this type of research activity and I found this exciting. Involvement in the Native Psychological Association provided me with new acquaintances and friendships with Native researchers, writers and politicians. Weekly, I have communicated by electronic mail with Native academics from across North America. Realms of dialogue with Native professionals have traveled across my computer screen over the past four years and the ultimate impact on me was comfort in learning that much is being done to address Native issues in general. Through this communication process, I learned a great deal of general knowledge about what had and continued to contribute to the plight of North American Native people in society.

When newspaper articles across Canada began to report the startlingly high suicide rates amongst Native people, I followed this with interest. I was hopeful that dissemination of this information through the media might indicate real interest and concern was emerging in public interest. When The Royal Commission on Aboriginal Peoples (1995) reported that suicides for Canada's First Nations and Inuit peoples are about three times higher than the general non-Native population and five to six times higher among Native
youth, I began to seriously consider what role I could play in participating in the need to look more closely at Native peoples' mental health issues. I felt enough self-efficacy in possessing certain knowledge of the subject area to consider researching it. I was enthused at the prospect of making a research attempt toward providing knowledge that could contribute to a better understanding of the mental health needs of Native people. This intent was also mobilized by my personal interest in finding out what was really causing the alarmingly high suicide rates among Native people. I intuitively knew what the contributing factors might be from personal experience in coming to know these people, their home reserves and life situations but I could not contextualize all the factors at play in any systematic fashion.

I made the assumption that depression must be a key factor for high Native suicide rates because the risk of suicide is a significant factor in all depressive states. Research has shown that the vast majority of those who complete the act of suicide do so during or in the recovery phase of a depressive episode. As a researcher, I wanted to learn more about the role depression played in the high suicide rates amongst Native people. Again, treatment for depression is more hopeful than it is for other severe mental illness difficulties. On a simplistic level, I wondered if treatments could be developed to address depression in Native contexts and whether these could be implemented in the Native population. If so, would the tragedy of high suicide rates be lowered? This was a research endeavor that I felt both a professional and personal interest and responsibility to pursue. Interestingly, my 1973 - 1977 unfulfilled efforts to academically research the life and works of E. Pauline Johnson was resurfacing in 1994 in a different form and becoming this time, an actuality! Similarities surrounding her own life circumstances resurfaced in much of the data gathered for this present study.
How the Research Process Began

Once I began volunteering in 1988 as a counsellor at the Native treatment centre situated on the reserve land where participants in this study live, I came to know people living on the reserve. I was a band member and able to approach the band leadership with my idea of doing this research. One must know Native people to appreciate their ability to be both surprised by little and flexible. They willingly agreed to promote membership participation in this study and their enthusiasm quickly moved the enterprise into a data collection reality. The project was accepted and approved before I assimilated its becoming a reality and it felt like I was taping and interviewing soon after my initial query as to its feasibility.

Prior to going to the reserve to collect the data in the summer of 1995, I was exploring methodological approaches to my inquiry that would be sensitive and respectful with regard to this particular culture. Already well-practiced in psychiatric interviewing, I wanted to alternatively explore my research question in a manner that included cultural awareness and sensitivity. I felt psychiatric interviewing missed a lot of pertinent information because this approach virtually ignores the role the cultural world plays in the psyche of the individual.

Fortunately, as Chapter two of this study presents, a few researchers including a Native psychiatrist, Charles Manson, had researched depression among Native people. Arthur Kleinman, an anthropologist and psychiatrist had contributed much to inform academics on both the importance cultural contexts play in the illness experience of individuals. He had developed an approach on how to perform research so that consideration of the role context played in local settings resulted in learning much more about not only the illness experience but how to utilize this knowledge toward delivering
meaningful and hence, more effective treatment strategies. The research questions in Chapter Three were designed to follow Kleinman's methodological approach to this research.

Early in this research process, I was able to both meet and listen to presentations by Dr. Manson and Dr. Kleinman. These two psychiatrists, academics and researchers advocated for abandoning research approaches heretofore practiced in their field. They were proposing to medical students that they abandon psychiatric categorization models when assessing mental health issues in peoples from other cultures. From the experience of listening to them, I felt more comfortable in adopting their proposed research approach in this present study. It is culturally respectful and promotes the disregard of a priori assumptions when entering the research inquiry with Native peoples. Manson and Kleinman's research model is presented in Chapter Two.

The original far-reaching aim of my research endeavor was to discover what helpers or helping systems these Native participants identified as useful for assisting them in overcoming what they identified as psychological distress. This knowledge could lead to the development of culturally appropriate care paradigms. Contributing, through research, to the knowledge about "what is happening?" and "why is it occurring?" could assist in the "how and when to?" process of promoting healing outcomes in this Native community. Further, if this knowledge were found to be generalizable, then helping strategies that develop from the knowledge these data produce may contribute to helping approaches in other Native communities.

The more realistic aim of this research experience turned out be limited to finding out information as to what the experience of depression and suicide meant in the context of this Native community. From learning the participants' understandings of the depressive illness experience, the causal
factors they attributed to creating psychological distress for individuals in this particular community also emerged.

Abandoning psychiatric or psychological theoretical assumptions about depression and exploring the illness experience at the local level in an approach that encouraged the participants to define their own understandings of the term "depression" as an illness experience and to explore their explanations surrounding causality provided for a much richer collection of information. From my research experience with survivors of cancer and their experiences of depression, I had learned that the distribution of measurement instruments to assess the severity and type of depressive experiences merely revealed predetermined information. These research results informed little about the complexity of the issues surrounding psychological distress from the participants' understandings. It was intended that for this present study, a qualitative research approach would provide greater insight into the Native individual's experiences of psychological distress.
II

LITERATURE REVIEW

Prevalence of Depressive Symptomatology

This chapter will begin by explaining why diagnoses of depression among Native people require close examination. Too often, depression is used as a catch-all term for conditions ranging from mild to moderate psychological/mental/emotional disturbance, to clinical psychological depressive psychosis. As such, the term is often misapplied and misused. From this, it follows that labelling Native people as clinically depressed may be a misdiagnosis, or misapplication of the term. Thus, it is important when considering the experience of depression among Native people to distinguish clinical depression from valid experiences of unhappiness.

Note well here that treatment decisions arise out of any diagnosis of depression, so that a misdiagnosis can have alarming consequences. In the present day, the treatments for "real" clinical depression are many and varied, and have mixed success. The most common approaches to treatment are based in Western medicine, and usually involve a combination of pharmaceutical intervention and psychotherapy. If depression is misdiagnosed in a Native person and a Western course of therapy is prescribed, more harm than good may result, because other important causes of that individual's suffering will have been overlooked.

The 1995 report of the Royal Commission on Aboriginal Peoples discussed at length the tragically high suicide rate among Canada's First Nations, Metis, and Inuit peoples (Waldram, Herring, and Young, 1997, p.90). Among the commission's findings was that the suicide rate among Native young people is up to six times higher than among non-Native young people. Native groups, long aware of this distressing fact, have been seeking ways to deal with their
members' emotional problems, in particular, those related to "depression" in the broadest (and least useful) sense of the term.

The link between depression and suicide is only assumed. In Western society, depression is regarded as mental health problem that, if not treated in the individual suffering from it, may result in suicide. The assumption is that Native people are suffering from clinical depression because of the high suicide rates. It is imperative that the validity of this assumption be investigated. If unhappiness and psychological distress are assumed to be "depression", then the responsibility for solutions is too easily removed from Canadian society as a whole, and placed on the shoulders of the individual, whose treatment (as opposed to reform of the surrounding social world) becomes the focus of interest.

**Questioning the Current Theoretical Assumptions about Depression And the Application of a New Theory to Peoples from non-Western Cultures**

This section of the literature review will focus on the theoretical work of Arthur Kleinman, who represents what he describes as the "new cross-cultural psychiatry" that has adopted a critical stance toward prevailing professional assumptions, which he regards as biased in that they approach mental health and illness from a biological and disease model or paradigm (Kleinman, 1977; Lewis-Fernandez & Kleinman, 1994, p.67). In contrast to this long-held theoretical model, Kleinman argues for an approach based on a:

> cultural theory of personality and psycho-pathology [that] asserts that the local cultural world precedes the appearance of the individual and fundamentally patterns his or her developing biological and psychological processes... Interpersonal experiences are contested and negotiated by real people who differ... Yet their mind-body states and notions of personality are profoundly shaped by collective cultural paradigms. (Lewis-Fernandez and Kleinman, 1994, pp.68-9)
Kleinman (1994) further contends that local cultural and gender norms must be taken into account before questions of pathology are raised. His approach is not to pathologize people who are experiencing illness, but rather to reformulate current models so that they focus on how social change affects sociosomatic and sociopsychological processes. Central to this present study is an analysis of how the social context affects the individual's experience of depressive distress. As Lewis-Fernandez and Kleinman (1994, p.69) assert, the disaggregations of individual experience that we call depression exist not just in the interior of the body-self but equally at several social levels. For example, the demoralization caused by political disenfranchisement, and the loss of supporting social networks, can both contribute to "depression".

"Depression" is a Western medical term used to describe and categorize a cluster of symptoms. At times (which are obviously relevant here), the term is applied to members of another culture, for whom it lacks coherence (Kleinman, 1986). Kleinman (1977, p.452) describes the "depressive syndrome" as characterized by "depressive affect, insomnia, weight loss, lack of energy, diurnal mood changes, constipation, dry mouth, and an apparently limited number of related psychological complaints". He adds, however, that the depressive syndrome represents a small fraction of the entire field of depressive phenomena, and that the syndrome as defined above excludes most depressive phenomena - even in the West. So: Is a Native person, or a community with distress, actually suffering from depression as a "disease"? Or is the "depression" really a socially caused form of human misery that is manifesting itself in psychological distress? Investigation is required if these questions are to be answered.

There is plenty of research to support the assumption that mental illness (including depression) is common in Native populations; but effective
treatments for the mental "distress" that Native people experience are only beginning to be explored. Before we can treat mental distress effectively in Native populations, we must determine which components of the mental distress they feel are actually "depression" as the term is generally understood. To this end, it is vital to analyze what the term "depression" means in a given Native community.

In Western societies, depressive illness is often viewed as a biological illness, and a pharmaceutical approach to treatment is frequently taken. But Kleinman, like many present-day Western medical practitioners, questions whether Western diagnostic approaches can be applied to non-Western cultures. In his view, the medicalized theory of mental distress is quite possibly flawed:

An anthropological analysis of cross-cultural research in psychiatry shows that the model of pathogenicity/pathoplasticity comes fairly close to being a medical orthodoxy. In this revealed version of psychiatric truth, biology is presumed to most, "shape" or "influence" the content of the disorder. The classical example is disease caused the delusional thought process but the system of cultural beliefs organizes the content of paranoid thinking (Kleinman, 1986, p.450).

Kleinman (1986) challenges the relevance of this biological disease-based model of mental distress, contending that it is the depression "experience" rather than the biological disease concept that predicts illness behaviour. For example, depression experienced as low back pain and depression experienced as guilt-ridden existential despair are substantially different forms of illness, with different symptoms, patterns of help-seeking, and responses to treatment. The disease in each instance may be the same, but it is the illness that is the determinant factor. Even in North American society, the social and
psychological components of the illness experience are more powerful determinants of disability than the biological ones.

This redirection of focus from depression as "disease" to depression as "illness" (or experience) is more informative and also less pathologizing of individuals. The process of pathologizing too often places blame on the individual (Fernando, 1991). This can work against treatment by closing the door to more useful pursuits, such as exploring the illness and its meaning, and how the individual views healing as achievable. This latter, personalized approach to treatment would involve a "culturally sensitive mini-ethnography of a patient that encompasses cultural and personal metaphors" (Kleinman, 1986, p.452). The present-day, impersonal treatment approaches are often practised by Western caregivers. The validity of their approach must be questioned.

To this end, Kleinman favours questioning the validity of applying Western diagnoses to peoples from other cultures:

Dysthymic Disorder in DSM-III (or neurotic depression in ICD-9) is a possible example. It may hold coherence in the more affluent West, but it represents the medicalisation of social problems in much of the rest of the world (and perhaps the West as well) where severe economic, political and health constraints create endemic feelings of hopelessness and helplessness, where de-moralization and despair are responses to real conditions of chronic deprivation and persistent loss, where powerlessness is not a cognitive distortion but an accurate mapping of one's place in an oppressive social system, and where moral, religious and political configurations of such problems have coherence for the local population but psychiatric categories do not (Kleinman, 1985, p.452).

Kleinman (1976) stresses how important it is for us to change long-accepted theoretical and methodological paradigms in cross-cultural research
on mental distress. For example, he contends that we must reconsider the terminology we use, especially the distinctions we make between the words disease and illness. The former stems from the medical theory; the latter is used by lay people. Recent cross-cultural research has underlined the importance of distinguishing between two interrelated aspects of sickness: disease and illness.

Disease can be thought of as malfunctioning or maladaptation of biological or psychological processes. Illness is the personal, interpersonal and cultural reaction to disease. Although social and cultural factors may or may not influence the etiology, pathophysiology, and course of disease, they always influence illness. Illness is by definition a cultural construct. Disease may occur without illness, as in acute overwhelming disorders, like massive trauma in which there is not sufficient time to generate an illness response. Illness may occur without disease, as in malingering and also perhaps in certain problems like non-medical aspects of drug abuse and alcoholism that are made into illnesses for political, social and historical reasons (Kleinman, 1977, p.9).

In the individual's reality, the illness "experience" is more important than the disease concept, and is what has the greatest impact on treatment outcomes. Kleinman (1977, p.9) further explains that the individual's reaction to the illness does much to establish the form the sickness takes, and its meaning. "The illness response may strongly influence symptoms and care... The 'disease' may respond to technological interventions, the illness frequently does not, and often requires psychosocial issues to be attended to". For example, technological treatment for cancer (such as radiation) will affect the course of the disease, but the healing experience involves a complex interplay of various elements including personal attitude, social support, and secondary psychological reactions (Gotay, 1987). In fact, it is in the
psychosocial arena that predictions of outcomes are best made. Among cancer patients, there is a link between survival rates and levels of depression (Spiegel, 1990). Kleinman's argument, that we should focus on the illness experience, challenges the assumption that only "cure" approaches are valid, and in so doing encourages medical practitioners to explore more holistic treatment paradigms. Example: nontechnological (that is, non-drug) treatments for depression are proving to be often more beneficial than traditional, pharmaceutical-based therapies.

Kleinman (1977, p.9) further distinguishes between the terms "curing" and "healing." "Treatment for the former [disease] we can call cure, while treatment of the latter [illness] we can refer to as healing." He argues that new paradigms need to be developed because "cross-cultural studies suggest most traditional healing systems provide both forms of treatment [cure and healing], whereas modern medical care provides principally the former [cure]." Treatment from the current medical paradigm is lacking because "patients appear to consider both [cure and healing] essential". Further, "evidence is accumulating that patient non-compliance and dissatisfaction with care is in part a function of the absence of healing in modern health care.... Biomedicine attends almost entirely to disease and appears to be systematically blinded to the evaluation of illness". Biomedical theory that labels illness experience as a disease ignores the importance of incorporating the individual's (illness) understanding into the treatment paradigm. Lewis and Kleinman (1994) explain:

The interpersonal study of mental health categories in local worlds based on recent anthropological concepts of culture is able to capture the cross-cultural and intracultural complexity of human personality development and psychopathology. Current professional theories, in contrast, are wedded to
individualistic assumptions that represent largely unexamined North American and Western-European cultural common sense that de-emphasizes the complex influence of social categories and relationships on experience. Clinicians and researchers trained to contextualize behavior and experience as a function of radically different environments would be less prone to category fallacies...that is, the imposition of one culture's categories onto another culture, for which they lack validity (p. 9).

Native traditional approaches to both cure and healing incorporate the above-described holistic approach, which Kleinman's investigation of cross-cultural studies revealed as most effective and most desired by patients. Kleinman's work acknowledges that the loss of these traditional healing systems has had a powerful impact. As Waldram et al. (1997, pp.99-100) comment:

It is clear that Europeans have often viewed Aboriginal medical traditions through biased eyes, and even where forced to admit that success in treating patients was not uncommon, were nonetheless unable to see traditional medicine for what it really was: sets of coherent beliefs and practices that were well integrated within Aboriginal societies and which served important social and religious as well as medical functions.

The hubris of biomedicine is challenged by cross-cultural research that highlights the need to acknowledge traditional healing approaches, and to return to those approaches.

Research on appropriate treatment approaches resulting from Native peoples' evaluations of their illness experience, regardless of clinical operational definitions of what they are experiencing, needs to be addressed. Identifying how psychological distress manifests itself in the specific Native cultural context is helpful, to inform both the Native community's leadership
and the clinicians/helpers who provide treatment. In non-Native care, which is frequently utilized by Native people, it is crucial that the Native client and the clinician (non-Native) have effective rapport. Non-Native valuations of depression need to be abandoned; addressing the illness experience of distress/depression in a local Native community requires a new approach. Kleinman (1987) states that Western concepts of reality are not necessarily "real":

And now we want to classify the culture-bound syndromes, not as a separate domain of experience, but within the technical terminology of international psychiatry...classification serves particular bureaucratic purposes: clinical care and research from the psychiatric perspective, but social control from the anthropological perspective...castigates the psychiatric profession for its hubris, its inexorable quest to consign all of "relevant" human reality to a short list of mutually exclusive disease states. It is indocile to alter Native codifications of reality; it is unwilling to accept subtlety, ambiguity...It reduces the complexities of individual experience to the typifications of a small number of psychological and physiological classes. It transforms social problems into medical ones. It splits off mind from body, cognition from emotion, theory from description in keeping with the dominant ethnopsychology of Western tradition. And the authorizing rationalizations are the scientific search for "natural" order and the mandate to treat (p.50).

**Organization of the Issues in this Study**

This chapter will explore depression as experienced by Native peoples, and the treatment implications. It will have three sections, the first of which will consider depression itself. The relevant literature review will explore the following:
Whether depression, as the term is understood in Western culture, is a problem for Native peoples.

What depression means for Native people, both at the social level and at the personal one.

What Native people perceive as the cause of depression.

The second section will explore Native attitudes regarding approaches to the problem of depression. Broadly speaking, there are two such approaches: individual, and social. Combinations of the two are possible.

The third section will review current and specific issues affecting depression and its treatment. This will include an overview of the political issues affecting treatment-funding, racism, and so on. A closer look at two remedies will follow this.

Because the present study is qualitative in design, support from the literature for this type of research approach will be incorporated in all three sections.

Section One: Examining the Depression

Is Depression a Health Issue for Native People?

It is vital it ascertain whether Native people really do suffer from depression as the term is understood in Western culture. O'Neill (1993) states that emotional difficulty described as "depression" is common among Native people, and advocates that immediate treatment for symptoms be made available to them. The same author also notes that Native people need help badly in the present, and that whatever research has been performed into the problem has done nothing to help them yet.

Part of the problem, as O'Neill explains, is that medicalized approaches to research are often inappropriate. For example, comorbidity research with
Native people is currently popular (example: major depressive disorder and problem drinking co-existing as a psychiatric disorder). However, such an approach can result in what Kleinman (1977) refers to as "category fallacies". Example: O'Neill found that among Native people on the Flathead Reservation, the coexistence of alcoholism and depression was not always indicative of psychopathological distress. Yet mainstream American society, being comfortable with medicalized perspectives, has long assumed that alcoholism, depression, and suicide are expressions of demoralization but really indicative of psychiatric distress. Clearly, medicalized diagnostic/categorization research can err quite easily if the process of establishing the cultural/contextual validity of comorbidity is flawed.

Mistakes can be avoided by carefully investigating the phenomenological reality of psychopathological distress. This means first conducting ethnographic research for each of the comorbid disorders and only then connecting them to the specific form of comorbidity, and to local and individual signs of distress. A diagnosis of comorbidity relies on two or more diagnoses and has the potential to draw Western researchers from a singly potentially culturally inappropriate diagnosis toward two or even more. If we are to avoid invalid results that confuse ongoing research, comorbidity, like any single psychiatric disorder, must be referenced to phenomenologically real pain for individual Natives (O'Neill, 1993).

Current research suggests that depressive-like symptoms are an important health issue for many Native people. For example, Walker, Lambert, silk-Walker, and Kivlahan (1993) researched the prevalence of comorbidity between alcohol dependence, drug dependence, and psychiatric disorders in Native populations in the Pacific Northwest, and found it high. Shore et al. (1987) reported that 83 percent of Native subjects in their study had
experienced a psychiatric disorder. Ross et al. (1988) evaluated individuals presenting at a public alcohol and drug treatment facility in Toronto and found that 78 percent of clients had a psychiatric disorder. O'Neill (1989) found that Native Americans were relatively underrepresented in mental health facilities, but overrepresented in correctional institutions. At a psychiatric hospital in Saskatoon, patients from "Indian reserves" were significantly more likely to be diagnosed with schizophrenia than "non-Indian" patients (Roy et al., 1970). Manson et al. (1985) found that 82 per cent of Hopi individuals in their study indicated that they had felt depressed, sad, or worried for two weeks or more, as compared to 50 per cent in a matched group. These same people also reported significantly more frequent experiences of other depressive symptoms, such as diminished appetite, weight loss, disrupted sleep, psychomotor retardation/agitation, a sense of not being likeable, and trouble thinking clearly. A marked number of them had attempted to kill themselves.

**Gleaning Important Understanding of What the Term "Depression" Means in the Native World-View**

Western understandings of the term "depression" may not be readily applicable in Native contexts. For example, Manson, Shore, and Bloom (1985) found that the Hopi made important distinctions between certain affective states, and that there was much more to the Hopi experience with depression than diagnostic categories and related symptoms alone would suggest. They found that among this group, illness categories and symptoms interacted with presumed etiologies (causes), various social situations, and an array of health-care seeking strategies.

The same researchers encountered a phenomenon they referred to as "double depression", the coexistence of major and chronic depression. This finding, which was obtained from the self-described experiences of the Native
people themselves, reinforced the clinical reports of many Indian Health Service psychiatrists. The phenomenon of double-depression may help explain why depression among the Hopi tends to be especially pernicious and debilitating. To the extent this is true, it provides highly relevant information about Native experiences with depressive illness.

It is worth noting here the finding by Manson et al. (1985) that Hopi illness symptoms interacted with presumed causes and social situations. Lewis-Fernandez and Kleinman (1994) acknowledge that current North American professional constructs of personality and psychopathology are mostly culture-bound - that they selectively reflect the experiences of those who are white, male, Anglo-Germanic, Protestant, and formally educated, and who share a middle- and upper-middle-class cultural orientation. They further comment that this results in a largely ethnocentric psychology which ignores the fundamental influence of social context and cultural norms on human behaviour. They add that current psychiatric nosology, while it claims to be universal, does not take seriously the great cross-cultural diversity of somatic and psychological symptoms (Mezzich et al., 1993). Research indicates that in some Native communities the particular impact of social circumstances on mood is related to Native people's experience with depressive illness (Manson et al., 1985).

The social context and its influence on moods may have much to say about what depression means in a Native context. For example, O'Neill (1993) found that the word "depression" is used at the Flathead Reservation (as in many places in the United States) to talk about a variety of experiences that extend beyond simple clinical understandings of depression. For example, to these Native people it is a mark of maturity to feel profound loneliness, to feel sorrow for the pain one has caused others, and to feel pity for those who have
nothing. Thus, to be sad is to be aware of human interdependence and of the gravity of historical, tribal, familial, and interpersonal loss. To be depressed, and this includes being tearful and suffering sleep and appetite disturbances, is to demonstrate maturity and connectedness to the Native world. A carefree attitude is often perceived as a sign of immaturity. In this light, loneliness and depression are potentially expressions of a positive moral virtue.

It is important to research the understanding that Native people have of the term "depression," their experience of it, and the causes they ascribe to it, both social and individual. According to Kleinman and Good (1985), cross-cultural research provides important evidence of cultural variations in depressive mood, symptoms, and illness. "Dysphoria", sadness, hopelessness, unhappiness, lack of pleasure with the things of the world and with social relationships, has dramatically different meanings and forms of expression in different societies. For example, the same authors comment that among many Native American groups, hearing voices of relatives who have died is considered normal, and not a sign of sickness. Yet in white society, hearing voices is often interpreted as a symptom of psychosis. Fernando (1991) notes that dreams of the dead returning to speak are an important part of Native peoples' grief experience and are of great comfort to them.

The same authors comment that the "single most troublesome problem plaguing the cross-cultural study of affect and affective disorder [depressive illness] is the failure to take an anthropologically sophisticated view of the culture" (1985, p.7). They note that the most innovative and productive approaches to an "interdisciplinary" study of emotion in society are "integrative" in nature. Kleinman: "We believe the biological component [medicalized view] of clinical depression is important and cannot be disregarded, but we also share that biological studies divorced from clinical
and ethnographic investigations have little to contribute to our understanding of the relation of culture and depression." These authors feel that anthropological accounts, especially those which regard culture as the "intersection of meaning and experience" for the depressed individual, are in greatest need of research.

Ethnographic investigations which reveal illness resolution strategies that Native people use when feeling emotional distress may provide information about the meaning they give to the illness. By learning about the unique approaches used by Native communities to understand mental illness, we will better understand their treatment needs.

**Understanding the Meaning of Psychological Distress (illness meaning)**

**From the Native Perspective**

Kleinman (1986) comments that research on "illness meanings" is scarce. He also states that illness meanings are too often discounted by researchers, who regard them as part of the soft, messy, "subjective" aspect of illness; and as difficult to transform into "harder," neater sets of behavioural variables (that is, "respectable" data), which can then be statistically manipulated. Thus, many investigators perceive narrative data as "contaminating" the solution framework. It is more difficult to transform local narrative data than to carry out the "hard" data analysis of the type that has long been performed with Western participants. As one result, the narrative data are viewed as noninformative because new parameters for non-Western clients must first be found. Also considered a hindrance to research is the ill-informed but still prevalent view that the manipulation of narrative data is basically useless for understanding any Western or non-Western psychiatric phenomenon.

Anthropological theory and qualitative research can both contribute to our understanding of Native people's experiences. Garro, in her 1990 study of an
Anishinaabeg community in southern Manitoba, argued that narrative data are an important means for us to improve our knowledge of Native illness behaviour. She found that a number of Ojibway cultural practices are quite persistent, and that contemporary Anishinaabeg think about and respond to illness quite differently from others in rural, non-Indian communities. The responses of the Native people to illness is a product of both past and present, of both continuity and change. For example, the Native participants in Garro's study considered certain illnesses to be "Anishinaabe sicknesses" that physicians would not be able to treat effectively and that could only be treated properly by a Native medicine man.

Garro (1995) found that Native people in an Ojibway community in southern Manitoba drew on two perspectives, Native and non-Native, and moved back and forth from one to the other. In their understanding of illness, these Native people did not perceive an overt contradiction between two explanatory models.

Local investigations into treatment-seeking behaviour can provide a wealth of information regarding what depression "means" to Native people. This may be reflected in how they pursue healing individually or collectively. For example, a depressed individual may seek psychotherapy because he or she feels that the distress comes from within (endogenous depression); or, that person may pursue political activities if he or she perceives the distress as having an external source (exogenous depression) (Sue, Sue & Sue, 1990). Many clinicians and researchers have distinguished between exogenous and endogenous depression. It is believed that exogenous depression is precipitated by external events, such as life stressors, job loss, or the death of a loved one (Leff et al., 1970). In contrast, endogenous depression is perceived as more biologically based, and as such may respond better to
biological treatments such as drug therapy. Garro (1995) and Finerman and Bennett (1995) comment that medical practitioners who ignore the broader social context of depression do a disservice to those experiencing it in the Native community.

Garro emphasizes that successful treatment draws on cultural, social, local, and individual understandings about the illness. This culturally or socially contextual approach may provide clients and caregivers with a sense of empowerment over the illness. Personifying depression, or giving it meaning (a "theme"), gives the individual increased control over their experience of it. Meaning then provides direction in personal decision-making when it comes to choosing healing strategies. Perceptions about how the illness was "created", that is, its cause, appear to direct the individual in treatment choices (Garro, 1995). This suggests that an important research avenue would be to explore whether Native people perceive depression as having internal or external causes, or both.

**The Importance of Native Peoples' Attributions as the Cause of Depression**

Native peoples' perceptions of how illnesses are caused seem to determine their choices of treatment. Garro (1990) found that Anishinaabe peoples in southern Manitoba utilized a variety of healing strategies for illness and that they would seek out biomedical treatment unless they judged an illness to be due to "Anishinaabe sickness." Ambiguity, on their part, as to etiology (cause) resulted in these Native people using both physicians and Anishinaabe healers concurrently and sequentially. Garro comments that Anishinaabe understandings of illness have changed in response to radical changes in all aspects of life, but that these traditional understandings also continue to give meaning to illness. For example, their view that white men's sickness is
distinct from Anishinaabe sickness provides the rationale for the actions they take to deal with the illness.

The effects of outside (i.e., non-Native) influences on Native people's mental health have been many and varied, and often negative. Long before the Europeans arrived in North America, Native peoples had developed adaptive and pluralistic strategies for seeking health care. The concept of mental illness is not new in the Native people's world. In pre-Columbian times, Native people had procedures for dealing with illness and deviant behaviour. Local treatment procedures included consultation, diagnosis, and treatment by a trained practitioner (shaman); treatment plans required participation by the family and by the entire tribal community. These practices were devastated by European contact, which ravaged traditional Native ways of living, including healing practices (Walker, Lambert, Silk-Walker, and Kivlahan, 1993). The result is that Native people now practice pluralistic help-seeking behaviours. Woody (1990) suggests that treatment efficacy improves when patients and therapists have a variety of treatment options from which to choose that allow specific patients to be matched to specific treatments. As Waldram et. al. (1995, p.208) comment, Native people practice medical pluralism and want a full range of services. They will quite willingly utilize several services regardless of what medical or other health care practitioners think. The same authors point out, as does Kleinman (1980), that the Native client's explanation or understanding of his or her illness is often different from that of non-Native health-care practitioners. Native people often seek help in ways that reflect their understanding of what the illness is, and how it was caused, and how healing can be achieved. These local understandings must be explored.
Native people do choose off-site treatment, and this involves seeking out off-reserve helpers. Thus, how prepared these helpers are to meet Native clients' needs is an important issue. Greater awareness of Native people's mental health concerns will help inform both Native people and the clinicians serving them about the experience of depression and appropriate treatments for it. For example, Pace et al. (1996) found that Native participants in central Alberta weren't sure what triggered mental health problems, or whom they should go to about them, or what sort of treatment they could expect to receive. The same researchers commented that in these circumstances, people in crisis on the reserve tended to be misled into making inappropriate choices. In the Pace study, Native people viewed several treatment methods as equally desirable, but none of them as especially effective. Some of the reasons for this ambivalence were provided by the Elders, who pointed out that many people on the reserve felt caught in a struggle to integrate Native and Western culture, and that many people did not honour their own cultural traditions. The loss of traditional cultural healing approaches resulted in confusion about treatment choices. Informed non-Native clinicians should be aware of this sort of confusion and respect its impact on Native clients. In this context, health care providers would do well to encourage Native clients to incorporate and honour traditional healing strategies in their treatment.

The issues that Native people must face when they experience psychological distress are highly complex. Native traditional helping processes are currently in the process of being "rediscovered"; this is happening in the context of the struggle for Native self-government. In the interim, approaches to health care in Native communities tend to be pluralistic, and this is not necessarily a bad thing, as it provides more options for mental health
treatment. Adaptive cultural strategies will eventually emerge from this process (Kunstadter, 1975).

**Section Two: Personal Therapy, or Social Change?**

_Differing Views on Healing Approaches_

As Kleinman (1976) notes, a focus on the local setting is useful in field studies because it allows investigators to relate local health-care systems to particular environmental influences. Even so, it must be recognized that knowledge of local systems cannot be extrapolated to entire Native societies. As Kleinman comments, intracultural diversity is extensive, and is so across lines of gender, class, age cohort, and political groups (Lewis-Fernandez and Kleinman, 1994). This social and political issues affecting mental health may vary both _within_ a community and _across_ several Native communities. Through qualitative research, "deep" knowledge of these issues can be gained in a local context.

In order to understand the experience of depressive mood in a local Native context, we must establish whether the emotional distress is the result of real social problems as opposed to psychological or biologically based psychiatric disorders. If Native residents describe their affect difficulties as arising from social problems such as sexual or other abuse, discrimination, poverty, and other environmental difficulties, this suggests that community-wide solutions should be sought out. By investigating the perspectives of Native individuals who are experiencing depression, we gain knowledge about their treatment needs. What do _they_ perceive to be the causes of depression? What do _they_ see as the best approach to healing? Does it involve individual treatment programs, or social change, or both? The efficacy of these two healing approaches has long been debated by Native people themselves.
Individual treatment such as psychotherapy is considered to be the non-Native approach, in the sense that it is a European construct. Social issues are within the purview of local Native communities themselves. Manson (1995) explains this difference by stating that definitions of the self vary on a continuum between "egocentric" and "sociocentric." Egocentric definitions, which are most typically found in Western, industrialized populations, characterize individuals as unique, separate, and autonomous. Sociocentric definitions are found in many non-Western cultural traditions, and characterize individuals in relational terms, as parts of an interdependent collective defined by kinship and myth. Native people may criticize personal counselling or therapy as an egocentric strategy that ignores the importance of addressing broader social issues.

Native people themselves disagree about what will heal emotional distress. An extreme example of low regard for Western therapy is provided by Roland Chrisjohn, a Native psychologist and policy consultant. He regards psychotherapy as actually perpetuating problems for Native people, problems that were originally created by the "the system" (by which he means non-Native helpers). He and many Native political commentators "share a critical attitude toward the system" (Chrisjohn, electronic mail, December, 1996). Chrisjohn and Young (1995, p.10) comment that in reference to 'healing from Residential Schools' experiences, the calls for 'therapy'...that have predominated the testimony of Aboriginal Peoples ourselves.... Is our own call for a 'healing process' a studied, considered response based on a clear overview of the issues, or are we merely repeating what we have been told over and over again?" Native political perspectives, such as the ones expressed by these authors, call for social action that would "undo what has been done" by resolving tangible settlements of land and resource claims.
However, these authors also support "unrestrained access to the treatment of their choice" for those suffering the aftereffects of physical, sexual, and emotional abuse experienced in Residential Schools. Chrisjohn and Young (1995, p.75) have misgivings about the intent and effectiveness of much of the therapeutic work being done with Native individuals, but also feel that they are in "no position to prejudge the manner in which [a Native] individual has learned to cope". They do, however, caution therapists to consider their own "standing as an agent of damage-control" on behalf of non-Natives, and they advise that "real therapy has the liberation of your client as its purpose, not the camouflaging of chains, psychic or otherwise".

Native people who, unlike Chrisjohn, are supportive of the psychotherapeutic approach are working to develop therapies that incorporate traditional Native ways of healing. Connors (1991) comments: "Most Euro Western healing, such as psychotherapy, often does not acknowledge the spiritual as an element of the healing process...it appears as though the more Native society has adopted the current scientific world view and accompanying lifestyle of the other races, the more unbalanced and unhealthy we have become. Connors adds: "Many of our communities are beginning to recognize the limitations of non-Native healing practices in addressing the healing needs within our communities. Consequently, many communities are reviving the traditional healing practices and are seeking ways to integrate this knowledge with non-Native healing within the new environmental paradigm". Others besides Connors are now suggesting that reverting to traditional healing ways is not a clear necessity. They call for "new paradigms", for new approaches to healing in which Native and non-Native healers collaborate. Thus, "what emerges is that despite the most varied explanations of the illness, from the possession of an evil spirit to an unresolved Oedipus complex,
healing proceeds on the basis of the powerful, socially sanctioned, two-person interaction [therapeutic alliance] in which both the sufferer and the practitioner exude the utmost faith and confidence in the healing rationale and methodology" (Fosshage, 1978, in Connors, 1991). This search for means of integrating non-Native therapies with Native traditional healing is occupying a greater and greater place in the research literature (Darou, 1994: McCormick, 1994; Morrisette, 1994).

Clearly, Native people differ in their attitudes toward treatment for emotional distress. Arguments exist for abandoning help-seeking from non-Native care providers, just as they exist for incorporating Native traditional healing into non-Native therapies. Because of these differing points of view about what healing should involve, research activity would do well to focus on local issues as they relate to specific groups of Native people. In any given situation, a good first question will often be this: "What do the Native people in this community see as the cause of emotional distress?"

Section Three: The Politics of Native Mental Health

It would be arrogant to promote outside perspectives as specific remedies for local problems of Native mental-health distress. Native people have begun to resolve these dilemmas for themselves, and will resolve them. That being said, there are aspects of care that non-Native helpers must begin to address, and that must be altered, if only because Native people still do seek our assistance. Non-Native help providers must evaluate those practices of theirs which hinder Native people in their efforts to heal themselves.

Current Funding Barriers

Medical Services Brand (MSB) has had difficulty providing medical and related care to Native people in their local contexts. For this reason MSB has sought assistance from medical schools, teaching hospitals, and professional
associations. However, in this endeavour MSB has attempted to limit the role of these non-Native helpers to a strictly clinical one. As well, MSB has resisted handing over any public health functions to local Native leaders (Waldram et al., 1997). All of this makes it more difficult for Aboriginal governments to work with outside helpers with the goal of meeting local needs as Native people know and understand them, and works against the development on-site public health initiatives. The present process merely involves non-Native helpers as short-term recruits, rotating medical interns, residents, and consultants.

**Resistance of Medical Personnel to Collaboration**

Pluralistic help-seeking strategies, and conferences between Native healers and biomedical practitioners, are becoming more common as the two groups seek to understand each other better and to facilitate collaborative treatment relationships (Waldram et al., 1997, p.208). Unfortunately, biomedical practitioners have been reluctant to accept Native traditional medicine as a viable alternative - mainly for epistemological and philosophical reasons. This is unfortunate, because many in the mainstream helping professions are influenced heavily by the accepted biomedical approaches to mental health care delivery.

Finerman and Bennett (1995) further comment that unfortunately, a medical world view has recently emerged, especially in Western and industrializing societies, in which the focus is on assigning responsibility and placing blame. Thus, diseases are blamed directly on the afflicted themselves, who are then subject to accusations of personal failure for having "caused" their own condition. These authors add that ethno-medical studies can contribute to an "enlightened prejudice," with the emphasis on particularism and cultural relativism inadvertently reinforcing assumptions about blame. As
a result, some may become convinced that alternative values and practices are the product of ignorance or superstition, and are barriers to successful treatment and medical change. Social and behavioural research must articulate more effectively the validity of context-specific systems that link pathophysiological processes, environments, beliefs, behaviour, and health.

**Patriarchal Attitudes Towards Cultural Healing, and Problems Created by Prevalent Diagnostic Approaches**

Biomedical constructions of illness have a powerful influence, and are often dismissive of alternative perspectives. Fernando (1991) and Gaines (1994) have criticism to make of anthropologists, noting that when psychopathology is interpreted ethnographically and psychiatry provides the theory, anthropologists see psychiatric illness as culture-specific if not culture-bound in the peoples they study. He comments that these researchers see a dichotomy between modern/scientific psychiatry and traditional/ethnopsychiatry (Gaines, 1994); thus, illness in Western culture is seen as "authentic" while illness in other cultures is seen as contaminated or distorted (by culture). "Thus anthropology and psychiatry have colluded in regarding illness seen in Western (white) societies as being on a different plane from that seen in non-Western ('primitive') societies. When culture 'distorts' a syndrome beyond a certain point, a CBS [Culture Bound Syndrome] is [mis]identified".

Fernando (1991) argues that all diseases are culturally patterned. However, this does not mean that culture, and culture alone, provides a complete explanation for a "culture-bound" syndrome. He cites Kleinman (1978) in noting that it may be useful in practical terms to see certain types of "disturbance" as culture-bound in a particular local health-care context. But he also argues that the racist connotations attached to the concept of CBS (Culture-Bound Syndrome) must be removed; also, the importance of arriving
at a cultural understanding of anyone presenting as emotionally disturbed must be accepted. Psychiatric understanding must be personalized and individualized. When it is, CBS becomes shorthand for describing a situation where the person's behaviour and feelings require an intense and specific knowledge of cultural background. When approached in this way, CBS is not merely a name attached to a constellation of "symptoms," but a statement about the individual's particular need at the time of seeking or requiring help. This implies that mental illness must be redefined so that it looks beyond "symptoms", beyond "presentation," beyond" illness category". Practitioners must learn what the illness is from the individual who is experiencing it. Overlaying prescribed categorization constructs on Native individuals can only result in meaningless labelling.

Steps Towards Achieving Remedies

Collaborative Attitudes: New Approaches for Non-Native Helpers

Research that explores the interactions between clinicians and Native clients has been carried out mainly by anthropological psychiatrists (Kleinman, 1976). However, psychologists have also been researching these interactions, because it has been found that the alliance between helper and help seeker may be more important to treatment outcomes than was first thought. Research on the treatment alliance may contribute significantly to our understanding of the therapeutic process in all forms of therapy with Native people (Bergin and Garfield, 1994). Research exploring which interactions are most effective in healing is required. For example, Pace, Mayo, Harpur, Kuelker, and Reimer (1996) found that Native people in the Treaty Seven area of central Alberta preferred psychologists over all other providers of mental health care, including traditional Native healers. These researchers concluded that both health care workers and the general
population on the reserve were biased toward Western treatments. However, their study also revealed that the general population on the reserve had little confidence in any of the people they would typically seek out for help with mental health problems. Native people gave psychologists higher ratings as helpers because psychology requires the talking out of problems and a stronger interpersonal relationship. Also, people from the small communities of the reserve perceive as desirable the confidentiality that a psychologist provides.

As a researcher representative of the discipline of psychology interviewing on the reserve to gather data, I found Native people to be very open and confiding. They seemed to enjoy the talking experience and revealed much about their personal lives. I felt that they did so because they saw me in my researcher role (psychology) as not part of the community on a daily basis, and therefore as more likely not to betray their confidences.

Pace et al. (1986) found that Native people living on the Blood Reserve in central Alberta believe that the "whole" person enjoys a balance of spiritual, mental, emotional, and physical well-being. The fact that these Native people saw all mental health treatment methods as equally desirable may simply mean that each method addresses at least one of the four elements; if so, this would explain why no one treatment method (as provided by psychology, psychiatry, friends, medicine men/women, social workers, family nurses, elders, and religious leaders) was preferred over others. However, none of the methods was viewed as especially effective, except psychology, which was seen as the best of the choices.

According to Lewis-Fernandez and Kleinman (1994), illness is the combined personal, interpersonal, and cultural reaction to disease. These authors state that patient noncompliance and dissatisfaction with care are in
part a function of the absence of "healing" in modern health care. This finding is supported by the fact that doctors and patients tend to differ in their evaluations of treatment, and by the number of patients who use alternative forms of care. The same authors add that treatment of psychosocial issues, which is what is meant by "healing," is considered essential by patients and is provided in Native traditional healing systems. Malloch (1989) comments that the underlying principles of mainstream Western medicine are at odds with the principle of traditional Native medicine. This author then notes that it is important to recognize that countertrends do exist in Western medicine. These trends can be seen in the way some doctors have turned to more holistic approaches to treatment, ones which take into account the importance of body, mind, and spirit. Malloch adds that these countertrends represent values and principles akin to a holistic approach, with emphasis on prevention and personal responsibility, that are more closely aligned with Native medicine. The doctors and nurses within the Western medical profession who support these trends may be valuable allies of those Native people who are working to build their own health care systems around Native values.

Fernando (1991) argues for a cross-cultural collaboration between psychiatric and traditional healing systems that is based on mutual respect. He sees Western psychiatrists and psychologists as the counterparts of "indigenous healers" and "shaman." In his view, in order to maximize this type of collaboration it will be necessary to ensure that a variety of "helping systems" are promoted without value judgements being attached to them. This will require the political will to challenge the dominance of Western "scientific" psychiatry and to recognize the importance of consumer choice.

Anthropologists who are interested in "educating" psychiatry and psychology have contributed a great deal to mental health practitioners
working in Native communities. Kleinman's work is the most widely referenced by anthropology, psychiatry, and psychology, which are the three disciplines that dominate the cross-cultural study of depression (Kleinman and Good, 1985). Kleinman has developed an explanatory model (EM) of illness, which he applies in local ethno-cultural contexts; and he advocates the use of treatment approaches that unite modern biomedical health strategies with local traditional healing treatments.

According to Kleinman (1978), collaboration is beneficial because it increases mutual understanding. When the explanatory models (EMs) of patients, families, and practitioners are similar, communication is improved, there are fewer problems in clinical management, and outcomes are generally better. Cultural healing is more likely to occur when EMs are similar. Kleinman favours the involvement of Native folk healers who are trained to recognize and treat illness. This enhances clinical communication as well as patient adherence. Patient satisfaction should improve, and problems in care should be reduced.

Fernando (1991) is more apprehensive than Kleinman about integrating psychiatric and anthropological methodology. He argues for a pragmatic approach in which culturally transportable "bits" of Western psychiatry are used in concert with techniques extracted from other cultures. In his view, psychiatry's current medical model of illness is a hindrance to cross-cultural sharing of techniques and ideas. Furthermore, Western psychiatry will have to move away from its current approaches to defining illness before it can acquire and use techniques from other cultures (p.194).

According to the Royal Commission on Aboriginal Peoples (1995), Native people are seeking to address the mental health needs of their communities. To this end, they are introducing alcohol and drug treatment programs and
facilities into many of their communities. Local rituals and support structures uniting Native spirituality, Christianity, and Western psychotherapy are becoming common. Social workers, police, addiction counsellors, teachers, priests, and traditional healers are beginning to collaborate in community healing networks. Many Native populations prefer a pluralistic approach that partly incorporates Western techniques. The academic literature must keep abreast of this multidisciplinary approach to healing.

