"I'm a Stepping Stone to their Healing":
An exploratory study of the role of treatment providers in Aboriginal women's healing from problematic substance use and experiences of violence

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ABSTRACT

The association between women's problematic substance use and their experiences of trauma and violence is well established in the literature. Research has demonstrated high rates of physical and sexual abuse among women seeking drug treatment services. Women who attempt to address their trauma-related concerns through conventional, male-centred substance use treatment options often find they do not succeed. In response, integrated treatment services have been developed to account for women's experiences of trauma. Not well addressed however is the unique experiences of First Nations, Inuit and Métis women.

Guided by the post-colonial feminist framework, this exploratory study applied a community-based, qualitative approach in an attempt to understand what it means to address trauma from a gender-informed lens in Aboriginal women's treatment for problematic substance use. Using the constructivist grounded theory method, I explored the perspectives of drug treatment providers within Aboriginal addiction treatment centres from across Canada.

A secondary analysis of 30 interviews with drug treatment providers in six facilities revealed that trauma and violence, based in historical and contemporary impacts of colonization, are significant concerns in the lives of Aboriginal women. Connections were made between women's histories of violence, low self-esteem, and associated substance use. In addition, parenting challenges and issues with the child welfare system were identified as significant concerns for women in treatment, which greatly impacted their healing journeys. Existing approaches to treatment applied by service providers were explored, and the findings highlighted the importance of culture, identity, and self-esteem building in addressing the trauma and substance use related needs of Aboriginal women. It was found that treatment providers, especially those with lived experience, play a key role in supporting Aboriginal women's healing from violence and problematic substance use. This study directs our attention to the need for further research and policy on the application of trauma-informed and trauma-specific approaches to drug treatment for Aboriginal women.

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Chapter 1: INTRODUCTION

Gender-based violence towards women is a widespread and ongoing problem in Canada. It is a social phenomenon that transcends age, ethnic, religious, social, and economic divisions (Statistics Canada, 2011). Data reveals, however, that there is a disproportionate incidence of violence against First Nations, Inuit, and Métis women in Canada (Brownridge, 2008); in fact, they report the most severe and life threatening types of violence. Between 1997 and 2000, for example, the mortality rate of violence against Aboriginal women was eight times higher than the rate for non-Aboriginal women (Johnson, 2006). The Native Women's Association of Canada's (2010b) Sisters in Spirit database reveals that there are 582 current cases of missing or murdered Aboriginal women and girls in Canada.

When available, cited reports specific to First Nations peoples, non-status First Nations, Inuit, and Métis are presented. The term Aboriginal is used in all other cases to collectively refer to "all peoples of Indian, Inuit, and Métis heritage, including non-status Indians" (Waldram, Herring, & Young, 1995, xi). Although this is not ideal because it overlooks unique historical and contemporary contexts, it is reflective of the extant literature in the field.

Research demonstrates that the legacy of colonization, including residential schools and the current child welfare system, are underlying factors that have led to the high rate of violence experienced by Aboriginal women (Mehrabadi et al., 2008; Puchala, Paul, Kennedy, & Mehl-Madrona, 2010; Standing Committee on the Status of Women, 2011). Chansonneuve (2009) explains that the ongoing effects of colonization on Aboriginal women have resulted in "internalized shame about their identity and culture that leads them to live lives filled with violence, addiction, and mental illness … they have been lost, disconnected from their spirit, culture, language, family and community" (p. 7).

Numerous studies document the profound connections between women's experiences of violence and problematic substance use. A 2004 study, for example, revealed that nine out of ten women in drug treatment report a history of trauma (Farley, Golding, Young, Mulligan, & Minkoff, 2004). There remains a dearth in the literature specific to Aboriginal women's trauma concerns and how drug treatment services should be administered to address these issues.

Drawing on interviews with drug treatment providers, my research addresses this gap in understanding.

In this chapter, I will introduce the topic of my research and discuss the purpose, goals, and rationale for doing this project. First, it is important to discuss the terminology that will be used in this thesis. This is important because the terminology that has traditionally been applied in the addictions and mental health fields has tended to stigmatize and pathologize women's use of substances (Haskell, 2003). This language was often degrading and judgmental (Dell, 2007). For example, in the mid 1980's the "crack scare" centered on unsubstantiated claims about women as immoral, dangerous, and bad mothers (Boyd, 1999).

In this thesis, I use terms that are less individually judgmental of women's use of substances or their responses to experiences of trauma. I have chosen to use the terms *drug use*, *substance use*, or *problematic substance use*, rather than *substance abuse*, *substance misuse* or *substance abuser* because these terms overwhelmingly focus on the actions of individuals who use substances rather than the context of their use. Additionally, terms such as "substance abuse" do not reflect the continuum of substance use problems or harms women face (Poole & Greaves, 2007), and certain substance-related terminology such as "substance abuser" or "addict" can have stigmatizing consequences and lead to barriers to treatment (Kelly, Dow, & Westerhoff, 2010).

For the purpose of this thesis, addiction refers to:

> A primary, chronic disease, characterised by impaired control over the use of a psychoactive substance and/or behaviour. Clinically, the manifestations occur along biological, psychological, sociological and spiritual dimensions. Common features are change in mood, relief from negative emotions, provision of pleasure, pre-occupation with the use of substance(s) or ritualistic behaviour(s); and continued use of the substance(s) and/or engagement in behaviour(s) despite adverse physical, psychological and/or social consequences. Like other chronic diseases, it can be progressive, relapsing and fatal (American Society of Addiction Medicine, 2011).

This definition was chosen because it is encompassing and holistic. Rather than focusing exclusively on the physical aspects of addiction, this definition considers the psychological, emotional, and spiritual aspects of addiction. Further, in this thesis, instead of referring to women who have experienced one or more traumatic life experiences as "victims", which has been identified as disempowering, I use the term "survivors". Additional definitions will be provided throughout this thesis as they arise.

1.1 Background information

Women's experiences of violence and trauma are serious public health concerns and

result in far-reaching consequences, including problematic substance use and mental health problems. Studies relay that approximately two thirds of women seeking drug treatment report lifetime physical and sexual abuse histories (Ouimette, Kimerling, Shaw, & Moos, 2000; Puymbroeck & Gutierres, 2006), with some reports demonstrating nearly universal rates of trauma among women in addiction treatment (Najavits, Weiss, & Shaw, 1997; Thompson Fullilove et al., 1993). Given that the incidence of violence against Aboriginal women is high (Amnesty International, 2009; Johnson, 2006), it is expected that a large number of Aboriginal women entering treatment would have trauma concerns. However, few drug treatment providers question whether trauma is central to the occurrence of problematic substance use among women (Poole & Urquhart, 2009), which may result in a lack of drug treatment services that address substance use from a trauma-informed or trauma-specific lens. Both trauma and trauma-specific approaches stress the importance of service providers who understand the impact of violence and identify trauma as a key variable in understanding women's healing. This study attempts to fill this gap in understanding and gain new insight from the perspectives of treatment providers regarding the relationship between trauma, substance use, and treatment for Aboriginal women.

Covington (2007b) argues that drug treatment services for women should apply a holistic and woman-centered approach where there is understanding and support for trauma-related issues. Research also elucidates linkages between providing parenting supports and childcare for women in treatment and positive treatment outcomes (Covington, 2007b). Further, Dell et al. (2010) established that Aboriginal women require treatment approaches that focus on assisting them in re-claiming their identity as Aboriginal women (or claiming it for the first time) through culturally relevant healing practices.

Aboriginal healing practices based in Indigenous traditions are used to combat the intergenerational effects of colonization. Aboriginal healing practices are "spiritual, wholistic, [and] often connected to expressions of identity, such as land, family and culture" (Williams, Guenther, & Arnott, 2011, p. 24). These cultural healing practices are being implemented in Aboriginal communities and in drug treatment centres across Canada to varying extents (Hopkins & Dumont, 2010). The National Native Alcohol and Drug Abuse Program (NNADAP) is the major funding source for addiction treatment services for First Nations and Inuit communities in Canada (National Native Addictions Partnership Foundation, 2005). Many NNADAP treatment centres provide culture-based healing methods that are central to Aboriginal

traditions. Fewer, however, pay specific attention to the influential role of gender and violence.

1.2 About this thesis

The goals of this study are twofold: to gain knowledge about treatment providers' understanding of their role in assisting Aboriginal women with problematic substance use and experiences of violence, and to contribute to closing this gap in the current knowledge base in this area in order to facilitate an improvement in the quality of care at drug treatment centres for First Nations, Inuit, and Métis women across Canada.

Drawing on interviews with mainly Aboriginal treatment providers undertaken at six NNADAP treatment centres across Canada, this thesis addresses women's experiences of trauma and violence as well as the role of the service provider in the treatment process. Specifically, four research questions structure my analysis:

(1) How do treatment providers at NNADAP treatment centres understand women's experiences of violence as impacting their pathway to problematic substance use, and their subsequent healing journey?

(2) How are self-identity and culture accounted for in the NNADAP treatment providers' practices?

(3) What are the past experiences of treatment providers? Do the lived experiences of treatment providers influence how they respond to their clients?

(4) How do the practices of the treatment providers align with and/or expand the trauma-informed and trauma-specific literature?

This research topic and questions were informed by the parent study, *From Stilettos to Moccasins Research Project*. The main finding of this study was that there is a need for Aboriginal women to reclaim their identity (or to claim an identity for the first time)—that is, to understand who they are as Aboriginal women—in order to heal. The treatment providers also noted that this was essential in their own healing experiences, with 80% of them also in recovery from problematic substance use (Dell et al., 2010).

Keeping these findings in mind, I developed the above research questions in order to fill gaps in existing literature and document new knowledge from the perspectives of drug treatment providers. In addition to a gender and diversity based lens, post-colonial feminist theory is used as a framework for recognizing the historical and social contexts that impact Aboriginal women's lives. The post-colonial feminist theory links racism, sexism, and patriarchy as legacies of

colonization (Browne, Smye, & Varcoe, 2007). Using this theory as a lens for studying Aboriginal women's experiences has allowed me to account for how colonizing practices shape Aboriginal women's current day experiences of substance use and violence.

For this thesis I analyzed data from 30 interviews with Aboriginal and non-Aboriginal treatment providers at NNADAP treatment centres, collected in the original parent study. In the original study, there were 100 community-based interviews undertaken with First Nations, Inuit and Métis women and 38 treatment providers in six NNADAP treatment centres. The Principle Investigator for this project is my Thesis Supervisor, Dr. Colleen Anne Dell, and members of the research team include Aboriginal Elders, treatment providers and directors (including those from NNADAP treatment centres), First Nations, Métis, and Inuit women who have previously been in a drug treatment program, academic researchers, community representatives, and government decision makers (From Stilettos to Moccasins Research Team, 2012). In April 2010, I was added as a member to the research team.

The original research team established four key stages as a part of the research plan. The first stage was to create a semi-structured interview instrument with the involvement of all the collaborators, including Aboriginal women in treatment and treatment providers. Second, interviews with women and treatment workers were carried out through a sampling of NNADAP treatment centres in Canada. Third, the data was analyzed and conclusions were verified with the research participants. And fourth, strategies of knowledge dissemination continue to be applied to inform understanding and practice (From Stilettos to Moccasins Research Team, 2012). My role in this project was to carry out an analysis of the original data and to review and analyze the treatment provider interview data in the third and fourth stages of the research plan, which includes a focus on disseminating the findings in order to improve the quality of care at addiction treatment centres for Aboriginal women across Canada.

1.3 About the author

Central to feminist and constructivist approaches is the significant role of the researcher in shaping the research process. Charmaz (2006) argues that research depends on the researcher's perspective; it cannot exist outside of it. As researchers, situating ourselves in the research process, rather than trying to remove or hide our influence, allows us to achieve greater clarity. Therefore, presenting my position is an important part of this thesis.

I am aware that my background as a non-Aboriginal female frames my understanding of

the research findings in this project. However, my work at the YWCA Crisis Shelter has enhanced my knowledge of the experiences of Aboriginal women living in poverty. I have worked as a crisis counselor at the YWCA for the past two years. The majority of the women that reside in the shelter are of Aboriginal descent. This experience has allowed me to recognize firsthand the role that trauma and problematic substance use play in the women's lives. Many of the women I work with are fleeing violence, have no social support system, and are involved with Child Welfare Services. Poverty and homelessness exacerbate their struggles with substance use, mental health, and trauma.

Throughout all stages of the research process, it is important to recognize as researchers, the position of power that we carry. This summer I traveled to Ghana and volunteered as a Research Coordinator with the Ghana National Education Campaign Coalition. I undertook interviews in small villages with students, teachers and community members. This experience allowed me to reflect on the role of researchers and how we often occupy a place in society of power and privilege. This position gives us the control to interpret and present the perspectives of our research participants. I came away from this research experience understanding the immense importance of conducting research that is community-based and community-driven. I feel that in order to accurately provide communities in need with assistance, they should be the ones to have control over what research takes place, how it takes place and how the findings are used. I am grateful that for my thesis I have had the opportunity to be a part of a research team that has been involved in clarifying my research findings and offering me guidance throughout the research process. This research team includes Aboriginal Elders, treatment providers and directors, First Nations, Métis, and Inuit women who have previously been in drug treatment, academic researchers, and government decision makers (From Stilettos to Moccasins Research Team, 2012). This research team has been essential to the development and progress of my thesis. I will discuss more about this research team throughout my thesis.

1.4 Rationale

Prior to developing my thesis, I was a research assistant/project coordinator on a project titled, *Coalescing on women and substance use: violence, trauma and substance use* with the British Columbia Centre of Excellence for Women's Health. For this project, I introduced trauma-informed approaches to service providers in order to address the needs of girls and

women with mental health, substance use, and addictions concerns. In this role, it became apparent that trauma-informed and trauma-specific practices are rarely implemented in mainstream women's addictions treatment (Gose & Jennings, 2007; Poole & Urquhart, 2009), and there is little documented understanding of what this looks like in Aboriginal treatment centres. Nevertheless, trauma has been identified as significant in women's pathways to problematic substance use (Brems & Namyniuk, 2002; Covington, 2008; El-Bassel, Gilbert, Schilling, & Wada, 2000; Finkelstein et al., 2009; Markoff, Glover Reed, Fallot, & Elliot, 2005; Najavits et al., 1997). Therefore, based on my experiences as a researcher and crisis counselor, I strongly feel that service providers need to be trauma-informed and sensitive to the trauma-related issues of women.

1.5 Outline of the thesis

In chapter two, I present a comprehensive review of the relevant literature to demonstrate the complex linkage between problematic substance use, experiences of violence, and their connection to drug treatment for Aboriginal women. This chapter is divided into two sections. Part one begins with a discussion of the gender differences among men and women's substance use and addiction concerns. It also examines trauma, violence against Aboriginal women, social determinants of health, and the relationship to colonization. Part two of the chapter examines issues concerning drug treatment; it discusses barriers faced by Aboriginal women, the interconnections between trauma and substance use among women in treatment, and pregnant substance using mothers. Additionally, it presents the role of the treatment provider and the trauma-informed and trauma-specific approaches that address substance use and addictions among trauma survivors. Further, it reviews the National Native Alcohol and Drug Abuse Program in Canada and the use of cultural healing practices to address problematic substance use in Aboriginal drug treatment centres across Canada.

In chapter three, I introduce the anti-oppressive theoretical lens that document the impact of gender, race, and history on Aboriginal women's experiences of violence and substance use. Gender, health, and feminist concepts are reviewed. Specifically, post-colonial feminist theory allows me to draw attention to Aboriginal women's current experiences of violence and substance use and how these experiences are influenced by the history of colonization in Canada. This theory adds depth to the research findings and makes visible the layers of oppression that impact Aboriginal women's lives. Subsequently, in chapter four I draw on components of

feminist research approaches, highlighting the dismantling of hierarchical power relations and researcher reflexivity, and discuss the constructivist grounded theory method used in this study.

In chapters five, six, and seven I present the findings of my analysis of the treatment providers' perspectives and experiences. Chapter five specifically focuses on issues concerning violence, problematic substance use, parenting, and the impacts of the child welfare system as key issues of concern in the lives of Aboriginal women in treatment, which greatly impact their healing journeys. Chapter six discusses the role of culture in Aboriginal women's healing journeys and the importance of lived experiences among treatment providers in supporting women's healing from violence and problematic substance use. In chapter seven, I present the treatment practices that service providers apply in assisting Aboriginal women with experiences of violence, highlighting the importance of culture, identity, and self-esteem building. I discuss how these practices fit with the trauma-informed and trauma-specific models of care and women's substance use related needs. The concluding chapter presents recommendations for future research that draws from the perspectives of the treatment providers and suggests policy implications for drug treatment for Aboriginal women.

Chapter 2: REVIEW OF THE LITERATURE

Substance use is an important health, economic, and social issue. Substance use refers to the use of any type drug that the federal government categorizes as having a higher-than-average potential to become addictive (Health Canada, 2009). The problematic use of substances is a devastating phenomenon for women, men, families, and communities across Canada. Problematic substance use has numerous consequences, including heightening the risk of violence, physical and mental health issues, and financial concerns (Varcoe & Dick, 2007). Problematic substance use refers to drug use, dependent or recreational, that is causing problems (Atlantic Canada Council on Addiction, 2011). I do not focus on the frequency of drug use in this thesis, but the effects that substance use has on an individual's life.

This literature review chapter is divided into two sections. Part one discusses the key areas that affect Aboriginal women's pathway to substance use. Specifically, it discusses women's gendered differences from men, the impacts of women's histories of violence and trauma, the social determinants of health, and the intergenerational effects of colonization. Part two explores Aboriginal women's healing from problematic substance use, which includes a discussion of the barriers faced in accessing drug treatment, the interconnections between trauma and substance use among treatment clients, and treatment concerns specific to pregnant and mothering women. In addition, it explores trauma-informed and trauma-specific drug treatment approaches, the significance of the treatment provider, and Aboriginal cultural healing practices. Together, although lengthy, these two sections situate this study in the current empirical literature.

PART ONE: FACTORS IMPACTING ABORIGINAL WOMEN'S PATHWAYS TO PROBLEMATIC SUBSTANCE USE

2.1 Gender and problematic substance use

Over the past decade, researchers and health professionals have recognized that substance use and problematic substance use issues should be addressed using a gender-based lens. This recognition is based on research that concludes that substance use issues manifest differently in men and women (Zilberman & Blume, 2006). Gender differences in substance use are reported

in a variety of areas, including differences in physical and psychological health impacts as well as social consequences. Although women have lower rates of substance use than men, research indicates that women's use of substances is increasing (Niccols, Dell, & Clarke, 2010), placing greater numbers of women at risk of harmful physical and social consequences (Greaves & Poole, 2007). In addition, studies indicate that women progress through their addictive cycle at a faster rate than men (Briggs & Pepperell, 2009), meaning the progression from first use to the appearance of drug related issues and seeking treatment is much faster among women (Zilberman, Tavares, Blume, & el-Guebaly, 2003). This is commonly described in the literature as the "telescoping" effect (Zilberman, & Blume, 2006).

Women experience greater physical and mental health consequences from their use of substances (Niccols et al., 2010). This is largely due to the fact that they metabolize alcohol and other illicit drugs at a slower rate than men, which results in greater harm to the body (Cormier, Dell, & Poole, 2003). Women experience increased morbidity and mortality from their problematic substance use (Zilberman et al., 2003). Further, substance use affects women's reproductive functioning and leads to impacts on fetal development, childbirth, menopause, sexual responsiveness, and early pregnancies (Chansonneuve, 2008).