**New Research Approaches**

Medical researchers are directing their efforts at expanding knowledge for clinicians who encounter Native individuals who are experiencing psychological distress. This is vital, because a number of large metropolitan centres are trying to help remote Native communities by providing short-term medical staff. Medical researchers, including Maser and Denges (1993), have struggled to find methods for assessing the presence of psychiatric illnesses in Native populations. Much of their research has concerned how to classify these illnesses under the categories in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994). These researchers call for more research activity focusing on cross-cultural methodologies for diagnosing depression. Their belief is that this diagnostic approach is crucial for arriving at adequate treatment strategies. However, this type of research activity merely superimposes non-Native models of understanding illness onto Native peoples. Unfortunately, these research endeavours continue.

Current research activity also focuses on validating non-Native psychiatric diagnostic instruments for use with Native populations. However, this present study favours abandoning diagnostic categorization with Native peoples. It is doubtful whether such a research endeavour has any validity.
Kleinman and Good (1985) argue for the inclusion of anthropological accounts, especially those which regard culture as the intersection of meaning and experience. They add that the cross-disciplinary (psychiatry, psychology, anthropology) study of culture and depression will be best advanced by coming to terms with the analytic questions raised by these (anthropological) accounts, and by critically examining the ethnocentric bias of psychiatric and psychological research categories.

However, they also feel that merely anthropological accounts fail to grasp the clinical dimensions of depression. Thus they promote clinical and epidemiological work that bridges anthropological and clinical frameworks. They also advocate more research, sociolinguistic, cognitive behavioural, developmental, ethnoepidemiological, and sociosomatic, that represents more innovative and productive approaches to the interdisciplinary study of emotion.

Hence, Kleinman advocates for the integration of methodologies as an innovative collaborative step toward making significant practical as well as theoretical contributions in understanding depressive disorders in cross-cultural contexts.

Further, Kleinman (1977) states that psychiatry must learn from anthropology that culture does much more than shape illness as an experience: it also shapes the very way that illness is conceived. He comments that the ideal cross-cultural study of mental illness would begin with a detailed local phenomenological description to compare indigenous and professional psychiatric explanations of disorders, independent of a unified framework. The results of this effort would be used to analyze how culture influences these disorders, and to compare these influences between cultures.
In support of this approach, Manson, Shore and Bloom (1985) attempted to develop an ethno-medical instrument to determine Hopi symptom domains that might plausibly be inferred as having some more or less close relationship to the American psychiatric category "major depressive disorder." Categorization in psychiatry is considered important because it provides nomenclature that can be shared and understood by non-Native practitioners. The development of diagnostic tools that permit a culturally sensitive assessment of the depressive experience in certain American Native communities improves on Western diagnostic assumptions that have long disregarded Hopi self-perceptions and life experiences.

Kleinman and Good (1985) describe this research endeavor as an innovative methodological collaboration between anthropologist and psychiatrist that makes significant practical as well as theoretical contributions to assist in explaining why depression among American Native people is often misdiagnosed and inadequately treated. It is puzzling that these authors support this type of research. Kleinman's theoretic approach critiques the application of Western psychiatric categorization approaches with non-Western cultures. The author of this present study can only conclude that Kleinman supports the development of a culturally sensitive assessment tool that will eventually replace Western ones. Kleinman (1987) explains this contradiction by stating that too often, medical research proceeds as if translation were a nuisance to be quickly handled in the same way as one controls the demographics in matched samples. Kleinman notes that problems exist with assessment tools (questionnaires administered to illiterate populations), but points out that the research activity itself illuminates the lexicon used by a particular culture. For example, he describes how Manson et al. (1985) found that one item in the non-Native assessment tool combines
the concepts of guilt, shame, and sinfulness. Hopi health care professionals clearly distinguished each of these concepts from the others and indicated that three separate questions were required to avoid confounding responses.

Research must explore what the depressive experience means for Native people, in their own lives and context. According to Kleinman (1987), clinical care should ideally provide a kind of culturally sensitive mini-ethnography of a patient that encompasses cultural and personal metaphors, but he notes that how to achieve this in a research project is a major problem. He adds that the presence of such information can greatly affect the validity of cross-cultural research findings.

Native peoples' descriptions of depressive experiences from both individual and collective perspectives will help increase understanding as to how this illness experience manifests itself in a particular Native community. Learning what the depressive experience is from their point of view will contribute to knowledge about their explanatory models regarding the depressive illness experience. Knowing and understanding their explanatory models, and contributing (when sought out) to treatment strategies that they esteem as synchronistic with their understandings of the illness, can assist them in achieving healing outcomes.

When Native people develop healing systems that do not access the care of non-Native helpers, research knowledge will work to inform caregivers from all cultures. Care must be taken so that Native people can continue to seek help in ways they choose, with understanding and acceptance of their cultural uniqueness on the part of the practitioners they utilize.

Research in the local context that explores the individual, interpersonal, and intercommunity meaning and local explanations of depression and suicide is important. Knowing how Native individuals in a specific social context
employ the term "depression" increases our understanding of how it is self-perceived and whether it is regarded as requiring treatment. As noted earlier, the term "depression" in a Native community can mean a mature response rather than a disabling illness. Learning what the term "depression" means to Native individuals helps suggest what is necessary to address it. For example, if depression is locally regarded as an appropriate but discomforting response to local social difficulties, finding out what the social problems are will reveal treatment interventions that may be useful for alleviating the unwanted aspects of discomfort.

Narrative research is most useful for unveiling local descriptions of the experience of depression, and can also reveal the illness's meaning and clarify its causes. This expanded knowledge about local understandings of depression can contribute toward site-specific treatment needs.

Ways must be sought to improve interactions between care giver and care receiver. Helping approaches in a local Native setting require a nonpejorative stance that sees the depressive illness experience not as culture-bound but rather as a unique set of illness symptom experiences relating to a particular context.

Research must address how to deliver treatment in an effective interpersonal manner that seeks to understand and collaboratively work with the Native client and community. Services must be attuned to the local explanatory model of the illness. This research activity promotes deeper understanding; from it, treatments emerge that are valued both by the Native individual and by the collective.
III
METHODOLOGY

This chapter will begin by providing a general introduction to the methodology, based on Grounded Theory, used for this research study. The methods used to identify and select participants for this research are described, as is the approach taken toward interviewing. The procedure for analysis of the data will then be described.

Methodology Overview

The purpose of this study was to explore the narratives of Native people living on a Native Reserve, populated by approximately 700 people, that is situated beside an urban city in Northwestern Ontario, to discover the understandings these Native participants possessed concerning their experiences with the emotional distress of depression and suicide. From this study's narrative data, it was intended to glean knowledge about these peoples' experiences of illness related to the mood difficulties. One intent from learning their meanings and understandings of the term depression was that this would reveal more information pertinent to their psychological treatment needs.

As described in Chapter Two, medical research methods employ the logico-deductive generation of theory and are "committed to logical deduction of a formal theory that forces the data to fit it" (Glaser and Strauss, 1967, p.142). Preconceived research strategies limit the possibilities that the grounded aspect of the theory will emerge on its own. As Glaser and Strauss (1967) comment:

This preconceived limitation prevents the reader from ever really knowing whether the core variable...[grounded theory] provides the most relevant relationships, because the complexity
of all relationships [in quantitative inquiry...is never shown. To preconceive relevance is to force data, not to discover from the data what really works as a relevant explanation. (p.142-143)

The previous chapter outlined that medicalised research perspectives seek to ask diagnostic questions which are the foundation of the medical model. These questions arise from a Euro-centric concept of mental health and seek to categorize symptoms to explain and hence, label the mental distress as a type within a category:

...testing a logico-deductive theory, which is dubiously related to the area of behavior it purports to explain,...is merely thought up on the basis of a priori assumption and a touch of common sense, peppered with a few old theoretical speculations made by the erudite. The verifier may find that the speculative theory forces a connection. (Glaser & Strauss, 1967, p. 29)

Inherent in the logico-deductive research methodologies is diagnosing by quantifying symptoms and features of the depressive illness. Isolating aspects of the phenomenon are of primary importance. Other aspects and other features of the individual experience are not investigated. Comparing scores on a variety of measurement instruments is the procedure usually employed. Quantifying the severity of the depression, diagnosing the type of depression, and comparing depression scores with other measures such as anxiety are investigated. However to respect Native researchers admonitions, further research of this type is uninformative:

What will help us to look further afield is definitely not the kind of psychosocial research [long practiced]. There is some value in presenting tables and numbers... but I must repeat what I have already stated...: personal experiences are not somehow more truthful when numbers are attached to them, nor is formal research likely to uncover information that could not be obtained by generating and carefully examining personal narratives. Indeed
adopting a Westernized standard of social science evidence would assure the continued marginalization of First Nations peoples in areas of crucial importance to us, while reinforcing the hegemony of the outside "expert". (Chrisjohn & Young, 1994)

A review of the literature had suggested that the best approach to a study of this type was one that involved basic research and description of the Native person's life from their own voice. Glaser & Strauss, (1967) explain why this process is more informative than the methods used in logico-deductive analyses:

... when we try to fit a category from another theory [i.e., medical model] to the situation under study, we can have much trouble getting indicators.... The result is that our forcing of 'round data' into 'square categories' is buttressed by long justifactory explanations for the tentative relationship between the two.... Working with borrowed categories is more difficult since they are harder to find, fewer in number, and not as rich...focus on the emergence of categories [from the data] solves the problem of fit, relevance, forcing, and richness. (p. 37)

These authors further explain the process of grounded theory, "An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study, in order to assure that the emergence of categories will not be contaminated by concepts more suited to different areas".

These comments suggested that the approach for this study should be that of grounded theory (Glaser & Strauss, 1967). Grounded theory is theory that follows from the data rather than preceding them. Grounded theory assumes that there is no a priori theory which could anticipate all the realities that the researcher will meet in the investigation, and thus the researcher approaches the data and invites the data to speak and the patterns to emerge. Grounded theory as a methodological approach also coincided with Kleinman's (1977) research approach suggestions.
This qualitative approach implied an emergent design. In particular, I did not know what would be specific to the depressive illness experience of Native people and so I was viewing the research enterprise as Glaser and Strauss (1969) describe, a 'tabula rasa' on which the researcher records the relevant aspect of the phenomena being studied. The design that emerged is explained in more detail later in this chapter. Using grounded theory, I attempted to place myself outside the data, to be objective and to focus on the data from the interviews with eighteen participants. However, I attempted as Smith (1983) describes, not to be detached in such a manner as to dehumanize participants. This author states that the goal that makes social science unique and separate from physical science was what allowed social science to deal with that essential human aspect of our subjects. To understand the meanings another assigned to his or her actions (experience of illness) required that these meanings be placed within a context, nothing could be understood in the absence of context. Researching the oral histories of these Native participants encouraged the opportunity to make sense of the events. In telling the story, the narrator gives her or his meaning.... The interviewer has an opportunity to expand her or his knowledge and understanding of a different world experience" (Hunt, 1991, Chpt.5 ). As Peshkin (1993) comments, the assumption behind the story of any particular life is that there is something worth knowing.

Manson, Shore & Bloom (1985) describe the richness revealed from their data using a qualitative approach. In their study, ethnosemantic interview procedures have enabled investigators to elicit lexicon taxonomies of disease entities in other cultures. Manson et al. (1985) described that in their research approach toward understanding Native depression at the local level, they employed a similar, but less rigorous interview technique to identify a broad
range of Hopi categories of psychopathology, including etiologies, context and potential sources of assistance.

These grounded approaches from a qualitative design, similar to those proposed by Arthur Kleinman's and Manson et. al (1985), suggested the methodology for this study and seemed to be most synchronistic with my personal interest in this area of depression as an illness experience in another culture. Although Kleinman's theoretical perspective is designed to promote changes to currently practiced approaches utilized in mental illness assessment and treatment in the fields of both anthropology and psychiatry, the profession of psychology would benefit should these two powerful groups evolve in their clinical approaches with different cultural groups. The qualitative approach seemed most appropriate for this study because as yet, no theoretical assumptions to explain and understand psychological distress with this population have been fully developed or presented in the literature (Renfrey, 1992). Clinical psychological practice frequently adheres to the psychiatric medical model paradigm in the areas of both cognitive and personality diagnosis/treatment and research approaches. Mainstream psychological practice has adopted the well-entrenched medical model approaches with regard to the clients' or patients' presentation of psychological difficulties.

**Grounded Theory**

**An Overview of the Application**

The methodology of grounded theory, originally developed by Glaser and Strauss (1967) is an inductive method of generating both substantive and formal theory widely used by sociologists. Grounded theory requires that data collection, coding and analysis be carried out simultaneously and the constant
comparative method is utilized. Data is systematically categorized until patterns in the data emerge:

...constant comparison causes the accumulated knowledge pertaining to a property of the category to readily start to become integrated; this is, related in many different ways, resulting in a unified whole.... By joint collection and analysis, the sociologist is tapping to the fullest extent the in vivo patterns of integration in the data itself. (p. 109)

**Data Collection**

**Interviewing**

Well-versed in the psychiatric mental status interview process, I entered the interview process prepared to resort to this type of query with participants about their experiences of depression and suicide. This standard psychiatric interview process includes observations about appearance and behaviour. It inquires of the individual about abnormalities in mood, affect, thought (content and process), judgement and self/other harm ideation.

Specific to depression and suicidal risk, the standard psychiatric interview process seeks to identify symptoms developed from established theory that are indicative of depression and its severity. Following the guidelines of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the presence of a certain number of symptoms and their duration will either include or exclude an assumption, and if psychometrically assessed, a diagnosis, of depression and the type of mood disorder (e.g., 'Major', 'Mixed', 'Dysthmic', 'Bipolar', 'Cyclothymic' etc.).

Fortunately, I was not required to resort to using this standard interview procedure because for the most part, interviewees for the study spoke freely and willingly in a monologue style on the topic of depression and suicide in their own lives. Their openness allowed for collection of the data suitable for
the application of grounded theory analysis. In some cases, I would re-direct participants back to the topic had they digressed but I did not have to do this often. The data inquiry was then focused on the topic of depression and suicide and the manifestations of this distress in participants’ personal experience(s).

The structured question and answer format utilized in both psychiatry and psychology to assess for the presence of depression and its type or severity that I was prepared to rely upon to query symptoms related to depression and suicidality risk was not needed and the result was data that required post-interview coding for categorization of depressive and suicidal experiences.

**Identifying and Selecting Participants**

I intended to choose adult female and male participants ranging in age from early adulthood to later adulthood. Women participants who demonstrated interest in participating in this study ranged from age twenty-one to age forty-four. Eight were in their mid to late thirties. Two women were in their forties. Two men were in their mid to late thirties and four were in their early thirties. One man was in his forties. (Tables 1 and 2).

Had I more time to visit homes and interview older participants more removed from the daily activity of coming into the centre of the community, I would have included them in the interviews. Older band members were not visible in the community and this may have been because they lived farther away from the community and spent more time in the area surrounding their homes.

The participants in this study were individuals who daily came into the community centre which at that time, served as the band office as well. I spent all of my time in this hub of the community and by observing me and learning through the "moccasin telegraph" or local gossip what I was
attempting to do, participants became quickly aware that I was conducting a study. Two local social workers assisted me by informing community members of my interest in interviewing. Initially, I approached participants to talk with them and explain the purpose of the study. I would invite them to inform me if they wished to participate. A few agreed to participate at the time of initially talking to them but others came back and informed the two social workers or other staff in the band office area that they would like to be interviewed. Through this process, appointments were made by my self or by other band personnel on my behalf.

Interestingly, by the time the month long period for interviewing was over, there were always at least two participants waiting to be interviewed with whom I had not met previously. It bothered me that I did not have a longer period of time to continue interviewing to include participants who seemed so eager to be involved. But I realized that my data categories were saturated and new information would likely not emerge. Most interviewees were in the same age and occupation range as those wanting to be interviewed, so I felt there would be no great advantage to extending the number of participants beyond the eighteen adults interviewed. (Tables 1 and 2).

I was attempting to get some variety in the current occupations of the participants but as the data revealed, most employed members living on the reserve were employed in two areas: in local administrative activities or in the local helping professions. Employment opportunities in other fields seemed non-existent on the site. Educational backgrounds ranged from having not completed high school to university-educated for the men and having completed high school to diploma or university-educated for the women. Half the women participants were more engaged in continuing their education at the time of interviewing. No male participants were in this process but two
men commented that they would consider it if their employment required it. (Tables 1 and 2).

Two female participants were married and living with their spouses. All the women but two had children. Half the male participants were also married and had children. The remaining female participants were divorced or separated except for one woman who had never been married. The three unmarried men had never been married and did not have children. (Tables 5 and 6).

In the women's group consisting of eleven, two women participated as participant-commentators. In the groups of seven men, one man participated in this role. The importance of these people to elaborating on the categories is explained below (Glaser, 1978).

With each participant, I established a face to face meeting prior to the interview. I explained the research intent in detail and included the information that the interview would be taped. I explained how the tapes would be used and how the interviews would be used in my research. I explained the issue of confidentiality, particularly that I would not reveal the content of their interviews to other band members. All participants were given time to consider their willingness to be interviewed by inviting them to return to make an appointment. Those who did not return were not sought out. After being given time to consider their willingness to participate, all participants scheduled an interview time by either approaching me or informing staff to inform me. Those who participated were shown the letter of consent and requested to sign it before participating.

While collecting this data by visiting the reserve twice, once in April, 1995 for four days and then in August on a daily basis for over a one month period, I encountered individuals who needed immediate treatment assistance
and whom I assisted in referring to the local city hospitals for immediate attention via the local Native O.P.P. personnel. One Native person who was self-described as suicidal was rejected at one general hospital and sent back to the Reserve. One man was presenting as quite psychotic and suicidal at the time of my suggestion to refer and I was made aware of the lack of resources accessible to him.

The Native reserve involved in this research was considering and beginning to mobilize collaborative strategies to promote mental health healing outcomes in their local context. Their approach is similar to that advocated in the research studies cited in Chapter Two. The participants in this study wished to voice their distress as they move forward from the silence surrounding mental health difficulties frequently practised on this Native reserve.

**Interview Process**

Data was collected through in-depth interviewing of eleven female and seven male adult Band Members who were both born and currently, at the time of interviewing, living on the reservation. A few participants had left the reserve to live in the nearby city or other cities after being born and raised during their early years on the reserve. These were one man and two women. However, all participants were living on the reserve at that time.

Interviewees were asked on an individual basis to discuss their experiences and understandings of depression, suicide and related mental health distress in their personal lives and in those of others in their community. The interviewer also explored with them as to how their mental health needs had been addressed and their vision as to how these could best be addressed. The narratives were qualitatively analyzed from a grounded theory methodology to extract categories, their properties and then, themes
(Glaser & Strauss, 1967, p.113; Glaser, 1978; Rennie, Phillips & Quartaro, 1988)).

An interview time period of approximately one hour was required for each interviewee. To collect the data, the researcher needed to be present on a forty-hour weekly basis for one month. The interviews were tape-recorded and later transcribed for analysis. Interview space was provided by the Band Council in the Band Office that is regularly accessed by all community members. Follow-up counselling was provided by the researcher and two on-site Native Social Workers who facilitated this research interview process. My own experiences of living within easy access to the reserve site and being familiar with many band members assisted in the research process.

On-going communication with band members as both friends and colleagues has facilitated my being able to access information as required and to follow experiences long after the data was collected. I continued to visit the reserve when in the area and continue do so at least four times a year. I am in regular telephone contact with two band counsellors employed by the Band Council. In the future, I anticipate participating in mental health care provision on this reserve site.

Because of my ability to be "outside" as a helper, I have learned from participants in this study that I am perceived as "helpful". Participants were amongst 700 people living on the reserve and they have stated that they felt that what they had confided was "held" and did not become part of local community gossip these people described as most troublesome to their own self-esteem. Keeping a personal distance has been valuable in my ability to provide counselling support that respects their need for safety in a setting where the site itself is enmeshed by the close physical proximity of band members with each other. Members are frequently related through family and
local divisions are present because families are not always in political agreement with each other. Local politics create divisions and tensions and helpers perceived to be psychologically "part" of the community yet, "outside" this struggle are removed from it.

Local band members were informed of the research process through regular information dissemination provided by the researcher and through the support of the band administration's helpers. The researcher continues to maintain on-going contact with the community for further input and consultations.

**Coding and Analysis**

Grounded theory analysis using the constant comparative method requires coding of the data for incidents of a category and comparing it with the previous incidents in the same and different groups coded in the same category. As Rennie, Phillips and Quartaro (1988) describe, the approach is systematic, places less emphasis on the researcher in co-constructing of the participant's responses and importantly, is a way of studying a relatively large number of individuals. Constant coding requires the researcher to stay close to the data through the constant comparative method (Rennie et al., 1988).

After each interview while collecting data from the first set of four participants, I transcribed the interview, one per day, in the evening. This allowed me to begin the process of identifying meaningful units and to attend to the need to close gaps in planning for the next interview period with the rest of the women and men four months later. I also made memos at this time. The "units" would form the basis for the analysis. Data collection in the grounded approach is influenced by the outcomes of the emerging analysis. The initial four interviews were transcribed for the identification of meaningful units, the mechanics Rennie et al. (1988) prefer over Glaser's
(1978) suggestion to analyze line by line. After all the eighteen interviews were completed, coding generated from comparing the data was begun to discover the theory rooted in the data (Glaser, 1978, p.38). As Glaser (1978) recommends, jointly coding and analyzing limits the likelihood of collecting irrelevant data; however, staying open is important to keep following up new ideas. While interviewing, I noted the relevance of a unit of meaning by its constant or patterned reoccurrence in participants' discussions and checked this by asking participant-commentators to give more data on categories such as suicide, sexual abuse, and drug and alcohol abuse.

**Categorization**

I chose a larger analytic unit defined by Rennie et al. (1988) in their application of grounded theory. Each narrative was broken into units. Because of the complexity of the material provided by the participants, units varied in length from sentences, phrases to paragraphs. Many units contained more than one item of information. As a result, each meaning unit was condensed by a series of reductions. For example, Bernice, one of the first women to be interviewed said:

I have experienced depression. Others too. From the very beginning of my life. I was incestually abused when I was a child, and by my brother. And actually I couldn't remember everything until later on, maybe when I was in my late thirties and then things got....

The meaning unit was condensed in steps with the first reduction being:

Bernice report that she experienced depression. She reported others experienced it. Bernice experienced this early in life. She said she was sexually abused. She said a brother abused her sexually. She said she did not remember all of the abuse until her late thirties. In her late thirties, her emotional problems were present.
Sorting the units of analysis into clusters on the basis of the meaning embedded in the items ties the items to a given cluster that is symbolized and this symbol makes up the category (Rennie et al., 1988). Responses from several interviews that have the same general meaning to each of the above reductions generates the category. Each category is descriptive and reflects the language of the participants. For example in the first data collection similarities were found:

Participant said she was depressed (3 women). Participant reports feeling depressed from early life/years (4 women). Participant says others in the community are depressed (3 women). Participant says she was sexually abused (4 women). The abuse was through incest (2 women). The participant experiences memory gaps (2 women). As an adult the participant remembers and she emotionally reacts (symptoms) (3 women).

The meaning units above are assignable to the category, The Participants Sexual Abuse Contributing to Depression. Each new unit of meaning is assigned to categories as they emerge. New categories are developed to fit new units. Open categorizing occurs when a given unit is assigned to as many categories as possible. As Rennie et al. (1988) remark, this technique separates the grounded method from content analysis. For example, some of the incidents that were first assigned to The Participants Sexual Abuse Contributing to Depression were assigned to other categories:

- Depression in Childhood.
- Sexual Abuse Experienced As Incest.
- Depression Experienced by Several Participants.
- Depression in Adulthood Related to Childhood Issues.
- Symptomatology of Depression Emerging in Adulthood.

Open categorizing permits the preservation of subtle nuances of the data and supplies the "groundwork for the development of rich theory" (Glaser, 1978, p.48-49; Rennie et al., 1988). Blending and constructing categories
occurs simultaneously. For example, the first category above, Depression in Childhood, was reconstructed as Unhappiness Occurring in Childhood.

As the analysis proceeds with material from other interviews, some categories become properties of other categories as in the above, Sexual Abuse Experienced as Incest which came to be put under the category of Sexual Abuse in Childhood. Categories are saturated when additional narrative material revealed no new categories, properties or relationships among them (Rennie et al., 1988). This occurred after the analysis of seven protocols for the women and five for the men.

The network of linked categories came to form a hierarchical structure in which central categories subsumed lower-order categories. The most central or core categories are developed and are usually abstract. For example, Low Sense of Self Esteem is most densely related to other categories and their properties in this study. This category subsumes sensitivity to others' opinions, feeling disdainful of the Native lifestyle, losing pride in one's Nativeness and determining that religious teachings lowered self-esteem. This category is associated with other categories such as Motivation from Within and from Social Support, Experiences of Racism, Abusive Re-Victimization, and Rediscovering Native Traditional Practices.

Constant comparisons were done by sorting the data from item to item, item to code, and code to code. The relationships between the substantive groupings began to emerge as described above (Glaser, 1978, p.55). As Glaser explains:

Coding gets the analyst off the empirical level by fracturing the data, then conceptually grouping it into codes that then become theory which explains what is happening in the data (p.55).
Once substantive codes conceptualize the empirical substance of the area of research, theoretical codes will conceptualize how the substantive codes are related to each other as hypotheses to be integrated into theory. For example, two substantive codes in this study, sexual abuse victimization and racism can be coded into an hypothesis that psychosocial stressors impact on mood states in this Native population. Theoretical groupings or themes that emerged from the substantive coding process for this study for both men and women were: Episodes of 'Depression' or Unhappiness Beginning in Childhood; Low Sense of Self-Esteem, Experiences of Racism; Losses; Low Motivation; Abusive Victimization in Adulthood (Women) and Becoming Abusive (Men); Self-Abuse; Experiencing Distress; and The Inability to Address Psychological Problems. In addition, related themes emerged: The Experience of Sexual Abuse and The Experience of Suicidal Thoughts and Intentions. Experiences with Treatment Provided for Native People and Ways of Coping were themes that accounted for the survival behaviour participants described exploring. These last two categories also provided information on treatment needs for participants.

**The Core Category**

Glaser (1978) describes that a "core category" accounts for most of the variation in a pattern of behavior and has several important functions for generating a theory" (p.93). It is the "main theme" that emerges from the data (p.94). Finding the core theme occurs at the end of the data categorization but the process begins in the early data collection.

Early in this study, I originally felt that the experience of sexual abuse would be the core theme related to episodes of mood difficulties or depression and suicide in the lives of participants. However, as the data categorization progressed and was re-organized, it became clear that this
experience was one of other negative experiences participants identified as sources they related to mood difficulties. Continued comparison, reconceptualization and repeated sorting of the study's "rubric" revealed that the core construct, unhappy experiences in childhood, was closely tied to the following theoretical constructs: negative childhood experiences; these followed by negative experiences while growing up; these experiences continuing to occur in adulthood; and, all were psychosocial stressors contributing to vulnerability towards mood difficulties. One key stressor was the experience of sexual abuse. Amongst other symptoms, a dramatic symptom of low mood was suicidal intentions or thoughts. Treatment and finding ways to cope were means by which participants sought to ameliorate negative feelings. Feeling unable to address the psychological aspects sourced in stressful events perpetuated mood difficulties.

In the following chapters, this theory will be presented through the comments of the eighteen participants who are directly quoted. Similarities between the participants' experiences will be found but the aim of the research, to explore the meaning of the illness with regard to the term "depression" and "suicide", will be achieved. Implications for helpers and the need of multiphasic helping systems are revealed.

**Research Questions**

(1) The purpose of this study was to explore the personal narratives of Native people living on a reserve in Northwestern Ontario to learn of their individual and collective experiences, understandings and beliefs concerning depression and suicide.

The precipitating events that result in a Native individual being or becoming depressed or suicidal have not been widely discussed within this particular community. The timeliness of this inquiry is highlighted by the
need to assist in facilitating shared communication among these Native peoples, since they are currently in the initial stages of the process of attempting to implement their own collaborative healing environment. The local Band Council, in its desire to implement mental-emotional-spiritual health programs (holistic), may benefit from this research information in their desire to meet the relevant needs of their people. This study can serve to provide an autonomous forum for these Native participants to "tell their story" and inform those most desirous and able to address their concerns.

(2) A second purpose was to inform care-givers about how Native people cope with their psychological distress. This includes how they utilize the services of outside helpers and what the results of this behaviour has been from their perspective.

Knowledge of these experiences provided by Native people living on this reserve will highlight both the benefits and disadvantages these people experience in employing their coping strategies and help-seeking behaviours.

Native people report utilizing a variety of help-seeking strategies. Their experiences in treatment in non-Native society are important knowledge to learn from in developing treatment approaches that are transformed from current non-Native medical practises that may disregard their healing needs. Native people demonstrate that they do approach both Native and non-Native healers. To better know how non-Native healers can best help is important knowledge for improved delivery of care.

Native people from the reserve describe having frequently accessed non-Native mental health services provided by city practitioners. However, dissatisfactions in treatment services, because they do not acknowledge local Native cultural treatment needs, has resulted in local band members
emphatically voicing a need for collaborative input into the provision of these services. Many stated that basic respect for Native people and their life-style of reserve living and resulting issues from this lifestyle was lacking. The present research can contribute knowledge for improved communication of needs between urban mental health-care providers and this Native community.

**Data Organization**

The data will be presented under the following sections:

1. *General Descriptions of Experiences of Depression and Subjectively Felt Distress*
2. *Major Themes or Causes Attributed to the Experience of Depression*
3. *Experiences of Sexual Abuse*
4. *Experiences of Suicidal Intentions or Actions*
5. *Ways of Coping*
6. *Experiences of Participants Who Have Received Treatment (Drug and Alcohol)*

**Originality**

This study is an original contribution to mental health care research and the findings provide a better understanding of Native peoples' experiences of psychological distress. First, the study advances knowledge about this Northwestern Ontario Native group's experiences of depression and suicide from their personal perspectives. Little of this type of narrative data is presented in the literature.

Secondly, knowledge from these participant's mental health experiences will heighten awareness and understanding about the nature of the distress these Native people experience. Knowledge can work towards a better
understanding for the development of appropriate care paradigms. Knowledge will better inform both local caregivers and Western medical caregivers.

Thirdly, this knowledge can serve to assist in the development of culturally relevant mental health treatment approaches at the local level. Better treatment paradigms can contribute towards increasing the clients' compliance with mutually agreed upon treatment plans. Mutually agreed upon treatment strategies will better work to alleviate the distress experienced from depression and reduce suicidal ideas among those who experience these emotional difficulties on the reserve.

This research also adds to the body of knowledge that is currently seeking to address what the meaning of illness is among Northern Ojibwe peoples. This research provided a unique opportunity to collect information which may assist helpers in developing collaborative partnerships among local caregivers, Western medical practitioners and Native clients. The study's caregivers were planning for the delivery of on-site mental health treatments and many were receptive to a new form of collaboration with caregivers from other disciplines.

The participants stated the their experiences of depression or suicidal ideas were rarely discussed within the community. Exploration of their experiences, through interviews, with Native participants who are depressed or at risk for depression, or, who are at suicidal risk can encourage dialogue that can reveal both individual and community-wide themes. Band councils who wish to provide mental-emotional-spiritual health programs (holistic) can benefit from more intimately knowing the mental health needs of their people. Qualitative research that provides these Native individuals an anonymous
forum in which to "tell their story" will inform those most interested and able to address their mental health concerns.
IVa

ANALYSIS AND DATA PRESENTATION

Part 1: Introduction

The eighteen Native participants, eleven women and seven men who were interviewed for this study were generous in their trust and in their willingness to describe their frequently painful experiences with psychological unhappiness. For the most part, they determined that emotion-related problems affecting their mood stemmed from certain sources. These sources will be given the term "psychosocial stressors" in this study. While the participants did not consistently relate their episodes or experiences with mood difficulties to that of being clinically depressed in the medical sense of the term, they often used the term "depression" to describe their reactions to the situations or psychosocial stresses they viewed as causing them unhappiness.

Through the meanings that the participants attributed to their experiences of emotional discomfort, various themes emerged and these will be presented in this chapter. These themes are presented separately for women participants and for male participants in five sections: Section One - The Experiences of "Depression" and Its Expressions; Section Two - A Major Theme of Psychosocial Stress: Sexual Abuse; Section Three - Experiences of Suicidal Thoughts and Intent; Section Four - Various Ways of Coping; and Section Five - Experiences of Participants Who Have Received Treatment.

For the most part, participants discussed their experiences or episodes of psychological unhappiness in a developmental fashion. Almost every woman began her narrative by including experiences that occurred during childhood. Many of these women's narratives indicated that these early experiences had
some impact on their lifelong sense of psychological well-being. Descriptions of emotional distress in childhood were followed by narrations of other occurrences that created negative feelings. Emotional problems were sourced in events that had occurred in the teens, early adulthood, and the middle adulthood. It seems that emotionally painful experiences in childhood were quickly followed by other negative experiences in later adolescence and adulthood. My impression is that the persistent nature of the psychosocial stresses that the female participants were exposed to allowed for no recovery time. Unable to heal psychologically, participants were unable to absorb the shock of further encounters with stressors. Listening to their stories often overwhelmed me emotionally and for a long time I was unable to write about them in a fashion that allowed the voices of the participants to be heard. As a mental health professional, I felt the need to withhold what I had heard. I experienced each individual's narrative as a constant barrage of negative occurrences. I felt a need to present the material in a more distant, personally removed, clinical presentation. Perhaps, that was my defence to protect myself psychologically and to remove myself from the pain in the stories. Forced to de-clinicalize their stories, I came to realize that my need to protect readers was an imposition I was making on the participants and that it was limiting their voices from speaking. They wanted their experiences to be heard.

Section One
The Women's Stories Describing Low Moods Occurring in Their Lives

4.1 Psychological Unhappiness Described Occurring in Childhood
Visibility as a child, whether feeling invisible or the opposite, feeling visible but in a discomforting way, was a metaphoric thread that ran through
the stories that the female participants shared about their childhood. This was a major theme that emerged in their discussions of their experiences of "depression" and of episodes of psychological unhappiness in childhood and early to middle adolescence. Sub-themes that arose among participants from this main theme were: having to cope with parental alcoholism, having to cope with parental break-up, experiencing physical abuse inflicted by parents, experiencing parental neglect or absence, and being exposed to sexual abuse.

Eight of the female participants stated that low mood difficulties began early in their lives. Of the remaining participants, two did not mention this as a personal experience in their own childhood because they contributed to this study as participant-observers and did not discuss their own experiences, and one commented only that her parents' marital conflicts were being repeated in her own marriage but did not mention the problems in her childhood.

Overwhelmingly, the women commented on an absence of a sense of good relationship with their parents. They revealed that their personal sense of visibility in their relationship with parents had been an issue. For two women, their feelings of being unacknowledged was influenced by parental use of alcohol or resulted from a parent's reaction to a spouse's alcohol use. Two participants talked about feeling "alone and cut off", "shut down", and not "allowed to speak up". Another said of the children in her family that "we weren't loved" and that "accomplishments" were not "acknowledged". In contrast, other women considered that they had been too visible because of the negative attention they had received. They mentioned feeling "intimidated" by "authority" figures through "verbal abuse" or feeling the "imposition" of "abuse" through "violence" or "real good licking[s]".

Feeling invisible did not arise only out of living with their parents' alcoholism, it came from feeling parental "[dis]interest", from feeling "pushed
aside", or from feeling that their parents were "not there". Being victimized by sexual abuse during childhood was talked about in two ways, first as feeling invisible, from a sense of being "abandoned" by parents, or, secondly as not wanting to feel visible: "I preferred being on my own".

4.1.1 Depressive Feelings in Childhood and Parental Alcoholism

Two participants explained how their parents' alcoholism had created unhappy experiences for them. Low moods were termed as "depression" by one woman. Donna's experience of having had an alcoholic parent led her to assume the role of caretaker, and for her this had resulted in a "lonely" and isolating existence.

Even as a kid I felt depression. I came from a family of six. I was the second youngest. I felt alone and cut off from the rest of the family. My dad was an alcoholic. My role was caretaker.

Donna said that she felt unable to talk about her emotions when she was a child. This resulted in her feeling "sick" when the issue of feelings arose because she knew only how to hide them. She noted that she experienced guilt when people talked about their feelings, and her inability to be comfortable with them caused her need to "shut down again".

The depression comes from when I was young, goes way back. I was just hiding it and not saying anything. Hiding it, block it out, no feelings until someone talks about it. Gets overwhelming, like a sick feeling. I just want to cry or take over somebody else's feelings. I feel guilt and then, all of a sudden you just shut down again. But it's always there.

The general state of fear that came from being in a family where alcohol abuse could lead to chaos resulted in Donna's attempts to regain a sense of personal control. She described the helplessness that came from being controlled by authority figures as a child and of the need to counteract this helplessness by
trying to be in control to some extent. She acquired this control by being invisible but watchful when she could not assert her presence or her voice.

When I was small the need for control started. I was told what to do, I had no choice. I wasn't allowed to speak up ...I would scan and watch every move they made... when [they were] drinking.

Evelyn stated that as a child her father's alcoholism upset her. He was frequently absent from the family home. Evelyn felt unloved. Her mother became the one who carefully monitored her children's exposure to the negative aspects surrounding the alcohol abuse. Evelyn could not understand how to get the love, attention, or approval she needed when she was "cornered away". She attempted to be visible and receive acknowledgment by becoming perfect:

And I had a mother that was so protective that kept us kinda cornered away into this corner and uh, a lot of times we weren't loved or ever told we were loved. Which I can understand now but at seventeen, eighteen, I couldn't understand it. And uh, anything around any accomplishments, anything I'd done I was never told I was good or did good or I love you....

4.1.2 Parental Breakup

One participant believed that her parents' physical arguments and their separation had a negative impact on her sense of emotional well-being. In turn, she attempted to gain visibility by crying out behaviourally. Arlene said that as a child she had suffered emotionally from her parent's marital conflicts. After their separation she lost a father who acknowledged her - we were "really close" - but her mother was silenced through his physical abuse.

When I was a young girl I went through a lot of emotions because of my parents splitting up and Dad leaving us. I was twelve years old.... I went wild after that. At twelve years old I used lots of drugs, needles, the whole bit. I wouldn't listen to my mother.
I was very angry. I was really close to my Dad. I didn't feel angry at my Mom. I felt sorry for my Mom because I used to see her get a good licking [beating]....

4.1.3 Verbal or Physical Abuse

Three participants described being acknowledged by their parents only through verbal or physical abuse. These women expressed anger at this violation of their selves. The absence of a sense of connectedness with her abusive parents resulted in long-lasting emotional distress. Donna believed that she had come to feel defensive from having experienced this form of attention:

[I experienced] lots of verbal abuse. I was told to respect others. Authority figures intimidate me [now] ... I become defensive.

Linda mentioned feeling unhappy in her childhood when her parents "imposed" on her through physical abuse. They defended their abusive behaviour by religious beliefs concerning punishment. Linda decided as early as when she was in high school to become a social worker and to work with children because she felt she could help children as a result of "[her] own experiences as a child". "Yes, it's [my own experience that has] made me a better helper". She explained that those who abused her misused church beliefs to rationalize their behaviour:

I was raised in a Catholic family and some of the beliefs that I was given or were sort of imposed on me I guess, um, worked against me later in life. ... So, I believe in there that I was abused using the Catholic belief system, um, because of being abused using religion.... I've been there [abused].... I wasn't a very happy kid. [I experienced] a lot of violence...past traumas.

Linda also talked about feeling upset about the physical abuse that occurred in non-Native children's aid services: "I heard of one lady who watched her cousin or niece or sister get grabbed by a CAS worker by the
hair. The girl was developmentally delayed, and when she came back to the reserve she was missing patches of hair, bruised up, and stuff like that".

Bernice said she had received severe beatings and other punishments from her mother and that these had begun in her childhood and had continued into her later adolescence. She came to hate her mother for this kind of attention:

My mom made me kneel, kneel down all night in the corner [as punishment] and she wouldn't let me go to bed.... I'd get a whipping at seventeen or eighteen...then, I'd get a real good licking. I hate those red willows. I hate those red willow sticks and when anybody, a lot of people say, "oh, I love those red willows!" and I hate those things.... I used to hate my mother, I hated her. I got over that later on in years.

4.1.4 Feeling Neglected by Parents

For two participants a sense of feeling invisible was encouraged by the experience of feeling unimportant through direct acts of being "pushed aside" or through indirect ones resulting from parents being "never around", either psychologically or physically.

One participant, Jamie, stated that she felt herself to be unimportant because she felt that her parents were not interested in her. She mentioned that she had felt neglected as a child. She thought that her parents gave her a "boy's name" because "they wanted a boy" and she believed they did not want her.

As a child I was told to be quiet. Pushed aside, they [my parents] never had time, I was not important. I see myself doing to my kids what my parents did to me.

4.1.5 Childhood Loneliness and Parental Absence

Ginger said that in her teens she failed two high school courses she needed in order to graduate. "I failed because I had an early season. I was just stressed out." At the time of our interview, she was studying to pass these
courses and was planning to enter university. However, she remembered having been "bummed right out" in high school. She recalled that her low-mood problems started in grade nine a time when she often felt "lost". "All by myself sometimes. You know, you'd always have your good days. Basically, I was always sad. Writing sad poems. It was pathetic." Ginger said that her parents were frequently absent from the home and that she missed them. She also remembered feeling lonely as a child because of the emotional loss of her mother whom she felt was depressed during those years. Even her father was unavailable to her:

I love my mom, we get along good now, but, I think, like I said, she was depressed since I was little. And she would work a lot.... Like, my dad was never around. Because he works out of town. It just seemed like we'd go to school, and when we got home from school...she wouldn't be there. We'd have a baby-sitter.

4.1.6 Childhood Sexual Abuse

Two women mentioned how their experiences of childhood sexual abuse impacted on their need for attention. Bernice sought out visibility by trying to please, by trying to "make people like [her]". In contrast, Shirley liked to be "busy" and to be invisible, by keeping to herself.

Bernice began her narrative by immediately attributing her ongoing psychological distress in adulthood to her experiences of sexual abuse as child. Bernice attributed her feelings of depression to her experience of being sexually abused as a child by a family member. She said she always felt "unloved" and "abandoned" by family members:

I have experienced depression.... From the very beginning of my life. I was incestually abused when I was a child, and by my brother. And actually I couldn't remember everything until later on, maybe when I was in my late thirties and the, things got.... I started
reflecting back. I don’t know what brought the situation on but I always felt unloved, I felt abandoned and unclean and I always felt I had to do things to make people really like me.

Shirley differed from other participants in that she was unaware of having been depressed as a young child. However, in her teens she began reflecting back on her childhood experiences of sexual abuse, and from this she became depressed:

I’ve been there [in depression]. I don’t know really what to say because I’ve been by myself even as a kid. I preferred being on my own and there really wasn’t too much depression and there wasn’t really any time to be thinking like that... I always had something that I had to do.... But as I got older, I would think about myself, my shattered dreams [from sexual abuse].

The women described childhoods where alcohol use, verbal and physical abuse, parental disinterest and absence, and sexual abuse were situations to be contended with at home. Even on their own, these psychosocial stressors would be emotionally demanding for small children to cope with and would seem to require strength beyond that available to children. However, the messages that the behaviour of the parent relayed to these women when they were children was that their visibility as persons was either unattainable or a negative personal experience. No woman mentioned having a sustained relationship with a parent in which they felt loved, appreciated, or worthy. A sense of self was not nurtured in any of these women and for most of them the resulting fragility of positive self-worth meant that they required validation or affirmation from elsewhere. Later I will show how the women stated that this validation from sources outside their family did not occur.
4.2 Low Sense of Self-Esteem Interpreted As An Aspect of Depressive Experiences

A negative concept of self extended from childhood experiences into the teenage years for several women. Issues surrounding a sense of visibility continued to thread through their experiences. A major theme that emerged from half of the women's narratives was the experience of poor self-concept and how at it contributed to feelings of low mood at certain points in their lives. Sub-themes were an adoption of an attitude that one must please others and the feeling of hopelessness about the possibility of a brighter future.

Participants chose to include the issue of self-esteem in their monologues describing the depressive episodes in their lives. Therefore, it appears that in their explanatory model (EM) or understanding of the meaning of the term "depression", they viewed low sense of self-esteem as a facet of their depressive experiences. For two women who had experienced negative attention as children, either from being visible and punished or from being invisible and pushed away, regard others had of them mattered more to them than how they felt about themselves. One woman continued her invisible yet watchful stance into adulthood where she cued the difficulties of others and "moved" in, as she had in childhood, to take care of them only to have them complain about her when she withdrew this attention. Two women, who had both alluded to feeling invisible as children, felt either "stuck" or "labelled" in life, and consequently unable to move forward. One of them had felt "cornered" or "stuck" as a child. The second had experienced sexual abuse that made her feel vulnerably visible and she was angry about it.

4.2.1 Needing to Please

Three participants said that their willingness to please others was problematic in their lives. These women believed that it was their low sense
of self-esteem that caused them to want to please others regardless of their own feelings. They considered that they felt the regard they paid to the evaluations others made of for them was too important. Bernice said she tried to gain love by pleasing others:

I feel lonely. A lot of times I always felt like the black sheep in the family.... I'm always worried about other people, too. I'd rather not hurt the next person. I want people to like me so if I did not like you or thought you were doing something bad, I would not say that. I would rather have you like me than not like me. I feel terrible when people don't like me. And it's not right - I should not be afraid to stand up and speak my mind to those people and not worry about if they're going to like me or not, just try not to worry.... I guess I think I want to be loved, I want to be cared for and someone to take care of me.

Jamie said she felt unmotivated to follow through on her desire to find some kind of outside work: "I don't have enough confidence in myself". Jamie too held others' regard of her as greater than her own self-regard, "I always think what other people think of me. I never think of what I think. I think of what they're gonna think of me before. I think that's what stops me lots." Jamie felt "[un]important" as a child and "stopped" from asserting herself by being "pushed aside".

Donna stated that her low sense of self-esteem contributed to her tendency to take on the family care-taking role early in her childhood. She described that this behavioural pattern of trying to troubleshoot and please others continued into her adult life, where her efforts caused her to feel those she tried to rescue were taking advantage of her. However, when she tried to become invisible again, a role she had felt safest in during childhood, she was reprimanded.
You go for people you feel need caretaking and types who'll blame you when you move away. It feels like I'm deserting them if [I] see what's going on and that [I'm] being taken advantage of. You cut yourself off and then you're put into another role and you have to explain yourself.

4.2.2 Believing the Future Is Hopeless

Two participants felt that their life situations would lead them nowhere in the future. For one participant, Evelyn, a sense of feeling trapped came from both her childhood experiences at home and her sense of the current local attitudes. She believed these worked towards creating a system of beliefs in which she thought she would be forever confined to the reserve just as she was "cornered" in her family, unable to plan for any other future. Evelyn said that in her late teens she felt that this sense of being "stuck" led her to feel poorly about herself. She had graduated from high school but could not envision anything better for herself in the future.

My self-esteem was really low even though I had graduated from grade 12. I guess I felt stuck. I don't know if we're brought up to feel stuck here or what it is. You know, I've been trying to figure that out, that part when we grow up, part of how we're raised. They raise us to feel stuck, not intentionally of course.

The second participant said that she came to believe that she had no future as a result of being a victim of sexual abuse. She felt awkwardly visible and became angry when others gave her personal attention. The abuse led to her feeling impure, and she believed that she was somehow assigned to be visibly singled out to be mistreated.

I'm no longer pure. And it kinda shattered everything for me. [I would say to the Creator:] Why did you put me here? Why did you allow this to happen to me? I used to think I had a sign on me, "Pick [on] me"!
4.3 Experiences of Racism and Self-Regard

All women participants described experiencing racism as a stressor, so that their experiences were negative psychosocial sources of unhappiness. Again, visibility as a Native person emerged as a part of this major theme from discussions of personal experiences of low self-esteem. Sub-themes stemming from this were a sense of damaged self-respect, racism experienced at its worst at school, and feelings of shame arising from racist treatment. All the women recalled experiences of racism within the context of times in their lives when they felt they had been depressed. Being visible as Native meant being vulnerable to negative experiences from both the Catholic Church and the school system. Consequently, the women's own sense of being was invalidated from childhood experiences within the family, and then pride in one's own collective cultural being within the larger community was diminished.

4.3.1 Damaged Sense of Self-Respect as a Native Person

Three participants mentioned that their self-image as a Native person was jeopardized by teachings imposed on them through the Catholic Church and other non-Native sources.

In her early years, Shirley was close to her grandmother who practised her Native traditional ways and taught them to her. Shirley drew a positive sense of esteem from this closeness but her pride in her Nativeness was stigmatized when she was removed from her home to begin her education at a residential school run by the Catholic Church. The church's aim in wanting to erase the visibility of Native people was directly communicated to Shirley:

They tried wiping the culture out. They said that was the only way at that time.
Evelyn mentioned how the teachings of the Catholic Church and the community attitude that developed from these teachings contributed to her poor sense of self-esteem. The church taught Native people to judge each other as "sinners".

My spirit, I feel my spirit now. There was a time I would go to church and you know, even when ... I went to church all the time and you never feel that real connection.... I felt I was in this building and I know I'm a sinner [laughs] and I always felt that [the people in the congregation are] looking at me funny here [laughs]. And it's supposed to be a place where people don't judge people....

Ginger's self-esteem seems to have been affected by disdain of her Native relatives whose lives represented poverty an economic situation that she did not want for herself: "I never want to end up like my cousins at all. Middle class, below, that was never for me!"

These kinds of experiences were shared by many in the community. However, for individuals the impact can be intense. What follows are descriptions that participants gave of their personal encounters with racist treatment.

4.3.2 Racism Felt at School

More than half of the group said that they had been racially mistreated at school. They said the racist attitudes towards them came mostly from fellow students, but two participants said that these attitudes were also shared by teachers. Some participants said their own children were experiencing racism from educators. Participants described the behaviours that violated a positive sense of self as a Native person. They felt they were being "put down", "segregated", or "unsupported", and they suffered from being called terms like
"burnt". They said that their pride in being Native was also damaged through "prejudice" and "bully[ing]".

Donna, who was removed from the more protected collective of the reserve school where all fellow students were Native, described how feelings of panic started when she was forced to integrate as a minority figure into the non-Native system: "When I went to school, it meant I had to be with lots of people. I'm better at crowds now, now I can control it [panic]." Donna had attended a school on the reserve where nuns were her teachers until she entered grade eight. When the nuns left, the school was closed. At first, Donna felt that going to a different school off the reserve in the white community was "exciting" at first and then she found it to be "petrifying, different kinds of people."

Donna soon realized that she was "singled out" because she visibly "look[ed]" Native in comparison to two Native school friends. She attempted to hide herself, to "cringe and shut up...and think they'll leave [me] alone". She was "pushed aside" but at the same time she was noticed as a Native.

I didn't know much about prejudice and then I heard "stinking Indian" and thought, "I don't stink?".... In high school I heard comments about Indians.... I remember farmers and Indians were put down.... I was singled out because my two friends didn't look Native. I would cringe and shut up and think, "They'll leave [me] alone." I had feelings of anger, fear, loneliness. You're segregated and pushed aside.... I wanted to ask them, "What's wrong with me?" but you're not used to speaking up for yourself, [if] you're not brought up to fight....

Linda was told by an individual in authority that she would not be able to realize her professional dream because of poverty. The teacher assumed that because she was Native, she was poor. Linda's guidance counsellor quickly
dismissed further education as an option for her. Linda said that her experience of encounters with "cruel" teachers was shared by many Native children.

A lot of the experiences that I had as I was going through school and stuff weren't very positive. I went to the guidance counsellor and told him I wanted to be a social worker and he started telling me that it would cost my parents thousands and thousands of dollars and said it wasn't a very good idea. And it held me back. Teachers were not only unsupportive but very, very cruel, very unsupportive. They made derogatory comments to Native kids in school and as recently as my own kids.

Margaret's school experiences caused her to hate herself for being an "Indian". She said that when she was a child in school, she heard derogatory remarks about her skin colour. She remarked that her own children were subjected to racism at school:

[I] hated being an Indian! [I heard comments like] "You didn't have to worry about being burnt, you're already dark". Even my kids, there's something about it [racism] out there again [affecting them].

Arlene stated that she was now "proud" about being Native, but this was a new experience. In school she said that she did not "want to be Native", and considered herself to be the object of "prejudice". Later, as an adult, she began to acknowledge her visibility through taking part in Native activities. She believed this had worked to change the way she was and that it now made her feel "proud".

At one time, I didn't want to be Native and that's changed. I'm very proud to be and I take part in a lot of activities today. [I think I didn't want to be Native] because of the prejudice.

Jamie differed from other participants in her reaction towards experiencing racism at school. She made herself visible by attempting to attack the
negative experiences. By "bully[ing]" racist students, she was able to feel some sense of "[em]power[ment]".

In grade school, yeah. There was lots, lots [of racism toward Native students]. But I had more power than them [non-Native students]. They were scared of me 'cause I was the bully and I got after them. I had a lot of control, I didn't let them push me around. I had a lot of friends but it was just the odd bad people.

Racism that participants described were the result of acculturation strategies imposed on these women by institutions like the church and the school system. Children who experienced being either invisible or negatively visible in their own homes had also to contend with a social world that marked them as visibly inferior and unacceptable because they were Native. Several participants said that a sense of shame developed from their encounters with racism. Below, four women enlarge on their experience with this feeling.

4.3.3 Experiences of Racism and Feelings of Shame

Being Native encouraged feelings of shame among the women. Racism from external sources heightened their sensitivity about being Native and they developed negative feelings about having to interact with the non-Native world. Bernice not only felt shame from how she was treated as a child within her family but also shame in who she was as a Native person. She said that in her childhood she felt "a lot of shame growing up, I don't know if I felt shame in being an Indian too. Maybe."

Evelyn felt keenly the impact of racist stereotyping from the behaviour of her own father. Her attempts to be "perfect" to counteract the "embarrass[ment]" and live down the "shame" of his alcoholism were evident in her story. She described a childhood in a family where her father was alcoholic and where her mother's fear led to her trying to control her children
by isolating them. Evelyn reacted by trying to control her own fears. She protected herself by trying to hide what was occurring in her family through her own "perfection". She did not want to be associated with the stereotype of the Native people.

And I think it had a lot to do with where I came from and uh, [you] know, I was always such a perfect kid and I grew up within a family where my father was alcoholic and I never spent a lot of time with my father. And when I did see him, I would see him on a street uptown and I'd be so embarrassed and ashamed and all the stuff about Indian families was right there, eh?

Racism divided families. Ginger, who had a white father could not blend in with her father's non-Native family. She felt that she was not accepted because her Native mother was not accepted, and she felt hurt and angry about feeling rejected by her father's side of the family. "I guess I never grew up with my mom's side, so I had to live with my Dad's side [non-Native].... I always wanted my [white] granny to love me, but I always felt ... especially when I found out she called me a bitch ... she didn't want my Dad to marry an Indian."

Linda felt shamed by mental health and physical helpers' attitudes toward Native people after having sought help from them. Because of their stereotyping of Native peoples, she was averse to Native people seeking treatment for depression from non-Native care services. She felt that non-Native helpers were "racist". She feared that she herself would be "labelled" if she sought help from them and her concern was that they would be "prejudiced" against her. Linda believed that outside helpers' racism expressed itself in a superior attitude and that Native people should avoid them in order to protect their self-esteem. "We don't have a lot of different
people coming in [now] to fix us. Because [healing] more comes from within". She commented that in her own role as a social worker she encounters racism. "I think [white] society has a hard time changing their views, they see Natives as in need of help rather than being able to provide it".

Evelyn mentioned that from a spiritual perspective, she had experienced a low self-esteem because she was taught that her Native spiritual beliefs were wrong. She struggled with the teachings of the Catholic Church which, by invading her pride in her Native spirituality, had crossed important boundaries. The church's teachings had worked to obliterate Native spirituality which she "missed", and left her feeling perplexed about issues of faith and caused her to feel angry "towards the Creator". Evelyn came to feel that "man-made" approaches to Christianize Native people were "not right".

I missed my spirituality with my religion and uh, 'cause now I know...it's [Native spirituality]. My spirit connecting with the Creator 'cause now I can feel it. It took me a long time to realize that, you know. And it took me a long time to even realize that I had a real big anger toward the Creator - from the hurt in my life. And I hurt to be able to get over that. And still at times in my life I get mad [laughs]. Because that part of my life is still really hard, eh. I still struggle with it everyday.

And I think somewhere somebody taught us something not right. And I think it's more man-made stuff than a connection to the Creator.

The above-described psychosocial difficulties of stressful familial relationships in childhood, followed by the stresses of experiencing racism through interactions with non-Natives, contributed to feelings of low self-worth among participants. In addition to these stressors, participants described other difficulties that taxed their sense of emotional well-being. For example, the feeling of loss discussed in the following was not merely an
existential feeling related to depression for these participants. They described having to cope with deaths of family members among other forms of personal tragedy.

4.4 The Experiences of Low Mood in Relationship to Losses

Experiencing losses in adulthood emerged as a major theme of the monologues. Sub-themes related to this main theme were losses through deaths, losses through accidents, and losses through family breakdown. Half of the women mentioned suffering from losses that deeply affected them emotionally. For several women, these were not described as single losses but multiple experiences of overwhelming proportion. Two women described their emotional reaction as that of feeling "numb". One woman even termed her experience as "Post Traumatic Stress".

4.4.1 Losses through Death

Arlene experienced several losses. She said she felt depressed when "my brother was killed, and by other deaths in the family". She added, "I feel sadness for my children".

Donna described the emotional toll she experienced from the losing two important family members who died. She became depressed because of these losses and the depression caused her to take a leave from work:

This depression has gone on for several years. My Mom was sick for three years off and on and I had lost a son, then mom. Anybody dying and sick would automatically just bring in the depression. And working with children, seeing what they go through, I sometimes catch it from them. I see it faster....

Margaret commented on her experience of depression early in her marriage when her baby accidentally drowned. The "baby died in a wash pail" while under the care of her sister. "I guess I didn't know how to handle it. I guess I
felt I was to blame. I know I can't take care of my children everywhere".

Margaret was angry that her husband felt she should limit her grieving to only three days. She also felt the weight of "community pressure" because of how the baby died. Margaret described her feelings of shock:

Numb, never noticed how numb I was. No one ever told me about Post Traumatic Stress. I wanted to see the baby and held him twenty minutes. Thought he would open his eyes and feel me touch his hands and fingers. He was really special to me. Numb. I can carry on if my mom gets mad at me. Oh boy! I can cry and we'll get a tear here and a tear there.

4.4.2 Loss through Accidents

Evelyn commented on her feelings of traumatic loss and depression after her husband became paralysed from being in an accident at work:

I felt really depressed and it was because a big hurt [had] happened in my life. Um, it happened when, I guess twelve years ago just after I got married. My husband was in an accident that caused him to be paraplegic and uh, we had already had my first daughter and I was pregnant with my second. And it wasn't at that very initial time that I felt the depression. Uh, he was diagnosed in the hospital being paraplegic from the upper chest down and I sort of walked around really numb I'd say for a good year and I still didn't realize I was depressed. Or, I didn't think I was depressed.

Evelyn said she felt emotionally "numb" and this worked to block out the pain". She later realized she was experiencing depression and she began to abuse alcohol:

It's almost as if I had blocked out that pain. And uh, after as if everything was ok in my whole life. I continued to struggle that way and I guess it was, really it was just survival and I guess I would say that for the next couple of years I did get really depressed and through my own depression I turned to alcoholism. Alcohol for uh, to
try and bring back, I don't know what.

Margaret said that she became aware that there were "different" types of depression. After her husband burned down their family home while using drugs, she lost her entire sense of familial cohesiveness:

I wasn't home that night and my husband knew and he was to take care of the kids. My brother won five grand and I drove home even though I wasn't going right home. I was just down the road at my sister's when my house was burning. [He was using] the cocaine and he wouldn't come out [of the burning house] and the kids went in [the house's] window [to get him out]. Out of this came charges, Family Court and Local Children's Aid. He's [denying] and not pleading guilty to arson and three counts of endangering life. And, that angers me.

Margaret explained that she had also to further deal with the threat of losing her husband, who nearly died from the burns he received in the fire. This resulted in a "different" kind of "depression".

And I went finally and he looked so awful [badly burned in the hospital] and life support and it was more anger and anger and I talked to God. And I didn't want to deny [my husband] seeing the kids [by court order he was to stay away from them]. Right now we're not together and it's like, it's different, the depression....

4.4.3 Loss from Breakdown of the Family

Bernice mourned the loss of two of children she had put up for adoption:

It hurt losing two children.... I gave my twins away. I was only concerned with their father.... I feel guilty. I feel like sometimes I just want to go into a hole and stay there....

It would be logical that there would be consequences from experiencing these psychosocial stressors, and in fact the participants did explain what these were, both individually and collectively, in the community.
4.5 Depression and Goals

Seven of the participants talked on the theme of motivation with regard to their ability to achieve goals when they discussed their episodes of low mood or depression. This emerged as a major theme. Sub-themes were low mood promoting feelings of inertia, low sense of social support working against feelings of motivation, motivation being immobilized by feelings of stress, and needing to find relief from work stress to stay motivated.

Participants mentioned wanting to change their life situations. They explained that the stressors that had occurred in their lives affected their ability to move forward with their lives. Low motivation was described as an internal experience, but participants also alluded to external factors they believed worked against their ability to feel motivated.

4.5.1 Low Mood and Feeling Unmotivated

Two participants believed that their low moods caused them to be unable to feel motivated. Bernice said she was like this and she also mentioned that the pressure of needing to please others was a personal issue she mentioned:

We don't get out and do anything. My daughter's addicted to the way I live. Procrastination - I know what that is. It's the father of boredom and boredom is plain not getting your ass off the couch and doing something with your life. I want to teach, go to university. I don't love myself or even like myself. I lose it [at work]. Those people standing around... I like to work while I'm here and I get pulled around here. I want to please everyone and sometimes I can see how other people are.... But I don't want to say, "Yes, yes, yes" to everyone else in my life. I'm sick and tired of it....

Jamie talked about taking courses, including counselling training, but she said that her low mood interfered with any career plans. "I just never followed
through on anything I ever did.... Can't help anybody if you can't help yourself!"

Jamie said she felt frustrated with her ongoing low mood difficulties. She said her mood problems worked against her ability to achieve her goals:

Scared. I'm always wondering why do I feel this way? What's causing it? I probably know what's causing it but I just don't deal with it. I thought I dealt with it when I went to treatment, but I guess I didn't, because all the feelings are still there. I don't know, just living alone and ...you feel really empty.... I think I try too hard and it always feels that I just push myself further deep inside and stay there. Don't talk to anybody. Just hold it all inside. It's safer there, I think.

4.5.2 Motivation Dampened by a Low Sense of Social Support

Two participants said that they felt motivated to pursue career plans but that the required social support was absent, which contributed to delaying their achievements. One of the two participants, Evelyn, felt this inability to receive encouragement from others was a social problem felt on the reserve as a whole.

Ginger was repeating high school courses to qualify for university entrance. She felt that her mother, whom she thought had also been depressed, did not support her ambitions: "Everybody can be as strong as they want to be, but you need somebody still.... My mom's like, she loves me and stuff, but she's always, like, "Oh, you should have just become a secretary".... I'm [angry at her]. Moms get scared because they think if you strive too high for yourself you'll um, get hurt."

Although Evelyn was beginning to achieve her career goals, she said that for some time, she personally felt she had encountered a lack of opportunity.
She said that she sees this predicament continuing to repeat itself for Native youth living on the reserve:

Trapped on the reserve. I do see that. I think again it has to do with uh, kids the time in their life, when they start to come in [to the social services office] at eleven, twelve years old to the teenager, and you start to get, to pick the options and stuff like that, and I don't think that's given to our kids a lot of times. At least it wasn't given to me and I don't remember ever being told I had a choice in what I could do. It was just "do it".

Evelyn provided an example of when she had observed that the reserve's youth appeared unable to realize, explore, or investigate options for themselves:

I took some [of our youth] to Regina and for some of those kids that was really new to them.... It [the trip] was all on Native, more culturally more Native oriented whatever and I could see those kids were really stunned. And I could see the places where those kids were really stuck. And I try to do things to help it.

And I know there's a difference. Even my own girl, she's fourteen and the other kids...she's more willing to look at other stuff or more open to keep an open mind about things than the other kids are. She wanted to check out the university they opened up in Regina, all Native, she was talking to me about going there.... I want her to think about that 'cause she could end up getting stuck somewhere....

Below are examples of how participants enlarged on the ways their experiences of psychosocial stresses in their own lives affected their ability to cope emotionally with any additional stress in their work environment.

4.5.3 Motivation Immobilized by Stressors

Four participants had at one time been motivated and had achieved their professional or personal goals by becoming helpers. However, three of them
stated that personal stress interfered with their ability to continue to function. The fourth participant, also felt stress but she was able to overcome the effects of it. One of these three, Donna, was unable to maintain her employment as a child-care worker because she was unable to cope with the ongoing stressors in her personal and professional life. She experienced a "breakdown" and had to take a ten month "stress leave" from work.

My kids pushed me into it [counselling]. They would try to get me to talk about my mother and [her death].... I would block out the death dates. So many funerals in my family. I wouldn't answer the phone. A client, a kid hung himself. Everything collapsed on my head and I suffered major migraine headaches. The doctor said I can't go on [working] anymore.

Arlene, by choice, was no longer employed as a helper. She was able to obtain retraining for herself and was looking for employment in another field. She described her emotional difficulties with her last job. She had been a life-skills coach working with children:

I think I felt a lot of their pain because of the things they told me. I hurt for them. Cried many a time in life skills class.

Margaret stated that her life-long dream of having a husband, children, and a good family life had disintegrated for her because of the stress her husband's addictions created for the family. Yet she was unable to emotionally forsake this marriage.

But all my life my four kids and my husband have been my life. Sometime I wonder if I made the right decision.... Being the only adult [in the marriage because of her husband's abuse of alcohol and drugs and his abusiveness to Margaret]. It's like I'm the referee and have to think four ways. And I just don't have the energy to carry on like I used to at home. To clean and I used to love that so much.
One participant, Linda, said her awareness of the need to "take care" of herself facilitated her ability to conquer stressful feelings and helped her to continue to function well in her work role.

4.5.4 Finding Solutions to Work Stress

Linda had achieved her goal of becoming a social worker. After a struggle at age thirty with suicidal feelings, she was able to maintain her social work role by changing her diet and lifestyle. She was also quite involved in beginning to learn and to practise her cultural ways and Native spiritual beliefs.

[I practice Native] spirituality, and [rely] on my own inner strength. [I deal with my emotions] by talking to people. I guess always following my gut, my heart. And trusting that I'm guided. Really taking care of myself. Doing what I enjoy. And making the changes that are necessary.

Other psychosocially stressful experiences occurred in adulthood for the women and these induced feelings of emotional distress. Re-experiencing abusive interpersonal interactions was a theme half the participants mentioned.

4.6 Abusive Victimization in Adulthood

Over half the group of women mentioned having experienced conflict in their relationships with a spouse or partner. This emerged as a major theme. Sub-themes related to this theme were experiencing sexual abuse as an adult and being involved in abusive marital or relational relationships. All but one of the women had also been through troubled relationships with their parents as children. Whether a relationship exists between these two types of experiences is unknown. However, three participants suggested that they felt there was a connection between their experiences of past abuses and those of abusiveness later in life.
4.6.1 Sexual Abuse Victimization

Bernice believed that her experience of incestual abuse as a child was related to her allowing herself to be abused later in her life:

My husband was abusive to me and I allowed myself to be used and abused my men.... I was incestually abused and then I was raped by three men when I became in my late teens, early twenties, and I just felt like my body was being used....

4.6.2 Relational or Marital Abusiveness

Ginger, the youngest woman in the group, had been sexually abused as a child and she was beginning to get involved in a physically and psychologically abusive relationship with a young man: "He hit me one time. He's just abusive in that way .... But, I flipped out on him one time. And I was hitting him, because he was cruel sometimes, but I guess everybody is".

Margaret witnessed her parent's marital conflicts as a child and she said that now she maintains an abusive relationship with her husband.

I had this good counsellor [provided by the reserve]. She was so kind and nice and knew how important my husband was and still [she] knew that my kids have a problem. And, my husband said he wouldn't do the treatment program he was to go to. He came once to see me. I was the one who had to tell him that he couldn't live with me [any more]. The police were supposed to do it [tell him there was a court ordered separation] and he was angry and swore at me but he did not understand. And he never considered himself lucky [to have survived the fire his drug using started].... His moods would change so much, the parties and the drinking. I would leave the home and it reminded me of my parents [abusing each other and one leaving] [but] he came back. His anger, his abuse. Even today he does percs and diazepam. He had chronic pain. Everybody knows about his drinking and his drugs.
Linda said that although she had married and had children her husband's physical abusiveness resulted in divorce. This left her a single parent with four children:

And some of the beliefs that I was given or were sort of imposed on me...like a wife's role, um, keeping the family together, staying...they worked against me and then I was married to someone who was through training school.... I was abused [in the marriage].

Donna said she had habitually placed herself in situations where others would "blame" her for not taking care of them as she had taken care of her own family when her parent's alcoholism disrupted their ability to be responsible parental care-givers. She said, "I jump in to help out...[for the] types who'll blame you when you move away [from helping them], [I then] feel guilt."

These women said that interpersonal stress in their relationships was an additional stressor that they were forced to cope with. Lacking in all their accounts was description of positive encounters with the world around them. Next, it will be seen that half of the group described engaging in drug or alcohol use at certain times in their lives. Of interest is whether this was a behavioural coping mechanism or a response to a social atmosphere where alcohol and drug abuse was a common activity people practised because of peer pressure.

4.7 Self-Abusive Behaviours

Five participants commented on engaging in drug and alcohol use that became problematic at a certain time in each of their lives. This emerged as a major theme. However, at the time of interviewing, only two women described being engaged in ongoing substance use, and only one directly stated that this was currently creating problems for her. All the women
disclosed that their current or past use of alcohol or drugs occurred at emotionally trying times in their lives, and several women connected alcohol and drug use to their mood problems. The remaining four participants did not mention using drugs or alcohol.

4.7.1 Problems Created by Drug and Alcohol Use

Jamie's narrative revealed that she had experienced the most severe life difficulties from her drinking behaviour. Her ongoing personal and financial problems stemmed from her heavy abuse of alcohol:

My mother is the "welfare lady" and she...pays my rent.... It'll be a while before everything's caught up. It's because I drank and that's where all my money went to, so I don't drink as much. I go out the odd time. So my bills are being paid off slowly so I can get my cheques back into my own name. It'll be another year at least until I can take control again.... Now, [the depression comes from] having no responsibilities at all and everyone else has them. I have to rely on other people. I still feel like a child ...can't blame anybody else.

Jamie also said that she had a long-standing drinking problem and she believed the severity of her addiction was related to her problems of low mood.

A lot of drinking [in the past]. I drank lots. I just drank, like just because I liked drinking. Today, I would say yes, maybe that's why I drank [because of my low mood] just because I don't [when drunk] have to think about all that, 'cause I am an alcoholic right right now.

Arlene initially denied that her current drug use interfered with her life:

I don't smoke [cannabis] because I'm depressed, I just like smoking up.... I have no problem [with sleep] and I'm trying to change my eating habits, trying to get
out of greasy food... I'm generally [a] pretty happy-go-lucky person... I'm up and gone out of the house by 7:30 a.m. I use a joint to relax.

However, Arlene did say later that she felt "guilt [from] just doing drugs around them [her children] and stuff. My oldest son... he uses drugs today. The circle is still not mended yet".

Margaret said that she had occasionally used drugs as an attempt to both relate to her husband and to seek relief from her feelings:

Counselling with my husband worries me. With drugs there's things you do to sort of please. [In the] bathroom... he was doing the needle and I said, "I want to do that". So, I did it. But only once but I had to quit. I was tired and had to take care of the kids and I liked it - smoking up. I still have a toke now and again. My bad habits are my husband and jail and treatment. And maybe jail time and maybe treatment. Maybe everything could be wiped off the slate with his treatment.

Shirley recalled that as a teenager she began reviewing what had happened to her in her childhood years, which caused her to become depressed because she felt that her experiences of sexual abuse had ruined her long-held dream of a traditional marriage. After coming to believe her dream of marriage was lost, she began to drink. She later attended a drug and alcohol rehabilitation program in the United States but she did not complete it and she eventually resolved her drinking problem on her own. Shirley commented on her teenage and early adulthood drinking behaviour: "I used alcohol for awhile and it just got worse".

Evelyn attended Alcoholics Anonymous meetings for the alcohol problem she developed after her husband's accident. She said: "There was a period when I classified myself as an alcoholic too".
The women's stories reveal that the majority of them who had engaged in drug or alcohol use were able either to overcome their addiction on their own or to avoid becoming addicted through their own resourcefulness. Their narratives indicated that they viewed alcohol use as an issue that required close monitoring both on a personal level and at the community level.

Feelings of emotional distress that drinking or drug use may have served to alleviate were mentioned by several participants. In particular, these women discussed their negative experiences with the emotion of anger. However, some participants also mentioned their disinterest in a desire to socialize. Also, several women mentioned they had to cope with physical illnesses of various kinds. Problems with sleeping and eating were also mentioned.

4.8 Manifestations of Distress

Feeling emotionally distressed at the subjective level emerged as a major theme for these women. Sub-themes were feelings of anger; wanting to isolate themselves socially or interpersonally, to withdraw from the world, or to avoid other people; experiencing physical complaints such as panic or generally feeling ill; and eating problems and sleeping problems.

4.8.1 Anger

A major theme all participants described was that of the discomfort of feeling angry. Anger was portrayed as a strong emotion that participants struggled with.

4.8.1(i) Chronic Anger

Jamie reported her difficulties with feeling chronically angry. She considered that the intensity of this emotion harmed her relationships:

[I feel a] lot of anger, anger mostly. I get mad. Always mad. Take it out on everybody. I know when it's happening because I can't stand anybody near me and
I just feel angry all the time. Just feel like killing somebody, punching the wall. And I scream at my kids 'cause I get mad at them, I never hit them but I just yell at them because I'm mad at somebody else.

Donna said that she frequently feels "anger, loss of control". She described that her "anger comes and then, goes away".

4.8.1(ii) Reoccurring Feelings of Anger

Ginger mentioned that she had bouts of explosive anger. "I used to blow up at my sister and abuse her physically, since she was little and I feel bad...."
Her mood encouraged her angry behaviours "Once in a while I just wake up and I'll feel shitty, sometimes I'll feel grumpy and I'll get bummed out...".

Arlene said she intermittently experienced recurring problems with bouts of anger:

Once in a while anger pops up. [The feelings] are not like before. I can talk about it now. Before, I went through a lot of emotions...and I've spoken about my issues so many times.

Linda said that she no longer felt troubled by her anger but she had been angry in the past and that the anger had manifested itself in "never being able to find good in people and never being able to find good in myself". She said she was now coping with her anger by talking about it with co-workers, putting out tobacco, going to a sweat....

4.8.1(iii) Recollecting Being Made Angry by Stressors

Margaret provided a description of one of her many episodes of feeling angry towards her husband. The anger occurred after the death of their baby, when her husband abandoned her in her grief:

I was angry. He [her husband] wanted to be close the night the baby died and the next day [he said] it was all my fault. .... I was afraid to be with him [because he was blaming me]. Stayed at my Mom's. Had a feast [after baby's burial]. He
[her husband] left right away after the funeral to be alone. And that made me mad.

Evelyn believed that her angry feelings about her husband's loss of mobility through paralysis caused her to begin abusing alcohol to cope with this emotion. She considered that she had betrayed her marriage. However, she thought she had overcome the feelings of anger and had stopped abusing alcohol:

In my own depression I uh, not physically left my husband but emotionally, spiritually and in every other way I left my husband....

4.8.2 Socially Isolating

Four participants mentioned that they felt little interest in either being with other people or engaging in social activities. These feelings of low social interest caused them to want to avoid close contact with others. Three women attributed their avoidance behaviour to their mood difficulties, and a fourth stated she wanted physical distance as a way to best manage her life.

4.8.2(i) Interpersonal Avoidance

Two participants said that they isolated themselves socially because of their low moods. Bernice said she tried to avoid contact with other people because they easily irritated her:

You know how some people can have friends over and have coffee and tea and sit there for hours? I can't. I can't. I can't have people come and visit me. I'm a stoic person. Like, I don't know.... I don't want to talk about nothing. Maybe I should try and get used to that, I don't know. I don't have people over visiting me. I feel irritable and I get mad at things.... Say a friend comes over, brings their kids and lets their kids crawl all over the house and they're just sitting there watching them and I get mad. Don't come visit me! I don't
think I'm supposed to be like that, I'm not sure.
Again, I wouldn't say nothing.... I'm afraid maybe.

Bernice's desire to avoid social interactions was strong enough cause her to
dream of fleeing the reserve:

Right now in my life I feel like I'd like to leave this where
I am right now.... I'd love to go to British Columbia, into
the mountains. I feel like there's a lot of healing out there
[for me].

Jamie said that she avoids "coping with life her" by barricading herself in
her home. She felt that her low mood was related to her desire to isolate
herself:

I just lock myself in my house and everything's locked
and blinds are closed and that's it! Don't answer
phones and stay away from everybody. Don't think
I ever got out [of experiencing low mood]. I think
I'm still in that. Must be about twelve years now,
I think, it's not as bad but just try and cope with life
all the time.

4.8.2(ii) Social Withdrawal

Two women did leave the reserve to live in the city. They stated wanting
to avoid the requirements of socializing with other community members.
Margaret said that she chose to avoid people on the reserve: "I live in town
[off the reserve] 'cause I can get lost there.... I avoid my family too so I don't
have, they don't have to be bothered with me or something." Margaret
mentioned a particular time when she wanted to flee from her life:

Wished I could have run away and been by myself.
Pressure to take care of four kids [alone]. Lots
of responsibility there too. I know I still have
some of that [depression from that time of loss] today....

Linda said that she chose to leave the reserve because she wanted
"independence" and "distance":
Like to live my life with anonymity and you don't get that on the reserve. I like to be a little bit apart... [If I lived on the reserve] more people would be having a say in my life than I would be comfortable with.

4.8.3 Feeling Unwell

Half of the women said they experienced symptoms that they believed worked against their sense of both emotional and physical well-being.

4.8.3(i) Feelings of Panic

Three women enlarged on their experiences of feeling panicky. Jamie mentioned physical symptoms from overwhelming feelings of anxiety and panic:

I even have anxiety attacks. Feel like I'm having a heart attack or something like that, or I lose breath and ...I can't think because my mind is just too hyper, or I get too nervous and I can't think. It's like, I don't know, just blank, or I feel like it's going to explode or something like that. I can't think.... I try to get my breath or try and relax to get that feeling away.

Donna too was able to articulate what the experience of panic was like for her. She said that she could not define where her fear came from, but that it was "there a lot of the time.... At times now I'll just feel like a panic like when people are drinking or kids are near. Maybe it was my Mom drumming in not to go near men when I was a child."

Donna explained that her attempts to escape from her fearful and panicky feelings precipitated her breakdown: "Thoughts were running through my head. I'd [work] to exhaustion to work off the stress. It was getting so I couldn't do that anymore. It helped to say, 'I'm safe, the world is good to me'. I had to learn to slow down".
Margaret talked about her experience of having thoughts race through her head and other unpleasant physical feelings:

I'm tired. Sometimes I feel like I could talk and talk.
It's so light inside of me.... I have a pounding feeling in my chest.... Frustration, lots of it, over kids' fights.
I get shortness of breath, I sit there and I don't even breathe.... I was numb and I didn't want to share nothing [in counselling].

4.8.3(ii) Physical Illnesses

Two women mentioned being troubled by physical illnesses. Linda said that she had once felt so unwell physically that she had planned to "hang" herself. She began to feel very frustrated with her health problems:

I was very old, in my thirties. And I think I was experiencing PMS really, really, heavy duty. Actually it was at a very good time in my life. The best time of my life. So that's why I say it had to be PMS. At one point in my life it was very, very strong. And I went to see my gynecologist and he helped me to find natural ways of dealing with that, like diet. Once I followed his direction and changed my diet, like stopping caffeine, cigarette smoke, M S G. The one month it got really bad and it got worse the next month and it was fine after that.

Donna believed that her physical illnesses were related to her feeling psychologically unhappy: "I have colds, migraines, kidney-bladder infections". At the time of the interviews, her experiences of illness had finally gone away. She particularly associated her earlier problems with headaches to her psychological problems:

I think way down deep you know you need help, but for most people you don't know how to ask for help or you're scared to face them. First, going to a counsellor, all [kinds of] things were going on in my head and...lots of floating.... That's where the headaches
came from, the building up. When I went to talk I'd get major headaches. I'd hold back and feel the headache coming and my neck would go stiff, and then I'd just block it out. It becomes secondary to finding a way of dealing with it at that moment. Strange what you can do with your body and you need counselling.

Donna's experiences with her moods seemed to result in greater physical distress than was the case with other participants.

4.8.4 Eating Problems

Three women mentioned disturbances in their eating behaviours. Two felt they over-ate as a strategy for coping strategy with feelings of "depression". A third felt she stopped eating because of feeling psychologically distressed.

4.8.4(i) Over-Eating and Low Mood

Bernice said she copes with feeling depressed by over-eating:

I think when I become depressed I avoid people. Just stay away from everyone. I eat a lot. I eat. I bury a lot of my problems with food. I know that. Even if I'm stuffed, I'll eat.

She enlarged on how she feels about herself and her shame about her body from her eating behaviours:

I always felt embarrassed being so heavy, but I know why I'm heavy - it's a lot of anger hidden by this weight. I'm so embarrassed by my body or my weight or myself, there's something behind it. Even to walk across a room with people on both sides or in a group and I have to get up and walk, I am so embarrassed. I don't like people to look at me....

Jamie said that her experiences of low mood and changeable moods caused her to over-eat: "I eat lots, and...I'm always depressed".
4.8.4(ii) Low Mood and Poor Appetite

On the other hand, Ginger mentioned problems with a diminished appetite, which she felt was related to her mood.

At one point, I stopped eating.... I didn't want to lose weight. I just didn't have an appetite. I couldn't eat. My Dad was all worried but I just couldn't eat. I was just worried all the time. Over nothing. My Dad worried because I didn't have a boyfriend. I was in [high school] and he was afraid there was something wrong with me [laughs]. I guess it was just concern.... He was just concerned. I was just always sad and always moping and I guess he just thought a guy, a boyfriend was like the normal thing to do.

4.8.5 Sleep and Low Mood

Three women said they experienced sleep disturbances. Sleep issues are quite often present among people with mood difficulties. Three women talked about their sleep problems.

4.8.5(i) Sleep as an Escape

Jamie mentioned sleeping too much:

I sleep all the time. I sleep to just waste all that time.
I sleep lots, to kill time, sleep the day away.

Donna also noted that she wants to sleep when she feels low in mood.
"Fear and anxiety go along with it. I'm afraid to deal with another problem. I don't want to wake up. I want to sleep because of fear of reality." She also said: "I'm tired, very, very fatigued. I can't do nothing in the day and if you do you get totally exhausted. My immune system's down. I'm afraid of other's illnesses like your body will easily pick it up."

Bernice too said she felt tired much of the time:

I'm very tired. I feel lazy. I lay on the couch. I lay there for months.
In their descriptions of distress, participants rarely mentioned possessing the knowledge on how to get emotional assistance. No woman knew where she could or would go for help. The tone that emerged from each woman's story was one of loneliness. Mere survival was what they struggled with. Remaining silent about emotional pain was believed to work against their ability to heal psychologically.

4.9 The Inability to Address Psychological Issues

4.9.1 Inhibited Exploration of Feelings

The participants claimed that their ability to verbalize and examine issues surrounding the sources of their psychological experiences of unhappiness, whether chronic or episodic, was curtailed by community patterns of silence around issues they identified as sources of personal distress. This emerged as a major theme. Related sub-themes were feeling forced to have to contain feelings and the impression that the problem was that the community as a whole practised secretiveness about important mental health issues. For example, negative feelings and mood problems arising from unresolved issues surrounding abuse victimization were described as having to be individually contained because the opportunity to discuss this form of abuse as a source of low mood or psychological distress within this community was hampered by community norms.

4.9.2 Containing Feelings

Two participants provided examples of how they experienced having to contain their feelings in their own lives. For Donna, what encouraged the persistence of her depression was her inability to talk, which had precipitated her need to take a leave of absence from work: "The depression stems from holding things inside, from not talking about my feelings". She also said: "I go
back to work on the twenty-first but I'll continue to see a counsellor [to continue to talk things out].

Evelyn said that keeping feelings contained occurs even in near tragic situations:

Yeah, I did [attempt suicide 15 years ago]. I took some kinda pills. I went to hospital when I threw up. Got my boyfriend to take me.... Everybody pretended it didn't happen. Swept it under the table. It was like nothing happened.

**4.9.3 Community Patterns of Secretiveness**

Evelyn, a social worker, and Bev, a participant-commentator and also a social worker, commented on the community's reticence toward discussing issues surrounding psychological distress:

I would say that's something that happens a lot within our community and that's why, um, that's why we feel stuck. Afterwards, because things are never talked about like that and that's why when I do things now with my kids with regards to things like that [suicide] I [discuss it openly]. Not only with my family but the whole community has a hard time with that.

We all know it [about those distressed], but then we don't. That's how the community is. It's not as if things are really secrets 'cause everybody seems to know, but people just don't want to talk about it, that's how things go, I think. Once we [community members] start to talk [about psychological problems] we'll start to move further.

Evelyn provided an illustration of the community's hesitancy toward discussing feelings surrounding psychological issues:

Last March, in '94, there was an incident with [drugs] in the community. And the way it was handled, I never felt so proud in our community. We all got together, all the different families, kids, all Moms, just Moms at first.... You could just feel the peace with them and we talked about
everything. The kids talked to Dads the next morning...did a sharing circle...fathers sat there and shared with the kids their story...most moving thing that ever happened in this community.... And all of a sudden again the parents pulled back out. Don't know why?

Bev's comments may explain why the parents "pulled back" from involvement in sharing circles. She said: "on this reserve, community involvement leads to success". However, "Fort William [the reserve] is not at the point where the abuse is open. They're still partially in denial, [a] thick wall of secrecy. Once people begin to accept what's happened to them and quit using drugs and alcohol, when they deal with what's happened to them, then there'll be a lot more suicides".

As Bev commented, "deal[ing]" with what has "happened to them" appeared to be a pressing need. However, fear of the consequences of opening up about the sources of pain seemed to be prohibiting community members from doing so. In the next section, a specific issue, that of sexual abuse, will be examined. Several women enlarged on this as a major source of their emotional difficulties.
Section Two

5.1 The Experience of Sexual Abuse as a Major Source of Depressive Experiences

One of the major themes that emerged from the interviews with the Native participants was the common experience of having been sexually abused. Sub-themes that emerged from this main theme were feeling that the victimization contributed to depression, that the abuse worked against self-esteem and the ability to pursue ambitions, and the feeling of being both fearful and unsafe in the world. As an interviewer and clinician, I did not expect disclosure of this in an initial contact interview. It appeared that these women wanted to reveal what had happened to them and to communicate the importance of sexual abuse as a source of unhappiness and half of them disclosed that it had occurred in their childhood. Five women discussed their experiences, a sixth, a participator-commentator, stated that she had been sexually abused but she did not elaborate on this.

The five women who talked of their experiences of sexual abuse mentioned its impact on their psychological well-being. One woman, Bernice, felt that the abuse was central to her current psychological unhappiness. Bernice is the person most frequently quoted below.

The other five women in this study did not describe their victimization as contributing to later mood difficulties. These women considered that their emotional problems were caused by other psychosocial difficulties that were described above. Their stressors were childhood unhappiness, low self-esteem, losses, or other forms of abuse.

5.1.1 Depression Related to Sexual Abuse

Traumatic experiences such as that of sexual abuse victimization that occurred in early childhood, were considered by the participants to result in
depressive feelings that continued into adulthood. Two participants, Bernice and Jamie, described their experiences and a third, Shirley, said that low mood difficulties had been problematic for a long time in her life.

5.1.2 Negative Feelings Arising from Childhood Experiences of Sexual Abuse

Bernice felt that her current feelings of depression stemmed from childhood sexual abuse and later from rape as a young adult. She was of the opinion that "the little girl" inside of her needed to heal before she could feel "free" in adulthood. Bernice still felt "afraid" of being "hurt" again. She was still sensitive to any forms of abuse.

It's like letting that little girl out of me, Bernice. It's that little girl inside of me that I have to heal... but I guess I'm too afraid to let her out because I don't want her to be hurt anymore. But I know for my own freedom, to breathe freely, to feel free, to feel good about myself.... I have to let that little girl out and take care of her and tell her, I know I have to tell her I love her.... I would love to go, do something with my own self because right now I can cry a lot. Every time someone yells at me and says the wrong things to me.

Jamie mentioned her ongoing feelings of despair from her childhood sexual abuse. She felt "alone" and "lost", and did not know how to be helped. She too mentioned feeling easily demoralized by constant "put-downs".

I'm always depressed. The feeling is you're alone...like there's no one there to help you. You think why, why am I feeling this way? And how can I get out of it? And I just cry lots and feel really alone. And there's no one there to help you get out of it. Lost. I think it's just because you remember a lot of things as a child and things that happened to you. I think that's how you get that way. Or, if you're put down all the time [with] no support.
Shirley said that she "hung on" to negative feelings for a long time after having experienced sexual abuse as a child at a residential school. Later, she was victimized again, "So, I hung on to them [negative feelings]. And the abuse at the residential school. And then I got into a brutal gang-rape. I was raped by some white guys. That happened at thirteen".

All three women described their aloneness in dealing with the aftermath of their sexual abuse victimization. Positive interventions to assist in recovering the psychological losses from the abuse were unavailable to them. Negative self-regard as an outcome of the abuse became entrenched. Below, the women talk about the impact on their self-esteem.

5.2 Sexual Abuse and Low Self-Esteem

Two participants explained how their self-esteem was damaged by the impact of early traumatic experiences. It appears that the exposure to the distress of sexual abuse experiences resulted in the development of negative feelings towards themselves. Bernice and Shirley offered their observations as to how this development manifested itself in their lives. Bernice described some of the negative feelings she had about herself and she connected these to her sexual abuse:

I always felt unloved, I felt abandoned and unclean, and I always felt like I had to do things to make people really like me.... I feel a lot of hurt, a lot of anger. Sometimes I feel so confused and lost. I don't know what the heck I'm at, I don't know what to feel sometimes.... And I think that all stems back to the abuse that I went through as a child,

Shirley said that her depression set in when she realized that her experiences of sexual abuse impacted on her self-concept. Her dream of seeing herself marry as a virgin had become tainted because she felt this way:

I wanted to get married the traditional way and I
could never have it, or so I thought [and then the depression set in].

Belief in oneself and in one's abilities are prerequisites for the strength to pursue the goals we wish to achieve. The women explained that this sense of self-worth was damaged by the sexual abuse they experienced and by the resulting emotional fall-out. Below, two women describe how this occurred in their lives.

5.3 Low Esteem and Realizing Ambitions

The preoccupation of coping with the discomforting psychological distress resulting from sexual abuse can leave a person with little energy or sense of self-assurance. Pursuing the demands of life can become difficult. As was seen above, one's self-regard can be damaged by the experience of sexual abuse. Shirley recollected how her experiences of childhood sexual abuse impacted on her self-regard and, hence, her confidence about being able to achieve her future goals. Shirley felt that her experience of sexual abuse would result in her life dream being unrealized:

But that's what I based my thinking on at that time [because of the sexual abuse experience at the residential school]. I thought, that's gone. The dream of marriage. I could never have that because of the abuse that happened. I'm no longer pure. I wanted, like, to have just one, one man, like a soul mate all the way through. But that left. It kind of shattered everything for me.