In Canada, the use of substances is widespread, with alcohol remaining the most commonly used substance (Health Canada, Canadian Executive Council on Addictions, & Canadian Centre on Substance Abuse, 2008). Statistics from the 2004 *Canadian Addiction Survey* reveal that approximately three quarters of all Canadian women (77%) and men (82%) consumed alcohol within the past year before the study (Health Canada, Canadian Executive Council on Addictions, & Canadian Centre on Substance Abuse, 2008). Although women consume lower levels of alcohol, they experience higher consequential rates of malnourishment, hypertension (Briggs & Pepperell, 2009), cirrhosis of the liver, brain shrinkage, damage and impairment, gastric ulcers, breast cancer, alcohol hepatitis, and cardiovascular disease from their alcohol use than their male counterparts (National Center on Addiction and Substance Abuse at Columbia University, 2006; Brady & Ashley, 2005; National Institute on Alcohol Abuse and Alcoholism, 1999).

Prescription drug dependence, specifically on mood-altering medications, is a widespread problem among women (Greaves & Poole, 2007). In North America and Europe, women are prescribed approximately twice as many psychotropic drugs than their male counterparts, which

include benzodiazepines, antidepressants, hypnotics, and antipsychotics (Currie, 2007). The National Center on Addiction and Substance Abuse at Columbia University (2006) claims, "Women of all ages become addicted to prescription and illicit drugs more quickly than men and suffer greater physical, psychological and social consequences" (p. 74). Although there is limited research specific to Aboriginal people and prescription drug use, there has been emerging research that points to a growing problem (Dell et al., 2012). Research from the National Native Addictions Partnership Foundation (2005) reveals that this is particularly an increasing problem among Aboriginal women. Some of the health and social consequences attributed to these mood altering drugs include depression, insomnia, increased anxiety, suicidal thoughts, increased suicide attempts, sexual dysfunction, over-sedation, and increased mortality (Currie, 2007).

Legal substances such as alcohol, tobacco, and prescription drugs are more widely used and cause more damage to society than illicit substances. Often illicit substances receive increased attention (Greaves & Poole, 2007); thus those who consume them can become subjected to severe stigmatization from the general public, health institutions, and social service sectors. Statistics from the 2004 *Canadian Addiction Survey* relay that 12.2% of women and 21.1% of men have used illicit drugs (excluding cannabis) in their lifetime (Health Canada, Canadian Executive Council on Addictions, & Canadian Centre on Substance Abuse, 2008). Although less studied, the use of illicit drugs can result in severe health impacts both directly and indirectly for women (Zilberman & Blume, 2006).

Injecting drugs is considered the most harmful mode of illicit drug use (Poole & Dell, 2005) and can be particularly detrimental to the health of women. For Aboriginal women in Saskatchewan, injection drugs remain a common source of HIV/AIDS transmission. Young Aboriginal females, for example, account for 80% of new cases of HIV due to injection drug use among 15 to 19 year olds (Saskatchewan Ministry of Health, 2011). In addition to HIV/AIDS, the use of injection drugs is linked with high-risk sexual behaviors, such as sex work, which leads to a wide range of health-related consequences (Poole & Dell, 2005).

Research demonstrates that women who use substances tend to experience higher rates of mental health problems than men (Zilberman, et al., 2003; Zilberman & Blume, 2006). As many as two thirds of women with drug use problems have concurrent mental health concerns, such as mood and anxiety disorders (e.g., depression, PTSD, eating disorders) (Cormier et al., 2003;

Zilberman, et al., 2003; Zilberman, & Blume, 2006). In addition, women with addictions are more likely to have attempted suicide than men with addictions (Haseltine, 2000).

Problematic substance use can have damaging social consequences for both women and men, such as child custody concerns, housing issues, and employment problems. However, it has a "greater impact on women because of ascribed societal gender roles and the way women derive their identities" (Covington, Burke, & Keaton, 2008, p. 389). Women are judged more harshly for their drug use (Briggs & Pepperell, 2009), and experience a higher level of stigma and condemnation than men because their drug use conflicts with society's view of femininity and the gender roles of mother and wife (Covington, 2002). This stigma is particularly severe for women who are using drugs while pregnant or mothering (Greaves & Poole, 2007). Stigma and discrimination are key barriers that prevent women from addressing their addictions (Dell & Lyons, 2007). Moreover, stigma can lead women to practice their addictions alone, which further isolates them and can lead to increased guilt, anger, and harm towards themselves (Briggs & Pepperell, 2009; Covington, 2002).

2.2 Gender differences and pathways to substance use

Research has shown that the pathways to substance use are different for women than for men (Covington et al., 2008). Problematic substance use is rarely a single dimension issue for women, and often "women's use of substances is symptomatic of both personal difficulties and of broader social ills" (Dell, 2007, p. 497). Addiction among women is part of a "larger portrait that includes a woman's individual history, and the social, economic, and cultural factors that create the context of her life" (Covington, 2002, p. 1). Problematic substance use is often inextricably linked to women's relationships (Briggs & Pepperell, 2009). Women may originally turn to substances to provide themselves with what their relationships are not providing, for example, energy and a sense of power (Covington, 2002). Research indicates that generally men take drugs to socialize and to be adventurous (Haseltine, 2000). In contrast, for many women drug use offers a means to cope with traumatic life experiences, such as childhood abuse (Brems & Namyniuk, 2002), intimate partner violence, and, for Aboriginal women, the continuing effects of colonization (Niccols et al., 2010).

Traumatic life experiences and other forms of interpersonal violence disproportionately affect women (Clark & Power, 2005). Data reveals that although men are more likely to be

exposed to trauma, women are often exposed to long term high-impact trauma such as childhood sexual abuse, physical violence, and neglect (Hien, Litt, Cohen, Miele, & Campbell, 2009). The concept of trauma is used to depict an event and "a response to violence or some other overwhelmingly negative event" (Covington, 2008, p. 379). The response to this experience can involve intense fear, a sense of helplessness, and horror (Finkelstein, et al., 2004). Trauma is not limited to directly experiencing violence, and can include witnessing violence, having a child taken away from child welfare authorities (Poole & Urquhart, 2009), and the trauma associated with stigmatization due to racism, poverty, sexual orientation, and incarceration (Covington, 2007a). Trauma can be experienced as a one-time event or a series of ongoing experiences over the life span of an individual as well as over generations (Chansonneuve, 2005).

Traumatic life experiences have detrimental health consequences. Trauma alters the way a person develops psychologically and emotionally (Haskell, 2008) and can negatively impact an individual's relationship and attachment to others (Covington, 2007a). Research indicates that survivors of abuse are more likely to be anxious, depressed, and demonstrate feelings of low self worth (Puymbroeck & Gutierres, 2006). A history of trauma and violence is associated with help-seeking behaviors, dysphoria, and higher rates of high-risk sexual behaviors, such as sex work (Evans-Campbell, Lindhorst, Huang, & Walters, 2006). Moreover, experiences of violence are associated with simple and complex post-traumatic stress disorder and suicidal ideations (Cormier et al., 2003). Numerous studies have also shown that a history of trauma and violence can increases an individual's risk for alcohol and drug use (Brems & Namyniuk, 2002; El-Bassel et al., 2000; Farley, et al., 2004; Markoff et al., 2005; Najavits et al., 1997).

2.3 Violence against Aboriginal women

Violence is a major issue in the lives of many women and has far reaching health and social consequences. According to the *Declaration on the Elimination of Violence against Women* (1993), violence against women refers to "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (United Nations General Assembly, Article 1). In contrast, abuse is typically defined as ongoing and often requires some form of relationship between the perpetrator and survivor (Council of Europe, 2007). For example, an intimate relationship, a child-parent relationship, or a relationship initiated by social factors, such as a teacher-child

relationship. Aboriginal women are particularly vulnerable to experiences of violence and abuse due to a wide range of social factors they disproportionately experience, including poverty, racism, the child welfare system (Standing Committee on the Status of Women, 2011), and the inter-generational impacts of colonization (Bopp, Bopp, & Lane, 2003; Brownridge, 2008; Chansonneuve, 2008; Native Women's Association of Canada, 2010b). In 2011, the Standing Committee on the Status of Women crossed Canada to hear from witnesses about the extent and nature of violence toward Aboriginal women. They concluded that they were "seized by the urgency of the situation of violence within which Aboriginal women, men and children live daily" (Standing Committee on the Status of Women, 2011, p. 3).

The issue of violence against Aboriginal women has been analyzed in many reports over the two past decades, including the 1996 *Report of the Royal Commission on Aboriginal Peoples*. This report outlines the risk factors that are linked to violence in Aboriginal communities, including systemic discrimination against Aboriginal people, high levels of substance use, economic and social deprivation, the intergenerational cycle of abuse resulting from the residential schools, impact of colonialism on traditional culture and values, racism against Aboriginal peoples, and overcrowded housing (Royal Commission on Aboriginal Peoples, 1996). Amnesty International (2004) explains that the elevated rates of violence towards Aboriginal women are due to poverty, marginalization, widespread racism, and inadequate protection from the police. Other factors include feelings of devaluation among Aboriginal people, lower educational achievement, higher unemployment rates, lower socio-economic status, a younger overall population, and high rates of cohabitation among common-law partners (Johnson, 2006).

Depending on the research methodology and sample, prevalence rates of violence against Aboriginal women are documented to range from 25% to 100% (Brownridge, 2003). Nevertheless, all studies report that the incidence and severity of violence against Aboriginal women is much higher than that faced by non-Aboriginal women (Amnesty International, 2009; Brownridge, 2003; Johnson, 2006; McGillivray & Comaskey, 1999; Native Women's Association of Canada, 2010b; Standing Committee on the Status of Women, 2011). According to the 2004 *General Social Survey* (GSS), Aboriginal women (15 years of age and older) are three and a half times more likely than non-Aboriginal women to experience violence (Statistics Canada, 2006). The GSS also indicates that 21% of Aboriginal women report spousal violence

compared to 7% of non-Aboriginal women (Brzozowski, Taylor-Butts, & Johnson, 2006).

Aboriginal women report higher rates of life-threatening violence and are subsequently more likely than non-Aboriginal women to suffer physical injuries, receive medical attention, and take time off daily activities as a result (Statistics Canada, 2006). They report experiencing multiple episodes of violence from the same perpetrator and are more likely to fear for their lives (Statistics Canada, 2006). The spousal homicide rate for Aboriginal women is eight times the rate for non-Aboriginal women (Johnson, 2006). It is important to note that the GSS was not designed to take into account socio-cultural differences, such as language barriers and the lack of telephone access in remote Aboriginal communities. As a result, Statistics Canada (2006) admits that the GSS "likely underestimate[d] the true incidence of violence against Aboriginal women" (p. 64).

Non-governmental statistics relay higher rates of violence perpetrated toward Aboriginal women (Brownridge, 2003; Native Women's Association of Canada, 2010b). One study conducted in northern Ontario (n=104) reported that eight out of ten Aboriginal women experienced physical and/or sexual violence at some point in their lives (Ontario Native Women's Association, 1989). Likewise, a recent American study found that 87% of Indigenous women reported experiencing sexual and or physical violence (Bohn, 2003). Almost half of their sample (n=30) were survivors of childhood physical and/or sexual abuse, with over three quarters of the sample admitting abuse by a partner (Bohn, 2003). A 2006 study conducted in Alaska relayed that over 65% of Aboriginal women experienced some form of interpersonal violence. Twenty-eight percent of the sample (n=120) reported childhood physical abuse, 48% rape and 40% partner violence (Evans-Campbell et al., 2006). Data reveals that rates of violence against Aboriginal women are higher in more isolated northern communities, including the Northwest Territories, Nunavut, and Yukon (Johnson, 2006).

Due to an absence of national statistics, Aboriginal women have taken the lead in drawing attention to violence against Aboriginal women and the missing and murdered Aboriginal women in Canada (Amnesty International, 2009). The Native Women's Association of Canada's (2010b) *Sisters in Spirit Initiative* has prepared reports outlining the causes of violence against Aboriginal women and documented a list of missing and murdered Aboriginal women. As mentioned, as of March 31st, 2010, there were 582 cases of missing and murdered Aboriginal women across Canada (Native Women's Association of Canada, 2010). The 2010

report, *What Their Stories Tell Us: Research Findings From the Sisters in Spirit Initiative,* puts forth that Aboriginal women represent approximately 10% of the total number of female murders in Canada; however, they only represent 3% of the total female population (Native Women's Association of Canada, 2010b). Two thirds of the Aboriginal women and girls went missing or were murdered in Western provinces and more than half of the women were under the age of 31 (Native Women's Association of Canada, 2010b). This report demonstrates that Aboriginal women are more likely to be killed by a stranger than non-Aboriginal women (Native Women's Association of Canada, 2010b).

Prior to the Sisters In Spirit Initiative, academic reports often understood violence against Aboriginal women as a "family issue" or an issue of "domestic violence," rather than violence rooted in systemic and gendered racist practices due to the impacts of colonization. The Native Women's Association of Canada (2010b) has found that the intergenerational effects of residential schools are underlying factors that lead to the elevated rates of violence against Aboriginal women and missing and murdered Aboriginal women. In addition, as discussed, the social and economic marginalization that Aboriginal women face, inadequate protection from the police, and racist attitudes pushes them into unsafe circumstances, which increase their vulnerability to experience violence (Amnesty International, 2004).

Sexism and racism are strongly linked to violence against Aboriginal women. According to the Native Women's Association of Canada, (2010b), many missing and murdered women and girls "were 'vulnerable' only insofar as they were Aboriginal women" (p. 2). The case of Pamela George, an Ojibway woman who was murdered in Regina, Saskatchewan in 1995, illustrates the gendered and racialized violence towards Aboriginal women who are involved in the sex trade. Razack (2002a) explains how Aboriginal women who are working in zones where sex work occurs are considered to be in spaces where violence is justifiable and where the law does not protect them. Aboriginal women in these zones are treated as "gendered racial Others," rather than as human beings (Razack, 2002a, p.126). Pamela George was not only denied personhood by her murderers, but also by the justice system and the greater Canadian society (Razack, 2002a). This is a clear theme for many of the missing and murdered Aboriginal women, as Canadian society has shown little reaction to the ongoing violence toward Aboriginal women (Standing Committee on the Status of Women, 2011).

2.4 Social determinants of health and the impact on Aboriginal women

Social determinants of health greatly impact the lives of Aboriginal women, their children, and their communities (Amnesty International, 2009). It is well documented that Aboriginal women in Canada experience lower rates of health in comparison to women in the general population (Chansonneuve, 2007; Native Women's Association of Canada, 2004). The life expectancy for Aboriginal women is approximately five to ten years shorter than non-Aboriginal women (Amnesty International, 2009). Aboriginal women experience disproportionately high rates of problematic substance use, mental illness, suicide, diabetes, cervical cancer, and partner violence (Native Women's Association of Canada, 2007). They are almost three times more likely than non-Aboriginal women to contract HIV/AIDS (Amnesty International, 2009). In addition, they experience elevated rates of poverty and single parenthood (Chansonneuve, 2009) as well as a lack of access to education and safe, affordable housing (Native Women's Association of Canada, 2007). Further, studies indicate that Aboriginal women earn approximately 30% less than non-Aboriginal women and 75% of families headed by Aboriginal women do not earn enough money to meet their daily needs (Amnesty International, 2009).

Social determinants of health influence a wide range of health vulnerabilities, behaviors, and health management (Loppie Reading & Wien, 2009). Although social determinants of health present the social causes that contribute to ill or impaired health, it is important to examine them as they open up the possibility of targeting policies toward specific social factors (Walters, 2003). The Public Health Agency of Canada (2011) lists twelve social determinants of health: (1) income and social status, (2) social support networks, (3) education and literacy, (4) employment/working conditions, (5) social environment, (6) physical environments, (7) personal health practices and coping skills, (8) healthy child development, (9) biology and genetic endowment, (10) health services, (11) gender, and (12) culture.

Inequalities in health and social indicators are the consequence of historically mediated disadvantages including political and economic environments (Browne, Smye, & Varcoe, 2005). These historically mediated disadvantages result in vast inequities in all levels of social determinants of health. Research demonstrates that in the case of Aboriginal peoples, colonialism, racism, social exclusion, and the repression of self-determination "act as distal determinants within which all other determinants are constructed" (Loppie Reading & Wien,

2009). Aboriginal health is largely affected by a range of cultural factors, which include loss of language and connection to the land and mental, emotional, and spiritual disconnectedness (King, Smith, & Gracey, 2009).

The National Aboriginal Health Organization (2007) lists eight broad social determinants that shape Aboriginal health: (1) colonization, (2) globalization, (3) migration, (4) cultural continuity, (5) access, (6) territory, (7) poverty, and (8) self determination. Aboriginal social determinants of health are also influenced by background factors, such as access to health services and geography (National Aboriginal Health Organization, 2007). Many communities that experience social determinants of health inequalities are restricted from access to adequate health services that could improve their health status (Loppie Reading & Wien, 2009). Additionally, social determinants of health can be intersecting and cumulative (Loppie Reading & Wien, 2009). For example, when Aboriginal women are living in poverty they are more likely to experience additional social barriers, such as a lack of employment and positive support networks.

2.5 Colonization

Colonization in the Canadian context refers to the process of encroachment and subjugation of Aboriginal peoples since the arrival of the Europeans; "it refers to loss of lands, resources, and self-direction and to the severe disturbance of cultural ways and values" (LaRocque, 1994, p. 73). This includes the process of ongoing colonization (the ongoing impact of residential schools, the "60's scoop," and the current child welfare system). The effects of colonization particularly had a detrimental impact on Aboriginal women (Native Women's Association of Canada, 2010b). Prior to colonization Aboriginal societies were not male dominated (Smith, 2007); Aboriginal women were respected and experienced autonomy, contrary to the experiences of European women at this time in history (Green, 2007). A report prepared by Amnesty International (2009) explains that "the history of colonialism in Canada has pushed many Indigenous women to the margins of their own communities and of Canadian society as a whole" (p. 6). LaRocque (1994) argues, "We can trace the diminishing status of Aboriginal women with the progression of colonialism" (p. 73). Before the arrival of the Europeans, violence against women and children was described as rare and even non-existent amongst some Indigenous populations (Smith, 2007).

Residential schools were highly destructive for Aboriginal peoples and their communities

(Mehrabadi et al., 2008; Monture-Angus, 1999; Schissell & Wotherspoon, 2002). Between 1831 and 1998, there were at least 130 residential schools that operated across Canada (Reimer, Bombay, Ellsworth, Fryer, & Logan, 2010). For over 150 years, the residential school system forcibly removed over 100,000 children from their homes in an attempt to assimilate Aboriginal children and "kill the Indian" in the child for European civilization and economy (Mehrabadi et al., 2008). For as many as five generations, Aboriginal children in Canada were taken away from their families and communities and were taught to be ashamed of their heritage, language, customs, spiritual traditions, and way of life (Chansonneuve, 2007). Physical and sexual abuse occurred regularly at residential schools (Schissell & Wotherspoon, 2002; Mehrabadi et al., 2008).