Bernice felt that her inability to forgive herself for the sexual abuse contributed to a low sense of self-esteem that continued to work against her realizing her strengths. She could not "forgive" and felt she blamed herself for "oppressing" herself:

I never really went into a deep, deep [depression].... I never forgave anybody for any of the abuse and I think that's the main part.... I still haven't forgiven myself to any of those people, really. I feel that I have a strong
...spirituality, but I feel I'm oppressing it or keeping my true self from coming out....

Participants described attitudes about the world and others around them that emerged from their sexual abuse victimization. Negative feelings toward self were followed by negative feelings toward others.

5.4 Negative Feelings Towards Others: Fearfulness

When sexual abuse occurs in environments where children are made dependent on caregivers who misuse their authority, mistrust is created and this can generalize to other situations. Shirley described how childhood sexual abuse had precipitated feelings of anxiety. She became constantly fearful. Shirley recalled her fear when she was in the residential school:

I was abused by a priest at age six and seven..... I made friends with one [nun] because she was more like my protector.... She made sure that I never got close to the males again and that type of thing. That's basically what she was, my bodyguard.

5.4.1 Feeling Unsafe

A general psychological stance of fearfulness appears to have developed as an aftermath of these women's victimization. Two participants explained how feeling unsafe affected their attitudes towards their communities and how it impinged on their own overall sense of safety. Ginger, a young woman in her early twenties, whose mother is Native, described how her non-Native uncle (on her father's side) sexually abused her. As one result, she felt unsafe in both her white and her Native environments:

I don't remember [the age at which I was sexually abused], before I was six.... My uncle had raped my cousin and stuff like that. On my Dad's side. I remember some of it.... Yeah, and my cousins. Two of my cousins tried to french-kiss me and it was really disgusting. I was like eight. That really ruins it. It just ruins it. And my Mom was so worried because she was sexually abused
by her cousins [on the reserve]. Down here. And she was so worried, she didn't want me to hang out with them.... And it happened to me anyways. On my Dad's side. I hate my Dad for it. Like because he knew what my uncle was like and he turned a blind eye to it.

Ginger had experienced sexual abuse as a child (the perpetrator was on her white father's side of the family). Also, because of her mother's fears, she had come to believe that sexual abuse was prevalent on the reserve. "She didn't want me to hang out with Native people because she was scared it would happen to me". Ginger's voice was angry when she spoke of the abuse she suffered and of the abuse she heard about on the reserve. "Like my Mom was telling me.... It's just sickening!.... I just heard really bad stories about this place. And it's true!"

Arlene recalled her feelings of terror after experiencing childhood sexual abuse:

I was [sexually] abused at age seven or eight. I was too terrified to do anything at the time, and so I just lay there and pretended I was sleeping. Never forgot it. [Afterwards,] I made sure I was closer to my Mom and Dad, stayed with my grandmother quite a bit when I was growing up then. I felt very safe with her. There was so much of it happening in all the families. I didn't know back then, but now I know. Probably I felt really afraid, not knowing it happened to others.

5.5 Feelings of Distress and Untreated Trauma from Sexual Abuse

A major theme among the participants were their accounts of other problems that they related to their sexual abuse victimization. Sub-themes that emerged were difficulties with memory, feelings of anger, wanting to avoid other people socially, and physical problems.
5.5.1 Memories and Sexual Abuse

One participant, Shirley, was able to describe one incident of her experience of sexual abuse clearly. Other participants either mentioned memory difficulties around the experience or chose not to elaborate on the actual experiences. Traumatic experiences imprint themselves in memory and can remain vivid for survivors of sexual abuse. Shirley was able to recount her experience of rape that had occurred long in the past with great detail:

When I got raped, I had to come through the snow and my pants were frozen. There was blood...because they used those...stove top [handle]. That was burning hot and shoved up inside of me. And then I was tied up and I had to go through these people over and over again. And they were drinking so I managed to just yank [the ties] from my hands and then I started running and I ran directly into the bush, but I had to, like, you know how it is when you have to duck because of the trees. So by the time I got to the highway my pants were just frozen and I guess it helped me in a way because I was numb, that frozen type of thing. And I seen some lights coming and I was lucky it was the Grey Goose [highway coach] and it just stopped and the bus picked me up and I woke up in the hospital.

In contrast, Bernice indicated that she experienced difficulties remembering the specific incidents of her sexual abuse:

I have a hard time remembering. Must be all blocked out. My memory, I block it out. I don't recall helping my sister [who was being sexually abused]. I don't remember that. I don't know how long it lasted.... It takes time to remember everything....

5.5.2 Feelings of Anger

Half of these participants enlarged on their experiences with angry feelings stemming from their experiences of sexual abuse. Bernice mentioned her feelings of rage:
I know there's a lot of rage inside of me because I know where my rage comes from - the hurt and pain. One time I really let a lot of rage out of me and I feel that I could do that.... I've been hurt by three people and I cried, and I sobbed and I puked and I know that was rage coming out of me....

Shirley described her anger after being sexually abused. She too felt rage:

And I used to get really mad, really upset when somebody would compliment me. Even like, even though maybe they didn't mean it or they were just trying to be friendly, that type of thing. But I took it where it got me really angry.... And I would just walk around like, just angry. It got to a point where I wanted.... This is the part I don't really like sharing because it's so mean. I would walk around with these feelings like I wanted to use a crowbar and just hit somebody in the head and just watch that blood....

Arlene mentioned her recurring bouts of anger arising from her sexual abuse experience:

I was abused by a member of the family. I've worked through all that stuff now. I don't get upset anymore. I don't hate the person who done it to me. [I dealt with it] by talking about it and confronting the person...every once in a while the anger pops up.

5.5.3 Commentary: The Need to Address the Anger

Rochelle, a local helper and participant-commentator commented that anger was an important area that needed to be addressed among abuse victims.

So then, during that last part [of treatment] when we started dealing with sexual abuse and we used different treatment methods. One of them, one of the areas that we dealt with was anger. So, what we did was um, we used uh, I guess you could describe it as similar to psychodrama. So what we did was we would use a pillow and get the person to role play and get rid of that emotion.
Rochelle said the program of treatment made available for Native people that attempted to address anger resulting from abuse was terminated soon after it began. The program was supposed to be aimed solely at drug and alcohol difficulties and outside politics forced the discontinuation of treatment that included a focus on addressing emotions. This occurred because "outside experts believed" it was unnecessary to "deal with the person's emotion" in drug and alcohol treatment programs.

5.5.4 Interpersonal Avoidance and Discomforting Physical Sensations

Bernice associated a dislike with being touched and her physical experiences of choking sensation with having been sexually abused. Bernice explained how the sexual abuse had made interpersonal contact aversive for her:

I won't allow them [her children and grandchildren] to hug and kiss me all the time. I won't hug and kiss them all the time. I don't think I should feel that way. It makes me sick when they used to give me a kiss on my arms or cheek or breathe on me. I still had all those feelings inside of me. I know talking about them is all right but, ughh!... And I can't stand dogs licking me. And I think that all has to do with the abuse but I'm not sure. Maybe I don't want to remember....

Bernice mentioned other uncomfortable physical feelings that caused her discomfort. She also connected these to her experience of sexual abuse:

I feel choking right here in my neck, and I feel tight in my chest, and even when I'm talking to people. Sometimes I cry but I know that's part of the healing [from sexual abuse], and sometimes I know I can feel the spiritual come out of me but I won't let it.

You know [crying], I feel like I got so much anger in my heart that I can't get it all out. Right now I feel
like I'm choking.... It's something in my life. I am sick. Something that I did or something that I didn't do or...my throat feels so thick sometimes or maybe it's from the abuse 'cause I don't know if.... I've got so much sickness inside of me myself....

Because sexual abuse victimization was unacknowledged as an important contributor to psychological difficulties within this community, the women had to cope with their distress on their own. Below, participants explain why silence surrounded this issue.

5.6 The Inability to Address Psychological Issues Associated with Sexual Abuse Victimization

5.6.1 Fear of Confronting the Perpetrators

A major theme was that participants felt unable to talk about sexual abuse issues within their community. Sub-themes arising from this theme were fear of confronting abusers, the belief that untreated abuse is a community problem, the belief that abuse is prevalent, and concerns about inadequate treatment for abuse.

Bernice explained one of the constraints she experienced in trying to resolve emotionally her experience of sexual abuse. She was afraid of exposing the family member who had abused her.

And you know, I don't wanna [go for help]. The thing is I'm so afraid. I think, you know, I'm afraid to hurt my brother because of him drinking and angry.... I don't want him charged and I don't want him disrupting his life even though what he did disrupted mine. I've never ever confronted him or anything, but we did belong in the same prayer group and you know he knows that I know all right. He asked me for forgiveness. Yeah. But, we've never actually talked about it....

Shirley described avoiding confronting her rapists in order to protect her family. "[The rapists] were not charged. After they were all done with me, I
was stitched up and I was recuperating. Then I heard the cops were going to come and I didn't want my family knowing about it. So I ditched the hospital and they came to the reserve looking for me but I went out to the cabin at the old reserve and stayed there for a month”.

Jamie described that contemplating disclosing the sexual abuse frightened her because she did not want to deal with the consequences of letting others know:

I'm scared about going [for further treatment] because I know that there's issues that I have to deal with and I don't know how to express them. Like the deep, deep ones that are really hurting me. I mean, the most.... When I was in treatment they were trying to make me sign a paper saying that they could give information out if it's like abuse, things like that. I just wouldn't sign the paper and I wouldn't talk about it because I didn't want to deal with it or let everybody know. I don't know if I'm that close to letting everybody know what's really inside me, I guess. I think once I deal with it, it will be easier.

5.6.2 Untreated Abuse Issues: A Community Problem

Two women, Bev and Rochelle, who were participant-commentators, and one participant, Evelyn, discussed their perspectives on the silence surrounding sexual abuse issues in their community. Above it has been shown how the women varied in their ability to discuss the sexual abuse they had experienced. Bev, a local Native social worker, who stated she had been sexually abused, commented on this:

A lot of times, the client doesn't want to address it. Partly because they don't remember it. It's a block, but they know something's happened. It'll always come back and haunt you at some point in your life. The fear of dealing with that, of having to break the chain of silence, is so thick you have the drug and alcohol and suicidal tendencies. All those things.

Sometimes there's physical abuse - that goes way back. In order
to deal with the abuse issues you have to go clean. You have to be clean, stay clean, for a length of time, and you have to want to deal with those issues.

5.6.3 The Prevalence of Sexual Abuse and Inadequate Treatment

Rochelle, the second commentator participant, who was employed as a helper on the reserve, commented specifically on the prevalence of sexual abuse experiences and their consequences. "One of the biggest things I could say very safely is that eighty-five percent of the men and women who came in [for the reserve's drug and alcohol treatment programs] were victims of sexual abuse...and all the other abuses".

Rochelle, both a social worker and member of the band leadership, commented on the shortcomings of mental health programs to deal with sexual abuse problems that have been offered on the reserves. She reported that comprehensive care required for sexual abuse treatment is lacking.

There is no treatment facility that I'm aware of in Ontario that is helping people like that [victims of sexual abuse], because ... once you start working with that person, you have to be prepared to take care of that person for more than a four-week period. It takes four weeks for that person to be able to open up. So you need residential care for at least two months.

Rochelle was experienced in working with sexual abuse victims who presented themselves to drug and alcohol treatment programs that were government-funded. However, funding specifically for the sexual abuse problems was not adequately provided for. Rochelle believed that until specific treatment was available, there were dangers in exploring sexual abuse trauma:

I have an idea of what's needed. And if a facility cannot be provided to take care of these people, they're better off to be left alone.
She explained why a follow-up residential program for treatment of what she described as the prevalence of sexual abuse problems on the reserve was not in place:

I think there's opportunity coming up right now [to apply for funding for adequate treatment]...[on this reserve] There's [currently] a lot of planning involved around health, child welfare. What's going to happen with that whole area is that it's going to evolve into treatment [for sexual abuse]. It has to. There is no way out of it.

Rochelle felt what she experienced as a helper taught her what was needed in treating sexual abuse. However, funding was not available.

Today, if there was a family healing centre or a family treatment centre, then you could get into that [sexual abuse issues], but you're looking at a government, federal or provincial, that you know, where their decision-making is controlled by where the buck stops.

As Rochelle explained, the counsellors providing drug and alcohol treatment locally for band members soon realized the importance of the inclusion of sexual abuse therapies for these clients. "During that last part [in evolving the drug and alcohol treatment program], we started dealing with sexual abuse and we used different treatment methods. One of the areas that we dealt with was anger".

Treatment that did not recognize the importance of the impact of sexual abuse on the mental health of band members appeared to frustrate Rochelle. She recounted that outside consultants interfered with the sexual abuse component of the treatment program that local Native helpers had formulated to assist in treatment:

So they brought this guy in, an AA consultant, and he just took over because the leadership was [afraid to address the issue]. [They liked] the way this guy believes and teaches and everything....
And he [the consultant] didn't believe in [sexual abuse treatments].... See, in the old school [AA treatment] they didn't deal with the person's emotions.... A person was not dealt with holistically. It was very intellectual.... So after then, things just kind of went down....

Rochelle said that treatment for sexual abuse has remained unaddressed since off-site non-Native decision-makers had taken over the design of the treatment programs. Rochelle considered that this interference had had a harmful effect on treatment when clients sought treatment for issues arising out of the emotional repercussions (alcoholism, substance abuse etc.) of experiencing sexual abuse.

Evelyn, a thirty-four year old Native woman who had not been sexually abused and who was employed for five years as a community support worker, offered some reasons as to why treatment for abuse issues was not fully in place in the community helping system:

...because as a worker, counsellor in this First Nation's... I'm really aware of all the problems in this community. And I've been touched by a lot of the same problems. Everybody has. So having a good support system for myself in place at work is really important because any time an incident comes up I've been affected by it in some way myself. So, it gives me a chance to take care of my own shit there before I start counselling....

She explained that local Native counsellors had only recently begun to be adequately trained in addictions counselling; however, training had not yet progressed to the point where helpers were prepared for addressing abuse counselling needs:

How did it happen [addressing the need for training]? I was starting the position here five years ago because as a band... the band or the chief noticed that people [helpers from with] in the community...there wasn't a high productivity coming from
the [helping] positions and uh, not saying the workers weren't working. Workers being from the same community, they carry the same shit that the people carry. So part of the reason was that they put together some training for workers for them to start to deal with some of their.... So that they could become more effective. So my first day at work I was sent [for training] it's an eight week course. Mostly about alcoholism and the whole process of addictions uh, and how it affects families and communities in perspective, I guess.

These participants said that the lack of sexual abuse treatment for band members and interference with available treatment from funding sources had resulted in no treatment being available. That the women felt alone and isolated in the aftermath of their victimization is explained by this situation. Silence surrounding the issue was not only a problem within the community but was reinforced by the agendas of outside funding agencies. Local Native helpers recognized that sexual abuse issues needed to be addressed, but their voices were soon silenced by outside forces. Silence around other troublesome psychological difficulties was also revealed by these narratives. Participants reported the same silence in reference to suicide, another major theme that emerged from these narratives.
Section Three

6.1 The Experience of Suicidal Ideas and Intentions

A major theme that emerged was that more than half the women in the group had contemplated suicide at some point in their lives. Sub-themes that arose from this major theme were alcohol use encouraging suicidal thoughts; feeling hopeless; marital betrayal and suicidal thinking; suicide associated with physical abuse and low self-regard; suicide as a means to avoid emotional pain; and factors discouraging suicide. Many research studies have found depression and suicide to be highly correlated (Beck, Emery, and Greenberg, 1985). It has been found that suicide among depressed individuals usually occurs after the depressive mood lifts. It is assumed that it is the experience of hopelessness about the future that is the important factor in suicide for individuals who have experienced depression (Beck et al., 1985). With six of the participants, it was certainly the feeling of having no choices in life or, of being in a hopeless situation that was described as a factor for considering suicide. In all, six female participants described having experienced suicidal thoughts.

6.1.1 Absence of Hope and Alcohol Use

A sub-theme that emerged was the occurrence of thoughts of suicide when under the influence of alcohol. Evelyn said her feelings of unhappiness began in her adolescence. She attempted suicide because she felt she had no other choice:

I was suicidal around eighteen, seventeen and uh, I wanted to commit suicide and when I look back I think it was, I guess for me I thought it was one of the only choices I had at the time. Then again, I was drunk. You know, I'd think about it other times but I wasn't drunk so I wasn't stupid enough to try it. But ehh, I think a lot had to do with that time because
it was around a boyfriend too ... but when I think about it this
time it had nothing to do with a boyfriend really.

Evelyn elaborated on factors that she saw as making the realization of
dreams for the future impossible, and how these were connected with suicidal
thoughts. She discussed the impact of isolation from the outer world has had
on community members. Interactions with non-Native institutions would have
encouraged this isolation:

I think something else too that led me to that point in my
life of [contemplating] suicide is, I was never given much
independence eh? Or trust, or options around choices and
that. I was always told this is what you had to do and that
was it. 'Cause pretty well our mother dictated to us what
our lives would be like.

6.1.2 Absence of Hope and Sexual Abuse

Jamie, a Native woman living on the reserve, said she had experienced
sexual abuse, but she did not provide details. However, she tried to explain
that memories of what had happened had contributed to her becoming
suicidal:

I think just a lot of things in the past were hopping, jumping into
my head. Things were coming back, and I just remembered
things, eh? And I never, ever dealt with it, the...problems.

Jamie mentioned her ongoing difficulties with suicidal thoughts, "[It's an]

easy way out. I don't know". Jamie also said:

I was suicidal in January and they were looking for help
to try to get me in treatment...I just stayed away from
drinking because it's mostly when I drink that I have
enough nerve to do it. No plan. Just when I'm drunk
it hits. Though sometimes when I'm sober I'll think yeah,
it'd be easier being dead. I'll say that. I always think of
my kids too, eh, when I'm sober. So I always think
twice what they would go through, who would look
after them and who would love them and support them.
But when you drink, it's a different story.

### 6.1.3 Absence of Hope and Suicidal Gestures

Ginger described having made a suicidal act when she was eighteen: "I really didn't try it. But I put like a knife to my wrists and I was like pushing down on it. I did it in fourteen spots, I would push down and just wait until I could see blood coming and do it again". She elaborated on her thoughts of suicide, "I just think of killing myself.... I can do it if I wanted to. It's no problem. It's easy to get pills. It's easy to knock myself out or just go up the mountain and get all pilled out and pass out on the ledge". But these suicidal thoughts no longer occurred to her she said, because she was "too excited about her plans for university".

### 6.1.4 Marital Betrayal

Bernice, a victim of incest, described her attempts to commit suicide that had occurred in her early adult years when all hope about believing in the continuation of her marriage dissolved. Her husband's treatment of her was too similar to the sexual abuse she suffered in the past:

I don't feel suicidal anymore, I don't feel that way. I don't feel like killing myself or doing away with myself. I don't allow people to get real close to me, though. Actually, I did try to...kill myself a couple of times. Once, way back, when I was in my middle twenties. My husband was cheating on me...and he used to lay down on the bed...and tell me how much he loved me and I'd have to get up.... I just felt like I was being used. I don't know, it must be all the feelings that I have to go through, my God!

### 6.1.5 Physical Abuse and Low Self Regard

Linda described the circumstances around her thoughts of suicide. When asked if she had ever had such thoughts, she replied, "Oh yeah", and explained why: "[I was never able] to find good in people looking at me. So I
was never able to find good in my own self". At one point she did have a plan to commit suicide: she was going to hang herself. Interestingly, she came to this decision during a very good time in her life. She wonders now whether she was suffering from PMS (premenstrual syndrome) at the time. Linda originally said that "past traumas" had precipitated her plan to hang herself. Fortunately, she never carried this plan out.

6.1.6 Avoidance of Psychological Pain

A sub-theme that emerged for one-third of the group was that suicide was a means to stop unpleasant feelings. Two participants described what they were trying to escape from. Donna described feeling suicidal: "Oh yeah. I felt I don't want to wake up but didn't [attempt suicide].... Not really to end it all, just didn't want to wake up and have to face it".

Evelyn described the feelings of "hurt" that precipitated her thoughts of suicide. She actually tried to commit suicide when she was in her early adult years:

[I felt] sad, lonely, [felt that] uh, I guess your heart stops feeling. Start to feel isolation, alone, I mean, you don't see that you have choices left in your life. Um, start to be withdrawn [long pause].... Uh, I think it's also when there's an event happening in your life where there's a lot of hurt with it.

6.1.7 Reasons for Suicide Rates

Bev, a participant-commentator, offered her observations on suicide in the community. She said that the suicide rate at the Native reserve examined in this study was "relatively low" and explained:

We have a suicide intervention team but prevention is needed .... We had one suicide a year ago. We have attempts, tendencies, and thoughts.... Being there is what works, being available at all hours of the night. Our
team is what works for us, team support for ourselves and the client....

She commented that suicide rates are lower on this reserve than on more northern, isolated reserves for sociological reasons: people on this reserve had fewer reasons to feel hopeless.

...[there is] a close proximity with the city. It's only five minutes to town and there's not that much poverty. The people are taxpayers and many work for the city. They have their own businesses, know how to apply for jobs, they're very sophisticated and do fine, very fine. A good many people [here] are half and half [Native and non-Native]. In remote communities they don't have jobs or close proximity [to a city].... They find life hopeless. It just takes two secs [seconds] to kill yourself and when one does it there's a chain reaction. When a friend goes the next does it.

In the above discussion, participants mentioned feeling that they were alone while having to deal with their emotional difficulties. Support from other community members was absent. Tenaciously, several woman devised their own strategies for coping. Several woman stated that achieving goals in their lives was a problem. Coinciding with their need to find options for themselves was a local political impetus to gain control over child welfare which provided employment for women as local helpers. Helpers need secretaries, and as a result two career options opened up for Native women on the reserve. Several women took advantage of these employment opportunities. Participants mentioned that the preparation that is required for people who became helpers in this type of employment enabled them to work through their own emotional difficulties. Their experiences are narrated in the following section.
Section Four

7.1 Ways of Coping

7.1.1 Choosing to Become Helpers

Native participants in this study mentioned various ways they approached for coping with their experiences of psychological distress. A common experience or a major theme is shown by the fact that six women became employed as helpers in their community. Sub-themes related to this major theme were: becoming helpers because of childhood experiences; helpers' histories of their own abusive encounters; personal stress from caretaking; caretaker burn-out; and the need to find mechanisms for coping.

Of the six female helpers, two, Bev and Rochelle, were participant-observers. Arlene, Donna, Evelyn and Linda were participants. In addition to these participants, Ginger was entering studies in psychology to become a helper, and Jamie had taken the training but had chosen not to become employed in the helping profession. Margaret was employed as a helper-assistant. The two remaining participants, Shirley and Bernice, were employed in other professions.

Five of these women worked with Native children who were experiencing psychological distress, and all of these women had experienced their own episodes of emotional difficulties.

7.1.2 Care-taking Learned in Childhood

Evelyn was employed as a community social service worker. She had not been sexually abused but had experienced episodes of depression and had felt suicidal in her late teens. She said that being a helper began for her early in life:

In my own recovery, I had a really hard time with this "having fun" because I was uh, my whole life has been, uh,
I was so serious about everything. I was the youngest of the first six [children] and I was the oldest of another five that my mother raised. And I've taken on that role [caretaker] in the family.

7.1.3 Helping Because of Having Experienced Past Abuses

Linda alluded to having been sexually abused in the past. Initially, she hinted at her own experience of abuse when asked why she chose employment as a social worker with children who have suffered from sexual abuse. "Oh my gosh! I guess, life experience". She noted that "lots of [Native] kids" she worked with had been sexually abused. When asked directly whether she was abused as a child, Linda replied, "Yes". When asked whether her own personal experiences affect her as a helper, she again replied, "Yes". Linda expanded on this:

I can almost see where they're at.... I think also because of the work that I had to do for myself, I've really learned a lot. If it hadn't happened to me [being sexually abused], when I went into placement like Thunder Bay Physical/Sexual Assault [training], I wouldn't have done anywhere near the reading or have had as much curiosity or interest.

7.1.4 Experiencing Personal Stress from Care-taking

Margaret worked closely with local helpers and she felt that being a caretaker was also a role imposed on her in her private life:

I was always left to pay the bills. To pay the arrears. People looked [at] us and they were really angry and it hurt me and my kids because we had to listen to it [blame]. Maybe if I hadn't heard he [her husband] was going to die, maybe I wouldn't [have cared about him]....

Bills, bills, my credibility and it's important. I'm the one that has to go out and pay...and the kids at school and work. But I came back [from stress leave] because I needed to work. My mother always told me I had so much patience,
I'm the family caretaker. I've always been cheery.

7.1.5 Past Abuses and Helper Burn-out

Because the had experienced emotional distress personally, two participants said the work required of them as caretakers became overwhelming. One chose to leave helping profession and the other took a medical leave to work on her own emotional problems. Both had experienced childhood distress. Arlene became a caregiver (life skills coach) professionally but she chose to change professions because the work took an emotional toll on her:

I feel sadness..., plus I worked as a life skills coach and went through sadness there because of students I worked with, I think I felt a lot of their pain because of the things they told me. I hurt for them.

Donna, also a counsellor with children, was in the process of trying to achieve a sense of her own emotional well-being. At the time of our interview, she had been off work for ten months for "stress leave". She was seeing a counsellor, having just lost her mother and prior to that, a son to death. Donna described the type of stress she felt at work: "I work with Native children with behaviour problems. A lot of them are experiencing depression and anger. I need to feel healthy to work with them". Donna said that she had felt stressed for a long time and was of the opinion that the stress was sourced in her need to assume a caretaker role in her childhood: "You look to see if everybody's in the right place in the morning. I'd try to intervene in the marriage of my parents. I do that now - go to somebody else's home and jump in to help out. Don't notice it until...".

7.1.6 Coping as a Helper

Two women believed that the stress that resulted from the working as a helper required both personal and collective initiatives for helpers to remain
psychologically well. Linda explained how she relieved her stress from this type of work, "I talk about it with co-workers". Linda also spoke of finding her own ways to heal. She gained knowledge on how to cope with stress from re-discovering her own Native traditional healing practices through her training to become a counsellor. "Actually, it was a program on the reserve.... It was eight weeks, but there were other things in there, so it lasted almost a year".

Bev, a social worker, explained how reserve helpers work together to alleviate the emotional impact they feel from working with others in states of psychological distress:

We as a team have to support each other. When I go down the rest jump in and get you up. Crisis after crisis. Most people don't understand that you're going through a lot. The team jumps in and we go talk together as a team. That's where our strength is. A lot of times our team know a lot about each other, more than our spouses do. Communication in the team is a biggy.

7.2 Ways of Seeking Healing: Rejection of Religion

A major theme for almost half the women participants was appraising the role spirituality played in their lives. Sub-themes were rejecting religious teachings, rejecting the Catholic faith system, rejecting all spiritual beliefs, re-evaluating belief systems, and struggling with family acceptance of new-found beliefs. Native traditional spirituality had disappeared in community practice. The Catholic Church and its belief system played a large role for many years in this Native community. The church has long been situated in the centre of the reserve and until the sixties, the elementary school was also on the reserve and was managed by the church. Four women described personally experiencing a need to re-evaluate the esteemed role that the Catholic belief
system held in their community and in their personal lives for so many years. Three women were moving toward revitalizing their lost Native traditional spiritual practices. Only one participant described that neither Native or non-Native spiritual beliefs interested her.

**7.2.1 Rejecting All Spiritual Beliefs**

One of the four women, Ginger, had become disdainful and rejecting of both the Catholic religious beliefs and traditional Native spiritual practices:

Native spirituality? It's bull-shit. I've seen so much molestation, drunks and women-beaters and then they say, "Oh, I believe in this and this" and then, they go beat their wives. The Pow-wows are really sexist, like only guys can drum. That's just my opinion. They do the smoke stuff [smudging] and drum and that just annoys me. I don't believe in God. My Grandma [Native] feels the same way. Sometimes my Mom likes it but Grandma, she says, "Ahh, those Indians!" [The] Catholic Church is bullshit too and my Mom was telling me like her cousin was only fifteen and slept with one of the ministers!

**7.2.2 Rejection of Catholic Spiritual Beliefs**

Linda felt that her disillusionment about the church's teachings arose from her personal experiences of both childhood and marital abuse. These abuses led her to abandon her Catholic faith. She felt the church promoted abuse through its teachings to be humble and accept personal suffering:

Some of the beliefs that I was given...worked against me. And then, I was married to someone who was through residential school [and sexually abused there].... I had to toss [Catholicism] aside for my own sanity.

Linda said experiencing her depression led her to make value changes as part of her healing process:

[The depression made me feel] very, very sad. Hopeless. Helpless.... In sort of a sense of [me being] a really,
really bad person. How did I cope with it? That was when I had to decide for myself what I wanted to keep for myself and what I wanted to throw away. And partly that was religion. I had to decide that wasn't for me. I was raised very much Catholic. And changing my beliefs helped [me with] being Native, a woman.

Linda commented: "In the northern reserves, I think they have a lot of people coming in to try to fix them and telling them what's right." When asked who was coming in, she replied, "Different church groups".

Arlene articulated her anger toward the Catholic religion for denying Native peoples' rights to practise Native spirituality:

I think the Catholic religion put us where we are today. They wouldn't let us practice Native traditions. I think the people going to the Catholic church don't want no part of Native tradition. I heard once that they don't, like they say tradition is bad and I think it comes from the Catholic religion.

7.2.3 Re-evaluating the Locally Practised Beliefs

Evelyn explained how she was moving away from only practising her Catholic beliefs:

Um, I did a lot of thing after that [realizing she was depressed].... Support from my own family, support from the church, but it didn't help me. It wasn't until I actually got in touch with who I was I guess, as a Native person and that's when a real change began in my own life. And I really can say that's when I started to like who I am and I can tell myself I love myself and uh, I think it came from knowing where I come from now. And being able to talk and share my hurts and attending support groups and being involved in sharing circles.

Evelyn experienced difficulties personally and with her family when she temporarily put aside Catholic faith practices and began focusing her spiritual interests on her lost Native traditional spiritual beliefs:
Maybe my second time in my life I used sweetgrass... and I felt really good about using it. And at that point I still struggled with using it because I hadn't learned from my parents that and being raised in the Catholic church and uh, [learning] some of this stuff was bad for me and my parents had told me it was bad and uh, so each time as I went back [to learn Native spirituality]...it felt more, every time I used it [sweetgrass] I knew it was part of me and I started feeling a real comfort level with it....

Evelyn enlarged on how her mother's engrained Catholicism contributed to an emotional struggle for Evelyn in her new-found practice of Native spirituality:

My mother struggled with me doing it and I had asked, I had her one day to use it with me and she did and she really struggled with that still and she still does today.... She keeps telling me "you gotta get back in touch with God" and I tell her, "You know Mom. The Creator is God and I feel good about the way I'm, what I use today". And you know, I don't blame my mother at all for that, I guess. Being raised or going to uh [the Catholic Church], she shared some stories with me too about when she went to school and stuff.... They didn't go to residential schools, just to [Catholic] schools here [on the reserve] and the nuns and stuff like that put that [Native spirituality] down.

7.3 Ways of Healing: Changing Behaviour, Thoughts, and Coping Style

A common theme was that the women individually attempted to achieve their own sense of well-being. Sub-themes related to this theme were wanting to leave the reserve, trying to change thinking styles, using disclosure as a form of therapy, and utilizing Western therapeutic approaches. Six women described the personal approaches they took in trying to find healing for themselves.
7.3.1 Leaving the Reserve

Bernice felt that physically leaving the reserve would help her to heal from her emotional turmoil that arose from her experiences of sexual abuse. She wanted a new identity, different from the one that she felt harnessed her in the community:

[I want to] leave [the reserve] to heal my inner child, to heal the person inside of me and maybe then I could come back. But I'd like to see like the real me.... Quit hiding behind this big woman.

7.3.2 Changing Patterns of Thinking

Shirley described changing her ways of thinking and using both her Catholic and Native spiritual faith practices to overcome her fantasy of impulsively attacking people. She described the rage she felt and how it frightened her:

And I'd think, "Hey, hey lady! This has gone too far, this is getting serious, you'd better start working [on the feelings]. And then I did start doing my work and I thought, this was foolish, so mean for me to think it. But I knew I couldn't to that extreme when you wanted to hurt someone to see the blood - that's just unreal!... Even though I asked for forgiveness, I just couldn't. Kept praying over and over again for thinking like that.

Linda described what she did both behaviourally and thought-wise when she felt stressed. She said she engaged in Native traditional rituals and "I just trust that things are going the way they have to go. Sometimes it's not good but it somehow works out in the end".

7.3.3 Disclosing

Arlene said that she was able to express her feelings and that doing so helped her in coping with bothersome thoughts:
Yeah, guilty thoughts - going to bingo, spending money when you know it should go for something else... that right there can cause depression. I got no trouble working with feelings. Before I used to be like that. No one needs to know my business. Tears work wonders. A lot think it's not OK to cry. I often think it's the best medicine, unless you get depressed....

Shirley chose to share her story as a survivor of sexual abuse in her healing process. This process was therapeutic for her. She was most connected, of all participants, to her Native traditional healing roots. She was one of few people on the reserve who spoke her Native language. She explained that she was taught both her language and her Native spirituality by her grandmother. She used this knowledge to heal after being raped. During the month she hid in the cabin, "I just washed and used that moss [to heal physically]". She has talked in a sharing capacity to other victims about her abuse. "I did a tape on my sexual abuse but I did it in Ojibwe".

7.3.4 Utilizing Western Therapy

Ginger said that she coped by seeking Western style therapy off the reserve. She believed that this had been "helpful" for her in her healing process:

I was just bummed. I felt so alone. I just felt like, unwanted. And I still feel that way. But it's not as bad since I saw a psychiatrist.... She helped me out. At first I wouldn't really talk to her. She asked me questions and I didn't.... [But] after a while...I really noticed a difference. I felt more open with her. I can tell her more things.... It's been helping a lot.

7.4 Healing and Rediscovery of Native Traditional Practices

A major theme was that four women were working to rediscover their community's lost Native traditional practices. This rediscovery was important
to them and recovering this knowledge was necessary to an improved self-
identity in their own healing. Sub-themes that emerged from this were
practising as a traditional healer, finding ways to self-heal using traditional
methods, rediscovering lost traditions, and finding ways to learn about lost
traditions.

7.4.1 Practising as a Traditional Healer

Shirley quietly practised as a Native healer because people sought her out
for this purpose: "I share what I know with them". Shirley's knowledge had
been passed down to her from her grandmother: "I knew I had it [traditional
healing gifts] when I was young. My grandmother was one of my teachers".
However, Shirley's Catholic upbringing also provided her with beliefs that she
drew on:

But when I look at it today, I see it's very similar
all the way through. Like I'm glad I heard about Jesus
and the two eagles. They're the same thing as the Creator,
Jesus. And when I talk about culture, I tell people not
to say the Native culture is the only way. If they've
been brought up Catholic they can combine it. Basically
that's what it is. They're still praying to the same person,
the Creator.

Shirley had achieved her childhood dream of having a husband and
children despite being told that she could never become pregnant because of
the physical damage done by the rape. "They said I could never have any, and
I have four!" She also had a professional career unrelated to the helping
profession.

7.4.2 Self-Healing from a Native Traditional Perspective

Linda outlined what she would do if she became "depressed again": "I'd go
Native. I'd look for an elder that I trusted. And maybe attend a sweat."
Linda described how she now attempts to avoid negative mood symptoms:
"[Practising Native] Spirituality.... Really taking care of myself. Doing what I enjoy. And making the changes that are necessary".

7.4.3 Beginning to Rediscover Lost Native Traditions

Margaret mentioned how a family member encouraged her to begin exploring Native traditional approaches in her attempts to achieve healing:

I keep everything under control. Friends don't really care or listen. Are they afraid of my husband? Are they avoiding me? My sister gave me this feather...pass it on to...house burns...go up the mountain to a special place. [She] gave the feather to me and I went to a friend's to get the feather and asked what does that mean? He said, "You're putting your spirituality on hold." But I love God and tell Him that every night. I was told the feathers have to float and maybe it has to be there....

I love Native spirituality but I don't know much about it but I want to.

7.4.4 Learning Lost Traditions

Evelyn felt the educational training she received to learn to become a local counsellor had helped her to learn about her Native traditional healing practices:

I go to Winnipeg once a month for a week to go to school [Native counsellor training] and I went to a medicine lodge. It was the most wonderful feeling that I've had for such a long, long.... When I went to this medicine lodge... it was wonderful.... I was given my medicine rock because sometimes my sad feelings about my husband 'til come back and I take my grandfather rock and put it on my chest and they go away....

By travelling out West for counsellor training, she had acquired new learning and Evelyn was able to bring the Native teachings back. She first began practising them in her own home:

I've been to a number of sharing circles involving
women and men. I was actually given an eagle feather ...and uh, that eagle feather, when I hold it gives me such strength. And I've started to smudge in the last five years. I've started to use sweetgrass, sage, cedar in my own home and I've started to teach my friends about that and we do have family meetings together and use that in our home....

I'm gonna go back again [to Winnipeg and the sweat lodge] next month. Stuff like that seems to be something that started to make me feel really good about who I am.

Evelyn explained why she believed Native traditional healing practices would emotionally benefit people living on the reserve:

Ritual helps with depression. I really do like.... I've been in circles. I've seen people come in there and feel really down and yet when they've walked away from the circle they really.... I think because it's ah, sacred. They've been places where whatever's been said there stays there and you're not judged, you're not judged for what's happening and uh, you use a feather....

Many Native people had not yet begun exploring or rediscovering their traditional practices as part of their healing process. Those who had been exposed to non-Native treatment models funded by outside agencies described the problems they encountered with this approach.
Section Five

A major theme for over one-third of the women participants had experienced treatment in programs provided for Native people. Sub-themes related to this were considering treatments to be unhelpful, finding attending treatment personally demanding, having issues with the type of treatment offered, having issues with high counsellor turnover rates, and encountering problems because of conflicting treatment systems.

8.1 Experiences with Treatment Provided for Native People (Drug and Alcohol)

8.1.1 Finding Treatment Programs Unhelpful

Shirley had been sent to a treatment program that was offered in the United States. Many Canadian Native people were sent to these program, until the past few years when government funding to attend them was terminated. Shirley did not find the treatment program helpful and she was not concerned that she could not "complete the program". When she attended it, she found herself among a group of people from other American minority groups. Shirley left the program before completing it because: "There were things happening at home. My sister went through a suicide and basically, I was the care-taker".

8.1.2 Issues with the Demands of Treatment

Jamie commented that even thought she had attended a treatment program and had received suicide interventions, she remained emotionally distressed. She felt that she would benefit from counselling. However, she believed attending a treatment program would be difficult for her because treatment required off-site attendance:

I keep putting it off because they put a lot of pressure on my kids and their lives changed lots since I went
there [to a treatment program], and their marks went
down to nothing and just going away from them for six
weeks changed their lives.

8.1.3 Issues with the Type of Treatments Offered

Jamie felt frustrated by the over-emphasis of Native cultural counselling
she had received in a funded treatment program:

I went once for six weeks. I figure I should go again 'cause the treatment I went to was more like culture
and there's not more dealing with what's happening
to you, like why are you doing this or what's happening,
why you feel this way? It's more like culture, and they
deal with it that way, like sweats. Like I seen my
counsellor like maybe once a week, like when you're
in treatment you have one on one a week and then you
have these little sessions like step groups and that.
I don't think there was enough time for more individual
counselling to do anything.

8.1.4 Issues with High Counsellor Turnover

High counsellor turn-over was a treatment program problem and the
instability of counsellor employment evoked Jamie's mistrust in the process:

I'd not get involved again with somebody like that [a
counsellor]. [You trust] and then they walk out or
they get fired.... You put all your...give them every-
thing that you have and then they're gone. It's just
hard to trust another person. I used to think, if
they quit or get fired then they spread things like that,
spread what I say. It's hard to trust, that's all.

A second participant, Margaret, also expressed how emotionally difficult it
is for Native people who lose counsellors from the high turn-over rate:

I loved one counsellor. She got another job and I miss her.
Someone I finally got to trust. She's just a nice lady.
8.1.5 Feeling Caught Between Different Helping Systems

Selections from Margaret's narrative illustrated the type of inadequate and inappropriate care Native people described encountering. Her situation exemplified why Native people are reported to need to engage in pluralistic help-seeking behaviours.

Margaret enlarged on her ambivalent feelings about treatment. One problem was that no back-up supports were in place and participants needed these:

I thought I just needed somebody there to talk to. My sister doesn't call me a fool to hope things'll get better ... I'll be leaving in three months again [to attend a treatment program] and it puts pressure on the other person [the family member managing things while I'm away]. We never get caught up [financially] and people [are critical of] .... St. Norbert's Treatment Family Centre, me and my kids. It's a family program. Six weeks. [For] bereavement after the baby....

Treatment programs were designed only to address drug and alcohol problems. Native people were sent to programs that did not provide treatment to specifically address other difficulties. Margaret felt compelled to have to justify attending an inappropriate program for her bereavement:

I went to a Treatment Centre for the baby. [This type of treatment was perhaps necessary because] I did drink and do drugs when we were young.

Margaret did need to engage in other help-seeking behaviours to have her individual counselling needs met:

I did see a doctor and the bereavement group helped a whole lot because I met other women whose.... I can't be alone with a baby [because of the reminder of her own grief].
This participant's situation also demonstrated the dilemma of being caught between two helping systems, the court-ordered non-Native one and the local reserve helping system:

The treatment centre was hush, hush [reserve provided]. The children and I go back [secretly] to see their dad [against court-ordered and non-Native social worker mandates]. I want the kids to understand.

Outside helpers lack of empathy for the issues an individual had to deal with in the closely knit Native community was demonstrated when Margaret narrated her experience of feeling shamed by her individual social worker from the non-Native community. The non-Native social worker was counselling Margaret to leave her husband. When Margaret arranged an Easter shopping excursion with her children and her husband, she encountered the social worker and her judgmental attitude towards Margaret:

[We] sent for jeans and shoes and my husband and I are not supposed to be together and we ran into the worker. She looked the other way. And that really pissed me off. When I do see him, I feel so good.... I believe in a home and a family so much and not just children and grandchildren.

Another participant, Evelyn, commented on the differences in types of treatment she has been involved in. She explained why treatment in tune with her own Native cultural background felt more suitable to her needs:

Like, I also attend a group [A.A.] in the city and it's not ah, there's no culture in it or anything. I attend al-a-non in the city and I enjoy it and I probably go because I still have friends there [laughs]. I still don't get the same feeling I get when I go to sharing circles. That peace....

Inappropriate treatment, high counsellor turn-over, off-site treatment program attendance requirements and non-Native interference in treatment were described by participants as working against their ability to receive
satisfactory care for their psychological difficulties. Addressing the sources of the psychosocial stressors such as sexual abuse and racism that participants felt contributed to their emotional difficulties was not occurring. It appeared that for the women, repeated stressors had to be managed. However, the women also had to cope with the distress of feeling their emotional pain and receiving no counselling support to deal with their emotions was yet another stressor.
Part Two: Introduction

Section One
The Men's Stories Describing Low Moods Occurring in Their Lives

Seven adult male Native participated in this study. Six of them chose to discuss their experiences as they related to being unhappy psychologically. The seventh participated as a commentator.

As did the women, the men reported that at certain times in their lives they had felt they had experienced episodes of mood difficulties. A major theme for the men, as it had been for the women, was their discussions of unhappy experiences occurring in their childhood. Sub-themes that emerged from this major theme were witnessing violence as a child, experiencing physical abuse as a child, experiencing parental alcoholism, going through the trauma of parental separation, being subject to childhood poverty, being abandoned by parents, losing a family member to death, and encountering problems at school. These experiences were described as psychosocial sources for mood difficulties. For all the men, childhood difficulties arose in the area of relationships with parents.

9.1 Depression Described As Beginning in Childhood

9.1.1 Witnessing Violence in Childhood

George described his emotionally tumultuous childhood experiences. He was frightened from watching his mother being physically abused when he was a youngster. His father's violence caused George to develop mental means of escape:

I seen a lot of things go down, mother getting beat up or having sex in the next room and I'm watching, you
how. [I was] a little kid. And um, my father on the other hand, he wasn't with us but when he did come he was very violent. Like he'd be fighting with my mom and I'd be sitting right there, eh. You know how most kids go hide under a bed but I didn't, I'd stay there and close up you know, gone to another world sort of, to speak. I was off in la la land while they're fighting....

9.1.2 Experiencing Violent Physical Abuse in Childhood

One participant elaborated on his experiences of physical abuse. His mother would experience rages and take these out on her children. A consequence of this was that Chris experienced tendencies to become tearful, even as an adult, when he saw children in unhappy circumstances. He experienced severe physical abuse from his mother throughout his childhood:

I was beat a few times where I, [and] the next day my mother seen the bruises [she caused] and had to keep me from school.

Chris mentioned when he took control, so that the physical abuse stopped:

All I remember was a big white flash from being hit across the side of the head with a hockey stick. She [my mother] took about fifteen, twenty more whacks. I saw red and I reached out and grabbed the hockey stick, I reached out and grabbed the hockey stick and threw it out of her hand. And that was the last time my mother ever hit me [at age sixteen].

At the time of the interviews, Chris continued to feel a strong resentment towards his mother, who he said "denied" that she "had ever physically abused" him.

9.1.3 Parental Alcoholism

Chris described his childhood experiences of witnessing parental dissension created by their alcoholism and the effect that being a member of
this argumentative family had had on him emotionally. He felt that it impacted on him psychologically and that the effect remained with him as an adult.

There was lots of times being dragged out in the middle of the night, going to aunts and uncles [Chris sighs]. Listening to them drinking all night. I had one experience I remembered. It didn't dawn on me until years later. Actually my mother to this day thinks I tried to commit suicide then. When I was a kid, I used to love my pillow. And I don't remember why I used to love it but I used to want to wrap it around my head. And I remember one night I got my belt and I tied it around my head [laughs]. My Mom came in the middle of the night and she thought I was trying to commit suicide. But to this day, I remember this now, that a lot of times, the screaming and fighting, I would wrap the pillow around my head to stop the noise. And to this day I like lots of pillows on my bed.

Wayne described a difficult childhood growing up with his parents and witnessing their conflicts and alcohol misuse: "They drank and argued and fought all the time in front of [pause]. They fought". Wayne described a happy family life from "ages three to five years old" but this he said was "changed by booze", a habit he said he too adopted when very young:

We used to go camping, we used to go and have fun swimming and boating [as a family]. My mom [started drinking at first]. At the time I didn't know what it was. [I started to drink at] twelve.

9.1.4 Parental Separation

Michael lost contact with his father through the separation of his parents. He never again achieved a sense of closeness with his father. At age five, Michael described the emotional loss when his mother chose to leave his father. She moved the family into the city, away from close contact with his
father. His father's alcoholism remained a problem in their father-son relationship:

I don't see him [my father]. He phones me when he's drunk. Nice guy and everything but not a father and a son. He probably just wants to hear me say I miss him and [say] "come on home Dad". And I always say the same thing but he lives in British Columbia. I don't know. He never phones me when he's sober and when I catch him off guard and phone him when he is sober, he really doesn't have much to say.

9.1.5 Broken Families and Poverty

One participant enlarged on his feelings about his childhood experience of growing up in a broken family. Chris remembered the deprivation and shame of the poverty he lived in. In effect, he lost two parents because of their separation and of his mother's need to provide for her family removed her presence from the home. Chris experienced two major losses during his childhood. His mother took the children and left both the reserve and his father. To earn an income, she left the children alone while she worked. The children frequently went hungry and eventually their house was repossessed. Chris described his feelings of embarrassment from the family's poverty:

We had moved into the city. We had moved off the reserve when I was six years old [after my parents divorce], moved into the city. We bought a home. We couldn't afford that, that got repossessed. It was embarrassing now that I remember it all. Me and my brothers and sisters talk about it know and kinda laugh but ah, in the mornings for breakfast, one would run across the street and borrow milk, the next one would run next door to borrow bread, the other would run across to the other side and borrow sugar and this was like a daily routine to us and [pauses]. I hated it.
9.1.6 Parental Abandonment

Phil lost both of his parents when they abandoned their children and left them to the care of his grandparents. Phil described the poignancy of this loss, which was intensified by the death of his grandparents as well when he was in grade eight:

I grew up with my grandparents from day one. Abandoned [by mother] and father too, I guess. I was abandoned by my mother. I had five brothers, one old and four younger. [She] abandoned three of us and kept three of us. The first two my grandparents took uh, one was placed in a foster home and the other three stayed with her. I was kind of disappointed that I didn't have a parent, my parents when I was growing up like every other kid, most of the other kids had. Parents that uh, went [with them] through their life.

Phil's grandparents raised him and he felt he had "learned a lot from his grandfather" who "taught [him] a lot". Still, he really missed having parents:

It would have been nice to have your parents there at your going to school, the first day of school, passing all that kind of stuff because with my grandparents I wasn't involved in any kind of recreations, sports ... 'cause my grandfather used to be a beachcomber and when he retired we lived on welfare and we never had a hell of a lot but we made do with what we had. So there was no money to do certain things.

Phil felt that his childhood emotional pain impacted on his ability as an adult to trust other people. This created difficulties in his marriage in which he was fearful of being abandoned again:

I always think because my mom left me somebody else is going to do it [leave me] anyways, again. So I try not to attach myself too close to anybody. Even my wife you know? I even told her that a few times. She says, "how come you don't cry?" or stuff like that. I learned to hide
that stuff when I was a kid and then I don't have to show that to anybody. But you know, it hurts. I still do that today. It hurts. But then again I guess that I learned to deal with that kinda stuff.

Phil said that children like himself who did not have parents were stigmatized at school and this created more stress in their lives:

It was especially hard you know when you're in grade one, grade two, you know the first day of school and everybody's asking, "who are your Mom and Dad?" or, you know, I don't know if the teachers they do it just to embarrass you sometimes? Like you got it written down like my guardian and my Grandparents. They ask you in front of the class.... I'd just give them a quick answer and they wouldn't ask the second question [about my Grandparents].

9.1.7 Loss Death of Family Members

Chris had experienced growing up in a family that was abusive and poor. In addition to these psychosocial stressors, he also experienced his sister's death when he was young. At the time, he was unable to process the psychological impact of her death.

I feel, when my [other] sister mentioned it to me, I feel that way too [that I didn't go through the grieving process]. I feel that I was so young at the time that uh, it didn't seem to affect me that much at the time. I know I missed her and all that and I went through a little bit of a period, but then it seemed to wash over right away.

He noted how he had blocked out his feelings to avoid coping with them. The feelings he needed to escape from arose from his childhood of poverty and then from his sister's death. Emotional stress was and continued to be hard for him to deal with:

And uh, I always felt that I wasn't uh, affected by it uh,
but I know I'm kinda of ah, I gotta hard way of dealing with things in my own situation and stuff. I have a hard time dealing with pain, I have a hard time dealing with ah, any emotional stress or whatever. I kinda block it out all the time.

Chris commented on how the loss of his sister impacted on him emotionally. He had to contend with watching helplessly the stress his mother went through over her child's death. This loss also affected the psychological states of other family members:

Uh, I have a brother that's going through a lot of alcohol problems right now. I have a sister that's going through a lot of uh, emotional problems herself. And...I went through an emotional state there when my sister died. I was really close with my mother and I used to always sleep with my mother or sleep in her bed 'til she got home and then move over to my bed after she got home and stuff like that. And uh, I used to share the same room with my sister that died....

Phil said he and his brothers blended into his grandparents family to create sixteen children. Phil felt that it was a "supportive" family with "strong family ties". However, his grandparents died when Phil "finished grade eight" and this loss caused Phil to be alone again so that he was, "kinda on my own since I was about fourteen." Phil lost out on his schooling because he needed to support himself:

I had aunts and uncles to live with, but then again it was still hard going to school because you have no money and any money that you get was paying somebody's rent and to stay in school and try to do everything like everybody else does and even the same kind of lunches even, I just couldn't do it. So I quit school when I was fifteen, I went to the railroad and told them I was, I lied about my age and got a job.
9.1.8 Problems at School

One-third of this group of men said that they had behavioural problems or interpersonal difficulties at school. Children who have troubled home lives frequently get into difficulties in other situations, especially at school. Chris and George both reported that they had problems at school when they were children. Both boys had no authority figures in their lives to provide both love and guidance. Chris said he became involved in criminal activities at a young age.

I had a lot of problems as a kid, um, I had a lot of hard time in school. Uh, lot of B & E's [break and enters], lot of shop-lifting. Uh, I was getting into drugs and drinking heavier. All kinds of stealing and stuff like that.

George said that he eventually gave up defending himself in school-yard fights when he was in grade school. It appears that the passive manner he adopted to cope with the arguments he witnessed between his parents carried over into other areas of conflict:

I stopped [fighting]. I became very afraid. And when it came down for me to fight, I'd just freeze up and didn't want to fight. And I'd allow myself to get beat up.

The psychosocial stressors that these men described experiencing as children were extreme in nature. Almost all of them felt that some emotional fall-out of what they had lived through affected them in their adulthood. Below, the men describe their feelings about what happened to them, in particular what they consider contributed to a poor sense of self.
9.2 Low Sense of Self-Esteem Interpreted as an Aspect of Depressive Experiences

Two-thirds of the group described their feelings of low self-regard. This emerged as a major theme. Sub-themes related to this main theme were experiencing unpredictable parental care, abusing oneself through substances, feeling shameful, feeling inadequate, and feeling alienated. The participants mentioned the sources of their poor self-concept in their descriptions of how they felt about themselves.

9.2.1 Unpredictable Parental Care

George felt his mother's treatment of him in his childhood contributed to his feelings of self-hatred in adulthood:

I remember uh, when I was living with my mother, when she was sober she hated us, when she was drunk she loved us. Very confusing on my part, I guess. It affects me to this day, I'm like my mother, kind of in ways, I love life when I'm stoned. However, when I'm sober, I hate myself....

9.2.2 Substance Abuse

George believed his behaviour contributed to a poor sense of self-esteem. His troubled conscience contributed also promoted his substance abuse and a suicide attempt:

Ahh, drinking and doing pills and stealing off my parents, being taken away by the cops, feeling really shitty about myself, I'd convinced myself that everybody would hate me and wouldn't want me, you know. So, I thought the best thing would be, to do, was to die. You know, they wouldn't have to worry about me, you know. They could just shove me aside.
9.2.3 Shameful Feelings

George also believed that his self-dislike ruled out the possibility of making any progress in treatment. He was fearful about disclosing his feelings, thinking he would be attacked for who he was:

And, being afraid, I was mostly afraid in treatment because I always felt like I was going to be like uh, attacked for being the person I was so, I had to talk about them [feelings] but I would minimize them and I wouldn't feel.... I didn't allow myself to get better....

9.2.4 Feeling Inadequate

Wayne felt he had no one in his life who valued him for who he was. He mentioned feeling "hurt inside" because the brother he loved was "living with [him], eating all [his] food", and "using" him. His said his friendship pattern was one of usury, where people befriended him "until his money ran out".

9.2.5 Feeling Alienated

Michael believed that his departure from the reserve at age five and later, his return as a young adult caused him difficulties in his attempts "to be accepted" and reintegrated "back into the community".

9.2.6 Feeling Burdensome

Phil who was paralysed in a work-related accident felt that his disability caused him to be a burden to others. He lost his friends as a result:

Even today, I don't feel like going to any of their [former friends] houses no more. 'Cause I don't want them to uh, pulling me upstairs.... I don't like somebody doing something for me ... since I got hurt....

Feeling badly about themselves as children and adolescents was further reinforced for these participants through their interactions with non-Native people. Experiences of racism at school not only affected the educational opportunities of these participants but increased their vulnerability to
psychosocial stressors. Then, lack of education limited employment opportunities. Discrimination against Native children further abused these already emotionally compromised children. The fears they developed when they were children from interactions with white society carried over into adulthood.

9.3 Experiences of Racism

A major theme of the impact on self-esteem was the description by half of the group of being exposed to racist attitudes from the non-Native community. Sub-themes emerging from this main theme were racism experienced generally, experiences of racism at school, and feelings of reverse racism.

Two of the participants said they had witnessed racist attitudes toward Native children in school. All three participants had achieved their life goals but their comments on racist attitudes felt by Native people provided insight into the effect these attitudes have on other members of the reserve, who do less well in life. This interviewer noted that the three participants were less easily identifiable as Native people than many other reserve members.

9.3.1 Racism Experienced by Band Members

Dan said that Native people who lived on the reserve, feared racism and that this increased his work duties. Dan's experience was that people on the reserve over-worked him by calling on him to intervene in conflicts when he was off-duty. He said that they did not call on the on-duty officers who were non-Native because, "people out here have had a bad experience of prejudice [from the police]. I just made a call when I was off-duty two days ago because she [a Native woman calling for help] didn't want to talk to anybody else".
9.3.2 Racist Experiences at School

Two participants mentioned that they had witnessed racism at school. Phil had clear memories of feeling racially discriminated against in school, where his Native ancestry would be known by teachers:

There was a time I'd get strapped and put in the hall but I'd rather get that than get put in front of the class and asked questions [about his parents]. Like I used to hate it when they used to do it to the Native kids, especially at school it seemed like at school they were picked on the most.

Phil said that Native children who had the fewest local social supports experienced the worst racist treatment:

Fort William [Native] kids didn't have it that bad because they're here but for [Native] kids that were from out of town, boy did they have it hard in school!

Native children who were disadvantaged because of family break-ups were described as most vulnerable to racism at school:

You know, "Who are your parents?" "I don't know my parents, I'm adopted". But they'd make them get up in the front of the class and say that, eh. And these kids were just, I remember this one kid Connie, she would just cry all the time, cry every time she had to get up in the class, in front of the class. Right up to grade 5 or 6 she'd cry. [I'd think] "Why do you keep doing this to her, you know she's gonna cry when you ask her a question?" You know, in school the only one I seen getting the strap was the Indians. None of them cried either.

Phil reported that school discipline was also physically abusive for Native students:

I used to get the strap and not even blink and it would seem like [the teachers would] try to hit you harder because you know he couldn't make you, you know, I mean
it hurt, boy did it hurt but I wasn't going to give him the satisfaction to cry or like they made you beg for it to stop. My hand was so sore one day, it was just stinging. He was trying to get me to admit something. But I never did it and I wasn't gonna admit it. It was funny, he'd start off a hitting and it seemed like he'd jump in the air to try to hit ya harder, eh.

Michael believed that because he did not "look Indian", he fared better in the non-Native city school system than other Native students:

Ah, yeah. I seen it [racism] but I never felt it. Like I said, I don't look Native so I never really had too much on me but I seen it. I've seen it both ways. I've seen Natives be racist to white people and the white people be racist to Natives. When I was going to university, I drove a cab part-time and I seen it all the time - both ways. There's racism both ways, "those damned white people".

When Michael saw racism towards Native children in public school, he said: "I guess I probably got mad, I know I used to stick up for them anyway".

Michael observed that Native students were treated as less intelligent:

The teachers did [ignore racism] when I went to school. That was twenty years ago when I went to school. It was pretty bad in high school, yeah it was really bad. It just seemed like they [teachers] picked on Native kids. If there was a bunch of kids acting up in the class they, the first one they grabbed and take 'em out in the hall would be the Native kids. I've seen them maybe talked down to a lot. Talk louder to a person maybe they'll understand it better sort of thing, you know. When they can understand what you're talking about, you know? They figure if you talk louder and make big expressions they'll understand it better. Where they're just a person just like the white kid in the next aisle. I'm sure it does [contribute to drop-out rates], I'm not sure how much.
9.3.3 Reverse Racism

In a case of reverse racism, Michael said that even his Native mother, who felt, "we could do better in town [than on the reserve]", was not accepting of his non-Native wife. Both his mother and his wife lived on the reserve "now". His mother's attitude toward his wife perplexed Michael because his mother encouraged him to "chase the white girls". She did not want her children "going nowhere like she seen [happening to] a lot of young people [on the reserve]":

I don't think she's prejudiced or nothing. She just want us to be exposed to wider opportunities, not as sheltered [as those on the reserve].

Racism contributed to a loss of a positive sense of self as a Native person. Schooling became an additional psychosocial stressor for participants who described feeling overwhelmed by what had already occurred to them in their lives. Experiencing more losses in adulthood caused further emotional distress.

9.4 The Experiences of Low Mood in Relationship to Losses

In addition to the childhood stressors the men described above, several faced additional psychosocial difficulties in adulthood. A major theme that emerged from the men's narratives was that of encountering losses. Sub-themes emerging from this major theme were loss of physical health, loss of marital stability, and losses as a result of deaths of family members. Half the men explained how the experience of losses contributed to mood problems in adulthood.

9.4.1 Loss of Physical Mobility

Phil's sense of grief when as a child, he lost his parents was tragically compounded when he lost his ability to walk and almost lost his wife. Phil
had worked steadily since the age of fourteen. However when he took a job working in the bush [paper mill labourer], he broke his back:

It completely severed the cords...so after that for the next two years, I was just recovering from my injury I guess. But, I left the hospital in ten weeks. When I woke up, I was knocked out for eight weeks. In that time my heart stopped twice. I was clinically dead there for couple of minutes, a few times. And I had these uh, I don't know if you call it out of body experiences, when your dead. I was going somewhere's anyways. But uh, for some reason I came back.... When I woke up I was about 110 or 115 pounds.

Phil fought for two years in a rehabilitation program to regain some physical mobility. He was required to travel to Toronto for a tracheotomy and skin grafts. Back home and away from the medical expertise of Toronto doctors, he soon became depressed. Being bedridden at a local hospital created more physical problems with the result that he faced more surgery:

I was getting so depressed. I thought oh God am I going to end up like this [bedridden]? I seen some guys that were sort of bent from the back down and I thought "oh geez, I don't want that!"

Phil attempted to fight the depression that was brought about by his paralysis but the problems his disability created within his marriage soon overwhelmed him.

It's so easy to lay there and do nothin'. But I was getting pretty depressed you know, your wife comes in and visits you at night and she's going [home again]. And I thought, "Oh shit, I'm not staying here". But I found out too, a lot of people when they get a back injury, their wife or their husband's would leave. You know, then they were alone. It went through my mind a few times.... After awhile there's nobody there, just your wife coming in.
9.4.2 Loss of Marital Stability

Phil succumbed to depression because his disability threatened the loss of his sense of stability in his marriage. His marital breakdown brought back memories of being abandoned in childhood:

Actually it [my depression] wasn't that long ago. My wife was thinking of ah, I don't know, she was having thoughts of being single, moving out, leaving. [I felt] worried and uh, don't know why this is happening again, being abandoned. Um, I wasn't only thinking for myself, I was thinking for my kids. You know, how this is gonna affect my kids. I don't think we let them know what the worries were.... I don't think my health would remain the same... the biggest fear was, "oh no, this is happening again [abandonment], how could this happen again? Being left again?" Because I do everything I can, I provide for my kids.... I give her everything I can. But that's it money can't buy happiness.

9.4.3 Loss from the Death of Family Members

Wayne had experienced the loss of two siblings to suicide and a mother to a stroke within a three-year period. The emotional intensity of these unexpected losses placed significant pressure on the remaining family members. In addition, according to Wayne he grew up in a home life situation of dissension and he said that his father was "depressed".

Just my father [is left]. He's an angry man and he holds everything in and he takes it out on us. We argue and everything. He doesn't hit us or nothin' but he won't do nothin' for us much anymore. I know [my father's] depressed.

Mike had experienced the losses of several family members, "Sister died first. Mother went next. Grandfather went third. And brother went fourth". Mike said he had "no emotions" and he demonstrated a flat affect, common
for depressed people; however, his addictions and aggressive behaviour may speak for him.

Because most of the band members are related to each other, the emotional impact of the losses of these men would have reverberated throughout the community. The narratives of these men reveal that they had faced relentless emotional hurdles. Overcoming the emotional strain from these hurdles would have required strength beyond that which most people possess in their adaptive repertoire. Experiencing repeated traumas may have also been negatively reinforcing. It is reasonable to expect that hope would be extinguished when skepticism towards the trustworthiness of the world around them has developed. Perhaps this is what occurred for the men who reported that they were unable to summon the energy needed to achieve life goals.

9.5 Depression and Goals

Several participants discussed their inability to make progress in their lives. This was a major theme, and over half the men enlarged on this as a personal issue. Three had been exposed to violent experiences in their childhood and although a fourth man had not experienced violence or abuse, his return as an adult to the reserve was very difficult. Another three participants, as well the last of the persons mentioned earlier, were well-employed and had achieved satisfactory work and family goals, even though two had faced stressors as children. Sub-themes arising from this main theme were tendencies to procrastinate, addictions interfering with personal progress, self-inflicted physical injuries that impeded progress in life, feelings of low social support, and the feeling that community attitudes blocked goal achievement.
9.5.1 Procrastination

George said he was unable to feel motivated enough to make the effort to move on with his life:

The only problem with me is thinking that [I'm unable] to jump forward, you know. However, I can't pull myself to do that right now. Someday, maybe tomorrow, I'll wake up and I'll take that jump forward.... I'll get things done. I'm the only one suffering from all this, nobody else is. I'm not afraid to admit that. Because I know everything about myself, what's wrong with me, so.

George explained why he did not finish high school. He said: "So, I just held myself back...and I regret it". George also continually battled his problem with alcohol addiction and this too would diminish his energy.

9.5.2 Addictions Interfering with Feeling Motivated

Mike was unemployed. Both his prison record and his addictions interfered with achieving any goals: "[I use] alcohol, pills, drugs, uh, coke, hashish, um, all kinds...twice a week [I use]."

Wayne too was abusing drugs and alcohol at the time of the interviews. He demonstrated an unwillingness to work towards sobriety and rejected a hospitalization referral made for him at the time of the interviews.

9.5.3 Physical Impediments

Wayne had no motivation to work and he felt he could never work because of his legs which he "damaged" during a suicide attempt. He also felt that he could not accomplish anything until he got "over this family stuff first". Wayne was so preoccupied with the strain of his emotional turmoil that all interest in anything else was obliterated.
9.5.4 Feeling Motivated but Encountering Low Social Support

Michael was well-employed with the band and had a university education. He had also been employed with the provincial government training as a land manager through Indian Affairs programs before returning to the reserve. He expressed his thoughts as to the employment situation on the reserve and how he felt it contributed to depression:

Perhaps if more people were employed and feeling better about themselves, mental illness would be a little bit ah, less. I don't like it (seeing psychological distress)...alcohol and drug addiction, I guess it's an illness...it is prevalent. There is a lot of alcoholism and drug addiction.

Michael mentioned feeling depressed "lots of times, yeah". He said this was from worrying about his possible loss of employment and the ability to provide adequately for his family. The inability of the band to provide commitments to its employees frustrated him:

Usually, for me, it's just money problems. That would be it, I don't know. Like I love my wife, I love all my kids all that, but I just can't give them all I want to give them. Maybe that's the biggest. When I see a neighbour or some other person has more than me, I don't mean to sound materialistic but that's just the way it is I guess. I guess it would be money and maybe [worry] job-wise. I'd like to be in something better or something more secure. I'm only in a contract position here. Kind of prevents me from doing anything like getting a loan or a mortgage because I'm only on contract. Financing and stuff like that is hard...not secure until my contract is renewed again.

Michael said that even the band was not "sure" how he was paid. He was unable to get a written employment agreement. He said, "the thing is they spent $20,000 to train me and now they haven't got any money to pay me".
9.5.5 Community Attitudes Blocking Progress

Michael felt that "community jealousy" demoralized those employed in the few positions that were available on the reserve all of which bothered him:

It's hard working in a little community like this 'cause everybody knows you and there's a lot of uh, jealousy back-biting and all that. "Why's he working? How come he's still there? Isn't he supposed to be done in June? Why is he still on?"

Michael felt he had lost the support of both the community and his family. He said that even his own aunt was "trying to get rid" of him because her own son's contract was not being renewed. In amazement, he said that, "my mother's sister!" was trying to force him out. He also felt that possessing a post-secondary education alienated him from other community members:

I think the fear is with her too that I'm, I've been to university and I've got my technologist [diploma] and engineering and stuff. I think there's a little fear that I know a bit too much and I might try, I might get in there and be signing cheques or something like that. A little jealousy.... They know I'm not stupid. Afraid I'm gonna use it against them or use it to my benefit and screw the band there somehow. I don't see it like that. I could do good things for the band if they'd give me a chance.

9.6 Engaging in Abusive Behaviours

A minor theme that emerged was that one-third of the men had become abusive themselves. Mike and Wayne had both witnessed family alcoholism and violent conflicts. They stated that they too engaged in this behaviour as adults. Sub-themes related to this theme were addictions and troubled relationships, sexual abuse leading to violent behaviours, and the difficulties dealing with addiction and violence within the community.
9.6.1 Addictions and Relationship Difficulties

Mike stated that he had spent several periods of time in penitentiaries. He said, "the shortest time in jail was six months, the longest time was two years". He had experienced both legal and addiction problems and he also said that he had "no friends". He then explained that his own abusiveness contributed to the loss of a male friend and of his girlfriend:

Listen, I got friends, but I ain't got best friends.... My best friend and my, the girl I'm with, they both screwed around with each other due to my neglect of her emotionally.... A lot of things are my fault.

9.6.2 Sexual Abuse and Violent Behaviour

Mike said that he had been sexually abused by "uncles" and "very heavily physically and mentally [abused] by [his] father and mother too". He stated that he had dealt with the perpetrators by becoming abusive himself: "Before [treatment] I punched them out. They said I'd go to jail".

9.6.3 Addictions and Violent Behaviour

At the time of our interview, Wayne, who admitted that he had been in trouble with the law since his adolescence, was ordered by the court to see a psychiatrist after having been charged with "Assault with a Deadly Weapon" against his "grandmother's boyfriend". In the interview, he denied that he had caused the assault but later, he admitted to being prone to violence:

I was at home cutting a baloney sandwich and I had a knife in my hand and my grandmother's boyfriend was passed out on the couch in the living room. I went over, asked him for a smoke and I still had the knife in my hand. He opened his eyes up and he started screaming his head off that I was gonna kill him. So he phoned the cops. So I waited for the cops and they were believing.... They [court] brought up my emotional stress, I guess, from the family that I had
and they says it's caused me to be violent but that's lies. Well, I guess it's not lies.

**9.6.4 Addictions and Violence in the Community**

A female participant-commentator who worked with male band members in the capacity of social worker offered her observations on what happens in the community to men who have been sexually abused, as these participants had been and who were untreated. She said: "With some it's OK because they've realized what's happened to them, with others it's not OK because they've become the abuser".

Bev mentioned that as a helper she had had to deal with some untreated male victims of abuse who have become difficult community members:

[They have come to my and] my partner's house [which they have] destroyed a couple of times.... If they're using [drugs or alcohol] we tell them to go away and come back when they're sober or straight. They don't really come for help, they come for money, they wheel and deal and scam, and they're good at it...they can talk psychology...typical sexual abuse ...deathly afraid to put [their] heart[s] into [therapy] ...afraid [they'll] explode. Fairly pervasive sexual abuse is common. It's not all out [in the open]. They have anger, it's everybody's fault but their own. They're trying to crawl out of a rut but keep sinking back in.

In the following, the men elaborated on the drug and alcohol abuse difficulties Bev described. They explain why they have difficulty "crawling out of the rut" that she alluded to.

**9.7 Self-Abuse**

**9.7.1 Drug and Alcohol Abuse**

The majority of the men admitted that they misused alcohol and drugs. Sub-themes related to this major theme were that they were repeating parental addictive behaviour, that they were using addictions as a form of coping
strategy, their inability to overcome addictive behaviours, their addictions and relationship difficulties, their attempts at keeping addictions a secret, and the community's problems with "legal" drugs. Three of the participants had chronic, ongoing problems with drug and alcohol use. The fourth still used both substances but that he felt he had some control over. Below, it is seen that these men explained that their drug and alcohol use was learned from parental behaviour. They felt it was a coping strategy which they were unable to stop.

9.7.2 Repeating Parental Behaviour

George said that he had become an abuser of substances "just like [my mother]". His poor feelings about himself in regard to his addictions had precipitated a suicide attempt. After briefly quitting, he had recommenced drinking, and he said this was because he was emotionally unable to continue with what he had learned in treatment:

I didn't take that stuff forward to deal with things, take that risk, follow through with things, you know, get things done. Because I was afraid. And its like that to this day ... [Now, because of resuming drinking] I'm back emotionally to where I was. It's like I always tell myself, 'You can never ever have a life, so why deal with it?' I convince myself to do a lot of things.

Chris said that he began to use drugs and alcohol at a very young age "My drug problem and drinking problem started at an early age too. Grade six. My older brother was a dealer...". These problems, that started in his adolescence, followed him into adulthood:

I've been busted for marijuana and cocaine. But I don't do cocaine no more, I don't do any chemicals. I just drink every now and then, um, I don't party all the time. I drink yeah, I usually drink once a weekend but it's never, ever nothing....
Mike felt that it was his family's alcoholism that "stunted his growth" emotionally. He presented his comments about this in an intellectualizing fashion, mirroring the deadened emotions he described feeling:

Inside of me, emotionally, there's stunted growth. Due to my family's alcoholism. That's caused from trauma and people that are parents that are alcoholics. They are so predisposed to alcoholism that they are unable to give their children the required nurture that they need to grow. So, because of the lack, because of the predisposition of alcoholism, you are unable to give the required nurturing to their child and because of this, you have what is called uh, stunted growth emotionally.

9.7.3 Using Substances or Alcohol to Cope

George explained how he coped with negative feelings that he had not fully worked through during his treatment:

I coped with those things through drinking and using drugs and um, totally getting bombed, you know, closing up, not talking much and really, I don't know how you say [sigh], closed.

Chris continued to use marijuana to alleviate feelings of stress. "[I use] when under pressure, work, family, money. The joint takes everything away. I guess it just masks everything".

Wayne followed the pattern of his parents and his grandfather in becoming alcoholic. He said: "It takes away the pain, until the next day. Then I wake up and I start thinking about my family [deaths, dissension] again".

9.7.4 Being Unable to Maintain Sobriety

After receiving treatment in a drug and alcohol program and being encouraged to address some of his feelings, George was still unable to maintain sobriety for any sustained period of time:

Although I stayed sober for six and a half months...
I started drinking again not too long ago. 'Cause I didn't take that stuff [the knowledge from treatment] forward to deal with things.... I'm back to where I was before I crashed and burned. Before I went to treatment.

Wayne's speech was slurred during our interview and he appeared to be under the influence of either drugs or alcohol. He said that he was on "pain-killers for injuries" that stemmed from the suicide attempt he made two years earlier.

9.7.5 Alcohol and Substance Abuse and Relationship Breakdown

Chris said that drinking and substance abuse occupied much of his time in early adulthood. In his mid-thirties he was still drinking. He commented on his nomadic lifestyle following his teenage years:

I was heavily into drugs and the party scene when I was younger. I lived in every major city in Canada over [a period of] six to eight years. And that was one of the reasons why my relationship [with a partner] out there [in B.C.] didn't last. [I came back to the reserve from B.C. on a holiday] and I got a job here and I just ended up staying here.

Chris knew that it was his drinking behaviour that caused difficulties in his first marriage. It became a problem again in his second marriage:

I have a tendency to fall back on my old ways. I'm kind of an outgoing person, I know a lot of people, I have a lot of friends. Uh, I like to go out and have a good party now and then. Because of that, there are times when I um, not necessarily take off but I'll stop off after work for a few drinks and I'll end up staying out all night or whatever, not all night but coming in at two or three in the morning and stuff like that doesn't please my wife. [Laughs] But, I don't blame her though.
9.7.6 Hiding Addictions

Chris believed that he was hiding his drug and alcohol use from his family. Quitting was a problem for him because he felt he needed drugs to relax:

I do drink, I still do drugs, but my drug habit has, I'm not trying to make it sound like it's lesser but I don't have any uh, I don't bring booze or my drug habit into the home and it's not visible by my kids or my wife. Uh, I do like to smoke a joint every now and then, usually when I'm drinking and if I do smoke a joint at home, I will smoke it late at night after my wife and kids are in bed and I wanna relax or something. I'm one of those people who'll say, "a joint will relax me".

9.7.7 Problems in the Community with Prescribed Drugs

Michael, who was not involved in drug or alcohol abuse, offered his observations concerning some of the community members who were not using alcohol or illegal drugs but who had channelled their addictions instead to the habitual use of prescription drugs:

I see so many people just walking around in a daze and I just know that they're not stoned on marijuana. They're all pilled up.... I never experimented with that, thank God. My sister's pretty bad for that. Like I see it personally in her. She denies it all the time but I can tell.... I think emotion triggers it, in her case anyway. Maybe it's just an economic thing. It's cheaper than buying booze. Easier to find, access [than illegal drugs]. Probably if I left here right no in a half an hour I could go get what I want, what I need [on the reserve]. Whereas I'd probably have a harder time finding grass [marijuana] or something...buy them off [each other].

Michael believed that access to "illegal" drugs was not the real community problem regarding addictions:

I do know people who are on, who are not on, while they're drugs I guess, but they're on prescription drugs. Seems like that's the most popular thing nowadays. Easy to get.
Everybody's got them to sell. Seems to be a doctor or two that people go to town to see that'll just write you a prescription like that. They [the doctors] shouldn't be. There should be some kind of mechanism to look into the proliferation of all these prescriptions. There's one doctor, Doctor X we'll say, you and just go see him and tell him what you got and get what you like.

Michael commented: "It seems to be more the women from what I've seen. Tylenol 3 painkillers, stuff like that". Michael added that "mostly they're addressing the illegal drugs [in treatment] not the prescription drugs".

Chris believed that drugs served to "relax" him and perhaps it is the relief from stress that drug or alcohol temporarily provides that perpetuates their misuse. Next, the men elaborate on their feelings of stress that they believed were related to their emotions. However, they also refer to other unpleasant subjective experiences.

9.8 Feelings of Distress

A major theme was that almost all of the participants mentioned that they had experienced at least one emotion accompanying their psychological discomfort. Sub-themes related to this theme were being angry about the parenting they had received (displacing anger and needing to work off anger); feeling anger about aspects of their childhood; and feeling anger from having suffered from abuse during their childhood.

Another sub-theme related to the main theme of subjective feelings of distress was that of sleep problems. Participants commented on their fear of sleep, on using sleep to escape emotional problems, on disturbed sleep and frequent awakening, and on the need to self-medicate to get to sleep. Another sub-theme was that of isolation which produced loneliness which allowed participants to avoid feeling emotions. Isolation occurred because of the distrust of others or of being unable to feel emotions. Still, another sub-theme
was that of feeling anxiety and other related sub-themes were feelings of hopelessness, experiencing tearfulness, and having to tolerate physically distressful reactions. Eating problems was also mentioned.

9.8.1 Feelings of Anger

Four participants elaborated on their experiences with anger.

9.8.1(i) Anger about Parenting

George mentioned how angry he was towards his mother for abandoning him:

[I just stopped crying you know]. And my feelings toward my mother, I just started to hate her, and to this day I don't even talk to her. I haven't talked to her in so many years. I lived with a [non sexually abusive] foster family since I was seven until now. They can't fill the emotional need, the nurturing.... Love is a very scary word for me.

9.8.1 (ii) Anger Originating in Childhood

George believed that his problems with anger began when he was in elementary school, "I remember when I was in grade school I was a very angry person. I would always fight but after awhile, I stopped".

9.8.1 (iii) Anger and Sexual Abuse

Mike did not talk about his feelings of anger but they were evident by the detached manner and the tone of speech he assumed when he discussed his own and the reserve's issues. He commented: "No one's [stopping abuse on the reserve] and that's all this anger [that is] coming out".

9.8.1 (iv) Anger and Alcohol Use

George explained how his anger erupts when he drinks alcohol:

... there is a lot of anger in me and I don't know how [to express my feelings in further counselling]. I check that anger when I'm straight. But when I'm
drunk it's just [snaps his fingers] like that, you know. I'll feel when I'm drunk, I don't know why? I don't know if I really feel or if it's just the booze, you know. Like I want to stop drinking but I don't know how and I don't, maybe I don't really want to right now.

Mike said that his anger "hurts [him]" and that when he feels angry he goes "drinking [I] go after the people that didn't save my family." He admitted that he "picks fights" when he is drinking.

9.8.1 (v) Displacing Anger

After denying feeling angry at one point in our interview, Chris then described his feelings of anger after learning about his wife's history of sexual abuse. He could not accept his wife's ability to still care for her father who was her abuser. Chris said that he occasionally used his wife's sexual abuse experience against her in arguments between them. He was particularly incensed when she chose her father's birthday as their wedding day.

I feel a lot of hatred about [my wife's sexual abuse]. I hate her mother and father today for it.... All they wanted to know was "who knew?" It kind of hurts me. I don't know how to kind of think about it or all, but she really cares for her father? A lot of our fights are because of this situation. Our wedding day is her father's birthday. It seems like our anniversary is not our anniversary. It always reminds me of that [the sexual abuse]. It angers me, she didn't tell me about all this 'til after we married. I don't understand. I don't hate her for it, but I don't understand how she put our wedding day on his birthday? It's always in the back of my brain.

9.8.1 (vi) Coping with Angry Feelings

Wayne said that he needed to find ways to work off his anger:

[I work on] weights once in a while. To relieve the anger and the - but after that's done it comes right back again and all that emotional stuff.
9.8.2 Over-Sleeping and Sleep Problems

Four men said that they had difficulty sleeping. These participants mentioned a fear of going to sleep, using sleep as an escape, and being troubled by both frequent awakening and disturbed sleep. There was also mention made of utilizing self-medication strategies to deal with sleep problems.

9.8.2(i) Fear of Sleep

George noted that he had difficulty sleeping because of his fearful thoughts.

Like, you know, there's times when I'm going through like these past few nights when I've had a very hard time to sleep because you know, I've been thinking that way. You know, I try to tell myself, you know, it's nothing. [I'm] not crazy, just being possessed or something. I don't know why it's like that?

George connected his sleep problems to his experiences of sexual abuse:

Find myself [when I wake up], I dunno just feel really shitty. I hate myself. Feel afraid. You know, I don't know, I've been thinking, you know, the abuse also happened while I was sleeping....

Mike said he had difficulty sleeping, falling asleep, and staying asleep. He said: "I'm trying to sleep during the day and stay awake during the night".

9.8.2 (ii) Sleep Used to Escape

George believed that he used sleep as an escape from feeling his emotions. His feelings were most problematic in the mornings, after awakening:

[I] feel my main coping skill is sleep where you don't have to feel nothing, I sleep. I recognize that from treatment. [If] I just [didn't] want to feel, I'd go to sleep. Like during the day that's when it's the worst, I feel really shitty and stuff. But at night, at night I feel OK you know, I feel right on. But when I wake up, I don't know
why that is, you know, I don't like that.

**9.8.2 (iii) Disturbed Sleep**

Wayne said that his sleep was disturbed by dreams about his dead family members:

I dream about them and everything, like crazy. They won't go away and it's driving me nuts. ... I start dreaming about my family. Nightmares and I wake up and I'm just pouring with sweat and everything. And then I go check the rooms out to see if they're still there and they're not. But they don't scare me.

**9.8.2 (iv) Frequent Awakening**

Chris said his sleep problems involved problems with frequent awakening:

If I go to bed early, I wake up in the middle of the night and I'm wide awake for the rest of the night. I don't usually go to bed until about two o'clock in the morning. And then again, I'm up at seven. So I get about five hours sleep I guess. [I awaken frequently during the night] yup, lots of times.

**9.8.2 (v) Self-Medication and Sleep**

Chris explained that he used marijuana as a form of self-medication:

Sometimes I think that's the reason [sleep problems] that I do it [smoking marijuana] is to get to bed [to fall asleep] 'cause sometimes I feel like it's a waste. I'll smoke one and I'll fall asleep twenty minutes later.

**9.8.3 Increased Social and Interpersonal Isolation**

Over half the men stated that they felt isolated. Unlike the women participants, who felt the desire to withdraw, these male participants did not choose to isolate themselves. Rather, they felt isolated and were unhappy about it.

**9.8.3 (i) Loneliness**

Mike believed his abuse experiences contributed to his feelings of isolation:
I was sexually, mentally, physically abused.... I feel different
You're not like everybody else. You're, there's no one like
you. You're alone. Nobody's there to help you. Nobody
understands you. Nobody can talk to you. Nobody can
reach you. And that unreachable is unresolved issues.

Mike said he had gone to a priest for support "a couple of years ago".
However, the priest that he "didn't want to deal with it [Mike's wanting to talk
about his abuse]". Mike commented that he would like, "someone to talk to
without feeling rejected, laughed at". He also said: "[I feel] aloneness.
Different. Somebody else. Different from everybody".

9.8.3 (ii) Isolating to Deal with Feelings

Phil also mentioned periods of feeling alone. He tried to manage his
painful emotions by going places by himself:

[I deal with painful feelings by] just go[ing] alone
somewhere. I go to a show by myself sometimes.
Just to get away, eh. Uh, or I watch TV by myself
but to show the emotion thing, I learned to cover
those up. Shouldn't of. But it was one of the ways of
me getting through the day to day stuff.

9.8.3 (iii) Isolation Created by Mistrust

Wayne said that he had not sought out counselling or someone to talk to
about his depression or difficulties. He was reluctant to confide in people:

I keep everything in here [points to his chest].
I don't like to get that close to anyone.

9.8.3 (iv) Isolation from Feelings

Chris believed that he was unable to feel his anger. He reacted emotionally
to the pain of others, especially that of children, but he was unable to "handle"
his own feelings:

Actually, I don't have an anger streak. I can't handle pain.
I can cry on a dime at any program on TV and stuff
like that. Like when I see a kid down the street crying or whatever, I want to get out of the car and go pick that kid up.

9.8.4 Feelings of Anxiety

Two participants reported that they felt fearful most of the time. Childhood experiences had taught George to live in a state of perpetual fearfulness in case external conditions triggered old memories. An earlier history of familial conflict had taught Wayne to live in dread of it leading to family tragedy. George noted that when he witnesses conflicts he becomes very nervous:

I get tense, I just walk away from it. I don't like it. Or, when even when two people are fighting and it's not even my problem, I get afraid and um, I tend to just walk away or go to a safe place and just sit there and relax.

George believed that his own thought processes caused him to feel fearful and that fear was triggered by external stimuli. He provided an example of the subjective terror he felt after he watched the movie *The Exorcist*:

I remember when I was a kid, when I was young, I always thought the devil was going to come and get me, you know? And, even when I was an adult, I always thought, it could happen to me!

Wayne said he lived in fearful expectation that deaths would occur even prior to the deaths of four of his family members:

I was afraid all the time that I was gonna lose someone in my family and wondering who it was going to be. I was like this since I was a little boy.

9.8.5 Individual Experiences with Distressing Feelings: Hopelessness, Tearfulness, Physical Reactions, Eating Problems

Two men described their struggles with emotion-related disturbances. George had problems with feelings of hopelessness and he also experienced
strange physical reactions. Chris mentioned weekly bouts of tearfulness and he also said that in his own estimation, he over-ate.

**9.8.5 (i) Feeling Hopeless About Achieving Sobriety**

George believed that he had little hope of being able to attain sobriety with treatment. He felt guilt about seeking further help and about possibly being labelled for "using the system":

I thought about it [returning for treatment] but what's the use, you know? It's like in that area I've convinced myself too, although like, I went to treatment, why do it again? What am I going to accomplish from it? I don't want to be one of those, like I read about, who use the system. Go in and out of treatment, they use the system, eh? Like I guess, they get a kick out of it. Nah, I'm not one of those kind of people, eh.

**9.8.5 (ii) Tearfulness**

Chris was the only participant who mentioned that he often felt tearful, which occurred particularly when he witnessed children in distress:

I probably get a tear in my eye maybe three or four times a week. Watching the news, it just totally pains me when I see kids in the news, it just, it's basically children that always seem to [make me] feel hurt [for them].

**9.8.5 (iii) Physical Distress**

George said he experienced the discomfort of severe bouts of physiological shaking. Chronic physiological hyperarousal to stimuli that was reminiscent of the trauma is a well-documented feature of the response to trauma. In traumatized people, visual and motoric reliving experiences, nightmares, flashbacks, and re-enactments are generally preceded by physiological arousal. Studies are exploring whether the activation of long-term memory tracts may explain why current stress is experienced as a return of the trauma
(van der Kolk, 1988). One participant in this study described his experiences with a form of these kinds of reactions.

George said his episodes of unpleasant physical shaking were noticeable to others. This reaction was most likely to occur when he either talked or thought about his experiences of sexual abuse:

Like I shake violently sometimes, I don't know I just shake. And some days I won't shake at all, I'm real relaxed. However, when I'm feeling things or remembering things, my hands will start to shake and stuff. And people ask me, "why do you shake so bad?" I say, "I don't know?"

George remembered that his shaking was most severe when he talked about the abuse during a group session in a treatment program:

I did a lot of that in treatment, like in treatment I'd bring issues and.... Like the first time in group there, I was talking with the group and telling them I was abused and stuff. I passed out, like uh, I shook so violently like after I was done talking and that. [George sighs]. I don't know, I just don't like to feel those things. I always wonder what it's like to be free or feel normal?

9.8.5 (iv) Overeating

Chris said that he tends to overeat to compensate for the scarcity of food when he was a child. His mother had been unable to earn enough income to feed her family.

I eat too much. I was always envious of the kids at school with the nice box lunches and the nice lunch bags. Uh, I know when I got on my own and was able to afford my own meals and that, I was always trying to have something different or exotic.

These men's descriptions reveal that they suffered from a variety of discomforting subjective experiences and they described these in relation to
their mood. For the most part, they also had a tendency to associate any current psychological problems with their experiences of anguish in childhood. Several men commented that they had difficulty talking about their feelings. Yet, that they felt strong emotions was evident from the content of their narratives. Generally, they seemed to say that their own reluctance to open up emotionally hindered their ability to explore their feelings.

9.9 The Inability to Address Psychological Issues

A major theme was that male participants mentioned that they were either reluctant or unable to address their feelings. Alexythymia, or the inability to feel, was a problem two men, Chris and Phil, mentioned. Two other male participants, George and Mike, said they attempted to distract themselves from any feelings that arose because they could not or did not know how to cope with them. This unexpressed emotion appeared to contribute to their inability to communicate and, hence, work through painful emotions.

Chris noted that he avoided having to address his feelings. He did this because he felt overwhelmed by his emotions:

> When me and my wife have bad times at home, I have a hard time dealing with it. She always says that I'm cold but I don't open up. But I find sometimes when I do open up and bring out the feelings or whatever all it causes is pain or hardship or whatever and I always think, "why bring it up, why deal with it because all it causes is heartache?” I'd sooner just hold it in or whatever, but [long pause]....

Phil did not think that he could acknowledge his feelings of despair when his wife was considering leaving him. He had learned to hide his emotions as a child:

> Just in the last few months I found out she [his wife] wanted me to be mad [about her leaving] but I couldn't
be mad, I was scared to be mad. But I think that goes back to my childhood, I hid my fears, I hid my emotions. It was like, I couldn't get mad, I didn't want to lose her, didn't want her to leave....

George said that he knew he needed to allow himself to feel emotions but he was unable to undertake this kind of exploration while in treatment:

I didn't allow myself to feel, while I was in treatment you know. Like uh, there's issues, you can talk about your issues but the important thing is to feel, to feel the feelings behind them, whether anger or uh, sadness or, whatever.

Mike vocalized his disinclination to speak about his emotions surrounding his depression: "I don't got no emotion. Talking to you, like, you want information. You're getting information".

Phil said that he was unable to disclose his feelings after his accident, particularly when he felt alone. Yet he admitted that there were a lot of feelings behind his silence:

I don't know. I think when I was young I learned to hide my feelings about a lot of things. And I never ever showed anybody my, even today, my wife - I don't show her how I feel or.... There was uh, plenty of feelings there I guess, sometimes.

Chris said that he was unable experience a validation of his feelings stemming from his mother's abuse of him. She refused to admit that she had physically abused him when he was young, and hence he could not resolve what had happened between them:

My mother denies it. I felt terrible [about her denial]. Me and my mother don't get along at all [now]. When I look back on it, I don't blame my dad for leaving.