Provincial governments are currently repeating the pattern of the past by removing disproportionately large numbers of Aboriginal children from their communities and families and placing them in the care of child welfare systems (Saskatchewan Child Welfare Review Panel, 2010). Research estimates that Aboriginal children are six to eight times as likely to be placed in foster care than non-Aboriginal children (Saskatchewan Child Welfare Review Panel, 2010). There are now three times as many children in the care of child welfare agencies than at the height of operations of residential schools (Assembly of First Nations, 2006). The disproportionate number of Aboriginal children being removed from their families and communities is largely due to the high proportion of Aboriginal people living in conditions of poverty, unfunded family services and programs (Amnesty International, 2009), and high rates of problematic substance use (Chansonneuve, 2008). While some of these children are the recipients of abuse, neglect continues to be the main reason that families become involved with child protection services, which is largely due to substance use and mental health issues (Saskatchewan Child Welfare Review Panel, 2010).

The Saskatchewan Child Welfare Review Panel Report (2010) demonstrates that 49% of primary caregivers (which are mainly women) reported alcohol use issues, 31% had drug/solvent use problems, and 46% were involved in violent relationships. The overrepresentation of Aboriginal children in the foster care system has a tremendous impact on the children involved, families, and Aboriginal communities as a whole. Many of the children that are removed are never reunited with their families and may never have the opportunity to reconnect with their culture and traditions (Amnesty International, 2009). The removal of children can also have

destructive impact on the mother's wellbeing; Chansonneuve (2008) explains that "according to frontline workers this has had devastating consequences for Aboriginal women who, after losing their children and subsequently their subsidized housing and welfare benefits, became enmeshed in the street/ drug culture and sex trade" (p. 8).

The intergenerational trauma resulting from colonization continues to have a damaging impact on Aboriginal people and their communities today (Chansonneuve, 2005), creating generations of traumatized children (Schissell & Wotherspoon, 2002). Intergenerational trauma refers to "the effects of trauma [that] are not resolved in one generation … [are] passed from one generation to the next" (Chansonneuve, 2005, p. 51). Monture-Angus (1999) argues, "This terror of residential schools is not a terror of the past alone; it constantly recreates itself and continues to transform Aboriginal communities" (p. 24). These schools have caused devastating socio-cultural changes, including disengagement by many from their ancestry, culture, language, family ties, and community networks (Loppie Reading & Wien, 2009). In a report prepared for the Aboriginal Healing Foundation, Reimer et al. (2010) contend that the intergenerational effects from the residential schools include family violence, drug use and addictions, physical and sexual abuse, loss of parenting skills, and self destructive behaviors.

Brave Heart's (1999) groundbreaking work on historical trauma among the Lakota people indicates that standard definitions of post-traumatic stress disorder do not adequately represent Aboriginal experiences of intergenerational trauma. Brave Heart describes historical trauma as the "cumulative and collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide" (1999, p. 2). This study explains that when there is unresolved grief, which impairs or delays mourning due to massive loss, it manifests itself later on through symptoms such as depression, suicide, and problematic substance use.

This section presented research studies and relevant literature regarding problematic substance use, violence against Aboriginal women, the impact of the social determinants of health, and the intergenerational effects of colonization. Drawing attention to the historically mediated disadvantages that lead to the current health status of Aboriginal women is essential to understand Aboriginal women's healing from violence and substance use. The next section reviews the literature regarding drug treatment and the need to make drug treatment centres and

their providers cognizant of Aboriginal women's histories in the context of gender-based violence and intergenerational trauma.

PART TWO: ABORIGINAL WOMEN AND DRUG TREATMENT CONCERNS

Many women with substance use and addiction problems never attend drug treatment. This is due to a variety of reasons, including a lack of gender-specific programs, stigma and shame, absence of childcare options, lack of family support, and for Aboriginal women, the lack of Aboriginal specific services (Currie, 2001). Research findings provide support for integrated system level responses using both community and residential services to reduce substance use problems in order to improve a wide range of health, social, and criminal justice outcomes (National Treatment Strategy Working Group, 2008). Suitable drug treatment options depend on the severity of the substance use problem. Some available alternatives in Canada include: pharmacological approaches, brief interventions, more intensive outpatient and day treatment and short and longer-term residential treatment (National Treatment Strategy Working Group, 2008). This section focuses on literature regarding residential drug treatment services.

There is a dearth of literature specific to drug treatment approaches for Aboriginal women, therefore this section draws on related research that guides this work. Reviewed are the barriers that are faced by Aboriginal women seeking drug treatment, the interconnections between trauma and substance use, and issues for pregnant and mothering women who use substances. In addition, this section explores helpful drug treatment practices, the importance of the treatment provider in client healing, Aboriginal healing practices, and the National Native Drug Abuse Program in Canada. This section concludes with a discussion of the need for integrated, trauma and gender informed drug treatment services for Aboriginal women.

2.6 Drug treatment and the barriers faced by Aboriginal women

Drug treatment programs were initially developed using a male perspective (Briggs & Pepperell, 2009). These treatment approaches had the view that the needs of women and men were essentially the same (Dell, 2007) and were designed to be confrontational. Specifically, they would "seek to break down the substance misuser's defenses" (Puymbroec & Gutierres, 2006, p. 251). For example, service delivery is judgmental and individuals in treatment are told to take responsibility for their substance-using behavior. However, this strategy has been

identified as problematic for women, as it can exacerbate their feelings of guilt and shame about their drug use (Covington, 2002).

In a report prepared for Health Canada, Currie (2001) outlines the key barriers that impede women's entry into drug treatment or continuation of drug treatment services. Four key areas are identified: personal, interpersonal, societal, and program/structural barriers (Currie, 2001). Personal barriers include shame and embarrassment due to social stigma, lack of confidence in the treatment centre's effectiveness, and accepting the belief that addictions are a personal matter (Currie, 2001). Interpersonal barriers include fear of losing one's children and a lack of family support. Societal barriers include the social stigma related to addiction concerns. And finally, program barriers include costs concerning treatment, lack of childcare services within treatment programs, and lack of flexible or appropriate gender-specific treatment options (Currie, 2001).

There are also unique reasons that deter Aboriginal women from accessing drug treatment services. The Women's Health Bureau (2001), a Canadian forum that brought together key addiction specialists, service providers from both on and off-reserve alcohol and drug treatment programs, Aboriginal women, and Aboriginal organizations, identified key areas impacting Aboriginal women from seeking drug treatment. For instance, Aboriginal women are greatly impacted by stigmatizing and negative attitudes in society towards women with problematic substance use concerns (Women's Health Bureau, 2001). These stigmatizing views present significant barriers for Aboriginal women accessing treatment. In addition, not being able to take their children to treatment and fear of having their children apprehended are very real concerns for Aboriginal women (Women's Health Bureau, 2001). As discussed earlier in this chapter, in many cases child welfare services regard substance use as reason alone to apprehend children. This creates a major problem for Aboriginal women in need of treatment.

Other barriers identified in the literature, include cultural barriers, including a lack of Aboriginal specific programs and shortage of Aboriginal staff in drug treatment centres (Currie, 2001). There also exists a lack of positive community supports and role modeling to encourage Aboriginal women to access drug treatment (Currie, 2001). Moreover, other barriers to accessing treatment include a fear of forced treatment, a lack of treatment readiness, coexisting mental illnesses, and guilt or denial about their substance use (Niccols et, al., 2010). Furthermore, many

treatment services are not gender segregated; thus, women who have experienced partner violence often do not feel safe in a co-ed treatment programs (Niccols et al., 2010).

In general, there is limited research that explores Aboriginal women's encounters with drug treatment services or health care services. Those that do exist indicate that there are formidable barriers which prevent Aboriginal women from accessing sensitive health services that respond to their needs (Benoit & Carroll, 2001). The few available reports illustrate that Aboriginal women often do not seek out health care unless absolutely necessary, because health care practices are expected to be alienating and service delivery is expected to be discriminatory and judgmental. Browne, Fiske, and Thomas (2000) argued that "the prevailing reality remains that health care institutions are powerful symbols of a recent colonial past" (p. 8). Benoit and Carroll's (2001) study with Aboriginal women in Vancouver's Downtown Eastside identified two main barriers to health care: access issues and support service concerns. Their report indicated that when discussing access issues, Aboriginal women "highlighted the importance of a nonjudgmental, encouraging, non-task-oriented environment, greater gender sensitivity, and more woman-centered care" (Benoit & Carroll, 2001, p. 4). In addition, they emphasized the importance of culture-based programs that include Aboriginal healing methods and the need to for health care services to focus on Aboriginal women's specific health care needs.

Helpful drug treatment for Aboriginal women includes gender and culture-informed approaches to care practices. For example, Covington, Burke, and Keaton (2008) argue that drug treatment with women requires an understanding of their unique differences from men. In addition, studies indicate that Aboriginal women require treatment services that focus on assisting them in re-claiming (or claiming for the first time) their identity as Aboriginal women by including culturally relevant healing services while they are in treatment (Niccols et al., 2010). A respondent in a 2007 report by the Aboriginal Healing Foundation (AHF) explains:

> Women need places to explore the impacts of colonialism in terms of its patriarchal influence over women and how that's been integrated into Indigenous attitudes and behaviours within Inuit, Métis and First Nation tribal systems so women can articulate for themselves what this has meant in terms of their own experience (as cited in Chansonneuve, 2007, p. 65)

The AHF report identified examples of gender-sensitive approaches to care for Aboriginal women in drug treatment. These included: (a) safety from further violence, (b) approaches that address the stigma and discrimination experienced by substance-using women, (c) gender-segregated counseling for women healing from violence, (d) treatment approaches based on the

needs of pregnant women, and (e) an integration of culture and teachings about Aboriginal history. This literature indicates that there is a need to address deficiencies and increase the delivery of culturally relevant and gender-specific services for Aboriginal women. The next section focuses on the links between trauma and substance use in the context of drug treatment.

2.7 The interconnections between trauma & substance use for women seeking services

Substance use is closely linked to trauma among women, particularly its use as a coping strategy for women in the aftermath of violence (Women's Health Bureau, 2001). The interconnections between trauma and substance use are evident when analyzing studies on women seeking drug treatment services. For instance, research demonstrates that women in drug treatment report considerably higher rates of violence and trauma in comparison to women in the general population (Engstrom, El-Bassel, Go, & Gilbert, 2008). A study undertaken by Poole (2007b) at the Aurora Centre, a women's treatment program located in Vancouver, illustrates this connection. Information gathered from 209 women who entered residential and day treatment services in 2005 revealed that 63% had experienced physical violence and 41% had experienced sexual violence. Moreover, 46% had experienced sexual abuse as children (Poole, 2007b). Notably, 54% of the women indicated that assistance with their past experiences of violence and abuse issues was rated as "very important to address" while they were receiving treatment services (Poole, 2007b, p. 212).

The statistics differ based on the population studied and the methods of data collection used (Markoff et al., 2005); however, research demonstrates profound connections between experiences of trauma and problematic substance use. For example, a 2008 cohort study of Aboriginal women and girls living in either Vancouver or Prince George, BC who had used illegal drugs in the preceding month demonstrates high rates of sexual abuse among young Aboriginal women who use drugs; 75% of those living in Prince George and 66% of those living in Vancouver experienced sexual abuse (Mehrabadi et al., 2008). A study from the United States found that over 50% of women with mental health disorders had a co-occurring substance use problem, and nearly all were rooted in histories of traumatic life experiences (Fallot & Harris, 2004). A 2004 study concluded that nine out of ten women in addiction treatment report a history of trauma (Farley et al.). Other reported estimates indicate that between 55% and 99% of women seeking treatment have had lifetime histories of trauma (Najavits et al., 1997).

Despite the high rates of trauma histories among women with addictions, there has been little integration of trauma within drug treatment services (Gose & Jennings, 2007), and few treatment providers recognize how trauma is central to the occurrence of drug and mental health problems among women (Poole & Urquhart, 2009). Studies indicate that the high prevalence of traumatic events among those experiencing addictions contributes to high dropout rates among clients at treatment centres (Farley et al., 2004). Research reveals that "trauma histories complicate engagement and continuation in services; women felt unwelcome and often left services that were not sensitive to the breadth and depth of trauma's impact on their lives" (Fallot & Harris, 2004, p. 187). Additionally, misidentified or misdiagnosed symptoms of trauma can interfere with a person reaching out and accessing substance abuse treatment, hamper their engagement in treatment, contribute to non-completion of programming, and increase the likelihood of relapse (Finkelstein et al., 2004).

2.8 Pregnant and mothering substance-using women

The focus of this thesis is not on pregnant or mothering women; however, relevant literature is highlighted here because pregnant women or women who are mothering young children while using substances face unique barriers to treatment and care (Hume & Bradley, 2007). Reports from Tait's (2000) study in Manitoba revealed that 89% of pregnant women reported experiencing barriers to accessing drug treatment services. These were barriers related to women's children, to social support networks, to the specific treatment programs as well as psychological and geographic barriers. A key barrier that many women face is the lack of integrated drug treatment programs for pregnant or parenting substance using women and their children in Canada (Niccols et al., 2010). This lack of childcare presents an additional barrier for women with children who are seeking treatment, and given that many of the women face economic challenges, they are often forced to manage their substance use and parenting concerns without any addiction services (Hume & Bradley, 2007).

Other barriers to drug treatment are the child welfare policies that place women, particularly Aboriginal women, who admit to substance use during pregnancy at risk for losing custody of their children (Salmon, 2007). These policies make it difficult for women who use substances while they are pregnant to seek out help for their addictions (Poole & Dell, 2005). Moreover, literature indicates that when substance-using pregnant women do seek out assistance from the health service sector they often face judgmental attitudes and are vilified for their use of

substances (Poole & Urquhart, 2010). Public discourse continues to blame pregnant women and focus on fetal and child health rather than understanding the mother and child as a unit whose health is intertwined (Greaves & Poole, 2007). This was highlighted in the case of Ms. G, a pregnant Aboriginal woman that was sentenced to mandatory residential treatment for her use of substances in Winnipeg (Dell, 2007; Roy, 2005).

Despite national efforts to create a paradigm shift and employ a more woman-centered response, there remain significant barriers to access treatment services by women with children (Poole & Urquhart, 2010). Studies illustrate that women-centered harm-reduction approaches help to stabilize and improve the health of pregnant and mothering women. Harm reduction services refer to programs, policies or interventions that attempt to minimize or reduce the harms associated with substance use, without requiring an individual to discontinue use (Beirness, Jesseman, Notarandrea, Perron, 2008). Moreover, research reveals that outreach services that provide gender-specific care are in a key position to offer assistance to high-risk pregnant women (Tait, 2000). This was evidenced by the research conducted at Sheway, an outreach and drop-in program in Downtown Vancouver. Statistics reveal that 30% of the pregnant women who accessed Sheway had no medical or prenatal care and over three quarters (79%) had nutritional concerns at intake (Poole, 2007a). Upon completion of the program, 91% of the women were connected to a physician or midwife and only 4% had nutritional concerns at six months postnatal. These findings reflect the outcomes of more compassionate, non-judgmental, and realistic options for improving the health of pregnant substance-using women.

Research demonstrates that drug treatment programs for women should include education in parenting, child development services, and counseling that addresses relationships with children (Covington, 2007b), and that this is particularly important for women who have a history of trauma and violence. For instance, some of the parenting challenges for trauma survivors with substance use concerns include: (1) shame, inadequacy, and guilt associated with parenting; (2) relationship with child may trigger a mother's memories of her traumatic experiences, therefore, mother may act neglectful; (3) mothers who have experienced trauma risk being too overprotective of their children; and (4) survivors of trauma often have not learned parenting skills because they were inadequately nurtured as children (Covington, 2007b). Drug treatment approaches need to reflect the realities of women in treatment. For many women, this includes a history of trauma and mothering/pregnancy concerns.

2.9 Helpful drug treatment practices and the importance of the treatment provider

Women recover from their addictions in an environment that is characterized by safety, connections, and empowerment (Covington, 2000). Treatment components associated with positive outcomes include workshops that address gender-specific topics, supplemental services, a focus on mental health issues (Niccols et al., 2010), longer lengths of treatment, and greater involvement in counseling activities (McLellan, 2006). Highly supported principles for treating women with substance abuse and trauma issues were developed by Covington (2002), which include the use of women-only groups, a comprehensive system of care that addresses the complexities in women's treatment, and an environment that fosters safety and respect.

Creating helpful drug treatment for women involves providing care in a supportive, non-judgmental way (National Center on Addiction and Substance Abuse at Columbia University, 2006), whereby treatment providers take into account the varying characteristics of women's psychological needs (Covington, 2008). Studies indicate that the treatment provider plays a key role in the success of patients in drug treatment centres (McLellan, 2006; Nordfjaern, Rundmo, & Hole, 2010). The relationship between the treatment provider and their clients is often described as a "therapeutic alliance." Gaston (1991) explains that the therapeutic alliance has four components: (a) the client's ability work on his or her problem, (b) the emotional bond with the therapist and patient, (c) the counselors empathy towards the clients experiences, and (d) agreement between the client and therapist on the goals of treatment (as cited in Substance Abuse Mental Health Services Administration, 2006). Studies note that the therapeutic alliance plays a key role in reducing risk of early dropout at treatment centres (Cournoyer, Brochu, Landry, & Bergeron, 2007; Nordfjaern et al., 2010; Palmer, Murphy, Piselli, & Ball, 2009). The therapeutic alliance, whether provided by the perspective of the client or the therapist, was a significant predictor of treatment participation and alcohol consumption during treatment and 12-month post treatment (Connors, Carroll, DiClemente, Longbaugh, & Donovan, 1997).

Research demonstrates that a treatment plan that individualizes a client's treatment needs is effective (Sellman, 2009). It is also important for women in treatment to focus on their strengths and to be assisted through the development of mutual growth-fostering relationships with their treatment providers (Covington, 2002). Moos (2003) argues that when counselors are empathetic, supportive, and able to establish a therapeutic alliance with their clients, they will enhance their involvement and success in treatment. Similarly, a supportive group and residential

treatment setting will enhance patients' participation in treatment and contribute to a reduction in substance use (Moos, 2003). White, a researcher in addiction treatment, noted that the major factor related to recovery is the presence of hope (as cited in Bannerman, 2000).

In their study for AIDS Programs South Saskatchewan, Stadnyk, Kennedy, and Smith (2007) surveyed women who injected drugs (78.3% of the respondents were Aboriginal), asking participants what they wanted service providers to know about their lives. One respondent noted, "Most women that do drugs are using some sort of mind altering chemical to escape from all emotional problems" (Stadnyk, Kennedy, & Smith, 2007, p. 25). Another woman explained, "They need to know what I am going through and how I feel" (Stadnyk et al., 2007, p. 25). These quotes indicate that women with substance use concerns want service providers to understand the underlying issues of their substance use. Treatment providers should have an awareness of the lives that their clients lead in order to provide support in a non-judgmental way and validate women's past experiences of trauma. A client in a drug treatment centre expressed how a treatment provider positively helped her to heal:

> I was trying to treat my symptoms of anxiety and PTSD [post-traumatic stress disorder]. I was suicidal; I just wanted to die everyday. I couldn't eat or sleep and I had body memories every day and was dissociating all over the place. I felt like I was damaged goods and I was never going to go anywhere. I was despondent and hopeless and they just let me be that way and they let me wail and whine. They never said I was a bad person and they always understood, they said, 'Why wouldn't you feel like this?' That validation finally made me okay. (as cited in Chansonneuve, 2007, p. 19)

A 2010 study on the role of the treatment provider in the healing of First Nations, Inuit, and Métis women identified specific skills and traits in treatment providers important to women's healing journeys (Dell et al., 2010). Aboriginal women identified the need for their treatment providers to relay empathy, show that they care, and recognize the impact of trauma and the struggles they have faced due to their drug use (Dell et al., 2010). In addition, they wanted their treatment centre staff to support their healing through spirituality and provide them with inspiration by acting as positive role models. The women also noted that they benefitted from non-hierarchical communication and wanted their treatment providers to assist them in moving towards the future.