These men's stories revealed that they were living in a state of unexpressed emotion, yet the depth of the turmoil walled behind their almost stoic
avoidance of their feelings echoed through these revelations. The content of their stories weighted heavily on me emotionally, and as an interviewer an inner sense of poignant grief for each man was stirred within me.

The relentlessness of the stressors they encountered both in childhood and in adulthood seemed bizarre in nature. Below, the men enlarge on their experiences as victims of childhood sexual, experiences that contributed further to understanding the overwhelming and aberrant nature of the stressors the men had been exposed to in their lives.
Section Two

Sources of Depressive Experiences

10.1 The Experience of Sexual Abuse

A major theme, common to half of this group of men was that of sexual abuses in their childhood. Sub-themes related to this main theme were recalling the experiences of their childhood abuse, being unable to feel better years after the experience, having to develop psychological escape strategies while being victimized, and experiencing post-abuse memory difficulties.

A related sub-theme was experiencing the subjective distress of both fearfulness and anger. Also emerging as sub-themes were: feeling unable to address the psychological issues surrounding sexual abuse because of denial, the inability to feel emotions, and sensations of being traumatized. The inability to address the trauma while in treatment was a sub-theme. Another sub-theme was the opinion that the silence surrounding the issues of sexual abuse was a community-wide problem.

From their stories, George and Mike appeared to be extremely traumatized by what had happened to them. Chris was unable to address his feelings that surrounded his sexual abuse.

10.1.1 Childhood Sexual Abuse Victimization

George was sexually abused as a child while living in foster care. He had been placed in several non-Native homes in the city close to the reserve:

And when I was taken away [from my mother], I went to different foster homes. Must of been about four and a half when I was taken away the first time.... to live with a family in town.... I don't remember much, maybe I just blocked it out.... And I moved to a family in town.... And I moved to a family out
here and I guess that's where you could say the abuse happened. Although, I must have been abused before because I talked about it in treatment. I must've been abused for about three years of my life. Little kid, you know. And I have a real problem with that today. 'Cause inside, inside I feel fucked, man! My emotions are fucked up. I don't know how to feel. Um.

George suffered two incidents of sexual abuse while living in non-Native foster care. He also experienced incest in his own Native family:

A man [abused me]. Yeah, [they then changed my foster home] and it happened again. Well, first off, I was abused when I was living with my mother by a uh, I don't know, I guess I denied the abuse ever happened up until a few months ago. My sister, one of my biological sisters, I was abused by her and after than it happened by two males [in foster care].

Mike talked about the shame he felt from being sexually abused at four years of age:

Well, when I was four years old, that's what I got [sexual abuse]. And I developed toxic shame. Uncles [were the abusers]. It's all over here [the reserve man!]

10.1.2 The Inability to Feel Better

George expressed his ambivalence about getting "better". His use of this word illustrated that he felt he had been made emotionally ill from his sexual abuse. He said that he believed he was emotionally unable to recover from the abuse:

There's two parts to me. There's the person inside the child that wants to get better. However, there's another part that's not allowing it, you know. There's a part that wants to be free. However, that's just not happening yet.
10.1.3 Avoidance Strategies in Victimization

George recollected that as a child he could only resort to the use of fantasy to avoid the misery of reality:

I remember when I was a kid, I used to pretend that I was a robot so that I didn't have to feel. Take on different characteristics like to take on many different forms to deal with those issues [sexual abuse] or whatever.

10.1.4 Memory Blocks

George's memory blocks served to obliterate his awareness of the actual abuse experiences. At the times of the abuse, he would mercifully suffer black-outs.

I remember that most times when I was afraid, I'd just black out. I'd wake up later you know, and it's uh, I don't remember what happened, nothing, you know. I know I was abused, I remember at times being abused, but uh, there's times the abuse wouldn't be there.

Chris said that he was unable to feel the impact of his own experience of sexual abuse. However, later in the interview he mentioned his wife's experience of sexual abuse and he felt intense emotions about this:

I had one incident [of sexual abuse] when I was a child. One of my uncles had a [teenage] foster child and I had a fondling. He tried to fondle me or whatever [long pause]. I remember being scared and I ran home. I remember running into a room but I don't ever remember telling anybody about it or anything like that. It just never dawned on me 'til years later, I remembered it. [silence]

Mike said that he seemed to be able to detach himself from his feelings. When the feelings emerged in adolescence, he experienced a "deadening" of them afterwards.

My mind was strong enough to bury it [the memories]. [In] puberty it came back. The feelings of it. Not the
memory.... No, I can't [remember]. It's like looking at it from a camera. I'm sitting back watching it. I become cold and uh, no. They're [feelings] deadened. They're just, it would take something, a hell of a lot to hit it, crack it and hope that it's busted open [the feelings].

10.2 Distressful Reactions Arising from Untreated Sexual Abuse

A minor theme was that the participants believed they experienced at least one emotional consequence associated with their victimization. A sub-theme related to this theme was experiencing ongoing feelings of both fearfulness and anger. George described his fear and Chris discussed his anger. The third sexual abuse victim, Mike, communicated his anger through his hardened manner. He demonstrated this emotion through behaviour that led to criminal convictions.

10.2.1 Fearful Recollections

Although George could not always address his feelings regarding his sexual abuse, he did vividly remember certain traumatic experiences. George said that what he remembered concerned his experiences of sexual abuse and incest. He disclosed a particularly disconcerting episode of depersonalization that occurred in his childhood:

I remember, I'm gonna tell you something, I don't know if it's right, I've told a few people. I remember when I was living with my mom when I was a little kid, we were sleeping with her and my sister was on the other side of her, you know. I remember I went to sleep [clears his throat], just a little kid. I don't know if this is a dream or what, however, I could see myself, I was on this side and my sister was on the other side and I was wetting my pants, and I was a little kid but I was on the ceiling. I don't know if this was a dream or what.
10.2.2 Feelings of Anger

Chris had not felt angry about his own experience of sexual abuse until he learned about his wife's abuse. He directed his anger towards both his in-laws and his wife. His anger persisted and affected his marriage. Chris could recount what had occurred in his wife's experience with great detail:

I couldn't look at them [when his wife was confronting her father who was her sexual abuser] so I basically stared at the TV and her mother, my father-in-law sat across from me on the couch and my mother-in-law was crying and asking my wife about it all and what angers me today about it all is she [my mother-in-law] asked my wife if her father had penetrated her and my wife [pause], he [my father-in-law] looked at my wife and shook his head for her to say "no". And she [my wife] said "no". On top of that, my wife tells me that on one incident her mother walked in on her with her father on top of her and her mother didn't do nothing about it.

Chris's wife's story provided an example of the secretiveness surrounding the issue of sexual abuse on the reserve. As can be seen in Chris's case, this secretiveness perpetuated emotional problems, even within his marriage. This secretiveness and the problems surrounding it are further commented on below.

10.3 The Inability to Address Psychological Issues

A major theme was the secrecy surrounding sexual abuse issues both on the reserve and in available local helping systems was described. Two-thirds of the male participants who had been sexually abused felt that this encouraged ongoing psychological difficulties. Related sub-themes that emerged were: encountering the denial by other people that there had been abuse; being in denial about the abuse; feeling traumatized by the abuse experience; finding treatment helpful in that it facilitated talking about the
abuse; and worrying that the secrecy surrounding the subject might soon be broken causing community-wide emotional difficulties.

10.3.1 Denial of Sexual Abuse

George said that he could not address his abuse issues when he was a child and he still had difficulties dealing with them as an adult. He said that when he was a child he told his social workers about the abuse but they did not want to "believe" him and chose to ignore what he confided to them:

They [Children's Aid] tried to send me to counselling but I wouldn't tell them nothing, you know. Like it was brought out into the open when I was about fifteen or sixteen. Like when C.A.S. got involved. But they never did nothing, nobody wanted to believe me. And so, I said "fuck it".

10.3.2 The Inability to Feel

Chris said that he felt an absence of feelings surrounding his sexual abuse that occurred when he was young. He reported that he had been sexually fondled by an uncle's teen-age foster child. "I remember being scared. It never dawned on me 'til years later, I remembered it. [Long pause]". Chris said he felt his experience of sexual abuse had not affected him emotionally but intellectually he realized it was important:

Ahh, I feel a little embarrassed by it. Ah, I feel it didn't go far, just a little bit of fondling and in one breath, I wanna basically say, "it was nothing". But, ah, I do realize it was something but I don't feel, ah, affected by it. I don't, don't think it affected me in any way. I don't, I don't, I guess I don't feel it affected me.

10.3.3 Unhealed Trauma

Mike said: "I was sexually, mentally, physically abused." In a flat monotone, he also said that his brothers and sisters went through the same experiences. He felt his current problems were from "trauma that's not dealt
with". Mike thought the whole reserve was "toxic". He came to this conclusion because his "entire family" had experienced some form of abuse.

10.3.4 Addressing the Sexual Abuse in Treatment

George described how treatment had taught him that he needed to talk about his sexual abuse experiences. He said that he felt he had minimized the impact of the abuse and that doing so had worked against him. He sounded almost self-blaming about his inability to open up, even though he knew that his only recourse had been to "suppress" these issues for many years:

Uh, childhood issues. Like I was in treatment not too long ago, last January I think, last November. I was in there 'til January and I, uh, discovered lots of things about myself in there, eh. Uh, childhood issues that uh, I haven't talked about or suppressed for so many years and um,... Just didn't want to deal with anything. Just didn't like it. But, when I was in treatment I had to face those things in order to get better. But, however, I minimized my issues. I didn't explore the whole aspect of it. I just. I just minimized those issues. I didn't really like talking about them because I....

From these interviews, it was learned that abuse, whether sexual or physical, was a major contributer to feelings of psychological unwellness in adulthood. One participant noted that he was aware that the silence practised by members of the reserve around abuse issues would soon be shattered.

10.4 Silence - Untreated Sexual Abuse Issues: A Community Problem

10.4.1 Beginning to Address the Sexual Abuse Issues in the Community

Dan, a local Native O.P.P. officer and participant-commentator stated that he believed approximately "forty per cent" of the members of the reserve were depressed and that "a small, small percentage are trying or say they're trying suicide". He noted that people were now opening up about their sexual
abuse experiences because they had been "holding in so long and [they're] getting angry instead of embarrassed or [of] feeling it was their fault".

Dan discussed local aspects of the issue of sexual abuse: "I think it's coming more [the eventuality of having to deal with sexually abused victims at a local level]. So far, it hasn't been the biggest problem out here, but I can see it coming. Because people are talking, through the grapevine, I've been hearing it. People haven't actually come forward to the police yet. They talk about things that have happened a long, long time ago. [Pause]. It's going to be hard to deal with it". Dan explained why addressing these problems on the reserve will be difficult, "So many of us are related to each other or are friends...." When asked why sexual abuse was being talked about more on the reserve, Dan said: "I'm not sure. Holding it in so long and ... feeling it was their fault". However, "seeing it [sexual abuse being discussed] on TV" was encouraging people to open up.

Abuse issues being brought out in the open might increase psychological distress and manifest itself, for example in increased suicide rates. As seen below, male participants were already quite vulnerable to being at risk for suicide.
Section Three

11.1 Suicidal Thoughts and Intentions

A major theme was that more than half of the male participants said they had considered or attempted suicide at some point in their adult lives. Sub-themes emerging from this major theme were: suicidal ideas from feelings of stress resulting from family breakdown; viewing death as an escape from family conflict; having suicidal ideas while feeling grief; feeling suicidal when using alcohol; and thinking persistently about suicidal.

11.1.1 Family Breakdown and Suicidal Thoughts

Chris said that he had contemplated suicide as a child after his parents separated. At the time, he felt hopeless about there being anything left in his life:

When my parents, when they first [separated], I guess I must've been in my early teens. I just felt there was nothing, you know.

Strain in Chris's marriage had caused him to consider suicide again. He felt that his wife would be better off without him:

And uh, a couple of years ago, me and my wife were going through a lot of problems or whatever, and uh, I knew I was the cause of the problems and uh, I felt that, uh maybe if I wasn't around, she would have it easier or stuff like that. For a little bit of time, I did go though those feelings and stages.

He stated that he had never discussed his suicidal thoughts with his wife. However, he noted: "I've contemplated counselling a lot. I guess just to see if I was normal". Here, Chris seemed to be saying that he wanted to discover if his feelings were valid in relationship to what he had gone through.

11.1.2 Death as an Escape from Family Conflict

Wayne said he felt death would mean "freedom from this miserable life".
With regards the loss of his family his thoughts were as follows:

Everybody drinks, argues, fights. Seems that nobody cares no more. Nobody helps each other out. Nobody wants to give a helping hand. I try to get that now from here right now, I got no food at my place.

Wayne said that his father demonstrated affection "only when he's drinking. When he's sober we don't even talk". Wayne did admit receiving support from his deceased mother's grandmother that was "pretty helpful" to him except that "she always says she's too busy" to talk to him. He explained why he felt suicidal at the time of our interview: "ah, a lot of arguing in the house and everything about family and debts and uh [sighs], just everything". He said, the "whole family" argues.

Wayne described the wounds he had inflicted on himself:

I got two knife marks right there, want to see them?
I got two knife wounds stuck in my chest. I did it.
I walked into the bush and I just woke up all full of blood.
Went home and washed up. Put some peroxide on it.
Put some band-aids on it and that's it. They said, "What happened?" and I said, "I fell down".

11.1.3 Suicide as a Grief Reaction to Suicides in the Family

Mike spoke about several suicides and deaths that had occurred in his family. "Two sisters. Two brothers. Two younger. Two older. Oldest and youngest passed away. Both suicides. One shot himself and one hung himself. My little brother [shot himself]. My older sister hung herself. Five and four years ago". Mike said he too had attempted suicide: "I attempted it. Three times".

Wayne said he felt "sad" that he survived his suicide attempt because he "wanted to join the rest of [his] family [who had died]". His hope came from his belief that he would go to "heaven" when he died:
I learned that from losing my brother and sister and my mom and my grandfather. I lost them all in two years. Four, I don't know. [I was] very close to my grandfather. He brought me up since I was ten years old. He was my dad's father. [I was] very close to my mother.

Wayne mentioned the persistence of his depression from experiencing so many deaths in his family:

Ahh, it's hard to talk about this part. Ok, I had one [long pause], I had six [brothers and sisters] and uh, two passed away. My sister died first in 1988, she was twenty-five, she hung herself. She was drinking and stuff. My brother died in 1990, he was twenty years old. Shot himself. Tell you the truth it still hurts. It's been awhile but it won't go away.

Wayne commented on his awareness of the permanence of his family losses and the longing within him that this was not so:

I feel he [God] loves me but he has taken my family away from me...not a chance for us to get together and love each other, to hold each other, to make peace, to have good family life.

11.1.4 Suicide Attempts and Alcohol Use

Participants who were prone to alcohol or drug abuse were most at risk of making suicide attempts. George stated: "like I tried to kill myself once". He disclosed the details of his suicide attempt at the time that he was abusing alcohol:

And uh, I remember ah, hanging there. Although I wanted to die, I probably didn't. I remember I kicked the chair over and I was hanging there and uh, you know, all the body fluids let go and uh, I was wet and stuff. Something, I remember, I couldn't feel my hands. I couldn't feel nothing from my neck down. But something
was there to help me get down. Something made my arms get the strength to pull me back up. The chair came back up. I don't know how I got the chair back up as I couldn't move my legs. Call it higher power if you will. God, whatever was there or something. I fell down, I was shaking. I remember my brother came in, goes "oh shit, what's wrong with you man!".... I remember I passed out somewhere, I fell asleep and I remember I woke up and they took me to detox.

Chris too thought about suicide when he was using alcohol and substances regularly. It was at a time when he felt he had "nothing" in his life:

I was living on my own out West. Uh, I just felt like I had nothing at the time. and uh, didn't feel like I was going anywhere and I thought about it. I don't think seriously though about it, but it did pass my mind.

Wayne had a long-standing substance abuse problem and in fact was under the influence of medication at the time of interviewing. He had a poorly healed foot, the result of a suicide attempt, and the pain bothered him during the interview. Suicide was a way out of not being able to "take it anymore":

I fell off Mt. McKay in 1993. Well actually, I tried to kill myself. Jumped. Couldn't take it anymore. Both my legs were all smashed. I was in hospital for two months. Took me over a year to walk, just to be able to walk on them. I was even asking somebody here to bring me a gun so I could kill myself.

After our interview, I referred Wayne to the local helpers to be seen at hospital for suicide risk. Wayne was immediately sent back to the reserve by the hospital. Local helpers again sent him to the hospital but he released himself the next day and refused to return.

11.1.5 Persistent Suicidal Thoughts

Participants said that they had ideas about committing suicide before making an attempt. George said that he had contemplated suicide long before
he tried to kill himself. He felt it would be a way to stop "worrying" and to stop others from worrying about him.

For years, like for years before I did that [the attempt]
I always thought about it eh, dying and all that. I guess
I had an abnormal fascination with it, just to die. Not
to live anymore. So nobody would have to worry about me
anymore, I wouldn't have to worry about anything. Really,
really uh, selfish on my part.

George revealed that his suicidal thoughts persisted even when he was sober. It bothered him that he continued to think about suicide even after an uncompleted suicide attempt:

To be very honest, I think about it. Even though I've done
it. Think about it still. But I know, I am, I am too afraid
to do it again because I know what happened the last time.
But why do I think about it?

Wayne said that he was sure he would try to commit suicide again. He had last thought about it two days before our interview. He described his suicidal feelings, at the time of our interview: "To tell you the truth, I don't feel anything. I just feel like giving up". Wayne said that he had been feeling this way over "the past week". Queries revealed that he had a plan, and he described it as "probably very simple"; "I've tried a couple of times
[recently]". He tried to cut himself with "a broken TV" but was saved when a car stopped. I was bleeding on the road like crazy and they drove me right in
to the hospital [in the city]". Wayne said that he did not receive counselling.
"They [the doctors] just let me go. The stitched me up and let me go."

The narratives of these men described what for each of them both preceded and was related to their suicidal thoughts or actions. Their stories revealed that the psychosocial stressors of losses contributed to their psychological distress. Several men indicated that they viewed suicide as an option for
escaping from troubling emotions. For those who were emotionally vulnerable, alcohol or substance abuse was especially dangerous because, as these men said, this behaviour worked to disinhibit any pre-existing suicidal ideas about suicide.

In the narratives discussed below, the men mention additional stressors they faced. One of these was being put in the position of having to help others, which was a role they did not want to assume. The emotional fragility of other reserve members who placed expectations of care-giving on the men was a heavy burden.
Section Four

12.1 Ways of Coping

12.1.1 Reluctance to Become Helpers

A major theme was that several men felt they had been forced into roles as helpers. Sub-themes emerging from this were: feeling burdened by family caretaking responsibilities; feeling forced into community caretaking responsibilities; and feeling that the community was unwilling to support responsible caretaking activities.

12.1.2 Family Care-taking Responsibilities

Chris was appointed the family helper. He did not choose this role and in his circumstances, it was an extremely stressful one for him. As a small child, he had dreaded having to take care of his grieving mother:

> when my sister died [when I was eight years old] my mom went through a really emotional crisis or whatever and she was seeing my sister at night in the bedroom [in visions] and stuff like that. And uh, for about a year I was the one, the only one in our family that was able to soothe my mother and get her to sleep. And it got to the point whenever she’d, we hear her in the bedroom talking to my sister, and it got to the point where my brother’s would force me into the bedroom to help her go to bed.

Chris said he realized how much stress he carried from this childhood caretaker role later in his life:

> That stuff never really dawned on me ’til later on in life that I remembered those kinda things and I started having situations that I to deal with stress and emotional problems, or whatever, and then I started thinking back and wondering about those times [of family caretaking and mother’s trauma].
12.1.3 Community Care-taking

Dan, a local Native police officer and participant-commentator who was married said that he was often thrust into a helper role to mediate between members of the reserve. This was a responsibility he did not feel trained to perform:

[I have to deal with] things that are not my responsibility.... Oh, so much political disputes, boundary disputes ... things that the police have no control over. The police do not like violence being forced on them.

Dan explained that being forced to intervene in family conflicts on the reserve caused him stress. He always felt "on-duty" with no time for himself:

People coming to my house, it [time] doesn't matter, At all hours of the night they come complaining about this or that or phone all hours of the night. I'm not even working! I've had complaints when I've been sitting out in the back have a barbecue with some friends and we're having a few beer and some kid will come over and say, "my Dad's beating my mom up".

12.1.4 Responsible Community Care Rejected

One participant believed that the skills he felt he possessed for bettering his community were rejected. Michael wanted to help by using his background as an engineer and land manager to improve his own and his community's life. However, he felt that the reserve's inertia in providing a secure income would cause him to seek work elsewhere.

12.2 Ways of Healing

12.2.1 Family Reconciliation

A minor theme was that, emotionally, the men were preoccupied with trying to heal inter-family conflicts. Sub-themes related to this theme were: reconciling with parents; attempting to successfully parent; and trying to work on marital relationships. One man was enjoying a new-found relationship with
his father. Two married participants discussed having explored how their own childhood family life experiences had negatively impacted on their psychological well-being. From this, exploration they were able to examine these family issues and had decided to make changes. They mentioned the importance of the stability they felt in their marriages, which may have contributed a sense of hope about being able to better their family lives.

**12.2.2 Reconciling Parental Relationships**

Chris began communicating with his father to learn more about his father's experiences that had contributed to Chris's childhood distress. Chris talked about the benefit to himself of reconciling his hatred towards his father for being an alcoholic and for abandoning the family. He found that his father's ability to "listen" to his feelings promoted the healing that occurred in their relationship:

> My dad's five years sober and uh, I've been able to bring up every issue in my whole life with my father and I've always wanted to ask and talk about and do this. And he's been honest enough and open enough to listen to my feelings and give me feedback on how he felt and uh, what he went through. So I feel really good with my father now, I feel like I've got a good rapport with him and uh, I feel closer to him than I ever was.

**12.2.3 Changing Parenting Approaches**

Chris said that he and his friends often discussed how to be better parents. They did not want their children to experience the kind of childhood stress they themselves had had "to deal with":

> I call me and my friends, guys my age that got married, the nineties parents. 'Cause we all talk about things and that and we all say to each other, even to our spouses that we don't ever want our kids to grow
up in the same situations that we grew up in. And I try everything in my power to not have my kids see what I saw growing up and deal with any of the things that I had to deal with growing up.

12.2.4 Working on Marital Relationships

Stability in his marriage was important to Phil, who had lost a sense of family life as a child through both parental abandonment and his grandparents' deaths. He was willing to effect personal change in an effort to avoid losing his sense of family again. He said that working with his wife on his ability to express his emotions and increasing his communications with her improved his marriage. However, the needs of his wife to share emotions still perplexed him:

But, you know, I kind of changed that. Since we started talking, talking more and more. But I still don't understand why she wants to go to these groups that she goes to...support groups or whatever. Like how the hell can you get in there and tell a bunch of people you know, your problems and uh, I don't know, to me I just can't sit down and do that in a group...soon as I'm gone they tell it to somebody else....

12.3 Rejecting Unhealthy Lifestyles

A minor theme was the male participants saying they were attempting to adopt practices for healthier lifestyles. Sub-themes related to this were: giving up drugs or alcohol; settling into marriage; and monitoring their use of drugs or alcohol. One man said he was working to change his drug and alcohol behaviour. He recognized that this would work in favour of improving his own life and the life of his family.

12.3.1 Dealing with Drug and Alcohol Misuse

Chris had reached a point as a young adult where he had become aware that his drug and alcohol abuse and the resulting lifestyle were harmful. His
desire to marry and settle down caused him to attempt to give up that way of living:

All my years in Vancouver and all the crazy things I did after ... I sat there on day and I just, I don't know why or how, or what kind of revelation I had or whatever, or whatever made me turn it around or whatever but uh, I just basically said to myself one day that I was sick of the life I had. I looked at my possessions I had at the time and all I had for all my years of working. I started working at the age of sixteen and I've always had a job, always worked and I traveled. I seen the city and basically all I had for all the travelling around, moving around and all I had to my name was basically a stereo. Anyways, I sat there and thought, "shoot, I have nothing!" And that's when I basically wanted to get out of Vancouver.

12.3.2 Settling into Marriage

Chris met a woman on the reserve who came from a very strict, disciplined background. He believed that the apparent stability in her family life would benefit him. Marital stability appealed to him:

And I was actually looking to settle down. And that's when I met my wife [on his return to the reserve]. She would be helping me [because of her conservative attitude and values].

12.3.3 Monitoring Drug and Alcohol Use

Chris felt that it was important to keep his family in the dark about his drinking (alcohol) and drug (marijuana) use. He particularly did not want them to be exposed to the arguing and dissension that had driven him to tie pillows around his head when he was a child:

if my kids. I do not get drunk, my kids have never seen me drunk. And one thing my wife and I do is never, ever fight when we're drunk. We always have a
good time. And we do keep our fighting, arguing and stuff like that [away from the kids]. We do keep it away from the kids.

12.4 Rediscovering or Rejecting Native Traditional Practices

A minor theme was the discussion of the issue of spirituality by participants. Sub-themes were: exploring lost cultural traditions; evaluating the loss to the community of Native elders; and rejecting Native spirituality as a personal need. Only two men offered their thoughts concerning spirituality. One felt the loss of Native spiritual practices. In contrast, the other viewed this loss to be irrelevant. The two men differed in their upbringing. The first, Phil, had spent his entire life living on the reserve, whereas Michael's mother had moved her children off the reserve. There were other differences between the two men. Phil had tragically lost parental figures in his childhood and had also suffered paralysis from a work accident. Suffering repeated losses appeared to stimulate more interest in existential matters. Michael had a strong mother and he had lived in a secure family life off the reserve. His life experiences had been less emotionally trying.

Phil talked at length about the lost role of community elders. He expressed the view that the parental and counsellor role that the elders could have provided was important. In his case, although he had known his grandfather for only a short time, he felt him.

12.4.1 Exploring Cultural Traditions

The role of elders as parental figures, teachers, and guides in Native culture is an important one. The important loss of these traditional symbols of security, especially for adults from deprived home-lives, was described by one participant. Phil talked bout his interest in Native cultural beliefs. He
believed that the loss of the Ojibwe language, that had usually been passed on by the elders in Native communities, was regrettable:

I believe in the Catholic Church but I'm also starting in traditional ways. I'm trying to keep them both. Because it almost seems that they have the same values but in different ways. I'd like to learn how to speak Ojibwe. The problem I see at all those Ojibwe classes there at the university anyways you got to learn to speak English first. And if you take somebody from the university and they want to teach you Ojibwe, I don't know, there's probably no result. When an Ojibwe person speaks Ojibwe it's nothing close to resembling English...people graduating speaking Ojibwe but it's the white man's version, it's something else they're stealing from you. It would be different if it was Ojibwe teaching Ojibwe.

12.4.2 The Lost Role of Elders

Phil said that elders from the reserve were not sought out to teach their Native language. He felt that the mutual disrespect on the part of both community members and elders had contributed to the loss of the input by the latter into community life. "Out here, the elders don't receive the respect that they should. And I also believe there're some elders out there that don't respect anybody either". According to Phil "To really call yourself an elder, [you must] practice what you preach". He believed that elders were needed in the community and that the negative consequences of acculturation the older generation had suffered had created the local situation of disrespect towards them:

We have some people in our community, I guess from the boarding school life that learned Ojibwe's a bad way or Native's a bad way but now that they're, we got talk of elders and respect for elders, like we're all taught to respect elders but in the Native it's
someone that's looked up to in the community. But I think that if you want that respect you should respect the person also. And we have people in our community that don't do that. But they want to be an elder.

Phil, who had lost his parents as a child, noted how an elder might have substituted as a parent for him:

I don't know what constitutes an elder but I think an elder to me is a person who can sit down and talk with you, you don't have to know all the answers, you don't have to know none of the answers but could sit there and listen and talk with you as a person and not talk down to you or try bull-shitting you. There's no formula that says an elder has to be a Ph.D. or a doctor or anything. It's just someone who you could look up to, who you can trust for advice and guidance. He can't tell you what to do but he could tell you how to do it or how to try to do it.

12.4.3 Rejecting Spiritual Practices as a Community Need

Another participant, Michael, commented on spiritual matters but he was not interested in practising any form of spirituality. In voicing his feelings, Michael said that he saw a benefit to religious practices for others in the community. However, he personally rejected both Catholicism and Native spiritual practices:

[Catholicism] seems like a joke to me. My mother use to go to church until I was probably eleven or twelve and then after that she said I could make my own decision and I did. My wife's Catholic and so she likes to go to church and she takes the kids there so.... It's a pretty good idea, it gives people hope when they think they're gonna die and that's it.... I have respect for them [the local priests]. I guess [Native spirituality] is back to the spiritualism thing, I don't know, whatever gets you through the night. It doesn't do anything for
me. I don't know if I have a lot of feelings about being Native. I guess I am, that's a fact I guess. I love all these people I see them as - we're one community here and I like to do the best for them I can but sweetgrass and all that, I don't know. I guess I don't understand it too much. Maybe that's it. But if it helps people you know and makes them more confident I think, "right on! Let's have another ceremony right now." No [I haven't seen it helping people]. It's a peculiar band 'cause we're not very traditional or Native. At least I ain't and I don't run into too many people who are. Maybe we should be more. We probably should be more.

Michael said "there's too much influence from across the river" for this reserve to have held on to its Native cultural practices. Through his own acculturation, he had lost access to his own elders and was uncomfortable with traditional ways:

As soon as you think of traditional knowledge, it's something that's passed down from your elders to you. Well my elder died when I was, or my grandfather died when I was ten and the other died when I was about twelve. And I was one of about one hundred grandchildren so nothing really ever got passed on to me. Plus I lived in town for most of my formative years, or whatever they say. I go to meetings and that and they have their prayers and that in Ojibwe and stuff like this and I really don't understand it. Maybe I should take some courses or talk to somebody about it, I don't know. I don't really feel any need for that. If it could help me in my job well then maybe.

Neither Phil nor Michael had drug or alcohol abuse problems. The men who did have problems and who were provided with treatment programs were also exposed to their own lost Native traditional practices in the process. The counselling offered to them was described as helpful. In more traditional
Native communities, counselling is offered by elders but their absence in this community was described as a void that needed to be filled.
Section Five

13.1 Experiences with Treatment Provided for Native People (Drug and Alcohol)

A minor theme was the discussion by participants of their feelings about treatment programs. Sub-themes related to this theme were: the experience of being assessed for depression; the benefits from treatment; and the limitations of available treatment. Two men had been referred to correctional institutions for their drug and alcohol problems and they felt they had benefited from the type of therapy offered to them. They were the only members of the group to have received treatment because they were exposed to it during their incarceration.

13.1.1 Assessment for Depression

George was the only participant who described having participated in psychometric testing. He was diagnosed as clinically depressed:

I had to do one of those um, it's called an...[MMPI], I had to do one of those in treatment, eh. She [the counsellor] said, um, I was very depressed and she read a lot of things.... She said, "You're normal, but you're [a] very depressed person and you got a lot of problems that you're going to have to deal with or they will make you go off in ways you don't wanna be".

13.1.2 The Benefits of Treatment

George felt that treatment provided him with both group therapy support and with a helper. He viewed this as having been beneficial:

However, when I found out [about my blocked memories of sexual abuse], when I was in treatment. People were there listening and they were trying to understand what I was going through. Like I had a great counsellor there. Like I'll never forget her, she was very uh, very comforting.
Mike said that his treatment in prison had taught him to cognitively reframe his understanding of his physical and sexual abuse:

People that have the strength can make it. Mine [my mind] takes the trauma and subconsciously buries it. Because the mind protects itself. By burying through the subconscious because the conscious mind at that age [four years old] hasn't the knowledge or understanding to deal with the traumas that has happened, so it automatically kicks in and buries the hurt and pain and that's it. And it comes out in the teenage years.

13.1.3 Limitations of Treatment

George mentioned that he had had apprehensions about the anti-depressant medication suggested to him in a follow-up program after his drug and alcohol treatment program ended. He had not received any psycho-education about the use of pharmacological interventions for depression:

Like uh, I remember when I got out of treatment [drug and drug and alcohol] and they wanted me to go into a family program and so on and made some arrangements. And uh, I remember the first day I got there the counsellor I had in treatment was doing the family program downstairs and she pulled me inside her office and wanted to have a chat with me and see how I was doing and stuff and she saw right away that I was very, um, depressed. And she recommended that I go on [laughs] anti-depressants and I didn't wanna because I had a hard time with pills, you know. I was a real pill-head, I did lots of valiums and painkillers and stuff. I just said I can't 'cause it's, my belief is that I can't do pills, you know? Because they're the things that really screwed me up.

He appears to have valued his treatment because of the counselling component. Unfortunately, access to this form of assistance was made available to the band members only through the criminal system. The loss of such local community supports as elders and the absence of other ways for
obtaining support deprived the men of the emotional and psychological resources needed to replace lost familial and community forms of assistance.

The men's stories resonated with their sense of the loneliness that they experienced in their attempts to manage stress and to pull their lives together in this reserve environment.
DISCUSSION

14.1 Knowledge Gleaned From a Local Contextual Approach

The purpose of this study's research approach was to explore, through qualitative analysis, the themes related to the meaning of illness surrounding depressive experiences of Native women and men participants in the context of their local reservation.

It is important to preface this chapter by addressing the comments put forth by Native writers and policy-makers. Some authors have referred to what has happened to Native people in North America as "cultural genocide" (Green, 1995; Morrisette, 1994). In keeping with this, Roland Chrisjohn and Sherri Young (1995) are critical of the "existing explanations" for the distress many Native people experience. They argue that existing explanations for distress only "blame the victim" and lead to findings that Native people suffer from personal adjustment problems or emotional deficiencies like "low self-esteem" and "depression". They believe that "None of the existing explanations have alleviated the situation [Native peoples experience] by acting or suggesting action against the forces of oppression [that created their present circumstances]; they don't even recognize them". These authors are scornful of the aims of government treatment programs and are critical of the "cost effectiveness [of treatment approaches] of the government's providing perfunctory, end-of-pipe social intervention programs instead of meeting their contractual treaty obligations". In fact, they say the government's intention of doing so "doesn't [even] surface as an issue".

It was not the aim of this study to further "victim-blame" Native people suffering from emotional distress. Rather, it was to illuminate better the consequences of the mistreatment of Native people over the past two hundred
years by the dominant society. This present research is for those readers who will not have access to the testimony delivered by Aboriginal Peoples and others to the Royal Commission. As Chrisjohn and Young (1995) state, the RCAP is an "immense and heterogeneous corpus of material" and "the testimony was 'not data' in a "social scientific investigation sense". The benefit of the testimonies, these authors say, was that "the hearing did allow information to be presented, and understanding can arise from its examination". These authors state that much can "be done from people simply being given the opportunity to tell their stories". This was the ultimate purpose of this research. Chrisjohn and Young (1995) object to "therapy, healing, and reconciliation as effective responses" to the problems Native people have experienced as a result of injustices done to them, such as occurred in "the Indian residential school system", which was "an attempt to obliterate First Nations". Regarding residential schools, Chrisjohn and Young (1995) comment: "That this [aim] was so is explicit in extant policy statements and other documents of the churches and the federal government...".

It is the wish of this author that the present research should not be used in the way that Chrisjohn and Young (1995) believe most social science research is. They say that to work ethically, psychologists must choose to become educated about a cultural group's history, culture, and economic situation:

In really productive times, useful new tools, like psychology come along to aid in the assault. The role of the psychologist, we suggest, is to put a human face on the barbarism of cultural genocide. If psychologists wish to change this, they must recognize (and admit to) their complicity in and regeneration of the genocidal program. They must go beyond their typically ahistorical and acultural strategies of "helping" individuals, and incorporate the cultural, historical and economic context in which First Nations peoples continue to struggle for survival.
With these sentiments in mind, this research was intended to provide a process whereby Native participants could tell their story regarding their emotional and psychological experiences. It is in agreement with the research purpose that Chrisjohn and Young (1995) support:

Whether narratives...personal recollections, stories told by one's parents or grandparents...they can contain material that will help us (individually or collectively) develop comprehensive understanding.... The format of these narratives is unimportant, except that it provide something that can be used by other.... Even if the task is solely to come to grips with one's personal experiences, the act of recording one's experience may itself be useful. Further, being able to draw upon someone else's journey...may help us clarify our experiences to ourselves (B21).

In the following discussion, "clarifications" by participants of their experiences with emotional problems are presented thematically.

Concerning my admiration for and overall favourable impression of the participants in this study, it is most important to note in the final analysis what is perhaps best expressed by Mail and Johnson (1993):

What gets little publicity is the incredible cultural survival and the strength of the people who have endured despite the battles, reservation incarceration and isolation, and discrimination, which have been so hard to bear. Two hundred years after the beginning of the conquest of the West and the treaty epoch, we still have some reasonably intact cultures and people who are proud of their heritage.

Gotowiec and Beiser (1993-4) further comment:

Canada's First Nations have experienced a long, damaging history of interaction with the dominant culture, and they have survived. This testifies to the strengths of these communities and cultures. If non-native researchers and service providers are to make any contribution ... this strength must be recognized.
Part One
The Women's Narratives

14.2 The Prevalence of Mood Problems

As in other current research findings (O'Nell, 1993; Ross and Davis, 1986; Manson, Shore, and Bloom, 1985; Shore, 1974; Walker, Lambert, Silk-Walker, and Kivlahan, 1993), this study's themes reveal that depressive-like feelings were prevalent among the Native people who participated in the research. For example, the majority of female participants felt that they had experienced episodes of depression in their lives. Similar to other research findings, this study found that difficult life experiences appear to be associated with a higher incidence and greater severity of mental disorders among Native Americans than in the population in general. Studies also find that depression seems to be the most common disorder suffered by both adult and children Native Americans and that it is frequently complicated by the use of alcohol and other drugs. Low self-esteem, substance abuse, and life frustrations contribute to a high incidence of violent behaviours, including physical and sexual abuse, spouse and elder abuse, assault, homicide, and suicide, in many Indian communities (Mental Health Programs Branch, Indian Health Service, U.S. Public Health Service).

14.3 Native Women and Childhood Distress

In this study, a major theme is that women determined that they understood the term "depression" to include experiences of being unhappy as children. Almost all of the women described being exposed to psychosocial stresses that occurred in their childhood. These stressors were discussed in relationship to personal feelings of emotional distress. In other words, the women expressed the feeling that there were causes associated with their mood problems. Similarly, Manson et al. (1985) found that symptoms of
illness among the Hopi interacted with presumed causes and social situations. Research has found that in some Native communities the impact of social circumstances on mood is related to their experience with depressive moods (Kleinman, 1977; Kleinman and Good, 1985; Kleinman, 1986).

14.3.1 The Social Problem of Poor Parental Caretaking

It is important to ascertain whether real social problems created the local experience of psychological distress as opposed to psychiatric or psychological disorders (Kleinman and Good, 1985). Childhood distress stemming from familial difficulties is a major theme and a relevant psychosocial issue that emerged from this study. Social factors the women described as having an impact on their moods when they were children were parental alcohol use, parental break-up, parental behaviours of verbal and physical abuse, parental neglect or absence, and experiences of familial sexual abuse.

14.3.2 Troubled Childhood Homelives

A major theme was that, overwhelmingly, the women described experiencing troubled home lives in which their relationships with their parents were strained. One woman became hypervigilant and watchful because of her parents' alcoholism. Feeling it safest to hide her own emotions she therefore never learned to process her feelings. Her need for control developed as a survival strategy to counteract fears that arose from observing so much disinhibition among her alcoholic family members. Another woman became a perfectionist in an attempt to be noticed in a family where her father's alcoholism drew attention away from the children. Parental break-up caused one woman to feel caught between her parents, favouring her father but pitying her mother who was abused by him. As a result of this conflict she acted out herself behaviourally and used drugs. Being the victims of verbal
and physical abuse led three women to become either intimidated, traumatized, or resentful. Two other women felt abandoned emotionally by their parents; this was a result of either the parental lack of interest in them or the parents preoccupation with their own psychological difficulties. The experience of sexual abuse violated personal boundaries during the childhood years for several women. Consequently, one woman described feeling unloved, unclean, and abandoned, from these experiences. Another felt it safest to "be on" her "own", and the experience also induced a sense of feeling impure.

Overall, these women described having experienced poor parenting. Familial violence, abuse, alcoholism, and breakdown were experienced by the majority of the women. As Renfrey (1992) comments, the destruction of traditional cultural values, practices, and means of material support, and the failure of the dominant culture to force full assimilation or acculturation have left most Native Americans caught between conflicting cultures. Many find themselves in a socially and economically untenable position, and the result is that personal and interpersonal stressors precipitate diverse health and mental health problems. The findings from this study of the prevalent abuse of alcohol by parents are similar to that of other research. Oates and Altar (1996) found that in a survey, 83 per cent of the Native women stated that they had come from families where alcohol was abused.

14.4 Low Sense of Self Esteem

Inevitably, esteem difficulties arose as an aspect of the women's experience of depression and this emerged as another major theme. Almost all of the women described feeling poorly about themselves as a consequence of their childhood experiences. For the most part, the women described the feeling that they gave too much credence to over-regarding the valuations others made
of them. The source of this appeared to be in childhood learning experiences. Learning the personal metaphors that the individuals utilize to explain their experience of illness, their explanatory models (EMs) for its cause, leads to learning what the experience of depression means for the person suffering its symptoms (Kleinman, 1986).

**14.4.1 The Prevalence of Esteem Issues**

Esteem issues were described by the women as problematic, and they viewed poor self-esteem and the sources of it as part of their illness experience. As Waldram et al. (1997) comment, self-esteem has been a problem in many Native communities. These authors provide an example of a paradigm for complete care that was attempted to remedy esteem problems. They cite a study (Fox et al., 1984) on Manitoulin Island, Ontario, five years after an outbreak of suicides in the mid-1970's. A decline in the incidence of suicide, para suicide, and violent deaths was attributed to a multi-dimensional program consisting of residential alcoholism treatment, family counselling, community feasts, job creation for youths, and assistance in self-esteem enhancement in the schools. Aboriginal mental health workers were employed to provide crisis intervention and to establish a liaison with non-Aboriginal professional health and social services sectors (p.92).

**14.4.2 Overwhelming Responsibilities Further Decreasing Esteem**

Related to creators of low esteem were my observations while visiting the reserve examined in this study, of the numbers of very young Native women with children of their own. These women were unemployed and my casual conversations with them revealed that for the most part they were unmarried. Findings by Warren, Goldberg, Oge, Pepion, Friedman, Helgerson and La Mere (1994) note that Native women married quite young and that sexual activity tended to begin at a younger age than it does in the general United
States population. They found a high level of unintended and unwanted pregnancies among Native women, almost twice that of the total United States population. Being young and required to support families emotionally and to financially support families on their own would contribute to these women's experiences of stress. Ill-preparedness, both socially and economically, for assuming parental responsibilities during one's own youth fosters stress and further contributes to low-esteem.

**14.4.3 Lack of Opportunities and Esteem**

A sub-theme was that two women felt that low self-esteem was perpetuated by the lack of opportunity for Native people. One woman said that "feeling stuck" contributed to her feelings of low mood. Another said that having been a victim of abuse had "shattered" any future plans she had for herself. The absence of educational and career opportunities appeared to play a role in preventing the development of self-esteem.

**14.4.4 Low Social Support and Esteem**

However, the women seemed to suggest that the attitudes of their parents' generation also contributed to their sense that they had no options for themselves. Certainly, none of the women described feeling encouraged by local mentors to pursue educational or career goals. Moreover, these low self-expectations were certainly reinforced by the outside influences described below.

**14.5 Racism and Self Esteem**

Experiences of racism emerged as a major theme. Being the victims of racist attitudes largely contributed to a poor sense of self for women in this study. Almost all of the women stated that they had encountered racist incidents, and, then felt poorly, even shameful, about themselves as a result. Racist interactions occurred first at school. As children, the women were
emotionally vulnerable and they described these experiences as working against their already fragile sense of esteem. The women were victimized by non-Native fellow students as well as by educators. One woman said she was "segregated and pushed aside". This made her feel that there was something "wrong" with her. One participant said an educator scorned her for wanting to pursue social work as a career. He intimidated her by suggesting that being Native and hence poor made that option unavailable to her.

14.5.1 Racism Encountered in Career

This woman encountered this attitude again from fellow non-Native helpers once she had become a social worker. She felt that white helpers had a "hard time" accepting Native social workers because they believed Natives were more "in need of help rather than being able to provide it".

14.5.2 Racism from Church Teachings

Even institutions like the church influenced Native peoples' attitudes about themselves as a culture. The efforts of the churches to Christianize them implied that who they were and what they believed in and practised culturally was evil.

14.5.3 The Prevalence of Low Sense of Self-Worth and the Impact on Community Mind-Set

A sub-theme was that community members did not support each other in planning for the future. Support was absent from the outside educational system. One woman said "teachers were not only unsupportive but very, very cruel, very unsupportive". Lack of encouragement from both home and school contributed to low esteem. One women felt this had been a problem in their own upbringing and one woman saw this lack of support as continuing to be a problem for the next generation.
14.5.4 Unable to Vision Life's Options

As a sub-theme, one woman stated that local youth in the community did not envision post-secondary education as a personal option. This participant also felt that community attitudes kept band members from considering furthering their education. Racist experiences in school were described by several participants, and those who viewed themselves as "not looking Indian" stated that they fared "better". Negative evaluations of education may have been encouraged by the experiences of schooling of older reserve members where the aim of the dominant society was to assimilate Native people into white society (Waldram et al., 1997, p.15).