2.10 Background of treatment providers

There have been very few studies that have researched the background of treatment providers (Mulvey, Hubbard, & Hayashi, 2003), with the majority of the studies focusing on the

credentials of drug treatment staff. Research indicates that treatment providers are more educated than was previously thought and generally come from different racial and cultural backgrounds than their clients (Mulvey et al., 2003). At times, this can create challenges in providing culturally relevant services and implementing and supporting cultural healing practices.

Recovery status has been identified as an important characteristic of treatment providers working in drug treatment centres (Stoffelmayr, Mavis, & Kasim, 1998). One American study (n=643) demonstrated that 44% of treatment providers are non-recovering, 30% are recovering and 26% identified that they were non-recovering but are part of families with addicted or recovering family members (Stoffelmayr et al., 1998). This study identified how recovering staff pursued a wider range of treatment goals and used more varied treatment approaches than non-recovering counselors. Humphreys, Noke, and Moos's (1996) study displayed similar findings; staff (n=329) who were in recovery were associated with endorsing a diversified approach to treatment and viewed their clients as a non-homogeneous population. Additionally, recovering treatment providers are associated with programs where treatment approaches apply a 12-step approach (Humphreys, Noke, & Moos, 1996).

Forman, Bovasso, and Woody's (2001) American study analyzed treatment providers' beliefs about addiction treatment practices. This study found that 84% of the treatment providers (n=317) in the sample supported the use of spirituality-based approaches and 82% of the respondents supported the use of 12-step-oriented methods. More than 80% of the treatment providers supported research-based interventions. Additionally, 35% of the respondents indicated that confrontational approaches should be used more in treatment, and 46% felt that it is appropriate to discharge noncompliant patients (Forman, Bovasso, & Woody, 2001). These findings contrast with the gender-informed research that emphasizes the importance of compassionate and client-centered care rather than the use of confrontational approaches (Covington, 2002). Moreover, what remains under-researched are the ways in which the role of treatment provider and trauma-informed approaches can specifically address the needs of Aboriginal women in drug treatment.

2.11 Trauma-informed and trauma-specific treatment

As discussed, drug treatment services need to address the realities of women's lives and examine the underlying pathways to substance use, which for many women entails experiences of trauma. In order to assist Aboriginal women who have trauma histories and addiction

concerns, there needs to be increased trauma-informed and trauma-specific treatment available in Canada. The more effectively trauma-informed and trauma-specific services can work together, the more those dealing with substance use issues and trauma histories will benefit.

Trauma-informed services incorporate the larger clinical, community, and government structures that influence a woman's access to treatment and care (Hien et al., 2009). Trauma-informed services are those in which service providers have an understanding of the impact of violence and abuse on an individual's life and development (Elliot et al., 2005). Therefore, in order to provide trauma-informed services, all staff must understand how violence impacts the lives of their clients. This understanding of the impact of trauma among providers can reduce the probability of re-traumatization and validate the significance of trauma in women's lives (Elliot et al., 2005). Further, it will allow health service providers in all fields to make referrals to trauma-specific agencies, which can aid in the healing of women who have experienced trauma or violence.

Trauma-specific treatment assists women with directly addressing their experiences of trauma and its impact on their lives (Hien et al., 2009). In the past, psychiatric and drug treatment providers stressed that clients need to first address their addiction symptoms before they can focus on healing from their experiences of trauma (Hien et al., 2009). However, new research challenges this position and puts forth that both addictions and experiences of trauma should be addressed concurrently (Hien et al., 2009; Puymbroec & Gutierries, 2006). Studies demonstrate that there are positive effects when there is counseling for both trauma and addictions during drug treatment (Briggs & Pepperell, 2009; Covington et al., 2008; Poole & Urquhart, 2009). Data reveal that when trauma symptoms are treated, alcohol and drug relapse probability is decreased (Farley et al., 2004; Hien et al., 2009).

The National Trauma Consortium has developed trauma-specific models for women with trauma histories and co-occurring substance use issues. There are five trauma-specific models and each model has a unique way of addressing trauma histories. Overlapping amongst these models is that they are (a) cognitively-behaviorally based, (b) stress safety first, and (c) address trauma within the context of addiction. Each trauma-specific method is briefly reviewed here. This information is important in order to provide some background information on the varying models, which can be used as comparison point for offering more trauma and substance use integrated care to Aboriginal women.

Seeking Safety: A Treatment Manual for PSTD and Substance Abuse is the most widely known evidenced-based, trauma-specific model (Hien et al., 2009). Its creator, Najavits (2002), notes that "safety expresses its basic philosophy" (p. 136), which includes reducing suicidal thoughts and behaviors, discontinuing substance use, ending unhealthy and abusive relationships, and gaining control over behaviors (Najavits, 2002). After safety has been established, treatments such as exposure therapy and trauma processing can assist in healing (Najavits, 2002). This model has been tested numerous times, has consistently shown positive outcomes for trauma survivors (Najavits, 2002). This model has also demonstrated improvements in other areas of the survivor's life, such as lowering the amount of suicidal behaviors, HIV risk, and improvements in the relationships among participants (Hien et al., 2009). A second model is the *Addictions and Trauma Recovery Integration Model* (ATRIUM). This approach is based on the premise that trauma impacts an individual's mind, body, and spirit (Finkelstein et al., 2004). It integrates cognitive-behavioral treatment while emphasizing the effects on all three levels (Finkelstein et al., 2004).

Third, *Helping Women Recover* is based on a theoretical framework that integrates art, interpersonal relations, and cognitive-behavioral theory. The curriculum utilizes a journal and provides a place for women to complete exercises and record reflections (Finkelstein et al., 2004). A fourth model, *Trauma Recovery and Empowerment Model* (TREM) addresses problematic substance use throughout the treatment intervention (Finkelstein et al., 2004). TREM consists of three major parts: empowerment; a focus on trauma and its impact on the individual; and skills building. One study indicates that over 95% of the participants reported that TREM was helpful to them (Fallot & Harris, 2004, p. 188). When asked about specifics, TREM participants explained that they felt support from other group members (95%), experienced better control over their lives (95%), were more able to assert themselves (85%), and were involved in safer relationships (79%) (Fallot & Harris, 2004, p. 188). Finally, the fifth model is the *Triad* women's trauma model. It is based on the premise that disorders arise from experiences of trauma and that these issues must be addressed using a long-term recovery model (as cited in Finkelstein et al., 2004). This model is designed to focus on recovery, survival, empowerment, and abstinence.

It is important to point out that none of these models recognize intergenerational trauma, but do respond to women's needs of gender-based trauma. The existing models need to be

expanded to include the importance of culture in order to address the substance use and trauma related concerns of Aboriginal women.

2.12 Aboriginal healing practices

Aboriginal healing practices have been introduced into many Aboriginal treatment programs across Canada (Hopkins & Dumont, 2010). A core belief in this approach is the view that culture is healing (Chansonneuve, 2008). Although there are many definitions of healing in Aboriginal contexts, for the purpose of this thesis Aboriginal healing is understood as holistic and is linked to expressions of identity including land, culture, and family (Williams, et al., 2011). Unlike Western medical models, Aboriginal recovery models reflect holistic approaches to health that encompass the physical, mental, emotional, and spiritual aspects of life (Health Canada, National Native Addictions Partnership Foundation, & Assembly of First Nations (2010); Hopkins & Dumont, 2010). Health is understood as a state of balance across the various aspects of one's life, not simply the absence of disease (Dell et al., 2012). Moreover, there is an emphasis on the importance of healthy families and communities as well as in individuals, which deviates greatly from Western models (Williams, et al., 2011).

Within the Aboriginal worldview, 'being spiritual' means that the person is "spirit-motivated, and that Indigenous culture is spirit-centred" (Hopkins & Dumont, 2010, p. 8). Chansonneuve (2007) argues that "the role of spirituality in healing is to help individuals re-awaken their sense of themselves and others as sacred beings worthy of respect, to honour the sacred in themselves, and restore their sense of connection" (p. 36). Aboriginal cultural teachings provide Aboriginal people with knowledge about maintaining connections with creation (McCormick, 2000). Creation refers to the family, community, culture, and the natural and spiritual worlds (McCormick, 2000).

Based on a belief in the interconnectedness of all things, an Aboriginal holistic approach to healing and recovery encompasses a wide range of practices. Aboriginal cultural activities are therapeutic when they are practiced in alignment with treatment goals. Nabigon's (2006) book *The Hollow Tree: Fighting Addiction with Traditional Native Healing* details his journey in overcoming his alcohol addiction using cultural healing methods. Nabigon's healing journey included the guidance of the Elders, the spiritual teachings of the Four Directions, the Sweatlodge, the Hub, the Medicine Wheel, the Pipe, and the Native Medicines. These teachings

brought Nabigon to a new understanding of his life and gave him the ability to recover from addiction. Nabigon (2006) explains:

> When we acknowledge the spirits, they in turn give us strength. Only then could I pick up the ancient teachings of my people. This is the courage I needed. My bundles core is tobacco, sweetgrass, sage, cedar, the sacred pipe, and the sweat lodge. Fasting and ancient teachings from the Elders helped me set aside the alcohol and pick up and carry my sacred pipe. (p. 34)

Some of the cultural healing practices that take place across Canada include: sweat lodge ceremonies; memorial, ceremonial, and social feasts; naming and identification; and the use of traditional medicines (Hopkins & Dumont, 2010). Other healing practices include family and communities within cultural ceremonies and cultural or land-based camps (Hopkins & Dumont, 2010). There are also forms of healing that take place through experiential learning, which include storytelling, art therapy, sharing circles, and performance art (Chansonneuve, 2007).

There are inherent challenges in evaluating the success of Aboriginal healing programs (Gone, 2012; Lane, Bopp, Bopp, & Norris, 2002). Gone (2012) explains, "indigenous forms of knowing are said to consist of deeply contextualized and “felt” understandings grounded in holistic experience that others evaluate in terms of the credibility and trustworthiness of the individual knower" (pg. 5). However, the effectiveness in using Aboriginal healing practices has been demonstrated in some research studies. A recent study, for example, identified identity-reclamation through culturally relevant healing practices as a successful component of drug treatment with Aboriginal women (Dell, et al., 2010). In addition, a study in British Columbia has demonstrated how cultural healing methods can reduce rates of alcohol use. For example, the community of Alkali Lake decreased its rates of alcoholism from 95% to 5% in 10 years (Lane et al., 2002; McCormick, 2000). The community achieved this through using cultural healing practices and creating an atmosphere that did not tolerate alcohol use as an acceptable behavior (McCormick, 2000).

Heilbron and Guttman’s (2000) Canadian study analyzed Aboriginal healing ceremonies for their impact on the counseling process with survivors of child sexual abuse. For this study, a healing group was formed with three Aboriginal women and two non-Aboriginal women. The research results revealed that the inclusion of Aboriginal healing ceremonies and beliefs increased therapeutic effectiveness (Heilbron & Guttman, 2000). Participants in the study shared how the healing circles gave them a safe and nurturing environment to share their stories with the group. The healing circle sessions, where participants held an eagle's feather and each member

had the opportunity to speak while the group listened, was described as a validating and an empowering process for both the Aboriginal and non-Aboriginal women in the group (Heilbron & Guttman, 2000).

The National Native Alcohol and Drug Abuse Program (NNADAP) is the major funding source for drug treatment services for Aboriginal communities in Canada (National Native Addictions Partnership Foundation, 2005). It is largely controlled and operated by First Nations and Inuit communities and organizations. NNADAP provides funding for 52 drug treatment centres and over 550 prevention programs across Canada. The focus of NNADAP is to reduce the drug and alcohol use rates among on-reserve populations. Many of the National Native Alcohol and Drug Abuse Program (NNADAP) treatment approaches provide healing methods for its clients that are holistic and based in Aboriginal traditions. NNADAP treatment services recognize culture as central to the health and wellness of Aboriginal peoples (Health Canada, National Native Addictions Partnership Foundation, & Assembly of First Nations, 2010). This is important to note since the research used in this study was collected from NNADAP drug treatment centres.

In summary, part one of this chapter discussed the key areas that affect Aboriginal women's pathways and healing journeys from substance use and addictions, including their unique gendered differences from men, histories of violence and trauma, social determinants of health, and the intergenerational effects of colonization. Part two of this chapter discussed the barriers faced by Aboriginal women in accessing drug treatment, the interconnections between trauma and substance use, and presented treatment concerns for pregnant and mothering women. In addition, it explored evidence-based drug treatment practices, the significance of the treatment provider, and Aboriginal healing practices. This literature highlights the need for Aboriginal cultural practices and gender-specific approaches to be blended with current and emerging trauma-informed and trauma-specific models in order to make them applicable to Aboriginal women. Essentially, drug treatment programs should fit the needs of the population using those services. For example, Aboriginal women in drug treatment are often burdened by many negative social determinants of health, such as poverty, violence, and mental health concerns, and continue to be impacted by the legacy of colonization. The literature presented here has shown that all of these concerns need to inform service delivery in order to meet the needs of clients as directly as possible.

Chapter 3: THEORETICAL FRAMEWORK

Theory provides a framework for understanding people's everyday lives and the larger social forces that connect them (Calixte, Johnson, & Motapanyane, 2005). The theoretical framework informing this study is post-colonial feminist theory. This theory informed the development of the study and served as the framework for analyzing the interview data. This anti-oppressive lens was chosen because it challenges Western patriarchal thought and highlights the ways in which colonization, race, gender, and class influence the lives of Aboriginal women. This chapter begins with an overview of concepts that have informed the study, including a discussion of feminist theory, gender-based lens, and culturally relevant gender-based analysis. These frameworks can be used as a guide to change policy and research in order to ensure that Aboriginal women receive helpful addiction treatment. The concept of post-colonial theorizing is then expanded to contextualize the development of post-colonial feminist theory. Last, I discuss post-colonial feminist theory, illuminating the connections between gendered positioning, class, and racialization. This theory acknowledges colonial histories and its current effect on lives, choices, and opportunities. It provides a lens to understand how gender, racialization, class, and historical positioning shape Aboriginal women's experiences. This in turn impacts our comprehension about the violence and substance-related treatment needs of Aboriginal women.

3.1 Feminist analysis

There is much diversity within feminist theoretical perspectives and practices. Often these perspectives vary according to beliefs about the ways in which women are oppressed (Calixte et al., 2005). However, feminist approaches do share certain common features. Simply put, feminism refers to the idea that women are as capable as men (Briggs & Pepperell, 2009). The main feature of feminist theories—be it liberal, socialist, Marxist, radical, standpoint, or post-colonial—is that it "takes gender seriously as a social organizing process" (Green, 2007, p. 21). Feminist theories seek to identify the ways in which women are subordinated to men in order to create social change and eradicate women's oppression (Calixte et al., 2005). Feminist theory can be considered a road map for understanding feminism (Calixte et al., 2005). It takes into account the social, cultural and, political aspects of women's lives (Matthews & Beaman, 2007).

There are three waves of feminism that have made major changes with regards to women's rights and their positions in North American society over time. The feminist movements have been instrumental in contributing to how Canadian society understands the causes and reasons for the perpetuation of violence against women (Hamby, 2000). The second wave of feminism is most directly associated with violence against women. This movement emerged during the 1960's and pushed for equal opportunities, reproductive freedom, and an end to violence against women (Matthews & Beaman, 2007). This movement focused on exposing issues that were previously considered private and moving them into the public sphere. At the time, this allowed feminists to identify the invisible power structures that take place between men and women.

In the past, feminism has incorrectly assumed that women cross-culturally experience the same oppression. More recent feminist analyses include the importance of class structures in order to understand violence against women (Hamby, 2000). Razack (2002b) argues that it is crucial to examine the historical ways that race, class, economic status, disability, sexuality, and gender all work together to structure women in different positions of power and privilege. The third wave of feminism stresses the importance of recognizing how class, sexual orientation, and ethnicity affect women's lives (Matthews & Beaman, 2007). Feminism is now viewed as representative of disadvantaged groups; modern feminist approaches seek to achieve equality for all people—not just women.

A feminist analysis of gender relations is key in recognizing the gendered nature of power, which perpetuates violence against women in Aboriginal communities (Hamby, 2000). Understanding the gendered nature of power that pervades our society is crucial in order to recognize the systems that continue to marginalize and discriminate against Aboriginal women. For example, violence against women results from control and power in relationships, but is also more likely among women who belong to minority groups and those living in poverty. Women in these groups lack power in our society and are therefore more likely to be experience violence. Moreover, perpetrators of violence also know that these women are less likely to report violence, seek out assistance, and have fewer options for leaving these relationships. A feminist lens exposes violence against women as resulting from gender hierarchies in our society. For example, Janus (2006) argues that violence against women "flourishes with social support, enforcing and expressing the socially imposed inferiority of women" (p. 78). In order to

eradicate violence against Aboriginal women, it is essential to dismantle the patriarchal and racist gender hierarchies that enforce the inferiority of Aboriginal women in our society. A feminist analysis has largely paved the way for mainstream tools to advance gender equality, such as the gender-based lens and the culturally relevant gender-based lens.

3.2 Gender and cultural lens

Gender is an important variable to consider when doing addiction-related research (Brady & Ashley, 2005). According to Paul (2002), gender refers to the social and cultural meanings that are attached to being female or male. Gender has been understood as socially constructed through social interactions as well as biologically constructed through chromosomes, brain structure, and hormonal differences (Matthews & Beaman, 2007). Throughout this thesis, gendered experiences that contribute to problematic substance use among women are discussed. For example, gender creates complexities for substance-using women, which include differences with regard to pregnancy, physiological and physical concerns, increased social stigma, greater economic considerations, and other barriers to treatment retention (Brady & Ashley, 2005).

On a national level, gender-based analysis is now the starting point for many research studies, policy reports, and current practices. A gender-based analysis refers to "a tool to assist in systematically integrating gender considerations into the policy, planning and decision-making processes" (Status of Women Canada, 2007, p. 1). This tool attempts to achieve gender equality and makes gender issues visible to mainstream society. Gender-based approaches recognize the unique challenges that have been identified for women in relation to substance use. A gender-based diversity lens further recognizes the different systems of oppression that impact the lives of women of minority groups. However, in order to adequately take into account the circumstances of Aboriginal women, it is important to not only recognize gender but also apply a more comprehensive approach to equity issues that takes race, class, and culture into account.

In order to address the realities of Aboriginal women, the Native Women's Association of Canada (2010a) argues that mainstream gender based analysis "requires a cultural framing that reflects Aboriginal ways of knowing, Aboriginal histories (both pre and post contact), and contemporary Aboriginal realities in Canada" (p. 2). In order to apply a culturally relevant gender-based analysis, the Native Women's Association of Canada (2010a) has developed a tool called the *Culturally Relevant Gender Based Application Protocol* (CR-GAP). This tool incorporates gender and cultural perspectives into policy processes, attempts to create more

responsive systems, and makes visible the systemic and structural barriers that impact the health of Aboriginal women. The CR-GAP is a useful mechanism for understanding how colonizing practices have affected the existing health of Aboriginal women, and it emphasizes the need for change in both Canadian and Aboriginal societies.