14.5.5 The Failure at Attempting Assimilation and the Impact on Students

A sub-theme was that several participants in this study enlarged on their negative experiences of racism when attending school in the city where they were expected to assimilate. Several participants stated that they felt unwelcome in the white school environment. This is consistent with the finding by Beiser, Lancee, Gotowiec, Sack, and Redshirt (1993) that despite enormous acculturative pressures, many Native people do not adopt the values of the majority culture. Consequently, in comparison to non-Natives, children with First Nations' backgrounds are more likely to be challenged by discrepant home and school values and socialization practices. As Native children mature, associations between their self-perceptions, teacher assessments and grades become increasingly tenuous. These authors found that results obtained by First Nations students support the argument for them, the school is an environment that is asynchronous with other major arenas of socialization. School-based symbols of success, such as teacher regard and grades, may be less relevant reinforcements for the development of self-
perceived competence for Native children than they are for non-Native children. If school is a place where Native children learn to expect failure and non-acceptance rather than success and acceptance, then they will turn to other arenas for validation of their self-percept. These authors state that the students' rejection of school may also be for them a way of coping with otherwise overwhelming value conflicts.

14.5.6 Educational Counselling Needs

A sub-theme was that the women indicated that within the school system, they found no support even from the educators themselves. Counselling services harmed one woman's sense of career purpose eighteen years previously and at that time, there were no Native counsellors for the Native school population. Recently, this need has begun to be addressed in some school boards. Now studies explore what is required from counselling services with regard to Native students. BigFoot Sipes, Duphinais, LaFromboise, Bennett, and Rowe (1992) studied the preferences for counsellors of American Indian secondary school students and found that they preferred talking to Native counsellors regardless of whether the problems concerned academic matters or were of a personal nature. Given the school experiences described by participants in this study, racist attitudes on the part of educators likely influence this choice. On the whole, the presence of Native counsellors in the school system has been lacking, and the extent of the attention given to the needs of Native students is questionable. Two women said that their children were also experiencing racist problems in school and that these were similar to those the women had themselves encountered at school. As Trimble and LaFromboise (1985) state, relatively little of the literature addresses the counselling process with Native peoples and there are few research-based reports. Articles of relevance to Native Americans in
therapy are scarce. As Renfrey (1992) comments, studies by Saks-Berman (1989) show that only 38 article had been published on psychotherapy with Native Americans in the previous 20 years. 

BigFoot et al. (1992) comment that the assimilationist underpinnings of the school system have long required that Native children be separated from their families, and many children became deculturized, losing both their ability to be culturally "Indian" and the ability to provide good parental role models to their own children. Interestingly, in this present study, most reserve members had attended a Catholic run school situated on the reserve. Only a minority of band members were sent away from the reserve for schooling. Still, the effect this had on acculturating children was apparent.

14.6 Losses and Psychosocial Stress

Losses occurring in adulthood emerged as a major theme and was described as a stressor for several women. The women mentioned these losses when describing the sources of their mood difficulties. One-third of the women experienced multiple losses through unexpected deaths. Two other women experienced losses through a spouse's disabling accident and the loss of children through adoption.

14.6.1 Loss Through Death

Several participants spoke of their feeling that their experiences of depression were associated with losses. These losses included the deaths of family members. The losses for several women were multiple in nature. For example, one woman described losing a "brother ... and [experiencing] other deaths in the family". Another woman's baby died, her husband was court-ordered from their home, and her family home burned down. The women described painful emotional reactions to these events.
14.6.2 Losses Impacting on Mood

Research shows that encountering losses is a common experience for Native people who live in this geographical area. Dalrymple, O'Doherty, and Nietsche (1995), whose study included participants from this present reserve, found that mental health clinicians working in the northwestern Ontario reported unresolved grief reactions to be present in the majority of Native people who presented themselves for mental health treatment. From their results, these authors believe that the overuse of mental health care facilities by Native people in the region may be indicative of an increased prevalence of undiagnosed affective mood disorders. In view of the large number of women who described their losses and their emotional suffering, this study supports the findings of Dalrymple et al. (1995).

14.6.3 The Prevalence of Losses in Native Communities

The number of losses by death these women in this study experienced was found to be similar to that given in other research findings. Dinges and Quang Duong-Tran (1993) state that research indicates that mixed types of psychosocial stressors seem to exist prior to the onset of depression among Native people. The common finding from their study was that depressed Native patients have experienced both more undesirable and more frequent losses through death of individuals from their social field or through their own loss of an identity-confirming social role. The experience of death or abandonment was prevalent among all the participants in this study.

14.7 Low Mood and Goals

A major theme was that over half of the women mentioned that they had struggled with issues surrounding motivation when discussing the topic of depression. They associated mood problems with their feelings of low
motivation and they felt that their difficulties worked against their ability to feel purposeful.

14.7.1 Low Social Support and the Prevalence of Mood Problems

The women also felt that an absence of a sense of social support had an impact on their ability to feel motivated and this emerged as a sub-theme. A sense of social support may be impossible to obtain if other members of the reserve are themselves depressed or coping with psychosocial stressors. As Renfrey (1992) comments, the most liberal interpretation of available research on the prevalence of psychiatric problems of Native Americans is that it may exceed fifty per cent. Renfrey believes this type of evidence suggests that Native Americans as a group have significant mental health care needs.

14.7.2 Lack of Opportunities and Options

As a sub-theme, the women in this study enlarged on other sources of stress that they felt contributed to low motivation. One woman said she felt "bored", too bored to "get off the couch". Another said "living alone" made her feel "really empty". One woman was of the opinion that her motivation was dampened by her mother's reluctance to encourage her to pursue her goals. She said her mother feared failure for her daughter. Lack of "opportunities", "options", and "choices" were described by one woman as prohibiting Native people from considering "doing" things. She expressed the view that the youth were "close-minded" about school and about exploring career choices because of their lack of exposure to the world and their inability to see a place for themselves in it.

14.7.3 Low Motivation and Stress

Other women mentioned as a sub-theme, the stressors that interfered with their ability to maintain professional activities. Stress from personal losses figured in this, but the women also said that their emotional vulnerability
arising from their own experiences of psychosocial stress made them
susceptible to becoming easily overwhelmed. Employment opportunities were
few for these Native women. The helping field was one of the few areas in
which they could find employment locally. At the same time, several women
had to struggle with their own stress issues, while being required to care for
those of other people.

14.8 Abusive Victimization in Adulthood

A major theme was abuse. Over half the women said that in adulthood
they had become involved in relationships in which they were abused. Two
women said they experienced physical abuse as adults. Another viewed her
marital relationship as abusive because of her husband's drug use. Another
woman said she set herself up to be psychologically abused by needy people,
a behaviour she thought came from her childhood. It is not known whether
unhealthy interactional patterns were learned to be accepted by the women
because of an exposure to these in their own families contributed to the same
thing occurring in their adult lives. However, the study's findings are similar
to those of other research. As Oates and Altar (1996) report, over half the
male (52 per cent) and two thirds of the female (69 per cent) Native
participants in their study reported historical sexual abuse. Some 44 per cent
of the women reported being sexually assaulted as adults. Over half of the
women (59 per cent) reported having been battered by a spouse.

Interestingly, one woman left her husband and was working hard at trying
to be psychologically well. However, another woman remained in her
marriage, and her husband's drug use entangled the entire family in the court
system and court-ordered therapies. She experienced further stress because of
her determination to keep her family together in the hopes of healing it. This
too is similar to other research findings. Oates and Altar (1996) found that
Native respondents in their research overwhelmingly favoured keeping the family together and they wanted to receive family counselling over prosecution and jail-time in dealing with domestic abuse. The responses of their Native participants reflected the desires of both nuclear and extended families to remain intact, and to heal both the offenders and victims. The type of seamless care-giving that is required for this kind of healing was unavailable, and as a result the family in this study was sent from one program to another to no real benefit.

14.9 Substance Abuse Behaviour

A major theme was that half of the women described engaging in substance abuse at some point in their lives. However, only one-quarter of the women experienced chronic alcohol or drug use. The use of alcohol or drugs appears to have coincided with occurrences of major stressors. For example, one woman started to abuse alcohol after her husband was paralyzed as a result of an accident.

14.9.1 The Low Incidence of Substance Abuse Among the Women

For the majority of women, the sub-theme of ongoing substance abuse behaviour was not described as a problem. But, for one woman in particular, it was a major problem in her life. However, again, she was given inappropriate treatment resulting in even more stress. Drug and alcohol programs, in which the aim is to immerse clients in Native cultural activities, frightened this woman, who had no previous experiences with her own Native traditions. Mail and Johnson (1993) report that there is a group of Indians that is rarely discussed: those who drink heavily, even becoming alcoholics, and then stop suddenly when they are about 40 years old without severe withdrawal problems or apparent difficulty in maintaining sobriety (Burns, Daily, and Moskowitz, 1974; Medicine, 1982). There are findings that the
women usually quit between the ages of 35 and 40 and report that they stop because they cannot reprimand their children for drinking unless they set an example themselves (Medicine, 1982).

14.9.2 Issues with Treatment Programs for Drug and Alcohol Abuse

Other problems regarding treatment programs were mentioned as sub-themes. One was that of a high turnover among counsellors which prevented a therapeutic alliance and caused one woman to feel even more frustrated. Programs did not appear to be attuned to the real needs of the clients, and they seemed to be driven by an agenda that favoured a saturated exposure to lost cultural traditions in the expectation that this would result in a good outcome. The gap between treatment delivery and treatment needs was made evident by this woman's experiences.

14.9.3 Related Addictions Problems

One participant in this study noted that the use of prescribed "legal drugs" used for treating mental health problems was creating addictions problems. He felt that this was particularly an issue for the women in the community. Mail and Johnson (1993) found that reports on the use of sedatives and tranquilizers are extremely rare in the literature, although anecdotal reports from tribal paraprofessionals and health care professionals would suggest that abuse of prescription drugs may be higher than surveys suggest.

Connors (1993) comments that "within Native communities the healing offered from the medicines produced by the causation model [Western medicine] have often proven ineffective in dealing with the illnesses of our [Native] peoples.... While the physical healing approaches have had some impact in fighting diseases, their overall impact appears to be dwarfed by the accumulating illnesses that are associated with the cures". Connors further states: "For example, the warehousing of various medications within our
homes has contributed to addictive behaviour and serves as a method for many First Nation's persons' suicides. Connors makes the generalization that "the medicines from this model of healing often do not address the sources of the illness and may become further sources of illness". As Renfrey (1992) found, the mental health needs of Native Americans are among the most underserved by the professions, yet Native Americans are the country's fastest growing ethnic group. This population growth trend is similar in Canada (Waldram et al., 1997, pp.3-4). Servicing this group, as Trimble (1990) suggests, is difficult, because of the few Native American psychologists and because of the number of Native Americans pursuing higher education is declining in relation to non-Natives. Native people seeking mental health treatment from non-Native practitioners currently come into contact with helpers trained in the medical model treatment paradigm. Medication is frequently over-promoted from this medicalized perspective, but as Connors (1993) shows, this only exacerbates addiction problems. Treatment from a non-medicinal counselling perspective is unavailable.

14.10 Subjective Feelings of Distress

A major theme was that over two-thirds of the women described experiencing either physiological or psychological discomfort in conjunction with their emotional difficulties.

14.10.1 Problems with Anger

All of the women mentioned anger as a major emotional difficulty. Feeling chronically angry was a problem for half the women. On the whole, these women did not address the sources of the anger. However, one participant said that for her this had been necessary. Being able to address the source of her feelings, and in the process to go "through a lot of emotions" by talking about them, had helped her with her anger. She said anger still "pops up" but
"not like before". One helper-participant said that she and other Native helpers soon realized that problems with anger were a consequence of having been sexually abused. Anger also appeared to accompany stressors. The stress of being powerless over one's financial affairs, of feeling alone in coping with tragic losses, or of seeing "no good" in others or oneself were mentioned as sources of anger.

14.10.2 The Lack of Therapies to Address Anger

However, a sub-theme was that outside interference came from treatment providers hired by the government to implement alcohol and drug treatment programs on the reserve. These providers did not view emotional problems as a treatment need. The treatment component of one program for addressing anger was eliminated. It appears that having input into their own treatment needs was impossible for these Native people, who had to rely on government funding for their mental health care services. Research indicates that addressing the anger at an early age brings about good outcomes. Oetting, Swaim, Edwards, and Beauvais (1989) found that for Native female adolescents, higher levels of anger predicted lower alcohol use. They also found that anger is positively related to self-esteem among them. It may be that for the women in this study, anger was a healthy emotion.

14.10.3 Isolation and Anger

A sub-theme was that half of the women chose to isolate themselves. The women's narratives suggested that this was a way of avoiding situations in which angry feelings could erupt. One woman said she became "irritated" in the company of others. Another said she needed to just "stay away from everybody". Another did not want more "pressure" from interpersonal interactions. Yet another said interacting with other Native people made her feel they would have too much of "a say" in her life. It appears that living in
close physical proximity to each other was also a stressor for these participants.

14.10.4 Low Mood and Physical Illnesses

A sub-theme was that half the women reported that negative physical illness symptoms accompanied their mood states. Three women described experiencing feelings of panic and all three said that particular memories precipitated their panic. For one woman, panicky feelings arose when she was around other people who were drinking and she linked her reaction to fears she developed as a child living in an alcoholic family. Somervell, Beals, Kinzie, Boehnlein, Leung, and Manson (1993) have found that in self-reports from Native respondents', there was a high correlation in the questionnaires between a depressed affect and somatic distress factors. Native participants did not make a clear distinction between somatic and affective items, or, in other words, between psychological states and bodily sensations. Within the Native population, the "somatization" of depression is common, and in some other non-Western populations normative. Therefore, a person may express severe depression in an idiom of physical distress, which in fact is how he or she perceives it (Katon, Kleinman & Rosman, 1982).

14.10.5 Problem Eating Behaviour

A sub-theme was that the women discussed their mood in relationship to problematic eating behaviours. Two women said they overate when their mood was low. Another could not eat when she was unhappy. Osvold and Sodowsky (1993) found that in a study of Chippewa women and girls living on a reservation in Michigan, seventy-five percent of the women were using "potentially hazardous" techniques to lose weight. These authors suggest that there is a higher prevalence of eating disorders among Native Americans than previously hypothesized. A study by Garb, Garb, and Stunkard (1975) found
that Native children who were classified as acculturated had a significantly higher obesity rate.

14.10.6 Low Mood and Sleep Problems

Sleep issues also emerged. A sub-theme was that one-third of female participants described sleep problems, and in particular that they used sleep as an escape. Sleep was described as a way to "waste all that time" or to avoid having to "deal" with another problem. Feeling "tired and lazy" much of the time was mentioned by one woman.

14.10.7 The Prevalence of Lonely Feelings in Native Communities

Several participants commented in the sub-themes that part of their feelings of depression was a result of a sense of feeling "lonely, all alone". O'Neill (1993) found that loneliness was a term of distress that appeared at every turn in her study of adult depression at the Flathead Reservation. Loneliness always seemed related to the disruption of affective and instrumental relationships. Loneliness was used by Native participants in O'Neill's study in two ways: first, it was used to talk about the feelings of grief that followed the death of a loved one or from experiencing a sequence of tragic deaths that left no time for recovery; second, it was used to talk about feelings of being aggrieved because of unfulfilled expectations of support or aid. Feeling aggrieved was usually described in terms of anger or irritability because of the undeserved shame of being treated poorly. Finally, loneliness was mentioned in terms of feelings of abandonment accompanied by an internalized sense of worthlessness. Timpson, McKay, Kakegamic, Roundhead, Cohen, and Matewapit (1988), found that Native people living in more remote communities in Northwestern Ontario, than the participants in this study, used several words in the Nishnawbe language to refer to depression. The actual meanings of the words incorporated the concepts of loneliness and sadness as
well as the implications of the term "depression" used by Western medicine. Participants in this study reported that all these experiences were present in their life stories. Morrissette (1994) comments that remarkably many Native clients feel very alone in their pain and are unaware that other Natives share a similar emotional experience.

14.10.8 The Feelings of Subjective Distress and Their Relationship to Common Symptoms of Depression

The women in this study reported experiencing the above-described symptoms, which are similar to those found among non-Native depressed people. Kleinman (1977) refers to the "depressive syndrome" which represents a small fraction of the entire field of depressive phenomena. The question that Kleinman (1977) wants researchers to explore is whether the depressive syndrome is a "disease", that is, a biologically based illness, or really a socially caused form of human misery manifesting itself in psychological distress. To look at this question, it is important to examine the meaning of the term "depression" from the point of view of the participants' world-view. First Nations Confederacy (1985) found that Northwestern Ontario people living in a remote area did not entirely define the term "depression" in terms of the clinical syndrome. Shore and Manson (1985) found much higher rates of reactive depression among Indians than non-Indians. In keeping with this study's findings, the term "depression" is the emotional reaction participants experienced from having things happen to them. These psychosocial stressors were often overwhelming in nature and little support for coping with them was available.

14.11 Exploring Psychological Issues

A major theme was that the women felt that local social norms encouraging the practice of denial imposed a social pattern of avoidance for addressing
feelings within the community. The women's narratives reveal that exploring their low mood difficulties was something they had to find a way of doing on their own. As one woman put it, "everybody seems to know, but people just don't want to talk about it". Perhaps the stress of hearing about other people's problems is too much to bear when one is dealing with one's own issues. As one helper-participant said, "when they deal with what's happened to them, then there'll be a lot more suicides". The only way of coping for these people appeared to be through an avoidance of the issues. Interestingly, Timpson et al. (1988) state that in their knowledge about Native people living in Northwestern Ontario is that by nature, these Indian people do not show emotions publicly.

14.11.1 Attributing Depressive Feelings to Sources

Native participants in this study did not attribute their experiences of depression to the two causes, white man's sickness and Anishinaabe sickness, Garro (1990) found among Native peoples in Southern Manitoba. Instead, this study's participants attributed their depression to external (exogenous) sources. No participant felt that she was depressed or experiencing depressive symptomatology from internal (endogenous) causes such as biological predisposition (Sue, Sue and Sue, 1990).

Participants in this study overwhelmingly attributed their psychological unhappiness to experiences that had happened to them. They considered these experiences to have been somewhat intensified by their negative interactions with white society, which ranged from cognitive experiences of religious indoctrination and racism to physical experiences of sexual abuse. However, for the most part, the participants attributed their psychological distress to local social problems in their own families and community. Key among these were early life experiences of family breakdowns that impacted on a sense of
safety or of feeling loved from childhood to adulthood. The ill-effects of these early life family experiences has been researched by Gfellner (1994), who found that Native adolescents in mother-only and mother-stepfather families were more likely to use alcohol or to be involved in problem behaviours than those in intact families. Timpson et al. (1988) state that for Native people from Northwestern Ontario, disruptions in the family, marital strife and depression seem to be increasingly prominent reflections of the almost overnight shift in their communities from that of a preagrarian economy to the age of information. They found that various symptoms of mental health issues arose from this rapid social change.

Section Two
14.12 Sexual Abuse Victimization

A major theme that emerged from this study was that two-thirds of the female participants had experienced sexual abuse. The resulting emotional difficulties were described as working against the development of a sense of well-being early in their lives. One-third of the female participants who said that they had been victims of sexual abuse as children continued to be affected emotionally by the experience as adults. Two women said that they continued to suffer from symptoms of depression. The participants reported that they considered that the experience of sexual abuse had encouraged low self-esteem, unattained ambitions, and feelings of fearfulness and unsafety.

14.12.1 Feelings of Distress Arising from Abuse

A sub-theme was that several women felt that symptoms commonly related to depression emerged from their experiences of sexual abuse including memory difficulties, feelings of anger, a desire to avoid social contacts, and somatic or physical illness distress. Two of the women engaged in ongoing substance-abuse activities, but neither had criminal histories.
14.13 The Inability to Address Sexual Abuse Victimization

A major theme was that participants in this study described the silence around sexual abuse and other abuse issues that was prevalent in their community. This resulted in individuals being unable to work toward resolving the effects of the abuse either individually or collectively. As Oates and Altar (1996) comment, the problems may have been pushed underground out of fear of severe punishment and destruction of the family by legalistic punitive approaches that are devastating to Native communities and families. These authors say that alternative approaches to court are simply ignored by those who have the power to fund or legislate in these areas.

14.13.1 Protecting the Perpetrators

The wish to avoid imperiling community or family members through charges of sexual assault worked against community-wide healing approaches to such problems was a sub-theme. As Oates and Altar (1996) comment, "It has been [our] experience during the last 25 years of working with Native families that most wish to remain together despite the pressure of non-Native workers and agencies to separate them". Participants in this study stated that they did not wish to report family members who had sexually abused them. This is understandable, when the only living environment available to participants is the reserve setting.

14.13.2 Limited Access to Alternative Attachment Figures

van der Kolk (1989) notes that as people mature, they develop an ever-enlarging repertoire of responses for coping but that adults are as intensely dependent as children on social support to prevent and overcome traumatization; under threat adults still may even cry out for their mothers (p.393). This author further states that people in general, and children in particular, seek increased attachment in the face of external danger. When
there is no access to ordinary sources of comfort, people may turn towards their tormentors. The bond between victimizer and victim is a very strong one in the absence of outside support or influence. Also, people who are exposed at an early age to violence or neglect come to expect it as a way of life. Typically, they are confronted with the chronic helplessness of their mothers as well as their fathers' alternating outburst of affection and violence. They learn that they themselves have no control (van der Kolk, 1989).

14.13.3 Alternative Ways to Gain Control

In this study, a sub-theme was that no woman mentioned that she had ever confronted her sexual abuser. Two participants who had stated that they had been sexually abused as children mention that they had developed a need for control as adults. One woman who had been sexually abused and exposed to her parent's alcoholism said that her "need for control started" in her "childhood". She said that because she felt she had "no control" as a child, she needed to control other's experiences in her adulthood. She said that she "rushed in to rescue" other people who would in turn, resent her when she withdrew from taking care of them. Another woman who had been both sexually and physically abused struggled with her feelings about her brother who had been the sexual abuser. She could not resolve the conflicted feelings of both love and hate she felt towards him. She loved him as a brother but hated him for what he had done to her. She could not gain a sense of control over her different feelings towards him. She also said she could not report the abuse. One example of her need to feel some sense of control in her life revealed itself through her inability to socialize with other women who brought their children to her home. Visiting each other's homes is a common socialization practice on the reserve. However, she could not control the children's behaviours or tolerate a mother's unwillingness to control her
children's "crawling around on the furniture" and their visits angered her. She did not want people coming to her house and she felt that their company violated her personal boundaries.

14.14 The Inability to Address Psychological Issues

A major theme was half of the women who had experienced sexual abuse felt that the local norms of silence surrounding the issue were encouraged by fears of exposing the perpetrators. They also feared that the community would regard them negatively. Three participant-commentators listed the factors working against addressing abuse issues: the reticence or inability of victims to deal with it; the lack of appropriate treatment strategies for either the victims or the perpetrators; the focus on other treatment issues (drug and alcohol); and inadequate training as counsellors for local helpers.

14.15 Treatment Needs

Healing the community from within requires financial resources and finding these was described by participator-commentators as an ever present hurdle. The absence of treatment or inappropriate treatment are a great source of stress in local Native communities where insufficient funds are available to develop on-site, self managed care. Participants in this study described how this stress was their experience when seeking treatment. As Waldram et al. (1997) comment, funding for Native health care and other community healing initiatives is a long-standing problem: all programs have experienced shortages, and funding is becoming more difficult to arrange just as progress is being made. On a more positive note, the current federal government seems to be trying to reduce the role of Medical Services Branch by transferring resources to Native communities and organizations. Under this new approach to health care delivery, Native groups appear to be attempting to keep the best of biomedicine while complementing it with more traditional Native programs.
Future research will reveal whether local control addresses local needs more effectively (Waldram et al., 1997, p.256-7).

Section Three

14.16 Suicidal Thoughts and Intentions

A major theme of the study was that two-thirds of the female participants had entertained suicidal thoughts. The women stated that feeling hopeless about their life situations, whether because of the absence of options in their lives, the inability to escape negative feelings, or, in one case, an unhappy interpersonal situation of a bad marriage, encouraged thoughts of suicide. Several women said that suicidal thoughts occurred most when they were using alcohol. However, two women commented that the idea arose even when they were sober. That the risk of suicide is increased by alcohol or drug use is worrisome.

14.16.1 The Modelling of Supports and Risk of Addictions

Gfellner (1994) found that some young Indian girls may be at increased risk of using drugs if supports (i.e. parents, grandparents) are engaged in substance abuse. Family sanctions against drug use were found to be important as a deterrent for subsequent drug use among Indian adolescents (Gfroerer, 1987). Gfellner's (1994) results underscore parent modelling of drug or alcohol use as a potential risk for young Indian girls. Female children of addicted parents are at risk for addictions themselves.

14.16.2 Family Breakdown and Increased Addictions

Broken families increased the risk of children becoming addicted, because as Gfellner found, adolescents in mother-only and mother-stepfather families showed greater involvement in problem behaviour. On reserves, the extended family may operate as a powerful influence on an adolescent's drug use because of multiple models and "peer clusters". Gfellner's (1994) findings
also indicate that Indian adolescents in non-intact families who live in cities may be at even greater risk for drug use and related difficulties than their white counterparts. Several of the women in this study said that they considered suicide most frequently in their adolescence and late teenage years and when they were using alcohol. The occurrence of these ideas in combination with alcohol or substance-abuse during these years would be particularly dangerous.

14.16.3 The Low Incidence of Suicide on the Reserve

A major theme was that a female participant-commentator remarked that suicide rates on the reserve were generally low because the band had a suicide intervention team in place to address immediately "attempts, tendencies and thoughts". This woman also felt that close proximity to the city and the greater availability of jobs lessened the sense of hopelessness compared to that felt by community members living in more remote sites.

14.16.4 Thoughts Preceding Suicide

A major theme was that several participants described that feeling "stuck" or having "no options" for themselves preceded their suicidal thoughts. Research indicates that there is a high unemployment rate among Aboriginal people of almost 25 per cent, compared to around 10 per cent for Canadians in general. Compared to Aboriginal people living in urban settings, unemployment is particularly high among those Native people who live on a reserve, where both low educational levels and higher unemployment rates are also more evident. (Waldram et al., 1997, p.21). First Nations Confederacy (1983) state that on reserves located in more remote areas in Northwestern Ontario and Manitoba "depression" was defined in words reflecting hopelessness and despair about the future. The inability to be meaningfully and gainfully employed not only increases low self-esteem, it also works
against psychological healing because a lack of purpose also decreases motivation.

14.16.5 Career Options and Healing

A major theme was that most female participants in this study who were employed worked as local helpers within the community. The availability of this career option encouraged self-healing behaviours by providing for the aim of being a better helper. Helping those who are suicidal was one of the job requirements. Only two female participants were unemployed and one of these was only temporarily out of work.

14.16.6 Careers and Stress

However, a sub-theme was the career option of becoming a local helper had taken an emotional toll on one of these two participants and one other woman. Two other women who were employed in secretarial capacities had also taken leaves at certain points in their employment. All these employment issues were mentioned by participants as contributing to the risk of suicide. Interestingly, Timpson et al. (1988) note that it is the gainfully employed, upwardly mobile Natives from reserves in remote areas of Northwestern Ontario that are over-represented as receivers of counselling services. These authors state that it is feelings of being stressed from the rapid social and cultural transition to modern ways that has encouraged the development of mental health issues.

14.16.7 Youth. A Time of Suicide Risk

Suicide has been reported to be a problem among many Native people. Most of the women mentioned suicidal thoughts as emerging in middle and later adolescence and in early adulthood years. This was a time in life when several women said they felt most hopeless about the future. The importance of peer modelling with respect to alcohol use behaviour has been mentioned
above. This has also been described as a problem in relationship to suicide behaviours. As Gotowiec and Beiser (1993-4) comment, despite the great variation in suicide rates from one place to another place, Aboriginal teen suicides show some common characteristics. There is a tendency for suicides to occur in clusters or as epidemics among particular groups of youths. The suicide of one young person may trigger a series of suicides or suicide attempts in a community (May, 1990). Manson (1995) may have given the best explanation for these suicide clusters. He states that definitions of the self vary along a continuum between "egocentric" and "sociocentric". The former, best exemplified in Western industrialized populations, characterizes the person as unique, separate, and autonomous. The latter, found in many non-Western cultural traditions, depicts the person in relational terms as part of an interdependent collective, defined by kinship and myth.

14.16.8 Alcohol and Risk of Suicide

Cluster suicides were not a problem in this study's reserve community, perhaps because acculturation had influenced a more egocentric view of the self. A sub-theme was that participants reported that their experiences with suicidal ideation occurred mainly when they were intoxicated. However, several women clearly stated that they also thought about suicide when they were not under the influence of drugs or alcohol, but that substance use did disinhibit them enough that they considered suicide more seriously. Several participants stated that their reasons for contemplating suicide arose from a feeling that they had no alternative strategy for coping against distressful feelings.
Section Four
14.17 Ways of Coping

A major theme was that six women in the group actively chose to become local helpers.

14.17.1 Caretaking at Work and Stress

A sub-theme was that three of these women who became helpers did not continue in the profession because of emotional stress. One of these participants took counsellor training but never assumed employment because she felt her own problems interfered with her work. The other two women found employment as counsellors but personal distress, combined with the employment requirements of looking after distressed children, caused one to take a medical leave and the other to change employment. All the women helpers described that they chose this career because of their own experiences with emotional distress.

14.17.2 Caretaking at Home and Stress

A sub-theme was that female Native participants described in particular feelings of exhaustion and of being burdened by family responsibilities. Several described the absence of male input into child and family care-giving and said they felt overwhelmed by the responsibility of taking care of their children and grandchildren and of having to provide the family income. One woman commented on the guilt she would feel in abandoning her children and grandchildren if she followed her wish to leave the reserve. Several women described viewing their role as one of sustaining other family members, both their children and grandchildren. Because of women having their children early in age, the grandmothers were in their mid-thirties. These women as well as older Native women felt their traditional roles as cumbersome because
other traditional forms of social support (i.e. male elders, intact families) were no longer in existence within the community.

14.17.3 The Stress of Being a Grandmother

The women's family situation was similar to findings by Bahr (1994) who discussed the continuing commitment of many Apachean grandmothers as bearers of the cultural heritage and as the persons ultimately responsible for the physical well-being of their families. This author states that Native grandmothers are defined by their culture and often by circumstances as the "caretaker of last resort". The grandmother devotes extraordinary efforts and personal sacrifice to perform the role of grandmother. Community respect for this role was more evident in the past times. American Indian standards defined the grandparent as very important in the socialization and care of children. Grandmothers were both authorized and expected to play a major role in the rearing of the new generation. The women accepted the heavy obligations of child care and support, whereas their counterparts in English-speaking society tended to celebrate their freedom from such responsibilities. This role was accepted and respected by Native grandmothers but there are now difficulties with grandmothers assuming this role in modern times. As Bahr (1994) has found, many young Apache mothers are more interested in individualistic interests, seeking personal goals, or simply having a good time. This increases the role of child-rearing on the grandmothers and leads to a greater strain on these women within the family.

14.17.4 Supports Mothers Require to Avoid Stress

Native mothers willing to assume their own parenting responsibilities report that other kinds assistance is unavailable to them. A sub-theme was that one woman said that she would not attend a treatment program again because it was situated off the reserve and her long absence from her children
caused them to suffer both emotionally and academically. In another sub-theme, a woman was trying to find help to emotionally support her children after their experience of having their house burn down and feeling the effects of their father being legally removed from the home. This mother and her children were being sent by various helping systems to various treatment programs but attending these different treatment programs created more stress for the family. Sontag and Schacht (1994) found that there is clearly a need for information on parenting for Native parents. They want a consultant, someone who provides expert advice about the policies, procedures, eligibility requirements, and other aspects of the service providing system, or a culture broker. They require someone who serves as a link between two cultural systems (the family and the service providing community), with the expressed intent of changing the system and not the family to meet unique family needs. These authors also suggest that there must be an understanding of the cultural differences and of the ethnic differences in which consultants work, with the emphasis for change targeted at the agencies themselves, not the families they work with. Families may want to be able to obtain information about the validity of different approaches to their perceived needs but they want the decision to be theirs.

14.18 Healing and Rediscovering Traditional Native Practices

A major theme was that over two-thirds of the women discussed spiritual issues. They described moving away from a Catholic belief system as part of their healing process. Two women had come to completely reject their Christianity and three were beginning to explore and accept lost Native spiritual practices.
14.18.1 Learning Lost Traditional Practices

This trend towards rediscovering lost traditions is reflected in other research findings. Malloch (1989) comments that many Indian people are no longer familiar with the philosophy or practices of Indian medicine but that Indian medicine keeps appearing on the agenda of workshops, along with comments about the "need more information on Indian medicine". Malloch suggests that these comments indicate a genuine interest in learning more about the subject, but also point out the current lack of knowledge among some people at the level of reserves.

14.18.2 Treatment and Native Traditional Healing

Morrissette (1994) reports that although Native people may seek mainstream medical and psychological treatments, the power and influence of traditional healing rituals (sweats, pow-wows, sweet-grass ceremonies, healing circles, etc.) should not be overlooked and that these should be integrated when therapy is proposed. Native clients should be encouraged to seek the guidance and advice of chiefs, elders, or medicine persons. This holistic approach encourages clients to connect with their own cultural healing practices.

14.18.3 The Inability to Make General Counselling Recommendations

However, Herring (1994) comments that the Native population is too diverse for general recommendations regarding counselling implications. Because no consensus is available for a generic term of identity, in most cases successful counselling requires tribal identity and cultural specification. This author further comments that another major variable for an individual is the degree of traditionalism versus the degree of acculturation to mainstream society. The continuum ranges from the very traditional individual who was born and raised on a reservation where the tribal language is spoken to the
Native American Indian raised in a city who speaks only English and may feel little connection with a tribe (Dillard, 1983).

14.19 The Need for Collaborative Treatment Paradigms

A sub-theme was that almost all of the participants in this study did not speak their Ojibwe language. Their community was acculturated and situated closely to a city. Children attended school in the city and many of the Native band members were also employed there. Ideally, regarding health care, it would seem that it would be helpful for non-Native mental health service providers to work with band members for a collaborative counselling effort. Problems were described as having occurred with previous attempts to form collaborative enterprises and several Native women felt that the arrogant attitudes of non-Native caregivers toward Native people would continue to interfere with the success of any future collaboration.

14.19.1 Individual Ways of Seeking Healing

A sub-theme was that two-thirds of the women described individualistic approaches for achieving a sense of emotional well-being. These included leaving the reserve, changing cognitions, and disclosing through Native sharing groups or to western therapists. Almost half the women were engaged in rediscovering lost Native spiritual and cultural practices which they viewed as a hopeful approach to healing.

14.19.2 Rejecting Church Doctrine

Rediscovering lost traditional practices and rejecting the doctrine of the Catholic Church was a sub-theme common to several women's experiences. Feeling abused by the church's belief system was also mentioned by three women. Morrissette (1994) and Bull (1991) both explain that the aim of the Catholic Church through its schools and churches was to assimilate First Nation people into the dominant society. In doing so, it had to overcome the
Indian people's resistance to the notion of corporal punishment of children. One of the results of this resistance was the establishment of residential schools for the purpose of removing children away from their communities and Native parenting restrictions. In this study, however, the church and church-run school were situated on the reserve but the effects of the church were as Morrissette (1994) describes: it was powerful in its attempt to "civilize" the Natives, who soon learned that questioning the intentions and behaviour of religious orders was not possible. As Timpson et al. (1988) report, Native people in remote areas of Northwestern Ontario were vulnerable to Christianizing influences because they were forced to move on to reserves and hence, made dependent. They were taught that their traditional spiritual beliefs were demonic.

Section Five

14.20 Experiences with Treatment (Drug and Alcohol)

A major theme was that almost half the women had experienced addictions treatment offered to Native people. This only available form of treatment was focused on dealing with drug and alcohol abuse issues. In sub-themes, the women participants described feeling that this form of drug and alcohol treatment was problematic. Their concerns were that the treatment required them to leave their homes and families for extended periods; that the programs were too focused on immersing clients into Native cultural practices that were foreign to them; that programs suffered from a high counsellor turnover which prevented the growth of trust in the process; and that Native and non-Native helping systems conflicted with each other causing the person being helped to feel caught in the middle.
14.20.1 Addictions Programs and the Emphasis on Culture

The heavy emphasis on Native culture in treatment programs particularly disillusioned the woman who experienced the most problems with her addictions.

14.20.2 The Women's Counselling Preferences

One woman stated that she preferred individual counselling. Pace, Mayo, Harpur, Kuelker, and Reimer (1996) found that Native mental health consumers from the Treaty Seven Region in Alberta perceived that the majority of healers, including medicine men and women or elders were less effective than psychologists. Native health workers viewed psychologists, family, and friends as more effective therapists than medicine men or women or elders. They also thought that traditional cultural interventions were less effective than Westernized interventions. Only older individuals or those who had strong cultural identities were likely to acknowledge the effectiveness of traditional healing methods. These authors surmise that psychologists were perceived as more helpful because psychology requires the talking out of problems and a stronger interpersonal relationship than most other healing formats. According to these authors, because reserves are small communities, people consider the confidentiality a psychologist provides to be desirable.

14.20.3 Utilizing a Variety of Treatments in Help-Seeking

When treatment for psychological problems related to abuse, loss, or related difficulties is not available, research indicates that Native people have adopted pluralistic help-seeking approaches (Garro, 1990; Walker et al., 1993). This was found to be the case for participants in this study. Drug and alcohol treatment programs were prevalent, but for the participants of this study whose problems were not related to substance-abuse, alternative
psychological treatments were scarce. Participants described attending several doctors or group programs in an attempt to have their needs met.

14.20.4 Problems with Culturally Insensitive Treatment Approaches

A sub-theme was that one woman stated that the court-ordered treatment from a non-Native social worker made her feel badly about herself. As Darou (1987) explains:

a typical counselling program could be seen as follows:
The client comes in for counselling because the social worker said so, to gain something concrete such as child custody.
The client is faced with a barrage of questions that represent a challenge to emotional restraint. To cope with this severe threat to outward amiability, he or she can take on an air of indifference, and if a response is inescapable, make a response that will please the counsellor. The obvious solution ... is simply to never come back.

As Darou notes, this scenario is supported by research. Sue and Sue (1977) found that 50 per cent of Natives dropped out of counselling after the first session.

14.20.5 High Treatment Program Drop-out

Participants in this study may offer reasons for high treatment program drop-outs. Sub-themes revealed that available treatment suffered from a high therapist turnover. Another problem was that some clients continued their substance abuse behaviours during treatment. Until recently, programs were available in the United States, but these were not suited to this community's needs. One participant described how she had been sent to a program in the United States with individuals from American minority groups and that she was "the only Native person in the program". Follow-up was not provided on the reserve after the treatment and this lack of continued care was a disadvantage for those requiring aftercare.
14.20.6 The Limitations of Drug and Alcohol Treatment Programs

Gutierres, Russo, and Urbanski (1994) state that programs to get clients off drugs and alcohol should be seen as only one step in an ongoing therapeutic process. They state that a 45- to 60-day program is not long enough to help clients address long-standing issues and concerns underlying low self-esteem. From their knowledge, they comment that short-term programs are inadequate and that clients should be offered 1- to 2-year aftercare services. These authors acknowledge that access to these services for American Indians is often problematic because many people return to reservations or other rural locales after treatment. Therefore, the authors comment, it is important for drug treatment centres to build strong links to the local mental health delivery systems so that referrals for mental health services can be made.

14.20.7 The Necessity for Treatment Linkages

Timpson et al. (1988) offers information that further argues for strong links between these to systems. These authors state that in remote areas of Northwestern Ontario, drug and alcohol abuse is only a symptom of other mental health issues. These authors imply that treating the underlying mental health issues would also treat the symptoms such as those of substance-abuse behaviours. Most of the women in this study linked their substance-abuse problems, be they episodic or ongoing, to their feelings of being depressed.

14.20.8 Problems with Treatment Funding

A sub-theme was that funding that has been deemed important by government agencies up to now has been felt by some participants to be misdirected. As several women in this study commented, more traditional Native drug and alcohol programs are not always appealing to those seeking healing for themselves.
14.20.9 Arguing for Collaborative Treatment Paradigms

Connors (1993), a Native psychologist who works with band members from this study's reserve, comments that in the case of Native people a greater degree of confidence can often be attained through traditional healing procedures as opposed to those offered by European and Western medicine. He argues for a collaborative healing effort or an exclusively traditional approach because he finds that Native traditional healing approaches are often far more effective with First Nations clients than are Western psychotherapeutic approaches. Connors also states that although there are considerable similarities between the two approaches, the differences are evident primarily in the match or mismatch of verbal and nonverbal healing symbols within the healing constructs of the person being healed. The faith and confidence of the client in the healer and the healing procedure can be more easily attained when the world views of the two match. Connors comments that many Native communities are beginning to recognize the limitations of non-Native healing practices in addressing their needs. Many communities are reviving their traditional healing practices and seeking ways to integrate this knowledge with non-Native practices within a new environmental paradigm. Connors explains that many Native people have adopted, been raised in, or born into a non-Native environmental paradigm. They can nonetheless employ their beliefs within the holistic Native environmental paradigm that provides a way of thinking but does not dictate what people should believe. Within this paradigm, spirituality is defined as the personal relationship that each individual has with his or her Creator. This paradigm helps to structure Native peoples' relationships with all of creation. As Timpson et al. (1998) explain, the loss of Indian spirituality as a cause for depression in Indian people goes beyond concepts contained in religious
beliefs. It encompasses an entirely different relationship with the world, linked closely with maintaining harmony with nature. These authors state that the description of the loss of spirituality by Native people is remarkably similar to the concepts of normlessness and anomie.

Part Two
The Men’s Stories

15.1 Experiences of Low Mood in Childhood

A major theme was that all the male participants experienced unhappiness in childhood. The men commented that their relationships with their parents was a key source of their emotional difficulties. Witnessing parental conflicts, being physically abused by parents, parental use of alcohol, parental separation, poverty, and abandonment were experiences that contributed to negative emotions. Their feelings were described as carried over into adulthood. One man felt "strong resentment" towards his mother for physically abusing him. Another still felt distanced from his "drunk" father whose alcoholism had pushed the family away from him. One man continued to feel the shame from growing up in a poor family where food was scarce. Another felt ongoing feelings of "hurt" from being abandoned by his parents. One man reported that his brother and sister were also having psychological problems as a result of their childhood experiences.

15.1.1 The Impact of Childhood Stress on Adult Moods

As Brown, Harris, and Bifulco (1985) comment, the role of early life stressors as predisposing factors for adult disorders has received little attention. Studies have been focused on current stressful life events as antecedent variables in predicting mental health status among Indian and Native populations (Dinges and Joos, 1988). Dinges and Duong-Tran (1993) believe that contextual approaches to an understanding of life events, in which
the meaning of the life event in the biography of the individual is measured over time, have considerable potential in terms of the cultural significance of historical, ongoing chronic, and acute life stressors. These authors feel that there is an equally compelling prospect that thematically congruent psychosocial stressors may be found to precede comorbid or the presence of two or more mental illnesses in one person believed to be prevalent among Indian and Native youth.

15.1.2 The Effects of Child Abuse

Waldram et al. (1997) comment that acts of violence in Native communities are intimately related to the mental health of individuals and to the social health of the community. One particular form of violence that is now receiving more attention is the abuse and neglect of children. Accurate data for this problem is extremely difficult to obtain, and media reports of flagrant cases do not necessarily reflect the true scope of the problem. In 1981 more than 5 per cent of Native children living on the reserves were "in care". This figure declined to 3 per cent by 1987, which is still three times the national average (Hagey, Larocque, and McBride, 1989). The study of this reserve indicates that the "scope" of the problem is flagrant. A major theme was that the male participants had experienced sexual abuse. Because of their ages at the time of the interviews, the sexual abuse these participants described would have occurred from the 1950's to the late 1970's.

15.1.3 Sources for Poor Parenting Practices

Tafoya (1989) comments that the effect of the church and the schools was to assault the Native's individual and cultural identity. They taught Native peoples that they and their families were savage. The result, as Bull (1991) states, was that Native people lost their parental role models and in turn
experienced their own difficulties in parenting. Children being parented poorly was a sub-theme.

15.1.4 Efforts to Improve Childcare

The reserve in this study had worked to stop the removal of children from Native care. The earlier practice had been to remove children from the reserve and place them in foster ("white") care, leading to greater social problems in the long run, and it was these problems which this Native community was attempting to solve (Waldram et al., 1997). Sub-themes were that one participant in this study reported being either sexually abused in white foster care, and, the other of having difficulties re-integrating the Native community as an adult. The local child welfare services now in place on the reserve offers a new model for local Native child-care.

15.1.5 Ways to Address the Therapy Needs of Abused Children

Regarding treatment implications for children living within their own Native families, Husted, Johnson, and Redwing (1994) found that modern psychotherapy seems to be most effective when dealing with Native victims of physical and sexual abuse and with children of active alcoholics. Teaching adolescents to avoid taking responsibility for parental behaviour, especially when it was abusive, seems particularly helpful. A sub-theme was that one man in the study stated that as a child he felt responsible for taking care of his grieving mother. Others commented that in their childhood they were present when their parents were drinking and fighting.

15.2 Low Sense of Self-Esteem

Low sense of self-esteem emerged as a major theme. One man felt that his self-regard was learned from his mother's regard of him. He said that when he was "sober", he "hated" himself. However, his drug and alcohol abuse increased his low sense of worth to such an extent that he wanted to "die" so
that he would no longer be a "worry" to others. He "disliked" himself so much that he expected others to feel the same, and he also expected to be "attacked" by people. Another man reported that he felt "used" for his money and food and that he was worthwhile only "until [his] money ran out". Another man was of the opinion that being brought up away from the reserve had led to a feeling of being "alienated" from his Native community. A physically disabled man felt poorly about himself because he saw himself as a "burden".

15.3 Experiences of Racism

Racism played a role in how reserve members sought help when they were in difficulty and was a major theme. One Native police officer participant said that they did not report problems to non-Native officers.

15.3.1 Racism at School

A sub-theme was the men both witnessed and experienced racism at school. One man thought that Native students in particular were singled out by teachers for corporal punishment. Native children with the fewest social supports were seen by these participants as especially mistreated by teachers. One man mentioned that it was a distinct advantage for him at school that he "didn't look Native". He felt that Native children were treated as less "intelligent". His own mother was aware of the racist experiences and encouraged her children to become acculturated to the white society.