3.3 The development of post-colonial thought

Before discussing post-colonial feminist theory, it is important to introduce the development of post-colonial theory. The work of colonial discourse theorist Edward Said, particularly his publications *Orientalism* (1978) and *Culture and Imperialism* (1993), is widely regarded as pivotal in the advancement of post-colonial thought. Said (1978) proposes that Oriental studies (presently known as Eastern studies) functioned as a set of social practices that legitimated European views. His discussion of the production of power through Oriental studies extends Foucault's concepts of disciplinary power (Sharpe, 2000). Said (1978) recognized Oriental studies as a discourse and essentially an institution of power that reproduces authority over the Eastern people. Said (1978) argued that the West presented other cultures that were different from the British as Other in comparison to Western norms. The Other was produced as lazy, barbaric, and uncivilized in comparison to the hardworking and civilized British (Mills, 1998). Said's account of Oriental studies in many ways is analogous to the written accounts of the Aboriginal peoples when colonizers arrived.

Said's groundbreaking work was instrumental in the development of colonial discourse analysis, which evolved into current day post-colonial studies (Sharpe, 2000). The field of post-colonial studies originally referred to the movements that ended Europe's dominance over the world after the Second World War (Schwarz, 2000). However, instead of limiting itself to this specific event, after the late 1970's the term post-colonial was used to understand past and present European colonialism and the effect of colonialism on culture (Ashcroft, Griffiths, & Tiffin, 2000). Post-colonial theorists recognize that the many different imperial relations during the nineteenth century continue to impact the way that people in colonized cultures view themselves in the present day (Mills, 1998). Further, post-colonial thought recognizes that the means in which knowledge is created (academic institutions) are structured in European Western thought (Schwarz, 2000).

The term post-colonialism implies that colonialism is finished and thus is not always welcomed by Aboriginal scholars and their allies. Neo-colonialism (current-day colonialism)

persists in a variety of ways, including social policies in the Indian Act, the regulations placed on self-government, restrictions on economic development in Aboriginal communities (Browne et al., 2005), the current child welfare system, and the ongoing health and social effects of colonization. Although, the term post-colonial implies that this theory focuses on past colonizing practices, this framework accounts for how the legacy of colonialism continues to impact people's lives and life opportunities (Young, 2001). This theory focuses on recognizing the past, attending to ongoing legacies of colonialism (Schwarz, 2000), and exploring the broader historical and social contexts that influence everyday life (Racine, 2008).

3.4 Post-colonial feminist theory

The field of post-colonial theory has largely been male-dominated. Often, this field has focused on the writings of nineteenth-century European males (Mills, 1998). Feminist academics such as Spivak and McClintock first discussed the ways in which colonization has fostered uniquely gendered experiences. Spivak (1995) identified the subordinate position of the marginalized female subaltern: "If, in the context of construction of colonial production, the subaltern has no history and cannot speak, the subaltern as female is even more deeply in the shadow... " (p. 28). In this article, Spivak recognizes the female subaltern as standing outside of hegemonic power structures. McClintock (1995) puts forth that gender was an instrumental part of securing colonial rule and explains, "imperialism cannot be fully understood without a theory of gender power" (p. 6). Thus, post-colonial feminists are concerned with inserting gender concerns into post-colonial thought (Lewis & Mills, 2003).

Both post-colonial and feminist theories want to identify the ways that women or racialized people are marginalized and eradicate such oppression. However, a post-colonial feminist approach extends the analytical boundaries of post-colonial and feminist theories (Browne et al., 2005). Post-colonial feminism is described as an exploration of "gender, nation, class, race and sexualities in the different contexts of women's lives, their subjectivities, work, sexuality, and rights" (Rajan & Park, 2000, p. 53). Post-colonial feminist theories shed light on issues of racialization, culture, class, and historical subjugation (Browne et al., 2007).

This approach has previously been deemed useful for addressing health issues in a context of social inequality in non-Western populations (Racine, 2011). However, there is minimal scholarship that applies this theory to address the contemporary experiences of Aboriginal women. Nonetheless, Racine (2011), Browne, Smye, and Varcoe (2005), and

O'Mahony & Donnelly (2010) provide exemplary studies in the nursing field. Their work demonstrates the potential value of incorporating post-colonial feminist perspectives in the health care system. Racine (2011) explores the challenge of applying culturally safe medical care to non-Western populations in the United States. Browne et al. (2005) draw on the concept of cultural safety to incorporate post-colonial perspectives in the nursing field. The authors consider this a useful framework in that it recognizes the colonial past and neocolonial present of Aboriginal peoples in health care settings.

Post-colonial feminist theory was chosen as the theoretical framework for this study because it accounts for linkages between racism, sexism, and patriarchy as legacies of colonial oppression (Browne et al., 2007). Additionally, this discourse "privileges the lived experiences of the subjects of research, thereby serving as a tool of empowerment" (Elabor-Idemudia, 2002, p. 237). It also allows for the inclusion of voices that have typically been excluded (McCall, Browne, & Reimer-Kirkham, 2009), which is important in the case of Aboriginal women whose voices were often excluded (and spoken about from racist and sexist interpretations) in Canadian research processes.

This lens enables the issues of race, gender, and class to be at the forefront of analysis and recognizes how the legacy of colonialism continues to shape the health status and marginalization of Aboriginal women. This is imperative because past research did not recognize the historical forces that shape an individual's social position and their experiences (O'Mahony & Donnelly, 2010). Recognizing the longstanding historically mediated disadvantages that lead to the current health, economic, and social conditions that affect Aboriginal people in Canada (Browne et al., 2005) is essential for transformative changes. For example, the high rates of violence, drug and alcohol use, and poverty need to be contextualized from the structural inequities that have produced them. Sexist discriminatory colonial policies implemented in the Indian Act, colonizing negative portrayals of Aboriginal women perpetuated throughout mainstream society, and the effects of the current child welfare system all need to be taken into account when studying the realities of Aboriginal women's lives.

The post-colonial feminist approach allows researchers to examine life histories and ask questions about the factors that put certain people or populations at risk (Browne et al., 2007). For example, opposed to the dominant discourses that focus on individual responsibility and choice (Browne et al., 2005), we need to understand violence against Aboriginal women as

existing in an environment shaped by the context of colonization (Weaver, 2009). Post-colonial feminist theory contextualizes Aboriginal women's experiences of violence, substance use, and poverty. It challenges the status quo and the oppressive forces that often exist in health care settings and mainstream society.

This chapter presented a discussion of feminist theory, gender-based lens, culturally relevant gender-based analysis, post-colonial theory and post-colonial feminist theory. These concepts inform the existing knowledge base that advocates for culture-informed treatment services for Aboriginal women. Drug treatment for Aboriginal women must recognize the past and ongoing effects of colonization. The post-colonial feminist perspective prompts us to recognize the historical, social, political, and economic circumstances that shape Aboriginal women's health (Brown et al., 2007). As such, post-colonial feminism is a relevant theoretical perspective to examine Aboriginal women's experiences as shaped by a gendered, racialized, and colonial history. This approach also suggests important directions for future research and further provides a contextual basis for developing more effective practices for Aboriginal women in addiction treatment centres in Canada.

CHAPTER 4: METHODOLOGY

Feminist research approaches attempt to eliminate biases from the research process (Wuest, 1995) and expose the power dynamics that exist between researchers and research participants. This project applies a feminist perspective to the constructivist grounded theory method. These two forms of inquiry are congruent because the grounded theory method does not address ethical issues throughout all stages of the research process (Olesen, 2007); therefore, the feminist perspective fills this void.

There are diverse ways of applying a feminist approach; for this thesis, applying a feminist approach involves reflexively situating myself and focusing on the subjective knowledge of the research participants. Therefore, the knowledge of the researcher is challenged and the knowledge of the research participants is used to guide the research process. In this chapter, I will first present background information about the parent study, *From Stilettos to Moccasins Research Project*. Second, the research questions are re-stated alongside the sample used for this study. Third, the qualitative approach, feminist research assumptions, and the constructivist grounded theory method used to analyze the interviews with treatment providers are discussed. Fourth, the ethical considerations involved in this study, which includes a discussion of the ethical protocols that need to be followed when doing research with Aboriginal peoples, and the ways in which the research findings were validated are presented.

4.1 From Stilettos to Moccasins Research Project

This study draws on interviews gathered in the parent study *From Stilettos to Moccasins Research Project*. This parent study examined the link between self-identity and healing among Aboriginal women in drug treatment who are in conflict with the law. It also explored the role of the treatment provider in assisting Aboriginal women in drug treatment. In this project, 100 interviews were conducted with Aboriginal women in drug treatment and 38 treatment providers in 6 National Native Drug Addiction Program (NNADAP) treatment centres across Canada. For this thesis, I analyzed data from 30 interviews with treatment providers at the 6 NNADAP treatment centres. My focus was to study the treatment providers' view of their role in assisting these women. Aboriginal women who are in drug treatment and are conflict with the law are not

a homogenized group; however, they do present some similarities, which are evident in their experiences of violence, poverty, and family history of intergenerational trauma (Dell & Kilty, 2012). For further details on the sample of drug treatment providers for this study, see 4.3.

The original findings obtained through the *From Stilettos to Moccasins Research Project* have contributed to my research questions. Specifically, the original study suggested that Aboriginal women in treatment wanted their treatment providers to recognize the impact of trauma in women's healing. Moreover, the study identified that 80% of the treatment providers were in recovery from problematic substance use themselves (Dell et al., 2010). The main finding of the original study was that there is a need for Aboriginal women to reclaim their identity (or to claim an identity for the first time)—that is, to understand who they are as Aboriginal women—for their healing. The treatment providers also noted that this was essential in their own healing experiences (Dell et al., 2010). The results of this study are now being put into action through health intervention workshops across Canada. These workshops are raising awareness about the role that identity and stigma play in Aboriginal women's drug treatment.

My research questions for this thesis were developed based on areas of suggested research that emerged from the *From Stilettos to Moccasins Research Project*. In this parent study, the interviews with the participants involved questions regarding how the treatment providers view the women in treatment and about the women's background/life experiences. The treatment providers were asked to share the women's experiences of violence and were questioned if they thought these experiences contribute to how the women see themselves and how it impacts their healing journey. In addition, the participants were asked about the treatment practices they employ and how they assist the women with experiences in their lives (violence, criminalization, mental health, caretaking, stigma from drug use, and the child welfare system). The interviews also delve deeper into certain topics that the treatment providers felt were important to discuss.

4.2 Research questions

This thesis examines violence, substance use, intergenerational trauma, and the role of the service provider in the treatment process. As shared, the research questions have been framed using a post-colonial feminist lens. This lens, combined with the key literature in this area, has enabled an understanding of the historical and current contexts that impact Aboriginal women's experiences. The literature review section of this thesis demonstrated clear connections between

substance use and violence among women; however, there continues to be gaps regarding the experiences of Aboriginal women, the past experiences of drug treatment providers, and its impact on client healing. This study aims to fill these gaps in understanding and to gain new information from the perspectives of treatment providers. As mentioned, this thesis investigates four interrelated research questions:

(1) How do treatment providers at NNADAP treatment centres understand women's experiences of violence as impacting their pathway to problematic substance use, and their subsequent healing journey?

(2) How are self-identity and culture accounted for in the NNADAP treatment providers' practices?

(3) What are the past experiences of treatment providers? Do the lived experiences of treatment providers influence how they respond to their clients?

(4) How do the practices of the treatment providers align with and/or expand the trauma-informed and trauma-specific literature?

4.3 Sample

In order to answer these research questions, I analyzed interview data that was collected from 30 treatment providers at six NNADAP treatment centres across Canada. Out of the total research participants, 20 were female, nine were male, and one did not identify. Twenty-four of the research participants identified as First Nations Status, three identified as Métis, two identified as Caucasian, and one did not identify any ethnicity. Although provided with the above information, the data was not analyzed based on differences in sex or ethnicity. This was due to the fact that this was an exploratory study with limited data and certain respondents choose not to disclose their sex or ethnicity.

4.4 Qualitative research

In order to answer the four research questions, qualitative interviews were analyzed for emerging themes. Qualitative inquiry refers to analyzing data that involves "in-depth verbal descriptions of behaviors, attitudes, or knowledge" (Smith, Gratz, & Bousquet, 2009, p. 4). This form of research was chosen for this study because it is human centered and can capture the richness of the treatment providers' experiences and insights. Eichler (1997) argued that qualitative research is useful for examining unexplored topics. This is important, as this thesis addresses the neglect of the perspectives of treatment providers in Aboriginal treatment centres

regarding women's healing journeys. Given that this study is an exploratory qualitative study, the perspectives and past experiences might be similar to other treatment providers in Canada at non-Aboriginal and Aboriginal treatment centres, however, these findings cannot be generalized to wider populations.

Dell (2007) argued that "qualitative-based methods of data collection provide crucial insight into women's experiences" (p. 501). This project applies a feminist approach to the constructivist grounded theory method in order to analyze the qualitative interviews. Unlike traditional research, this project focuses on the subjective knowledge of the research participants. Therefore, the knowledge of the researcher is challenged and the knowledge of the research participants is used to guide the research process. I will describe this in more detail below.

4.5 Feminist approach

In the past, research almost exclusively analyzed men's experiences (Harding, 1987), providing only a partial understanding of social life. Feminist research is necessary to provide insights into the perspectives and experiences of women. Feminist research creates new ways of knowing and places women's lives as well as those considered "Others" at the centre of social inquiry (Hesse-Biber, 2007). It attempts to discover more objective truths by eliminating biases from the research process, based on gender, class, and race (Wuest, 1995). The perspectives of feminist researchers are diverse and researchers continue to debate how to address issues of truth, knowledge, and power in the research process (Hesse-Biber & Brooks, 2007). Feminist inquirers have disputed the existence of a feminist methodology (Eichler, 1997); however, there are distinct ways that feminist researchers analyze social life. Harding (1987) explains how feminist researchers can use any of the different methods of analyzing research, but points out that it is "precisely how they carry out these methods of evidence gathering (that) is often strikingly different" (p. 2).

Feminist research has generated immense contributions to understanding ethics and objectivity in research methods (Eichler, 1997). Olesen (2007) argued that feminist research exposes the power dynamics in the research processes. Feminist research approaches often try to dismantle the hierarchical relations between the researcher and research participants. It is important to note that the community-based interviews that took place through the *Stilettos to Moccasins Research Project* at Aboriginal drug treatment centres were conducted by Aboriginal interviewers. The Aboriginal interviewers often had been in recovery themselves and/or worked

in drug treatment centres. This is important in helping the research participants feel at ease when they are sharing their stories and in removing the power dynamics between the researcher and the research participants. These community-based research procedures align well with feminist research approaches, which advocate for the removal of power dynamics and recognize the inherent biases that researchers have, despite their background and culture. Conducting research this way can lead to a greater chance that the research findings reflect the existing "truths" taking place in Aboriginal drug treatment centres.

Mies (2007,1983) has created seven criteria that should inform feminist inquiry: (1) the postulate of value-free research, of objectivity, or indifference has been replaced by conscious partiality; (2) the hierarchical relationship between the researcher and research subjects (view from above approach) should be replaced with a view from below approach; (3) the uninvolved spectator approach should be replaced by a researcher that actively participates in the movement for women's liberation; (4) changing the status quo should be the starting point for a new research quest; (5) the researcher and research participants should engage in a process of conscientization; (6) the collective conscientization of researcher and researcher participants must be accompanied by the study of women and their history; and (7) in order to appropriate their own history, women need to collectivize their experiences. Eichler (1997) explains that while not all feminist researchers follow the above criteria, these postulates capture significant segments of feminist research approaches.

These procedures (specifically 1-4) have been applied in this thesis in several ways. For example, I recognize that the research findings in this thesis are my interpretation of the interviews, and I thereby acknowledge my influence on the research results. In addition, I draw on the "view from below approach," rather than the traditional "view from the top approach" (Mies, 1983). Using the "view from below approach," the researcher attempts to abandon the hierarchical relationship between the researcher and researched and acknowledges the power derived from those differences (Mies, 1983). In this project, the treatment providers hold important knowledge on this subject, and as a researcher, I simply have the opportunity to present their knowledge to society. Further, I am an advocate for women's liberation and thus I support any and every opportunity to present the knowledge I have gained from women that can produce positive change. In particular, I am hoping this research can contribute to improvements for Aboriginal women seeking drug treatment.

Feminist approaches to research often emphasize the importance of reflexivity. Reflexivity refers to the extent to which researchers identify themselves in the research process (Olesen, 2007). This process can be used as a methodological tool to expose power throughout the research process (Hesse-Biber & Piatelli, 2007). Reflexivity allows the researcher to appear "not as an invisible, anonymous voice of authority, but as a real, historical individual with concrete, specific desires and interests" (Harding, 1987, p. 9). Reflexivity can take several different forms, including: (1) full disclosure on how the practical concerns were handled in the research process; (2) analysis of the researcher's background and how it influences the research process; and (3) reflections of the researcher's own feelings and emotions when approaching the data (Olesen, 2007). This approach recognizes the sociologist as an active participant in the research process and acknowledges that they are responsible for the data that they shape (Hesse-Biber & Piatelli, 2007). Used as a guide for this study, this view has helped to ensure an ethical research process. For instance, I recognize that the research findings in this thesis are shaped by my personal culture and background. Recognizing and acknowledging this allows me to admit my own biases, which results in more valid research findings.

4.6 Grounded theory method and the feminist perspective

The interview data in this project was analyzed using the grounded theory method. This method is heavily rooted in symbolic interactionist theory, which is based on the understanding that people act as both autonomous individuals and as collectivities (Bryant & Charmaz, 2007). Glaser and Strauss (1967) originally developed this method through their analysis of terminally ill patients. Their book *The Discovery of Grounded Theory* (1967) was the first to articulate strategies to discover theory from data obtained through social research. The grounded theory method allows the researcher to discover "what is going on, rather than assuming what should be going on" (Glaser, 1978, p. 159). This method is an inductive form of inquiry, which cannot be separated from the process that was used to generate it (Glaser & Strauss, 1967).

Employed across a wide variety of disciplines, the grounded theory method is the most widely used qualitative research method (Bryant & Charmaz, 2007). Despite their concerns with certain aspects of this method, many feminist researchers apply this method in the social, cultural, health, and education fields (Olesen, 2007). Feminist researchers have critiqued the traditional grounded theory position, which proposes that researchers begin investigating data with a blank slate and thus with no knowledge on the topic of study (Olesen, 2007).

Additionally, feminist processes of reflexivity as well as the emphasis of the role of the researcher in the research process contrasts with traditional grounded theory methods. In order to take into account these critiques, I apply a feminist perspective to the constructivist grounded theory method.

4.7 Constructivist grounded theory

This project draws on a feminist perspective and applies the constructivist grounded theory method. These two forms of inquiry are congruent because the grounded theory method does not address ethical issues throughout the research process (Olesen, 2007). A feminist perspective is applied in order to fill this void and ensure that ethical protocols are followed. Wuest (1995) argued that the feminist perspective and the grounded theory method have common epistemological underpinnings. She maintained that both approaches reflect the assumptions that "participants are the experts about their experiences and that subjective experience is valid" (p. 128). Clarke (2007) argues that the grounded theory method is actually implicitly feminist. She understands the grounded theory method as feminist based on different five criteria: (1) its roots in symbolic interactionist and pragmatic philosophies, which emphasize actual experiences and practices; (2) its use of the concepts of partiality, multiplicity, and situatedness; (3) assumptions of social constructionism; (4) its processes of deconstructive analysis; and (5) its attention to variations as processes of difference (Clarke, 2007).

This project applies the constructivist grounded theory method advocated by Charmaz (2005, 2006). A constructivist approach uses the grounded theory method as a guide, but does not subscribe to its positivist assumptions (Charmaz, 2005). It emphasizes the studied phenomenon, rather than the tools used to study it. Unlike the classical grounded theory method that assumes that data emerges separate from the researcher, Charmaz (2006) acknowledges researchers' impact in shaping the research process and findings. She argues that as researchers, "we construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research participants" (p.10). The constructivist grounded theory approach aligns well with feminist assumptions, acknowledging the influential role of the researcher.

Charmaz (2006) argues that "what you see in the data relies in part upon your prior perspectives" (p. 54). Therefore, in order for researchers to avoid identifying their own perspectives as truth, they should view these perspectives as only one view among many others.

This allows the researcher to recognize their influence on the data. The constructivist approach contends that the researcher should not assume that research participants are denying significant facts or truths about their lives (Charmaz, 2006). Rather, the researcher should try to envision the world from the research participant's viewpoint, which may bring unique insights for understanding.

4.8 Data analysis

The primary method of data analysis in this study was the constant comparative method. This method of data analysis was originally developed for the grounded theory methodology of Glaser and Strauss (1967). The constant comparative method involves four stages: (1) comparing occurrences involved in each category, (2) integrating those categories and their properties, (3) determining the limits of the theory, and (4) writing the theory (Glaser & Strauss, 1967). The constant comparative method is used in order to establish analytic distinctions and make comparisons at all levels of the research analysis process (Charmaz, 2006).

Following the core process that takes place in grounded theory methodology (Holton, 2007), in this project themes arising from the interview data were identified and coded. First, I performed initial coding, also referred to as "substantive coding," where I worked with the data directly and analyzed it through open coding, searching for the emergence of a core category and concepts (Holton, 2007). Open coding refers to a preliminary process of "breaking down, examining, comparing, conceptualizing and categorizing data" (Strauss & Corbin, 1990, p. 61). Second, I undertook focused coding, using the most significant and frequent codes to analyze large amounts of data (Charmaz, 2006). Third, I used axial coding to relate categories to subcategories, exploring how they are associated (Charmaz, 2006). And fourth, I carried out theoretical coding, which allowed me to specify relationships between categories that developed during the focused coding phase. I continued the constant comparison process until I achieved saturation, that is, until there were no new properties or dimensions that I had not already found. I went over the data twice in order to capture the complexities in the data set. I first read and coded the transcripts manually. Then in order to clearly see my research findings, I went through the interview data using NVivo9, a flexible tool designed to assist in linking and coding raw, complex data sets (Silverman & Marvasti, 2008).

In order to keep track of the research process, I took methodological notes, also referred to as memo-writing, throughout my study (Glaser & Strauss, 1967). I wrote notes while I was

reading the transcripts and during the data analysis phase. This process allowed me to see a more complete context of the work after the entire project was completed. It also allowed me to examine how my presence and standpoint may have influenced the outcome of the research process. Charmaz (2006) argued that memo writing constitutes a crucial part of the grounded theory method, because it allows the researcher to analyze the data early on in the research process. Glaser and Strauss (1967) expressed that in order to generate theory it is useful to write memos. These memos allowed me to illustrate my ideas, and they become the foundation of "my" grounded theory (Charmaz, 2006).

The quality of the research process was assessed according to various methods, including attention to negative cases, fair dealing, relevance, and reflexivity. In my analysis, negative cases were emphasized in order to help refine my analysis and develop explanations for my research questions (Mays & Pope, 2000). Fair dealing was ensured through the incorporation of a wide range of perspectives, as opposed to presenting one viewpoint as the view for the entire group (Mays & Pope, 2000). This research is relevant based on the fact that it adds to the current knowledge on the relationship between violence and problematic substance use among Aboriginal women in treatment. Reflexivity was ensured throughout this study, as I remained sensitive to the ways that my assumptions, experience, and personal position influenced the research findings.

4.9 Strengths and limitations of this study

In the health context, qualitative research provides information about how people experience their health as well as the context in which these experiences take place (Morrow & Hankivsky, 2007). This project allowed me to develop an in-depth study of the perspectives of treatment providers. These personal perspectives and experiences are powerful and provide compelling insights into "what is really going on" in drug treatment centres. The grounded theoretical approach used in this study was useful insofar as it allowed me to make changes to the direction of the study as new information emerged.

Presenting the limitations of this study is important. This study involved a secondary analysis of 30 interviews with Aboriginal and non-Aboriginal treatment providers in Aboriginal drug treatment centres. I am not an Aboriginal woman or a drug treatment provider, which I feel would have provided me with greater insights on this topic. Moreover, this research data was collected in 2005 and 2006. Therefore, there may have been alterations to the programs since this

research was collected. Moreover, I did not perform the interviews myself. Being involved in the interview process would have allowed me to ask the treatment providers questions, to follow-up on specific questions, and delve deeper into certain areas. Nevertheless, this thesis contributes new knowledge concerning the experiential perspectives of treatment providers and offers suggestions for building on and improving drug treatment services for Aboriginal women.

4.10 Ethical considerations

In the past, research with Aboriginal people has been initiated and performed by non-Aboriginal people (Saskatoon Aboriginal Women's Health Research Committee, 2004). Numerous examples concerning the harms that have occurred through research (Canadian Institutes of Health Research, 2008) and the general lack of respect for Aboriginal culture from non-Aboriginal researchers are documented in the literature. In the past, Aboriginal people "had almost no opportunity to correct misinformation or to challenge ethnocentric and racist interpretations" (Saskatoon Aboriginal Women's Health Research Committee, 2004, p. 2). Consequently, research with Aboriginal people was not reflective of Aboriginal experiences or perceptions. It is now widely recognized that it is important to follow ethical protocols to ensure that Aboriginal perspectives guide the research process (Canadian Institutes of Health Research, 2008).

In the parent study, respect for the Aboriginal and non-Aboriginal participants was ensured by adhering to the ethical guidelines created by the *Revised Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2009) and the *CIHR Guidelines for Health Research Involving Aboriginal People* (Canadian Institutes of Health Research, 2008), specifically articles 1-11. In addition, my thesis supervisor Dr. Colleen Dell's research is grounded in a community-based participatory approach specific to First Nations, Inuit, and Métis populations.

Prior to the commencement of the data analysis phase of this project, ethical approval was gained from the University of Saskatchewan Behavioural Research Ethics Board. During the original interviews, the research participants were fully informed of the uses to be made of the material collected, and their confidentiality was ensured in this stage of the research process. The rights of the research participants were protected, as the data was kept confidential throughout

the research process. When I was not using the data, the paper copies of the information were stored in a locked cabinet and the digital versions were stored on a password-protected computer.

In community-based research studies it is important to ensure the inclusion of a cross-section of different community experiences and perceptions (Saskatoon Aboriginal Women's Health Research Committee, 2004). To ensure inclusiveness, reports of the preliminary research findings were circulated in draft form to treatment centres across Canada. The treatment centre directors and their staff had the opportunity to reflect upon the analysis of the data and to share their thoughts about whether it captured their experiences and those of other service providers working at drug treatment centres. As mentioned earlier, the members of the original and continued research team include Aboriginal Elders, treatment providers and directors, First Nations, Métis, and Inuit women who have previously been in a drug treatment program, academic researchers, and community and government decision makers. The research team reviewed the research findings and shared their experiential and academic knowledge on the research findings. This process, called *member checking* or *respondent validation*, is important in reducing researcher bias (Padgett, 2008). This diversity of expertise from the research team contributed to a broad understanding of Aboriginal women's health and was essential in the development and success of this project. The process of having community members, treatment providers, and the research team review the findings confirms that the findings are valid and representative of what is currently taking place in Aboriginal treatment settings across Canada.

In summary, this chapter presented some of the background information on this research and identified the feminist research approach that was applied to the constructivist grounded theory method. The feminist and constructivist grounded theory approaches provided me with the necessary tools for analyzing and interpreting Aboriginal drug treatment providers' perspectives.

Chapter 5: PATHWAYS AND HEALING JOURNEYS: The impacts of violence and parenting struggles among Aboriginal women in drug treatment

The interviews with drug treatment providers reveal that trauma, violence, and abuse are significant concerns in Aboriginal women's pathways to substance use and subsequent healing journeys. As discussed in chapter 2, *trauma* focuses on the responses resulting from experiences of violence or abuse; *violence* refers to an act that results in physical, sexual, or psychological harm, whereas *abuse* focuses on various forms of harm resulting from women's kin, intimate, or dependent relationships. In this study, the treatment providers understood the women's experiences of violence, abuse, and drug use as rooted in the intergenerational trauma resulting from colonization. Findings draw connections between the women's histories of violence and their existing low self-esteem. In addition, parenting challenges and issues with the child welfare system were significant concerns for Aboriginal women in drug treatment. Impacts of the child welfare system compounded the women's substance use problems, and the lack of childcare within drug treatment settings lead to major concerns regarding women's opportunities to attend treatment and treatment retention.

This chapter is divided into two sections, which correspond to the first research question investigated in this thesis: How do treatment providers at NNADAP treatment centres understand women's experiences of violence as impacting their pathway to problematic substance use, and their subsequent healing journey? The first section focuses on the connection between violence and problematic substance use among Aboriginal women in drug treatment. This includes women's reasons for drug use, the impact of violence on their self-esteem, the linkage with mental illness, and the intergenerational effects of colonization. The terms *drug use* and *substance use* will be used interchangeably. The second section explores parenting and describes the impact of the child welfare system on women in treatment. Although this research did not set out to collect information about Aboriginal women's mothering concerns and the impact of the child welfare system, it was a topic the treatment providers frequently spoke about when discussing Aboriginal women's pathways to and healing journeys from problematic substance

use. Following the presentation of the research findings in the two sections, I discuss the implications of the findings and make comparisons with the recent research.

5.1 Violence and problematic substance use

One of the major themes that emerged from the treatment provider interview data was the connection between violence and substance use. The treatment providers often discussed how the women's experiences of violence highly impacted their pathways to problematic substance use and shared their clients' extensive history of violence and trauma. The treatment providers (25 out of 30) explained how many of their clients had experienced some form of violence (i.e., sexual, physical, or emotional) at some point in their lives, with many of the women disclosing childhood experiences of sexual and physical abuse. Moreover, as adults many of them endured high rates of domestic violence from their partners. Treatment Provider no. 17 explained:

> Most of these women come from extremely violent backgrounds whether it is self-harm or a spouse that is violent. They come again beaten and it is very hard to watch. I think I have said they come in messed right up and have a low concept of self. There is so many things going on that they have no idea which way is up. It is not easy.

Another described:

> I see the women as lost, hurt, sad and badly abused. They come here beaten and desolate. They come here not knowing what to expect and I see lots and lots of anger, hatred and most of this is geared towards themselves at the beginning of treatment. (Treatment Provider no. 3)

These quotations illustrate both the emotional pain that results from traumatic experiences and how violence is a key issue in drug treatment.

5.1.1 Reasons for drug use

The effects of violence are far-reaching and can have long-term impacts. The treatment providers described how their client's violent upbringings and/or their more recent experiences of domestic violence resulted in deep-seeded emotional pain. Subsequently, these experiences led many women to drug use as a means to cope with their pain. Treatment Provider no. 13 shared:

> I think basically it always comes down to a coping mechanism. Some of the things that we talk about there, it's used as pain medication … So someone who's been sexually abused, mentally, physically, um, as Aboriginal women being oppressed, residential schools, all of those traumas that people suffer. Um … people use it [drugs] to cope.

Another shared: I don't think it's uh … drug abuse that affects these women. They turn to drugs because of things that have happened to them … maybe sexual abuse or … anything of that nature (Treatment Provider no. 15).

Treatment providers further noted that violence and abuse leads to other forms of self-destructive behaviors. Treatment Provider no. 26 explained, "Almost all the women [that] have been abused either sexually, physically or emotionally will do something to harm themselves, be it drugs, be it prostitution, be it alcohol." The treatment provider identified coping with violence as the main factor that lead to women's drug use. Other factors included trying to fit in with those around them and coping with stressors in their lives. The treatment providers also suggested that the women use substances because there is a lack of social and family supports in their communities. One treatment provider explained, "Drugs are a vicious part of their lives [...] The drugs are a means to an end. For many of them drugs and such are a way out or were a way out. Like a stress thing" (Treatment Provider no. 3). Another treatment provider explained that the women use substances for other various reasons, including "just to fit in [...] so that they can ah feel part of something ah whether it's the drug culture, whether it's the bar scene whatever, just to belong someplace for whatever reason" (Treatment Provider no. 12).

The treatment providers also expressed that experiences of violence and related substance use were so prevalent in the lives of the women that it was just "a way of life." Treatment Provider no. 27 shared: "Yeah, you don't know what a healthy relationship is, so to you it's okay to party on Saturday night and beat up your spouse because it's acceptable. You've seen that all your life." Treatment Provider no. 13 repeated the same idea with regards to drug use: "People use it [drugs] to cope but they also use it I think at times because it's just been a way of life. So it's something their family has always done so they just grow up to think that that's what they'll do to".

5.1.2 Self-esteem

The treatment providers expressed how the women felt a lot of shame about their experiences of physical and sexual abuse, which resulted in low self-esteem. Additionally, they expressed that many of the women may have participated in other behaviors they were ashamed of such as sex work or drug use resulting in their children being apprehended from child welfare authorities. These feelings of shame can worsen their drug use and contribute to a lowering of their self-esteem. In fact, the interviews revealed that low self-esteem was a very common theme

among the women in treatment. The treatment providers revealed that the women have such low self-esteem that in many cases they felt they deserved the violence perpetrated against them.

Treatment providers also explained how the women felt this lack of worth and low self-esteem because in many cases they had grown up witnessing and experiencing violence from an early age. Treatment Provider no. 15 stated:

> I don't blame these women when they come through these doors. They have absolutely no self-esteem. They walk through this door … like for example, abusers will tell their mates, remind them everyday they're nothing. They'll never amount to nothing. They're … they're useless. Like how do you expect them to turn out? Like if they're told that everyday it's just like them being brainwashed and they do believe it eventually.

Another described:

> Because these women, you know, they have been abused, some are really badly abused. They cannot even, they cannot even, uhh, speak up for themselves. They have really been put down a lot, not only from their husbands, from people around them. (Treatment Provider no. 16)

These quotations illustrate the shame and low self-esteem that the women feel due to their experiences of violence. It is evident that past and current experiences of violence have an immense impact on the women's current well being.

The treatment providers further discussed how experiences of violence affect many aspects of their clients' lives, including their relationships and relations with their communities. Treatment Provider no. 27 expressed:

> It [violence] affects everything. It affects the relationships they have with their spouses. It affects the relationships they have with their family and it affects the relationships they have in their community—like [if] they can hold down a job. And that's what I think relates to self-esteem so some of them don't have the self-esteem because they witness that at an early age.

This quotation makes the connection between experiencing violence at a young age and low-self esteem.

The treatment providers frequently indicated that the women felt too ashamed to tell anyone about their experiences—particularly if it was a family member who had perpetrated the abuse. Moreover, many felt that discussing their experiences might create more problems or they might not be believed. Likewise, although some women had previously disclosed their abuse to authority figures, it had led to few criminal charges. As a result, the women were deterred from seeking support from others. According to the treatment providers, for many of the women the

treatment providers were the only individuals with whom the women felt comfortable sharing this information.

5.1.3 Intergenerational effects

As mentioned, the treatment providers indicated that their clients often accept violence and drug use as "normal" since many had grown up with it in their homes. Treatment provider no. 24 explained, "My understanding of it, like I said, they accept that as a reality. That's the way it is." The treatment providers view violence and the high rates of drug use as a behavior learned through generations, rooted in the trauma emerging from the residential schools and other colonizing practices. In the interviews, the treatment providers discussed how many of their clients or their clients' parents (or grandparents) had attended residential schools. They maintained that the intergenerational effects from the residential schools profoundly impact women's present lives. Treatment Provider no. 25 explained:

> That's where abuse and where drinking starts. That's all they see when they grow up. Survivors from the residential school drink to numb the memories, to kill the pain. And little kids see all that drinking. That's where they grow into it. But then they don't realize they have a problem until they come here [....] Why people drink in most cases, violence. What causes violence is what happened years before.

Another described:

> What was taught in residential school was the abuse, sexual abuse, all the abuses you can make. And uh, they have, they come out of there and they get married and have children and abuse the children. And the children are taught what the parents were taught in residential schools because they don't know what else to teach. (Treatment Provider no. 6)

These quotations emphasize the connection between the intergenerational effects of residential schools and the high rates of violence and drug use that are affecting Aboriginal women.

The treatment providers expressed that many of their clients were not knowledgeable about residential schools and other colonizing practices that potentially contributed to their current life situations. Treatment Provider no. 24 demonstrated this point by explaining that "they just accept poverty, substance abuse, being over-represented in all the social systems. I guess it's the reality. They don't understand how it got to that point." The treatment providers shared how it was important to teach the women about the history of the residential schools to provide them with a greater understanding of their experiences with violence and substance use. One treatment provider explained: Their parents were in residential school[s] so that's what we

try to teach too that it's a cycle. That they need to try to break and then they see like you know—we tell them that it's not the way to live (Treatment Provider no. 21).

5.1.4 Mental illness

The treatment providers emphasized that they see low rates of mental illness among their clients. Moreover, when issues of mental illness do manifest, they believe they are not equipped to provide adequate psychological treatment for the women. According to the treatment providers, they do not have time to distribute and monitor medications, so they do not accept clients who have been diagnosed with mental disorders. Nevertheless, a few treatment providers mentioned that some of the women have dissociations or boundary issues from their traumatic life experiences. When asked if the treatment providers encounter women with mental illnesses one treatment provider explained:

> Well, not really that many, but there is signs of mental illness because of their continued trauma that they have faced and endured throughout their lifetime and they feel really inadequate about themselves in terms of resentment and anger … that they continue to endure. (Treatment Provider no. 23)

The treatment providers mentioned how mental health problems generally exacerbate the women's existing problems with poverty and problematic substance use. However, many treatment providers expressed that they did not see a lot of mental health illnesses among their clients, as these clients are not readily accepted into the program.

5.2 Mothering and the impact of the child welfare system

A clear theme that emerged from the treatment provider interview data was the difficulty that the women have mothering while they are in drug treatment and how important being a mother is to their identity and therefore healing journeys. Additionally, having children apprehended by the child welfare authorities has a tremendous negative impact on women's lives. The ways in which mothering and the child welfare system affects women's pathways to and healing journeys from problematic substance use are explored in this section.

5.2.1 Mothering

The treatment providers spoke about the challenges that women with children face in drug treatment, noting that most of their female clients have children. In particular, it is difficult for mothers to be separated from their children when they attend residential drug treatment. According to the treatment providers, when the women leave their children with caretakers it can

interfere with treatment, especially when the women are focused on the wellbeing and safety of their children outside of the treatment centre. One treatment provider explained:

> The biggest thing I see in a woman is when they come in here they worry about their kids or their families that are out there still [...] well you know the first phone call they get they call their kids and see if their ok or if they say you know "I'm worried about my kid, are they gonna be taken away?" and they have a lot [of kids] you know, they worry a lot about their families. (Treatment Provider no. 7)

Another treatment provider shared:

> That's the hardest part for them. You know it would be nice if we had a treatment centre that had a program for kids so they don't have to leave their kids with strangers or relatives cause you can't trust people these days eh. And I can see why they're in turmoil when they have to leave their kids and stay in here for thirty-five days. Like then they keep phoning and they're more focused on the outside. (Treatment Provider no. 15)

These quotations demonstrate the harms associated with women being separated from their children while in drug treatment. Foremost, the fact that the women do not have anyone to take care of their children is problematic. These issues can force the women to drop out of treatment early. The treatment providers explained how this issue does not affect their male clients in the same way.