15.3.2 The Effects of Low Self Regard in Childhood

Beiser, Lancee, Gotowiec, Sack and Redshirt (1993) found that Native and non-Native children's self-percepts are at the same level in grade two. Non-Native children's self-percepts become more positive with age but Native children's self-evaluations tend to remain static or decline. These authors comment that research suggests that a child's self-perceived role competence helps predict his or her school achievements, and that, during times of stress,
positive self-regard may help protect the child's mental health (Harter, 1990; Boggiano, 1988). In their study, Beiser et al. (1993) found that First Nations' children who were in grade two and then dropped out of their study had lower scores on competency scales and had higher depression scores than did children who stayed in their study. It is unknown whether the children who dropped out of their study quit school. These authors suggest that the stronger a school's commitment to taking into account appropriate local cultural norms, the better the child's self-percept will be. From the descriptions of racist treatment at school that the male participants in this study related, much improvement in how Native children are regarded within the educational system is required.

15.4 Low Mood and Losses

The impact of losses on the creation of low mood problems emerged as a major theme. In one case, work accident not only destroyed a man's ability to walk, it almost destroyed his marriage. Feelings of depression arose from these experiences. Another man experienced multiple deaths in his family, and these family losses left the remaining family members in a state of depression. One man could not express his feelings to his wife and he discussed how difficult learning to do so was for him. However, he was forced to open up emotionally in order to sustain his marriage because otherwise his wife planned to leave him. Morrissette (1994) comments that non-victimized spouses commonly report feeling emotionally distant from their partners. Not knowing how to change a situation and feeling frustrated with failed attempts to do so, the non-victimized partner experiences defeat and withdraws, thus perpetuating a vicious cycle.
15.5 Depression and Goals

A major theme was two-thirds of the men were unemployed and appeared to be unable to make any progress in their lives. Leaving school without having finished and becoming involved with addictive behaviours were described by three men as obstacles in their lives. One had so physically damaged himself in a suicide attempt that he did not see himself as able to work. He also had problems with addictions.

15.5.1 Motivation and Low Sense of Support

However, a sub-theme was that for men who were employed and motivated, a low level of support from the community impeded their progress and dampened their enthusiasm. One member explained that he almost felt the community was "jealous" of his educational success. He thought members of his extended family were trying to sabotage his employment.

15.5.2 Reasons for Inter-Community Conflicts

Timpson et al. (1988) offers an explanation for discord between families often observed on the reserves. When people abandoned their nomadic lifestyle to live on reserves, these would contain several extended families. Frequently, antagonistic families were thrown together resulting in a heightening of historical inter-familial tensions. In the study, similar tensions existed among Native families on the reserve.

15.5.3 Childhood Learning Being Unable To Envision Goals

Lack of goal-directedness may have begun in early life for many of these men and this was a sub-theme. Husted et al. (1994) found that one of the most distressing things they found in their study of Native adolescents was their inability to articulate goals, in either the short or long term. They found that as the children advanced through a mental health program, they appeared to act as if they were beginning to believe that the choices they made would
make a difference in what happened to them. This the authors say, is the opposite of depression.

15.5.4 The Role of School on Children's Self-Concept

Gotowiec and Beiser (1993-4) cite the Statistics Canada (1989) findings that only one-quarter of Canadian First Nations people receive a high school diploma. These authors suggest that positive role models in the schools and the absence of racial discrimination increase the Native child's sense of academic self-concept.

15.6 Engaging in Abusive Behaviours

A major theme was that half the men had criminal histories. Two men had been charged and jailed for aggression towards others. A local social worker believed that men in the community with similar histories had been sexually or physically abused and that the consequences were that they experienced uncontrollable anger, alcoholism, and a blaming attitude towards the world. Widom (1989) notes that about one-third of the children who are abused or exposed to violence as children become violent themselves in later life.

15.6.1 The Need to Address Abuse Issues

Waldram et al. (1997) further comment that many Aboriginal people recognize that the interrelated problems of self-inflicted and interpersonal violence (including child and spouse abuse) can be resolved only through a healing process undertaken by the communities themselves (p.92). It is important as a major theme to this study's findings as well, to note that these authors state that the re-establishment of individual and community self-esteem requires overcoming the denial of embarrassing or painful community problems on the one hand and emphasizing and enhancing positive traditional values and customs on the other.
15.6.2 What is Required to Intervene

As Renfrey (1992) comments, cultural familiarity would assist the integration of conventional and traditional interventions, the latter still favoured by many indigenous people. In this study it was found that, several participants had come to reject the Western helping system. The men were not attempting to revive lost traditional practices. French (1989) reports that although 65 per cent of Native Americans are compelled to live within two cultures they are inadequately prepared to live in either. These "marginals" want to become more acculturated to traditional ways but lack the knowledge of how to do so appropriately. Effective transcultural counselling with this group should begin with the enhancement of the traditional identity of the Native-Americans followed by problem-solving training within both cultures. LaFromboise, Trimble, and Mohatt (1990) found there were therapeutic benefits to strengthening the troubled Native American's traditional cultural values and family and community networks.

15.7 Self Abuse

Alcoholism and drug abuse emerged as a major theme for two-thirds of the men. All the men had begun using alcohol at a young age and all had at least one alcoholic parent. It appears that misusing substances was learned from within the family and adopted as a community norm of behaviour. Oates and Altar (1996) found that 100 per cent of the Native men in their study stated that they came from families where alcohol was abused.

15.7.1 Mood Difficulties and Alcohol or Drug Abuse

However, a sub-theme was that it was evident from the men's narrative that mood difficulties were described in conjunction with alcohol use. One participant said that he "coped with those things [negative feelings] through drinking and using drugs, totally getting bombed...". Another man said that
he, "[used drink] when under pressure.... The joint takes everything away. I guess it just masks everything". Yet another man said: "It [alcohol] takes away the pain...". Similar to findings by O'Neill (1993) this study found that the men who said they had experienced depression also had concurrent difficulties with moderate or severe problem drinking. She found that experiencing depression and engaging in drinking was a lethal combination. Half of her respondents who had attempted suicide were depressed at the time of their suicide attempts and had experienced drinking problems.

**15.7.2 The Problems Resulting from Misdiagnosis**

Dalrymple, O'Dohery and Nietsche (1995) found that substance abuse among the Native population of this study's reserve was the most frequent diagnosis when they presented themselves for treatment. These authors consider it possible that this group is suffering also from unrecognized or atypical depression. Their data suggest a significant underdiagnosis of depression in the hospitalized Native group and the authors comment that properly mandating and directing community mental health services to work with depression among Natives would assist in providing adequate mental health treatment and reduce hospitalizations and the risk of suicide. These authors stress the need for community mental health services, culturally sensitive approaches, and substance abuse programs that are targeted to the male population who are in a depressive mood state.

**15.7.3 Problems with Other Forms of Addiction**

As mentioned by one male participant in this study as a sub-theme, alcohol addiction was not the only addictive problem. He stated that many band members abused prescription drugs. One male I interviewed for the study was obviously under the influence of tranquilizers and pain-killers during the session. The local band council and others in positions of responsibility met
while I was visiting the site to discuss problems with certain band members selling prescription drugs to minors. Their goal was to stop at least one doctor in the city from prescribing these types of medications. They were successful. A study done by Kaufman, Brickner, Varner, and Washman (1972) found a high rate of sedative or "minor tranquilizer" prescriptions in an American Indian community. A program to reduce the prescribing of sedatives in their study's Native setting was highly effective.

15.7.4 The Prevalence of Addictions

Unlike findings by Waldram et al. (1997) that only a minority of Aboriginal people experience alcohol-related problems, contrary to the widely held notion that racial stereotyping has encouraged, that of the "drunken Indian", this study found that in the male group, a majority had an alcohol or drug problem or both. This emerged as a major theme. As the authors cited above comment, alcoholism should be seen as a disease that affects individuals, and the fact that some Aboriginal communities appear to experience disproportionately the negative effects of alcohol abuse suggests the fairly uniform negative effects of poverty, racism, and marginalization. The reserve used for this study is situated closely to a city where the use of alcohol is a central social pastime. It is likely that the Native people on the reserve have also been influenced by the heavy use of alcohol by city dwellers. As Mail and Johnson (1993) comment, the failure to learn alternative drinking styles because of prohibition, discrimination, and isolation have permitted the intergenerational transmission of highly distinctive and destructive styles of drinking and of abuse of other drugs or substances.

15.7.5 The Impact of Appropriate Treatment on Mood Difficulties

Boehnlein, Kinzei, Leung, Matsunaga, Johnson and Shore (1993) found that in a Pacific Northwest American Indian community, the prevention and
treatment of alcoholism and affective disorders would have a significant effect on psychiatric and medical morbidity and mortality. A study by Boehnlien et al., like that by Shore, Kinzie, Hampson, and Pattison (1973) and Shore, Manson, Bloom, Keepers, and Neligh (1987), found a frequent co-occurrence of alcoholism with major depressive disorders, particularly among Native males. These authors believe that the high prevalence of alcoholism among males suggests that symptoms of primary depression may be obscured by acute and chronic alcoholism. Nelson, McCoy, Stetter, and Vanderwagen (1992) state that it is the combination of poverty, poor opportunity in jobs and education, frustration, and substance abuse that has led to the high incidence of depression among Native adolescents and adults.

15.8 Subjective Feelings of Distress

A major theme was the men who experienced discomforting feelings explained them as the result of what had occurred in their lives as children.

15.8.1 Feeling Angry

Anger was a sub-theme and a common emotion for the men. They blamed certain sources in particular for their anger. One man believed that his anger came from the way his mother had treated him as a child. He said that even when in school he had been "angry". Another man felt rage at the sexual abuse he had experienced, and his anger was directed at the whole reserve which he believed was "toxic". Another man was angry about his wife's history of sexual abuse. Two men said that their anger was triggered when they used alcohol and one of these men said he "goes after" people when he drinks.

15.8.2 Problems with Sleep

Sleep problems were mentioned as a sub-theme by almost all the men. Two men reported that these were directly associated with childhood
emotional distress. One man had a fear of sleep which he attributed to his childhood experience of sexual abuse. Another man was disturbed during his sleep by nightmares of his dead family members. A third man used drugs to be able to fall asleep but he woke up frequently; he commented that as a child he had to cover his ears to block out the sounds of his parents' drunken fights.

15.8.3 Feelings of Loneliness and Isolation

The men also mentioned feeling lonely and isolated as a sub-theme. One man described this in relationship to his experience of sexual abuse and of being unable to find anyone to talk to about it. He said the experience of being abused had made him feel alone and different. Another man described his need to go places alone when he was emotionally distraught and said he did not know how to talk about his feelings. Another man mentioned his sense of mistrust and not being able to share what he felt.

15.8.4 Related Feelings of Subjective Distress

Hopelessness and fearfulness were mentioned by two men. Feeling teary quite regularly was described by one man. Another mentioned that he experienced uncontrollable physiological distress, which manifested itself in tremors and shaking and which he directly attributed to his experiences of childhood sexual abuse.

15.9 Low Sense of Social Support in Childhood and Adulthood

All these men described childhood experiences in which they received low social support and were victims of abuse as a major theme. For the majority, alcohol or substance abuse was a problem. Two of the four men with drug or alcohol problems had been referred for treatment, and this occurred through the court system.
15.9.1 Treatment Needs

One participant-commentator noted as a sub-theme that treatment for childhood traumatization was removed from the curriculum of available drug and alcohol treatment programs because this component was viewed as an unnecessary. The treatment that was available to people on this reserve was focused only on drug and alcohol behaviours. That the treatment offered was inadequate treatment without this component was supported in the literature.

15.9.2 Social Support Required to Promote Appropriate Treatment

Local encouragement to receive treatment for childhood traumatization is important. As Novins, Harman, Mitchell, and Manson (1996) found, Native students with better support systems were more likely to come to the attention of caring individuals and that students who were given a non-court ordered recommendation to receive treatment experienced a raised perception of social support. These authors also noted that students who received alcohol treatment appeared to have problems in more than just one area, not just with alcohol, including problems were depression and suicidal ideation. Alcohol treatment reduced suicidal ideation among the subjects in their study. These authors noted that recommendations for treatment by caring individuals are rarely made for individuals suffering from distress, yet findings indicate that recommendations for treatment work to reduce both psychological distress and alcohol use and abuse.

15.9.3 Counsellor Training Requirements

Gutierres, Russo, and Urbanski (1994) found that both males and females who entered a drug treatment program had low self-esteem and moderately high levels of depression. Both conditions improved with treatment but self-esteem did not rise to the norm for the general population. They concluded that the large proportion of respondents in treatment who had abuse histories
indicated a need to train drug treatment service providers in the physical and mental health consequences of physical and sexual abuse.

15.9.4 The Long-Term Effects of Childhood Trauma

Gutierres et al. (1994) also noted that victimized individuals may use alcohol or drugs to deal with or even repress trauma, particularly childhood trauma, and, that complicated the treatment of substance abusers. McGrath, Keita, Strickland, and Russo (1990) comment that even after a year of drug avoidance, memories of abuse may resurface and trigger depressive episodes, suicidal ideation, and a return to drug use. They say that a failure to address victimization issues may undermine effectiveness of treatment and heighten probability of relapse. A sub-theme was that the resurfacing of memories appeared to have triggered relapse for at least one participant in this study.

15.10 Exploring Psychological Issues

A major theme was that all of the men who described being victims of sexual abuse commented on the secrecy surrounding the issue on the reserve. One felt that outside helpers encouraged the denial, but another man said his own ability to deny his feelings was a contributing factor. A third man thought that sexual abuse had been prevalent throughout the "entire" reserve the "entire" reserve because his brothers and sisters "went through the same experiences". Two of the three men had begun to deal with some of the psychological difficulties surrounding their abuse by means of court-ordered treatment programs while in jail or on parole.

15.10.1 Problems That Will Arise in Dealing with the Abuse

A sub-theme was that one male participant-commentator stated that it would be "difficult to deal with" sexual abuse issues when they start to "come out more" because of the close-knit community lifestyle and the fact that many band members were interrelated. He thought that addressing the sexual abuse
issue would soon be addressed in the area because he had witnessed people beginning to feel their "anger" about it rather than remaining silent because of "embarrassment".

**15.10.2 Reasons for the Secrecy**

Morrissette (1994) comments that Native parents who were victimized frequently shielded their children from their past by remaining silent. Therefore, many Native youth are unaware of the devastating histories of their parents. Parents are fearful that their children will disrespect them since they did not rebel or fight back against church indoctrination or other discriminations. Morrissette (1994) advocates for the sharing of buried pain and shame to improve parent-child communication and emotional ties:

Some secrets are toxic, engendering debilitating symptoms and erosion of relationship reliability. Toxic secrets are often long-standing.... They are frequently about actions that occurred in the past, but whose power to affect relationships and individual well-being remains alive in the present (p.11)

**Section Two**

**15.11 The Experience of Sexual Abuse**

As a major theme, two male participants stated that their experiences of sexual abuse resulted in fearful psychological re-experiencing of the trauma and anger. They both were abusing alcohol and drugs, were unemployed, and had been involved in criminal activities. Both had also served time in jail. One described how he directed his anger outward in aggressive acts, but the second described chronic fearful and anxious feelings. A third male was married, employed, and functioning normally, and he claimed that his sexual abuse, which was less physically invasive than the experiences of the other two men, had no impact on him.
15.11.1 Misusing Diagnostic Approaches

The reasons for advocating Kleinman's argument for approaching the study of the experience of illness using local ethnographic investigations are based on the information that emerged from the experience of childhood sexual abuse of one of the participants in this study. He was the only participant who had received psychological testing designed to identify and classify his symptoms from a Western diagnostic categorization approach. It revealed that he was "very depressed". In fact, his narrative reveals that he experienced an intense array of distressing symptoms to which he could attribute social or environmental causes.

Psychological testing for victims of sexual abuse that is based on another culture can result in dangerously invalid results. Waldram et al. (1997) describe a study done (Jilek and Roy, 1976) that exemplifies how psychological testing can inappropriately evolve into categorical generalizations. Jilek and Roy found that, generally, Native homicidal offenders were poorly educated, were occupationally unskilled, and had a past history of alcohol abuse; at the same time, these offenders were less likely than non-Native offenders to show evidence of psychiatric illness or sexual deviance. In terms of personality development, a lack of exposure to traditional Native culture was associated with the early onset of antisocial behaviour. However, items for identifying antisocial behaviour in a popular psychopathology assessment instrument are as follows: "I was suspended from school one or more times for bad behavior (True); In school I was sometimes sent to the principal for bad behavior (True); and, I have never been in trouble with the law (False)" (Minnesota Multiphasic Personality Inventory-2, 1989). Native children who are alienated socially from their non-Native peers and attending school away from their reserve would likely encounter these
difficulties as a result of racist attitudes, yet in white society these difficulties saddle them with antisocial personality profiles.

15.11.2 Appropriately Assessing the Reasons for the Development of Troubled Children

Jilek and Roy (1976) found that Native adolescents who showed a positive identification with their Native heritage were more likely to benefit from the education and therapy provided by correctional institutions. This suggests that involvement in traditional Native culture works against the development of antisocial behaviour, a conclusion that minimizes the impact of other factors, such as the presence of local social problems and external racist ones that are revealed in the present study, in the development of troubled Native children.

The case of the Native young man in this study who was psychometrically assessed supports arguments by Native academics against the use of psychological instruments to diagnose Native people (Chrisjohn, 1995). Thus, the use of the Rorschach and other instruments to assess "antisocial personality traits" to profile this young man's difficulties seems inappropriate. He clearly described his traumatic experiences of sexual abuse and the resulting symptoms of fearfulness and the terrifying physiological symptoms. Yet, during the treatment he received after his assessment, only one counsellor suggested a treatment that was appropriate to the sexual abuse experiences he had suffered with their resulting symptoms of shock, terror, and depression.

15.11.3 The Need to Address Abuse Issues

Gutierres, Russor, and Urbanski (1994) found that family dysfunction manifested in (substance use and physical and sexual abuse) undermined the Native individual's ability to respond to treatment. Gutierres et al. (1994) say that a failure to address victimization issues may undermine the effectiveness of treatment and heighten the probability of relapse. The secrecy on this
study's reserve may work to increase vulnerability to psychological difficulties.

15.12 The Inability to Address Psychological Issues

The narratives of the men reveal a major theme that on the whole they had difficulty expressing their emotions. This difficulty was likely exacerbated by the details of the abuse which many of them could not describe. Morrissette (1994) comments that clients are generally reluctant to disclose intimate information about their personal mistreatment or the mistreatment of others. The shame and humiliation experienced by victims inhibits their ability to recount and discuss abusive events. Morrissette (1994) further states that these memories are painful and couched in shame. Recounting abuse is comparable to reliving the abusive experience, consequently a generation of Native people in cruel environments have been left with haunting memories and deep emotional scars.

Section Three

15.13 Suicidal Thoughts and Intentions

A major theme was that the men considered or even attempted suicide. Male participants linked their suicidal thoughts and actions to family problems and to losses, like the death of family members. Three men stated that alcohol use encouraged their suicidal thoughts. Two men attempted suicide while intoxicated, but both also stated that they had considered suicide when sober. Two of the men had lost several immediate family members to suicide.

Two of the men had made several attempts to commit suicide. One man said he attempted suicide so that no one would have to "worry" about him any more. He felt hopeless about his ability to stop using alcohol and to move on with his life.
15.13.1 Reasons for Suicide

A sub-theme was that one man felt his suicide would stop others from worrying about him. O'Neill (1993) found in her study of Native men at the Flathead Reservation in Montana that feeling worthless explained the relative preponderance of suicide attempts among male respondents. O'Neill reported that the feeling of worthlessness was a condition that is marked by a sense of guilt for being selfish and for acting without regard for others, and, that it is a condition to be expected in young men in their late twenties or thirties who are making the difficult transition from the status of "condoned irresponsibility" to the roles of young leader in their family and in the community.

15.13.2 Low Mood, Alcoholism and Suicide

A sub-theme was that the coexistence of alcoholism and depression was for the most part indicative of psychopathological distress for men in this study. Two-thirds of the men stated that their past or present use of drugs or alcohol was related to difficulties with their moods. This too is similar to current research findings (Walker, Lambert, and Silk-Walker, 1993; Ross and Davis, 1986).

Section Four

15.14 Ways of Coping

15.14.1 Healing Families

A sub-theme was that one-third of the male participants approached personal healing through attempts at a familial reconciliation, particularly with parents and spouses. One male stated that he and his friends wanted to be better parents, and another wanted to be a better spouse. Controlling his drinking behaviour around his family was important to one of these men. However, half of the men were unmarried and disconnected from a sense of family.
15.14.2 Rediscovery or Rejection of Native Practices

A sub-theme was the discussion of Native spirituality. One man discussed at length his sense of loss over the absence of older reserve members who would have been able to contribute to the community as elders.

15.14.3 Elders and Mood Problems

The honoured role of elders was lost when traditional practices and beliefs were suppressed. Barney (1994) and Manson (1990) comment that research indicates that Native elders suffer from clinically significant levels of depressive symptoms, more than twice the rate reported for elderly whites. Manson (1990) also notes that on reservations, elders who have access to traditional spiritual healing appear to have less need for other mental health services. With regard to this study's reservation, it may be that elders are suffering from their own psychological problems and do not have access to either Western or Native traditional treatment. With this in mind, their inability to function as elders would explain their absence in this community role.

Section Five

15.15 Experiences in Drug and Alcohol Treatment Programs

A sub-theme was that male participants thought they had benefited from the type of drug and alcohol treatment programs that are made available by government funding. Interestingly, these programs included intense exposure to Native traditional culture. Male participants spoke somewhat positively about the programs offered to them. These men had serious drug and alcohol problems and they had received court-ordered treatment. They noted that the therapy in the programs had encouraged them, and, had offered them the opportunity to begin to exploring their psychological difficulties. However, the men resumed their alcohol or drug use once they returned to the
community. That the men found counselling helpful is supported by research. Oates and Altar (1996) report that Native males want counselling and that they are more apt than non-Native males to discuss or admit to their problems in treatment.

15.15.1 Treatment Implications from Drug or Alcohol Abuse

Dalrymple, O'Doherty, and Nietsche (1995) found in their study, which included band members from this study's reserve site, that long hospital admissions occurred for urban Natives. Economic and social marginalization was a persistent condition that affected length of stay. Length of stay was noticeably longer for Native males, a situation that may have resulted from their greater traumatization by role dislocation and by their higher likelihood of engaging in aggression or in substance abuse. They comment that these behavioural choices may have been the result of the paradoxical adoption by Natives of Western cultural stereotypes of Natives. Oates and Altar (1996) found that half the Native men in their study reported battering their spouses.

15.15.2 The Perils of Inappropriate Treatment Approaches

With regard to treatment, Dinges and Quang Duong-Tran (1993) comment that it is necessary to entertain the unsettling prospect that the current foci of substance abuse and mental health programs for Indian and Native youths have been insufficiently assessed and that they may unintentionally produce chronic disorders (depression) by failure to recognize and respond appropriately to severe comorbid clinical conditions (the coexistence of addictions with a mental illness). One Native participant in this study estimated that at least 40 per cent of the Native band members living on the reserve were depressed at the time the interviews were conducted for this research. Treatment programs that address only the addiction and that ignore the mental health concerns that can both create and perpetuate the addiction,
in fact delimit treatment and may very well encourage the chronicity of such illnesses as depression.

15.15.3 The Importance of Better Understanding Treatment Needs

Narrative data that explores cultural, social, local, and individual understandings about illness or the more general, broader social context of depression provides a better understanding of the illness and of the treatment needs (Garro, 1995; Fineman and Bennett, 1995; Timpson et al., 1988). The causes of the feelings of depression among the participants suggest ways to approach healing.

Treatment that addresses solely the behaviour resulting from depression, that of alcohol use, and not the psychosocial stressors that induced the depressive feelings, does not ameliorate the potentially lethal consequences of the comorbidity of substance abuse with depression and possible suicidal ideation.

15.15.4 Low Mood, Problems in Childhood, and Learning Addictions Young

In this study, a major theme was participants with problems of alcohol abuse were also those who described experiencing the least sense of familial support both in childhood and adulthood. All the men who were abusing substances stated that their abuse of alcohol started early in their lives. Dick, Manson, and Beals (1991) found that the level of family support was related to drinking patterns in Native adolescents. Garrison et al. (1987) comment that adolescence is a period of time when the stress surrounding social, physical, cognitive, and academic growth is enhanced. Feelings of helplessness and powerlessness surrounding major life events may become overwhelming because of the person's lack of experience in dealing with these
situations. Labouvie (1986) states that it is not surprising that adolescents may turn to alcohol to relieve symptoms of negative affect.

15.15.5 The Importance of Family and Acquiring Addictions

Dick et al. (1991) found that high alcohol use was correlated with factors of low familial support. High familial support corresponded significantly with a low rate of intoxication and self-perception of use. Correlations between depression, familial support and stressful life events and alcohol use were found. In this study, a sub-theme was that participants who engaged in alcohol abuse, experienced the least sense of familial support and had experienced the stress of losses. Also, most participants described using alcohol or drugs in their early years and that their parents abused alcohol.

15.15.6 The Need for Treatment Collaboration

Walker, Lambert, Silk-Walker, and Kivlahan (1993) comment that competing and different programs and agenda in the treatment offered for alcohol, drug abuse, and mental health services are not integrated and that they deny the issue of comorbidity. In their research, each provider addressed only one part of the Native patient's mental health care needs. The lack of access to appropriate care remains a serious issue. The programmatic separation of treatment services creates obstacles to the treatment of a patient with more than one problem. Historically, various philosophies in the United States on substance abuse and mental health treatment have differed in fundamental ways. Traditional psychiatry views substance abuse as a psychiatric disorder and treats it with psychotherapy and medication. Substance abuse therapies rely on personal motivation and shared group discussion with the single goal of abstinence. There is evidence that long-term use of alcohol and other drugs can produce symptoms of depression, anxiety,
and other psychiatric illnesses. Treatment fragmentation results in patients continuing to have their mental health needs inadequately addressed.

Boehnlein, Kinzel, Leung, Matsunaga, Johnson, and Shore (1993) comment that a successful program for the prevention and treatment of alcoholism and affective disorders would have a significant effect on psychiatric and medical morbidity and mortality. Psychiatric treatment must go beyond the usual procedures for assessment and medications prevalent in many of the institutions that serve Native people.

15.15.7 Treatment Needs on the Reserve

Protective environments such as detoxification facilities and emergency hospice beds are not present on this reserve. During high-risk periods for Native people this creates difficulties for those living in close community with persons suffering from comorbid symptoms because community members are forced to take care of them. This problem emerged as a sub-theme.

15.15.8 Barriers to Effective Treatment

Band personnel noted that collaborative health treatment models were in the developmental stages, but there had been problems with the modes of collaboration utilized in the past. Problems are not uncommon in Kenora which as Waldram et al. (1997) point out, has the most progressive Native health care site in Northwestern Ontario, biomedical practitioners were reluctant to relinquish control. Only 55 per cent said they would allow a healing ceremony to be held in their hospital. Nurses, who were more exposed to working at the community level where most traditional healing takes place, were much more receptive to collaboration. Non-Native helpers require intensive education before assisting Native people in care delivery in local contexts. Those who are unwilling to adjust their care practices to take into account Native healing practices must be excluded from Native care
delivery. When local funding is managed by Native people, the education and attitudes of helping personnel will change towards a greater acceptance of alternative treatments.

15.15.9 Local Constraints in Help-Seeking

A sub-theme was that the personal treatment that some community members reported having used in seeking help for their illnesses was in some conflict with the vision of social change held by local band leaders and helpers. People who wanted to use Western therapies felt they were being criticized for this. One participant said, "the higher ups on the reserve" were dictating how she should access treatment. Band leaders scorned Western treatment approaches but had not implemented the "holistic" treatment programs they wanted for the community. Forced to collaborate by seeking outside assistance to address local social problems such as substance abuse was occurring only because the federal government provided funding for this type of treatment. However, participants stated that they had to individually cope with their own depression-like symptoms and band leaders recognized the lack of treatment resources as a problem. Prior experience had taught band leaders to be apprehensive about seeking outside assistance with the result that members of the band in distress were left to find individual solutions to psychological distress until political solutions were found. It was an awkward period in the illness experience of the participants and a new paradigm for addressing social problems such as sexual abuse had not yet materialized.

16.1 Gender Comparisons

16.1.1 Childhood Experiences

The women and men described similar developmental processes in gender in their experiences of childhood distress ranging from parental alcoholism to
sexual abuse that laid the foundation for low sense of self esteem. The women acknowledged being affected more greatly by racism than did the men. The narratives of both genders revealed that the school in the nearby city provided a hostile environment that worked against the development of a sense of affiliation and of a positive sense of self worth. This is an area educators must address given that participants stated that their own experiences of racism were being repeated by their children. (Tables 3 and 4).

16.2 The Impact of Losses

For both men and women losses encountered in later years induced feelings of distress. Several participants described experiencing multiple deaths within the family. Whereas, the men who experienced losses engaged in even more drug and alcohol abuse, the stress from these types of losses forced several women to require work leaves because they felt emotionally overwhelmed. There were exceptions and an example is that one man who lost his physical mobility and faced the threat of losing his marriage felt prompted to learn to express his feelings and regain communication with his wife. One woman who thought about "hang[ing]" herself at age thirty, decided to work hard to dramatically change her lifestyle towards improving her health and sense of psychological well-being.

16.3 Mood Problems and Achieving Goals

Women and men both felt that their mood problems and other experiences of psychological distress impeded their ability to achieve life goals. The women appeared to overcome unemployment through local initiatives to employ Native helpers within the community. This offered them options they had not previously envisioned for themselves. Half the men were unemployed, and of those who were working none were engaged in the social services field of social work. Their interests were more in the area of urban
development and planning. Psychological issues were, however, mentioned as ever-present, even for those who were employed. Employed women and men described bouts of emotional distress and wanted more satisfaction in their lives.

16.4 Abuse in Adulthood

Differences occurred in the area of abuse victimization during adulthood. The women described being victimized by abusive interactions with men as adults, while almost half of the men admitted to becoming abusive. Several women had disentangled themselves from their abusive partners but were left alone to support their children. Their decision to end abusive relationships was no doubt made easier because, as helpers, they served as community role models. The men who had become abusive did not describe taking active steps to attempt stopping this behaviour. However, one man who recognized that he could be psychologically abusive towards his wife expressed the opinion that counselling might help.

16.5 Substance Abuse

The majority of the women who had begun abusing drugs or alcohol early in life were able to stop without requiring treatment, whereas the men continued to do so in adulthood. The drinking and drug use behaviours of the men appeared to be more entrenched than the women's. Only one woman mentioned experiencing severe problems financially and socially from her alcoholism.

16.6 Feelings of Distress

Men and women described similar feelings of subjective distress, and anger was a major theme and common emotion experienced by both genders. The women chose to isolate themselves socially and felt this was a symptom of their low mood, whereas the men felt socially isolated and were unhappy
about this. Both genders associated eating and sleeping difficulties with low mood problems. The women were more likely to mention more difficulties with health concerns that were related to their mood. The women also described more incidents of panic-like symptoms than did the men. Both women and men felt that they were unable to explore psychological issues stemming from sexual abuse and other negative experiences because of a community "code" of silence.

16.7 The Impact of Sexual Abuse Experiences

The women did not describe their experiences of sexual abuse victimization as did the men. Instead, the women talked more about feelings that stemmed from these personal violations. The men discussed their inability to describe or address their feelings and focused on secondary behaviours such as drug and alcohol use that resulted from their emotions. The women were more reticent about confronting their abusers than were the men. Both women and men felt that the negative psychological impact of their sexual abuse experiences continued to affect them in adulthood. Several of the women had developed their own self-healing strategies by trying to find forums in which to tell their story and thereby, begin to heal through disclosure. No male mentioned using this approach as a healing strategy except for two who were court-ordered to receive treatment. These two men found therapeutic disclosure helpful.

16.8 Suicide

Almost all the women and men admitted having contemplated suicide at some point in their lives. However, half the male group had actively attempted suicide through violent means. By contrast, the women mentioned that their suicide plans involved "pills", although one woman did say she had thought about hanging herself and another considered rolling herself off the
mountain ledge or cutting herself with a knife. Several of the women and men had lost family members to suicide. Both genders associated drinking and drug use with increased contemplation of suicide. Half of the women had thought about suicide when they were sober but for all, except for one woman in this group, suicidal thoughts had occurred in their younger years. Whereas, half of the men mentioned they had recently thought about suicide when they were not using drugs or alcohol.

16.9 Ways of Coping

Women differed from men in their ways of coping. The women chose to become helpers, and training for this career enabled them to learn ways to help themselves. The men reported that they were reluctant to be placed in familial helping roles. They conceded that they felt uncomfortable or psychologically unable to cope with the demands of distressed family or community members.

16.10 Interest in Native Traditional Practices

The women were far more interested in exploring lost Native traditional spiritual practices than men: only one man expressed an interest in Native traditions. The women were more aware of community-wide treatment needs than were the men. (Tables 5 and 6).

16.11 Attitudes Towards Family

Both genders were seeking ways to change their own family's experiences so that the difficulties they had encountered as children would not still prevail for the next generation.

16.12 Drug and Alcohol Use

More men than women were disabled from what appeared to be their drug and alcohol addictions. Half of the men were unemployed, and these same men had also experienced sexual abuse as children and disruptive childhood
family lives. However, the other half were well employed including one person who had suffered severe physical abuse and deprivation as a child. One-third of the men also had criminal histories, whereas none of the women had been in legal difficulties.

16.13 Attitudes Towards Available Treatments

It would appear that the men's incarceration experiences stemmed from aggressive behaviour while drinking or using drugs. The men who had been exposed to counselling while in jail, both non-Native and Native cultural, were more satisfied with their experience than were the women who had sought out voluntary drug and alcohol treatment that was available locally through federal funding initiatives. The women were disenchanted with the heavy emphasis on Native culture in treatment programs. It appears that they wanted more individual counselling. The women were also more likely to choose to seek help pluralistically or from a variety of sources and they mentioned seeing medical practitioners and attending AA groups and sharing circles. Only one man described receiving more than one type of treatment. After participating in group counselling in jail, he received some individual counselling in an aftercare program in the city. He found both to be helpful, but he had nonetheless resumed his substance abuse behaviours. He had not continued with counselling. In his narrative, he described traumatic symptoms of depersonalization and panic. He had been sexually and psychologically abused repeatedly as a child but this was not addressed in his treatment.

16.14 Receiving Inadequate Treatment

Neither the women nor the men who experienced panic symptoms reported having receiving the treatments that were then available, whether cognitive-behavioural therapy described as an effective treatment approach with Native people (Darou, 1987; Renfrey, 1992), pharmaceutical intervention, or a blend
of the two. The narratives confirm the participants' lack of knowledge and the caregivers' inability to direct participants with intensely felt psychological discomfort to appropriate care. If collaborative models of care-giving were implemented and made accessible to these participants, an alleviation of some symptoms would occur. At the time the interviews were carried out, it appeared that the participants did not have the resources to obtain access to counselling or other interventions to treat symptoms in non-addicting ways.

17.1 Examining Other Sources for Mood Problems

The findings that emerge from this study suggest that the participants believed that there were particular sources for their mood difficulties. For the most part, the participants described their mood problems as socially created. However, it must be explored whether the sources were more individual in nature, either biologically based or secondarily induced by such behaviours as chronic substance abuse. Comorbid illnesses, such as those of depression and alcoholism, need to be more closely investigated. A closer examination on an individual basis is required to better determine individual experiences of mood difficulties and causality. If the sources for the emotional difficulties can be identified, then attention can be paid to these.

Meanwhile, this study explored what participants believed were the sources of their psychological unhappiness. Important information emerged from the major themes in the participants' narrations. This was that from their viewpoint, mood problems were sourced to psychosocially negative experiences that had happened to them. Their insight into these as sources of psychological distress appeared to be beginning to mobilize participants to eliminate these sources as future stressors.

With regard to future research directions, Roland Chrisjohn (1997) comments that participatory research conducted by Native people in their own
contexts will be important. At present, there is a scarcity of controlled investigations by Native people for identifying treatments of choice and for determining their efficacy. Research by Native people will best provide caregivers with information on the therapeutic needs in a community. With regard to social or individual causes for illness, it will also identify what these are and how they should be addressed. Ultimately, the goal of providing culturally sensitive services will be best achieved through Native ownership of the research. One step towards advancing this ownership is that Native psychologists are now able to join their own psychological associations in both Canada and the United States. Research activity and networking are very actively pursued by these professionals.

18.1 Strengths within the Community

It is important to stress the strengths of this community. Weaknesses were described by participants to the study but it must be kept in mind that this was the focus of the narrative material. It is important to note that there existed a strong helper-knowledge base in the community. The narratives revealed that these helpers recognized the existence of local mental health problems. Trained helpers who knew well the psychological needs of the people were few in number but their presence was of great assistance on the reserve. Unfortunately, the work-load of these individuals was dual in nature by the need not just to tackle program development but also to attend to the requirements of their job descriptions. The first need they regarded as essential was that of addressing child welfare. Helpers were actively involved in developing a process to regain control over child welfare from city child welfare control and at the time of interviewing much had been accomplished. This had been the focus of their intervention efforts for several years and this involved a great deal of political wrangling with the non-Native helper system.
Gaining control over their own child welfare provided them with the required funding to address the needs of children and families on the reserve. Possessing both funding and control facilitated Native helpers in providing more appropriate interventions. Their tenacity in this endeavour was admirable.

Helpers mentioned that for the future they envisioned a place for a local medical clinic and on-site practitioners from all professions. Clearly progress was being made and to start the process by addressing the needs of children was an astute move since most participants mentioned that their troubled childhood had precipitated emotional difficulties.

Participants were aware of the social problems related to drug and alcohol abuse, and several had attempted to deal with their addictions difficulties. Several were successful in managing the problems on their own. Issues surrounding treatment programs were also acknowledged, and necessary programmatic changes are likely to follow. The local policing unit included a Native officer, who was able to intervene in disputes before they led to greater difficulties. He could identify the community needs for future policing and crisis-intervention requirements. Local helpers mentioned that they worked well as a team within the community and mentioned that this inter-community collaboration was necessary for their effectiveness. For example, the police consulted with the helpers regularly and these liaisons worked to intervene in community members' problems before they escalated.

Self-identity issues - the sense of who one is in the world - were being addressed through an exploration of lost Native traditional practices, particularly by women participants. This exploration was working towards increased esteem for several of the female participants. The rejection of abusive acculturation strategies by means of both religious and educational
indoctrination was also occurring. Participants discussed their awareness of what had happened to them in the acculturation process, and this knowledge was empowering them to be resistant in the future.

Multi-phasic treatment needs were also recognized as important. Several participants described feeling left on their own to find psychological healing. However, the positive impact of counselling, Native traditional healing, Western medicinal treatments, and other therapies were mentioned as helpful by participants. The evolution of holistic treatment strategies and of collaborative interventions were mentioned as required by several participants, and, it seems that these needs were soon to be addressed. Participants appeared to be moving in a direction where they would be able to choose or reject what they needed for improving their own psychological health.

In my role as interviewer, I was impressed by the strong sense of care the band members felt for each other. The desire to take control of their health needs, whether physical or psychological was very present. Past experience had taught members that they had to carefully develop on-site programs with great care so that negative experiences would not be repeated. I have since learned that elementary school education will be delivered on the reserve in the near future. Until problems in delivering education to Native students are addressed by the school system, the participants in this study will be the best persons to protect children from the psychosocial stressors of racism.

19.1 Strengths and Weaknesses of the Study

This narrative study was exploratory in nature and designed as an initial investigation into what the meanings of the illness experience were for participants who had experienced depression and suicidal ideas. Because I was only well-experienced as a quantitative researcher, I had not anticipated the unwieldy amount of information I would gather from conducting open-
ended interviews on the topics of depression and suicide with the participants. They responded to the research approach by providing life histories detailed with examples of times in their lives in which they understood that they had experienced depression. Had I been experienced as a qualitative researcher, I would have been prepared to focus on a specific time that each person had experienced depression and I would have explored the details of that particular experience more deeply. As it turned out, participants provided me with examples of times when they felt they had experienced bouts of low mood throughout their lives. These experiences coincided with developmental stages and provided knowledge as to what contributed to their experiences of low mood at different stages in their lives. However, a deeper or more textured understanding of the actual experience of the depression itself for each participant was not achieved by this broad interview approach.

More detailed information about an experience of feeling depressed for each individual such as that related to the experience of having been sexually abused was not obtained because of the research approach. Focused and repeated interviews with each participant who had experienced sexual abuse would have revealed more richer information about the depression that was sourced in the sexual abuse experience.

Because I was not prepared for the many sources participants attributed to their experiences of depression, I gathered a great deal of information. Had there been more time for collecting the data, I could have explored the many themes more deeply. Realistically, more experience as a qualitative researcher would have taught me to concentrate on saturating fewer themes for the purpose of exploring each one more fully. A more intensive understanding of the experience of depression related to one theme was limited because I did not concentrate on pre-selected themes. From this error,
I learned the required skills to manageably collect qualitative data in the future.

Because I did not repeat interviews with each participant, each interviewee focused on their negative experiences related to episodes of mood problems in their lives. As a counsellor, I know that an initial interview will elicit the most morbid feelings surrounding the topic of an individual's experiences with depressed affect. Follow-up sessions with clients usually introduce a variety of other feelings, even those related to their sense of personal strengths that they may have also experienced as part of their depression. This information was not collected because participants were not given the opportunity to provide this material through follow-up interviews. The result is data that are slightly one-sided and focused on the most morose aspects of their experiences of low mood.

Ultimately, the data provided a survey of the many factors participants voiced as sources for their mood difficulties. The themes the data reveal provides interesting information to be followed up in future research. The study successfully provided an overview of many themes participants related to depression and offers insight into the complex interplay of factors contributing to mood problems for Native people living on the reserve. Future research must examine the contributions of each factor and the interaction effects of the factors more closely.

Other problems with this investigation involved the size of the sample. For an overview study, it was relatively small, involving as it did only eighteen participants. For a narrative study, it involved almost too many participants. The women outnumbered the men by four, and so the unequal representation was a problem. The proximity of the Native reserve to a nearby city made acculturation influences evident. It would not be possible to generalize the
findings from this to other reservation settings, particularly those sites that are more remote and less influenced by non-Native culture. Most of the participants in this study were in their young to middle adulthood years. The contents of their narratives should not be generalized to either younger or older persons living on the reserve.

As Renfrey (1992) notes, there is much cultural heterogeneity among Native Americans. They are not members of a common culture, but represent a diverse cultural collage. Waldram et al. (1997) note that this diversity is similar in Canada (pp. 5-10). LaFromboise (1988) points out, there are 511 federally recognized Native groups and 365 state-recognized tribes in the United States. More than 200 distinct Native American languages (not dialects) are still spoken. Trimble (1990) notes the complexities arising from these distinctions are increased by the fact that more than 60 per cent of the individuals with Native American status are of mixed heritage and, regardless of blood quantum, can range from very traditional in alliance and custom to fully acculturated to the dominant culture. As Renfrey (1992) notes, stereotypes of Native Americans simply do not apply, and making generalizations across tribal groups should be attempted with extreme caution even though certain general issues are germane to clients from all indigenous groups.

Finally, although the study provided much important information concerning the psychosocial sources contributing to participants' experiences with depressed moods, more objective measures would help to distinguish these psychosocial factors from other, more individual sources of mood problems. For example, individual measures of depression, anxiety, suicidal risk and social measures of psychosocial issues would allow for comparisons to be made using validated instruments. One approach might be to apply a
multiple regression analyses where the models could explain the contribution of personal and social variables (predictor variables) on the experiences of depression (dependent variables). This type of research would provide a clearer understanding of the pertinent personal and social factors and what combination of them contributes most to what kinds of depressive experiences among these Native people. The acculturated nature of the Native people on the reserve would not invalidate the results obtained from instruments normed on the general population, a criticism levied against those doing research using validated instruments to assess Native peoples. With this particular group, this quantitative research approach would provide useful information.
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Table 1

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Note: Participants names are pseudonyms. All women were employed on the reserve.
Table 2

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Note: Participants names are pseudonyms. The employed men worked on the reserve.
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<td>No</td>
</tr>
<tr>
<td>Wayne</td>
<td>Single</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Dan</td>
<td>Married</td>
<td>3</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Appendix I: Consent Form
Consent to Participate in Research Study
Investigation into Suicide and Depression: Illness Meanings in a Northwestern Ontario Native Community

Dear Band Member:

As part of a research project conducted by Cheryl Walker, Doctor of Education student at the Ontario Institute for Studies in Education, University of Toronto, you are being invited to voluntarily participate in individual interviews concerning your experiences, understandings, and beliefs related to depression and suicide in your life and in your community. This study strives to explore how the mental health needs related to depression and suicide can best be addressed in your community. The results of the study will inform local caregivers living on the reserve and Western practitioners about the ways they can best work to promote healing outcomes for Native people. All band members are being asked to participate.

Your agreement to contribute about 60-90 minutes of your time to anonymously participate in a taped interview will be greatly appreciated. Although I will be asking you for personal information, your name will not be attached to any of the documents used in the study and after analyses, tape recordings will be destroyed. Every attempt will be make to preserve your privacy. However, there exists a possibility that someone familiar with a case will read the report and may recognize a participant. Although I, Cheryl Walker, will be visiting your reserve after completion of your interview, you will not be involuntarily obliged to further participate. Your right to withdraw at any time from participation in the study will be respectfully accepted and will not affect any care you receive currently or in the future. Upon completion of this study, a summary of the main findings will be distributed to the Band counselling office.

If you agree to participate, please sign this consent form and give it to the counselling office or to me when your interview begins. Please feel free to contact ___________________ or ___________________ at the Band counselling office or me, at (416) __________. Please call collect if you are contacting me.

Your participation and input is greatly appreciated! Thank you.
Cheryl Anne Walker, Doctoral Student, OISE

Signature of the Researcher: __________________________ Date: __________

I __________________________ agree to participate in the study.

Signature of the Participant: ______________________ Date: __________