According to the treatment providers, the women predominantly take on all caretaking and parenting responsibilities in their homes (and for extended family members). One treatment provider described, "They are someone's mother, they are someone's partner, they are a good daughter, they are all of those things and sometimes they're just so warn out that they don't even know it" (Treatment Provider no. 13). The treatment providers explained that the women are often so focused on taking care of others that they neglect their own needs. Treatment Provider no. 4 discussed: "Some take care of family and extended families and they're so focused on that that they neglect themselves. I think that interferes with a lot of their own personal feelings. They are so focused on the external demands and needs of others they overlook themselves." The treatment providers try to teach the women to take time to care for themselves and emphasize that this is necessary part of being a healthy parent to their children.

The treatment providers indicated that family is a very important part of the women's lives. They explained that for Aboriginal women, immediate and extended family are particularly important. One treatment provider stated, "Like with Indigenous women … family is very important even though it doesn't seem like that because we're over-represented in the child

welfare system. The family is it. [...] It's what causes you to be stronger" (Treatment Provider no. 30).

From analyzing the interviews, it is clear that treatment providers believe that the role of mother is an important part of the identities of the women. This was made apparent when the treatment providers explained how children are a source of hope for the women to overcome their addictions. Many of them shared that their children were a motivating factor for the women to enter treatment. Conversely, some providers explained that when the women have their children apprehended by the child welfare authorities, this brought much emotional pain and shame to the women.

5.2.2 The impact of the child welfare system

The impact of the child welfare system was a prominent theme in the interview data. The treatment providers noted how many of their clients grew up in the foster care system. The women were often moved around between many different foster families, causing a detrimental impact on their identity and self-esteem. One treatment provider discussed one of her client's experiences:

> I think she'd been in over a hundred and she's uh, you know a young girl not even eighteen years old yet. And that's awful. That plays such a detrimental role in their self-esteem and their self-worth. They don't believe that they're worth anything and that's why substance abuse is so predominant. Well "it doesn't matter anyways. Who am I? What am I?" Yeah there's definitely been a lot of that and even seeing their friends apprehended from child and family services and not even understanding what's going on. That makes it even worse that they don't understand. It destroys. (Treatment Provider no. 24)

Abuse was a predominant theme in the treatment providers' discussion of women's experiences growing up in the child welfare system. Treatment Provider no. 3 explained:

> Often they will then apprehended from their homes, from their social workers and then they have lots of abuse often in foster homes so I working a lot with people who were sexually abused in foster homes and just this feeling not belonging, really not loved that is, you know, big, big trauma impacting them.

Another described:

> Right and it is really frustrating to hear the same story and I have even heard one women told me she reported to her social worker what she was experiencing and was not believed. And I think that is sometimes worse than the actual abuse is when you disclose it and the person in power to protect you says you know, blows it off as, you just don't want to live here, you don't like what she has done, you've made up this story. (Treatment Provider no. 19)

The treatment providers expressed significant frustration with their clients' experiences in the child welfare system. When asked about this system, one treatment provider explained that the foster system is mainly a problem for her Aboriginal clients. The treatment providers often talked about the child welfare system being a predominantly negative experience for their clients, although one treatment provider explained that one of her clients has a good relationship with her foster parents.

The treatment providers point out that many of the women are now currently involved with the child welfare system with their own children. They mentioned that having children apprehended does not affect their male clients to the same extent because women's identities are much more intertwined with their role as a mother. In the words of one of the treatment providers, "… and then you're dealing with the loss of your children, the loss of your family life, sometimes the loss of your dignity. Cause any woman who loses children feels that a part of them has been taken from them" (Treatment Provider no. 30). According to the treatment providers, many of the women share this similar outlook.

The treatment providers expressed the great difficulty for women to be apart from their children when they have been apprehended. They expressed that many of their clients became depressed and some suicidal. One treatment provider explained:

> They think that … they think that they want to give up. They think that they want to commit suicide. They think it's no use. (pauses) If they don't get their children back it's really hard on them because that's their life, is those children. And when they take them away … oh, they really … I see them. They really suffer. (Treatment Provider no. 20)

The treatment providers also explained that having children apprehended often perpetuated and aggravated the women's drug use. As one treatment provider described:

> Yeah and sometimes it kind of uh … perpetuates the addiction as well, like fuels the addiction as well. If you're a person who goes partying once in a while or on weekends then you don't have the children you could be partying every day. (Treatment Provider no. 30)

In contrast, once their children were apprehended, some women took this as an opportunity to go to treatment and care for themselves. One of the treatment providers explained that attending treatment also gave the women the opportunity to learn about parenting skills.

The treatment providers asserted that they find it challenging to help the women deal with the child welfare system. In many cases, they disclosed that it was difficult to see their clients

going through this experience and in response try and support them as best they can. One treatment provider described her experience trying to help her client:

> There's always a battle that I remember anyway with the clients I had were fighting against CAS, wanting their children back, trying to make changes. Um, not being heard, not being listened too and they even felt, many times I remember story after story of CAS workers not helping them. And it was really sad to see them going through this and we did the best we can to help them see what they can do. (Treatment Provider no. 11)

The treatment providers said that they often tell women that they need to focus on themselves while their children are in care. For example, they will encourage the women to go back to school or to get a job while they are waiting to get their children back. One treatment provider shared her experience of working with a client:

> The first thing we talk about is the children. We listen to their stories. It is important for them to know that the child will always love them. They are their mother. They will never forget their mothers. They don't know how long their children will be in custody. We encourage them. (Treatment Provider no. 29)

Some of the treatment providers explained that they tell the women to try and stay strong by practicing their faith. One treatment provider explained:

> I tell them they have to have strength. They have, some of them, they have ceremonies. They like that. Some of them like to go to church. I let them go. You know? Because they like going to that. They need anything that helps them. (Treatment Provider no. 20)

On the other hand, one treatment provider took a more confrontational approach to addressing this issue: "Yeah, and I tell them not to point fingers. That they're responsible. That it's their fault if they lose their children" (Treatment Provider no. 25). This was uncommon amongst the responses overall.

5.3 Discussion

Findings from this research indicate that experiences of violence and trauma highly impact the lives of Aboriginal women in drug treatment. The treatment providers in this sample recognized its historical foundation and understood the high rates of violence towards Aboriginal women as rooted in intergenerational trauma originating primarily from colonizing practices. In addition, parenting challenges and issues with the child welfare system were significant concerns for Aboriginal women in drug treatment, impacting their pathways to substance use and subsequent healing journeys. This section situates the implications of the findings discussed in this chapter within the recent research literature. Specific attention is paid to my research

findings in relation to offering trauma-informed and specific services for Aboriginal women healing from problematic substance use.

The treatment providers expressed that the majority of their clients experienced some form of violence or trauma at some point in their lives. They understood that experiences of violence ultimately led women to use drugs to cope with their emotional pain. This finding reflects claims made in existing literature that traumatic life experiences are significantly associated with the development of substance use problems (Engstrom et al., 2008). In addition, it coincides with research that demonstrates high rates of women who have histories of physical and sexual abuse that are seeking drug treatment (Puymbroek & Gutierres, 2006).

Research indicates that the inability of treatment providers to recognize and validate women's trauma histories can lead to many problems. For example, failure to acknowledge the impact of trauma on women's lives can lead to misdiagnosed psychiatric disorders and possible referrals to support services may be overlooked (Vaillancourt & Keith, 2007). Moreover, the lack of attention to the effects of trauma can lead to enhanced distress and even re-traumatization (Poole & Urquhart, 2009). According to Elliot, Bjelajac, Fallot, Markoff, and Glover Reed (2005), "The absence of this understanding about the impact of trauma on a woman's life is... the equivalent of denying the existence and significance of trauma in women's lives" (p. 462). Additionally, symptoms associated with the trauma in women's lives may be misunderstood by treatment providers as resistance or a lack of motivation to engage in the treatment services (Ouimette et al., 2000).

Traumatic life experiences can have damaging health consequences. The treatment providers maintained that the women's experiences of trauma greatly impact all aspects of their lives. In addition, they understand women's histories of violence and abuse as contributing to their low self-esteem. This finding is consistent with research that has linked experiences of childhood and/or adult abuse with psychological health problems, which include low self-esteem (McCauley et al., 1997). Self-esteem refers to

> the attitudinal, evaluative component of the self; the affective judgments placed on the self-concept consisting of feelings of worth and acceptance which are developed and maintained as a consequence of awareness of competence and feedback from the external world (Guindon, 2002, p. 114).

It is important to note that although *self-esteem* is a socially constructed concept from Western psychology, the term is used here because the treatment providers in the interviews used this terminology.

The treatment providers openly expressed that they lack the adequate knowledge to assist women with serious mental health illnesses such as schizophrenia or bipolar disorder. Research demonstrates clear linkages between substance use and mental illnesses (Zilberman & Blume, 2006). For example, research reveals that approximately two thirds of women with drug use problems have concurrent mental health concerns, such as mood and anxiety disorders (e.g., depression, PTSD, eating disorders) (Cormier et al., 2003; Zilberman & Blume, 2006; Zilberman et al., 2003). Moreover, literature reveals that experiences of violence are associated with simple and complex post-traumatic stress disorder, suicidal ideations (Cormier et al., 2003), anxiety, and depression (Puymbroeck & Gutierres, 2006). The connection between problematic substance use and mental illness among women is well documented; however, the treatment providers in this study expressed that they rarely see clients with mental health disorders. Based on these findings, it follows that in order to assist Aboriginal women with mental illnesses, providers need the adequate training and knowledge to work with the women as well as the comfort with referring them to next stages of trauma-specific counseling. It is important to note that since this data was conducted in 2006, there have likely been some improvements in this area, as significant work is currently being undertaken in Canada to integrate mental health and addictions services.

The treatment providers frequently indicated that the women felt too ashamed to tell anyone about their experiences of trauma, and for many women, the treatment providers were the only individuals with whom they felt comfortable sharing this information. This demonstrates that the treatment providers often serve as confidants for the women. It follows that treatment providers would be of key importance for the implementation of trauma-informed and trauma-specific models.

The treatment providers also revealed that parenting challenges and issues with the child welfare system were significant concerns for Aboriginal women in drug treatment. One of the concerns among treatment providers was that the women in treatment have the desire to parent their children while they are in treatment; however, few Canadian drug treatment programs integrate care for pregnant and/or parenting substance-using women and their children (Niccols

et al., 2010). This lack of integrated treatment for substance-using women often dissuades women from attending drug treatment services (Hume & Bradley, 2007).

The impact of the child welfare system was an enduring issue for the women in treatment. The treatment providers noted how the women were often moved between numerous foster families while they were growing up, which greatly impacted their self-esteem. Many of the women are also now currently involved with child welfare authorities with their own children. A large majority of women in drug treatment are there to help regain access to their children. Child welfare policies often regard women's substance use as reason alone for a child's apprehension. Research indicates that the primary reason that children are apprehended is due to alcohol and drug use issues (Saskatchewan Child Welfare Review Panel, 2010).

According to the treatment providers, when the women in treatment have their children apprehended this often leads to many of the women losing hope and ultimately compounds their drug use problems. The Native Women's Association of Canada (2010b) explains that when Aboriginal women's children are apprehended this contributes to an increased use of alcohol or drugs to cope, depression, and increased vulnerability to violence. The report put forth that research with families have emphasized how "a woman losing her children may push her over the edge" (p. 35). Increased efforts to focus on working with Aboriginal women and their families need to be made.

Some of the treatment providers mentioned that child welfare involvement was a relevant problem in drug treatment for their Aboriginal clients, but not their clients from other ethnicities. This is consistent with research that estimates that Aboriginal children are much more likely to be placed in foster care than non-Aboriginal children (Saskatchewan Child Welfare Review Panel, 2010). Studies indicate that the high number of Aboriginal children being apprehended from child welfare authorities is linked to the disproportionate amount of Aboriginal people living in conditions of poverty, with unfunded family services and programs (Amnesty International, 2009). The social and health disparities between Aboriginal and non-Aboriginal people are largely influenced by an expansive range of social determinants of health which include the intergenerational effects of colonization (Loppie Reading & Wien, 2009).

The findings in this thesis provide support for more gender-informed, family-centered systems of care, that focus on keeping mothers with their children while they are attending drug treatment. Research reflects these findings as well. For example, Chansonneuve (2008) found

that a high proportion of women would benefit from drug treatment centres that accommodate women and their children. Further, these findings demonstrate support for more collaborative relationships between drug treatment centres and child welfare systems.

Using an anti-oppressive theoretical framework to analyze the perspectives of treatment providers and the relevant literature concerning Aboriginal women's experiences, it becomes apparent that drug treatment services should be altered to better meet the needs of Aboriginal women. The findings presented in this chapter demonstrate support for drug treatment that addresses the connections between violence and substance use among Aboriginal women and for stronger relationships between the child welfare system and drug treatment centres. These service systems should work together to support women in treatment, reducing the amount of Aboriginal children in care and contributing to healing the next generations.

CHAPTER 6: HEALING, CULTURE, AND THE PAST EXPERIENCES OF TREATMENT PROVIDERS

This section corresponds with the second and third research questions investigated in this thesis: How are self-identity and culture accounted for in the NNADAP treatment providers' practices? What are the past experiences of treatment providers? Do the lived experiences of treatment providers influence how they respond to their clients? Herein, the research findings are presented. The findings from the interviews reveal that treatment providers view drug treatment as an opportunity for the women to learn about their culture and identity as Aboriginal women. Briefly, cultural healing practices are connected to expressions of identity, such as land, family, and culture (Williams, et al., 2011). The treatment providers believe that learning about their culture helps the women with their self-esteem and substance use concerns as well as their overall well-being. In addition, the interviews revealed that the treatment providers' own past experiences influenced how they respond to their clients. The treatment providers explained how sharing their own personal experiences of problematic substance use and violence helped to develop a sense of trust between them and the women, opening up dialogue on past histories of violence and substance use.

This chapter will explore the role of self-identity and culture in the treatment providers' practices and will discuss the treatment providers' perspectives concerning the importance of self-esteem building. Further, it will present the findings regarding the past experiences of treatment providers and how these experiences inform current treatment practices. A discussion section will follow in which I will analyze the research findings within the context of existing literature and will relate the findings to trauma-informed and trauma-specific literature. Post-colonial feminist theory has given me the lens through which to interpret these findings. I have framed them within a socio-historical approach that acknowledges the importance of Aboriginal cultural practices to address the ongoing and intergenerational impacts of colonization.

6.1 Aboriginal healing practices

By analyzing the interviews with treatment providers, it becomes apparent that the cultural component of treatment is very important in the Aboriginal women's healing journeys.

Treatment providers view Aboriginal healing practices as important in countering the effects of residential schools and other colonizing practices. Twenty-five of the 30 (83%) treatment providers stressed that culture is an important part of the healing journey for their clients. When asked about the importance of culture, treatment provider no. 18 replied:

> Culture is so important because that to me that is our survival. That's what helps us survive from all these years of colonial and assimilative processes. That's how important it is, its a persons life. Life or death, that's how important it is.

The treatment providers emphasized how many of the women that come to treatment have no, or a very diminished, cultural belief system. Many of the women did not learned about their culture during their upbringing. In addition, many of the women have not seen the positive aspects of Aboriginal culture, but rather, have been exposed to discriminatory and racist images/ideas about who they are.

The treatment providers viewed treatment as an opportunity for the women to learn about their culture and identity as Aboriginal women. The treatment providers related the healing journey to finding one's identity. Treatment Provider no. 24 explained: "That's what healing is—you're getting back to who you are." Another participant discussed the connection between addictions and identity:

> And we're just now starting to heal ourselves and bring our culture back. And bring our identity back. And that's the thing … that's the big, big part of why women and men in Aboriginal societies have these addictions, is because a part of our identity has been stolen from us. (Treatment Provider no. 26)

According to the treatment providers, when the women engaged in cultural ceremonies it brought them peace and sense of belonging, which is often not the case in mainstream society. The treatment providers explained that cultural healing practices are important to heal the mind, body, and spirit. These healing practices are important to help the women become "whole" again and begin their healing journey. The participants expressed that attending cultural healing ceremonies and developing a relationship with a higher power (i.e., Creator) helps the women to heal from experiences of violence and abuse and commence their healing journey.

Self-identity and culture were accounted for in treatment providers' use of cultural healing practices, which include sweats, smudging, healing circles, visits with Elder and opportunities to go out on to the land. The treatment providers explained how they also incorporate medicine wheel teachings to their discussions. Treatment provider no. 29 provided information about the cultural practices that take place at their treatment centre:

> The cultural teachings are very important. On Mondays, there is a pipe ceremony. Every day, there is a smudge and a prayer. The circle gives everyone-the staff and clients- a sense of belonging, connection. They are all going through the healing process together. There is also an outdoor retreat once a month where they go for the day for sweats and other traditional activities. An Elder also comes into the centre to talk to the clients.

Some of the treatment providers (5 out of 30) highlighted how language is an important part of healing and an important part of Aboriginal culture. Treatment provider no. 24 described language as "the backbone of culture." The providers explained that many of the women do not know their Aboriginal language, because it was lost due in part to forced residential schooling. Treatment providers mentioned speaking in their Native languages when the women come to the treatment centre, demonstrating that it is positive to speak your language. Treatment Provider no. 20 notes:

> That's the time that you got to use their language is when they first come in. They're shy. They're bashful even, to say something. But I tell them "don't feel that way." I tell them in a group eh? "Don't feel that way. We all went through the same thing as you people." And once they open up it's good.

Some of the treatment providers mentioned that the women can sometimes feel excluded from the cultural ceremonies if they have never learned about them before. Women that are still using drugs/alcohol sometimes feel excluded from certain healing practices, such as sweats. One treatment provider illustrates this point:

> And there is a couple of reason for that, one is they don't feel a connection to the community, they don't feel you know because they have been raised outside of the community they were removed as a child, they don't feel a connection there and others feel that there is a stigma around handling the medicines or being part of the medicines when you are using and you are not clean. (Treatment Provider no. 19)

However, this was not a prevalent view, and when it did arise, it was addressed with historical teachings and explanations. The majority of the treatment providers argued that Aboriginal healing methods were essential in order to help women overcome their addictions and experiences of violence.

6.1.1 Self-esteem building

The treatment providers often expressed that an important part of treatment is to build up the women's self-esteem. Twenty-four out of the 30 (80%) treatment providers admitted to helping the women heal in treatment through self-esteem building. This is often done through the use of Aboriginal healing practices and empowering care practices on the part of the treatment provider. The treatment providers discussed how enhancing the women's self-esteem is

important for them in gaining the courage to leave violent partners, feeling good about their identity as Aboriginal women, and having the confidence to get an education/ become financially independent. One treatment provider described the importance of building up the women's self-esteem:

> Because they're really beaten and broken ah their spirits are broken, their hearts are broken, ah it's their whole being is broken and it's like okay let's put them back together. It ain't never gonna be the same because all this stuff that's been done, well let's put it back together and let's build up that dignity and that pride and that self worth and all those other good things. Take a little while, but they usually come around. (Treatment Provider no. 12)

The treatment providers help the women with their self-esteem through using of client-centered care, being supportive, and caring. One treatment providers explains: "When I see women come here that's what I see and that's, they don't even know that they can do things and we encourage them, support them, and try to help their self esteem" (Treatment Provider no. 9). The treatment providers discussed how learning about their culture helps the women with their self-esteem. Treatment Provider no. 22 described:

> Well, the culture, their native spirituality plays a really big part in their self-esteem. Um, I think once they start to know a little bit about their native spirituality and their culture it helps them in their self-esteem in that it makes them proud. Um, proud that they are Aboriginal people and that they have a great cultural heritage.

6.2 The past experiences of treatment providers

In the interview data, the treatment providers would often discuss the women's experiences, relating to the women by expressing their own past experiences dealing with these issues. Many of the past experiences that treatment providers spoke about paralleled the women's experiences. Treatment Provider no. 26 illustrates this point: "They … they all have similar backgrounds to what I had growing up. They were taken away from their family. They were abused in care. They were abused by anybody that was supposed to be protecting them." There were clear commonalities between the experiences of the treatment providers and the women in certain key areas: (1) they shared their own personal experiences with drug addictions, (2) they had a history of violence and trauma, and (3) they had past experiences with the child welfare system.

6.2.1 Presenting their past experiences

Twenty-one out of 30 (70%) treatment providers in this sample had experienced drug addiction(s) and were on their own healing journeys. The treatment providers that did not have a

drug addiction shared how they were greatly impacted by the addictions of their family members. Treatment Provider no. 26 elaborates on her experiences:

> I also grew up in foster care and started drinking and doing drugs when I was eleven. I was taken away from my mom when I was ten. From the age of eleven upwards until I was seventeen I was an alcoholic and a drug addict.

She went on to describe:

> It wasn't until … my daughter was fourteen that I actually really stayed off the alcohol completely and the drugs. And uh … I've been clean ever since. Don't want to touch it. Don't want to go back to it. It's not the life for me. I went and I progressed more and more into realizing what it is I wanted to do with my life. And realizing that I was harming myself. I was hurting myself. I was hurting myself because of all the abuse I suffered as a child and as a teenager.

Some of female treatment providers (55%) disclosed their own experiences of trauma and violence growing up. They commonly mentioned their own personal experiences while discussing the women's experiences of violence. One treatment provider disclosed her experiences of abuse:

> I grew up in a very abusive home. My father was physically, emotionally, and sexually abusive to me and my sisters. He raped four of us. And uh … throughout my life as I grew I was put in foster care and I went through a lot of discrimination. (Treatment Provider no. 26)

She also explained how her experiences of abuse continue to affect her:

> And then, you know I always tell people the bruises go away, but when someone sits there and tells you for five years straight that you're nothing but a piece of shit and you're never going to get anywhere in life … that, that, that … I still suffer with today. That feeling of … not being good enough. (Treatment Provider no. 26)

Some of the treatment providers expressed that they were abused in residential schools. They discussed how these experiences were psychologically damaging and how they still struggle to overcome them. One treatment provider reflects on her experiences in residential schools:

> It's a life time thing. Those abuses never go away. They're always on your mind. When I used to hear the church bell ring images of violence would appear right away in my mind and kind of affect my day. Or whenever I see a mother hit a child right away, it reminds of a playground and you just hear that stick and bone hitting together. There was a lot of violence. (Treatment Provider no. 25)

The treatment providers stressed how these experiences of violence and abuse were particularly detrimental for their self-esteem and confidence, which (among other things) lead them to develop substance use problems. One participant explained: "In addiction, violence is usually

involved... And yeah, like uh … when I started my journey there was a lot of uh … lots of violence" (Treatment Provider no. 30).

The image of their children as a source of hope and a reason for recovering from drug use was an important theme in both the treatment providers' and women's experiences. Some of the treatment providers explained how having a child gave them something to live for and made them want to stay away from drugs and alcohol. When asked what helped her to heal, Treatment Provider no. 26 explained: "My kids helped me a lot My kids did. I owe my children a lot." She went on to explain further:

> My children are the most important things in my life. I don't think I could ever live without my kids. Um … I … I have a very strong will power. I quit drinking when my daughter was six. That was when my son was born and my daughter was six. I quit drinking because she told me I was drinking too much. If a six-year-old child tells you you're drinking too much you know you're drinking too much.

6.2.2 Recovering from their addictions

In the interviews, the treatment providers explained how Aboriginal healing practices helped them heal from their addictions. They felt that these healing methods helped them find their identity. Treatment Provider no. 25 shared her experience with culture in a treatment centre:

> So um … the reason why when I first came here … that's what it was. That's what I found – the culture. That's what I was looking for was the medicines. That made a big difference. Body, mind, and spirit. So um … I'm glad that I found something that helped me overcome my addictions. That's what I tell them—the medicines will help you.

Another discusses the relationship between culture and identity:

> Throughout my years of drug abuse and alcohol abuse, I never thought I was a person. I didn't think of myself as a person. You know? I was an object. I wasn't a person. And once I started healing and getting into my culture and learning more about my Native identity I was realizing hey I'm a person. (Treatment Provider no. 26)

The participants expressed that they felt that their main role as a treatment provider was to teach the women about their culture. They also expressed that it was important to avoid discriminating against other religions and believed the women should attend church or perform other cultural practices if they felt it would help them.

6.2.3 Past experiences inform current practices

The interviews revealed that the past experiences of treatment providers influenced how they presently respond to their clients. Some of the providers shared how they try to treat their clients as though they would have wanted to be treated while they were in treatment in the past

(in a non-judgmental way). Sharing similar backgrounds and experiences with their clients allows the treatment workers to be empathetic and understanding of what their clients are going through. One treatment provider explains:

> And I'm not any better than anybody, not even them. Cause I was there too at one time and I was scared and you know, thinking "oh another person I have to see in order to do this" and they kind of feel small. I know when I can put myself in their shoes. I've walked in their shoes too. (Treatment Provider no. 21)

The treatment providers felt it was important that they could relate to their clients' past experiences. In order to make their clients feel comfortable and open up, the treatment providers share their own past experiences of addiction and violence, or encounters with the child welfare system. One treatment provider explained:

> If I let them know that I'm Cree then after awhile you know I let them know not to feel ashamed of themselves or whatever; that I've been there myself. And once I share a little bit like I am a recovering alcoholic, my kids were in care and I did this and that then they feel "wow" like this is someone that they can talk to. This is somebody that's not going to judge them. (Treatment Provider no. 21)

A treatment provider who did not experience addiction felt it was difficult to establish a connection with the women:

> I don't have any experience in the sex trade and I don't have any experience with addictions so other than, like not first hand experience with addictions. Like I am not a recovering addict or anything I definitely grew up with a lot of addicts. And so even though, gaining that trust with me they, you know it is not easy. I would say that that, that's part of the challenge of gaining the trust. (Treatment Provider no. 19)

When the women learn experiences of the treatment providers, it allows them to realize that they are not alone and that it is possible to overcome their addiction. The treatment providers' expressed how this process is particularly important in building trust with the women. Treatment Provider no. 20 illustrated this point:

> We have to build that relationship with them first and then that trust comes in. They start talking and opening up. They don't talk at all when they first come in. They're just like closed in because that's how they lived back home eh? And it takes time for us to be able to work with them eh? And I always tell them we'll treat them right. It's the way we treat them that counts. And they're starting to heal then you know?

Developing this sense of trust is particularly important for the women to feel comfortable and disclose their past histories of violence and trauma. Treatment centre staff developed a relationship with their clients by not only revealing their own past experiences and expressing how they overcame them, but also through the use of humor. Treatment Provider no. 20 noted:

"You start being friendly with them. You start laughing with them. You start telling them you lived that way too." The treatment providers explained that in order to develop a sense of trust it was also important to demonstrate that they care for the women and express non-judgmental views.

In order to help the women, the treatment providers explained how it is important for them to be in a positive place in their lives, to have dealt with their issues, in order to prevent falling back into their old ways (drug/alcohol use). According to the treatment providers, the reasons they were motivated to work in this field came from these past experiences, the desire to want to help others along their healing journeys, and to "give back" to their communities. Some treatment providers suggested that helping others with their addictions was therapeutic. Treatment Provider no 20 explained: "When I help people like this you know it gives me a lot of strength—it gives me life." Another explained their reason for working in this field:

> I think … you know I was gifted by our creator in some way and my focus is on people who walk through those doors who need help. And that's what continues to motivate me because you know, I wake up every day …hoping to make a difference for one person. Every day (Treatment Provider no. 23)

6.3 Discussion of the findings

The treatment providers viewed culture as an essential component in both the healing journeys of Aboriginal women as well as in their own personal healing journeys. Many of the treatment providers used Aboriginal healing practices to recover, and therefore felt this was an important component of the healing journeys of Aboriginal women. This research stresses the connections between the past experiences of treatment providers and their current practices in drug treatment centers. The findings provide evidence for the inclusion of culture, identity, and self-esteem building in addressing problematic substance use among Aboriginal women in drug treatment. This section will discuss Aboriginal healing practices and the past experiences of treatment providers in relation to the literature.

The treatment providers argued that developing a cultural identity is a key part of the women's healing journey. The incorporation of Aboriginal healing methods in drug treatment centres is important to promote healing and to counter feelings of shame instilled in Aboriginal people due to intergenerational trauma resulting from colonization practices, such as residential schools (Chansonneuve, 2007). The Royal Commission on Aboriginal Peoples (1996) puts forth that Aboriginal healing approaches look beyond the biomedical model of health and wellbeing

and recognize that "well-being flows from balance and harmony among all elements of personal and collective life" (as cited in Wilson, 2004, p. 1). As discussed in the literature review section, Aboriginal approaches emphasize a holistic approach to well-being, which includes healing the physical, mental, emotional, and spiritual aspects of life (First Nations Addictions Advisory Panel, 2010; Hopkins & Dumont, 2010). Research indicates that with Aboriginal clients it is important to move beyond Western approaches to healing and integrate holistic approaches to health (Dell et al., 2011; Wilson, 2004). Bridging the gap between Western and Aboriginal understandings will lead to improvements for Aboriginal participants (Dell et al., 2011).

The treatment providers felt their main role was to help empower the women with confidence-building techniques and teach the women about their culture. They served as a support, role model, mentor, and cultural teacher who guided the women along their healing journeys. According to the treatment providers, building self-esteem is an essential part of drug treatment with Aboriginal women. They explained how building up a woman's self-esteem creates positive changes in many aspects of her life. The treatment providers' expressed that this is done through the use of client-centered care practices and Aboriginal healing methods. Nabigon (2006) notes how "Native healing traditions are used to build self-esteem" (p. 31). This is congruent with the treatment providers' perspectives; they emphasized that learning about Aboriginal culture increases the self-esteem of women in treatment, as it teaches them to be proud of whom they are. By teaching them to be proud of their culture, these practices also help the women confront the discriminatory attitudes and negative representations that persist in mainstream society.

The incorporation of self-identity and culture in drug treatment practices is essential in helping Aboriginal women heal holistically from their experiences of violence and problematic substance use. A recent Health Canada, National Native Addictions Partnership Foundation, and Assembly of First Nations (2010) report advocated for cross-system recognition of Aboriginal healing practices in order to address the current health of Aboriginal people. Although there are inherent challenges involved when evaluating the success of cultural healing programs (Gone, 2010; Lane et al., 2002), studies have documented important links between recovery and the use of Aboriginal healing methods within drug treatment centres (Dell et al., 2010; Dell et al., 2011). A recent study, for example, demonstrates that identity-reclamation through culturally relevant healing practices is a successful component of drug treatment with Aboriginal women (Dell et

al., 2010). Moreover, the *Living Well* project, conducted in Manitoba, affirmed connections between the health and cultural identity of Aboriginal women (Wilson, 2004).

Findings indicate that treatment providers within drug treatment centres play a critical role in Aboriginal women's healing journeys. This research draws connections between the past experiences of treatment providers and their current practices in drug treatment centers. Many of the treatment providers in the sample were on their own healing journeys, had experienced trauma, and had grown up in the child welfare system. In the interviews, the treatment providers explained that they were able to heal from their addictions through cultural-healing methods. They believed that cultural-healing methods helped them find "who they are," and they asserted that their main role as a counselor was to teach the women about their culture.

There is limited research that investigates the past experiences of treatment providers. In the studies that do exist, recovery status is highlighted as an important characteristic of treatment providers working in drug treatment centres (Stoffelmayr et al., 1998). This thesis demonstrates how sharing similar past experiences with clients enables treatment providers to be more empathetic toward their clients and to develop a deeper understanding of what their clients are experiencing. This disclosure on the part of the treatment provider is particularly important in building trust with the women and allowing them to open up and share their personal experiences with their treatment provider. Research demonstrates the need for treatment providers to provide care in a non-judgmental, supportive manner (National Center on Addiction and Substance Abuse at Columbia University, 2006) that recognizes the impact of trauma and the struggles the women have faced (Dell et al., 2010).

In this chapter, Aboriginal healing practices and the past experiences of treatment providers were presented. In summary, the research findings obtained in this study support the application of Aboriginal healing practices within drug treatment centres for Aboriginal women. The treatment providers in this study emphasize the importance of the use of healing practices in order to help build self-esteem, develop a cultural identity and promote feelings of belonging among Aboriginal women. Many of the treatment providers had experienced problematic substance use, had histories of violence, and had dealt with the child welfare system. These experiences allowed the treatment providers to connect and build trust with the women in treatment, thereby helping the women heal from their experiences of trauma and problematic substance use.

CHAPTER 7: THE TREATMENT PRACTICES OF DRUG TREATMENT PROVIDERS

Treatment providers are an integral part of Aboriginal women's healing journeys. The treatment workers in this sample expressed the importance of employing a client-centered approach when working with their clients. They asserted that their main role was to listen to the women and guide them toward healing and forgiveness. One participant described her role as a treatment provider, expressing: "I'm a stepping stone to their healing" (Treatment Provider no. 6). This was a common theme among the treatment providers, who expressed that they provide the women with the tools to heal themselves, but whether they are ready or want to overcome their addictions is ultimately up to the women. The care practices of the treatment providers correlate with trauma-informed approaches. However, findings reveal that integrated systems of care for mental illness and problematic substance use are lacking. In order to work with women with mental illness, the treatment providers believed that they would require enhanced training. This section corresponds to the final research question: How do the practices of the treatment providers align with and/or expand the trauma-informed and trauma-specific literature? First, this section will present the treatment practices that the providers employ in helping the women heal from violence and problematic substance use; second, I will discuss the trauma-informed and trauma-specific models of care.

7.1 Treatment practices to assist Aboriginal women with experiences of violence and problematic substance use

Using a variety of treatment practices, which often correspond to the individual's needs, the treatment providers helped the women heal from problematic substance use and experiences of violence. A clear theme in the interview data was that treatment providers believe it is important to act as a support and listen to the women's experiences in order to help them release their pain. According to the treatment providers, many of the women feel silenced and powerless in their lives. Talking about their life experiences with the treatment providers allows the women to have a voice and an outlet for their pain; with support and encouragement from the treatment provider, the women can feel empowered. Treatment Provider no. 29 explains: "To help a

woman with establishing a healthy self-identity, it is important to listen to their story. Everyone has a story—you, me, every one. Listen and then help them begin to look at their feelings."

The treatment providers try to help the women set goals and identify the best ways for them to heal from their substance use problems. One treatment provider illuminates her role:

> Well … in a counseling role for me I would probably … facilitate them … in looking at what was the answers. What do you think the answers are for you? Always putting it back to them because for me, it's not up to me to fix them, but it's up to me only to facilitate them. (Treatment Provider no. 30)

This was a predominant theme throughout the data. The treatment providers emphasized that ultimately the women need to make their own choices and they can only provide them with guidance and knowledge along the way. Another treatment provider further illustrates this point:

> My main role is to uh, to be there for them in a supporting role and, and listen. Um, I facilitate the group once a week and I have a lot of knowledge of life skills facilitation so that's one of my main roles here and also to be here and to be a listener to them. A lot of times I'll just come in and we'll talk about what's bothering them. I don't think they really want to find out what they need to do because I think they know what they need to do, it's just a lot of times they need just a sounding board for, for you know for things that are bothering them. (Treatment Provider no. 22)

In order to help the women overcome their addiction problems, it is essential to address their experiences of violence and trauma. As the treatment providers noted, they often do this through one-on-one counseling where they listen and validate the women's past experiences. As one treatment provider explained:

> We need to listen to them, to validate, to say you know what I believe you. That happened. And to really take a look at it; let's take a look at it then. What did it do to you? Ah to be there, to you know give them offer them comfort offer them ah support offer them nurturing and caring offer them that shoulder to cry on if they need it ah offer them just sometimes it's just standard hold their hand while they're crying, you know offer them whatever they need at that time when they're going to dealing with their traumas here. (Treatment Provider no. 12)

The treatment providers explained that it is important to give the women the tools to confront their experiences of trauma. For example, treatment providers stressed that instead of turning to drug use, the women need other means of coping with their experiences of trauma (i.e., focusing on their strengths, guiding them towards the future, and not focusing on the past).

In order to help them move forward from these experiences of violence and trauma, the treatment providers try to guide the women towards forgiveness. Forgiveness includes forgiveness of themselves and of those that have perpetrated violence towards them. The

treatment providers expressed how forgiveness is important for the women to let go of the past. The treatment providers elaborated that forgiveness does not mean that what happened in the past is acceptable, but rather it involves "letting go." Treatment Provider no. 23 explains:

> Well how do you let go? How do you forgive somebody who has raped you? You know? Well, the bottom line is if you don't let go that incident will continue to control your emotions, the way you think, your physical life and your spiritual life.

The treatment providers try to help the women with their experiences of violence by stressing that these experiences were not their fault. They recognize that it is difficult for their clients to heal from experiences of violence and trauma and that healing is a lifelong journey; in other words, treatment is only the first step on their healing journey, and it is important that the women continue to work to overcome these experiences and their addictions long after they leave the treatment centre.

The treatment providers explained how in one-on-one treatment sessions they sometimes go through the women's lifeline and analyze what has brought them to where they are today (most often it is experiences of abuse). The women are often encouraged to write letters to those that have caused them pain over the years. The treatment providers noted that group therapy was an important treatment practice as the women met others who have gone through similar life experiences. This process is imperative in recognizing that they are not alone. Treatment Provider no. 16 expresses:

> You know, you know their, their life stories are all similar. That's what I see. You know, come to think about it, they are all similar. Cause when they start sharing in group, some of them are really scarred to start to open up in group. But once they do, there is always somebody else gets it, you know, "This is what happened to me. You are not alone here." And that's what, that's what makes them to start working on themselves. Because they know they are not alone what's happening to them.

The treatment providers also employed cultural-healing practices to help the women heal from experiences of violence. For the treatment providers, Aboriginal healing methods are critical when helping Aboriginal women in all aspects of their healing journey. Treatment Provider no. 6 explains:

> We need the culture and tradition. None of us knew the culture. All we grew up with was what our parents were taught in residential school which was really just abuse, and all the abuses you can think of. Now I slowly uncover the spiritual piece and show them, you know, once you start praying, try praying once a day, you have a higher power, they call him Creator.

Other treatment providers underlined the importance of alternate healing methods, such as art therapy and storytelling. A treatment provider who uses art therapy expressed how this method helps the women express themselves in a unique way, without having to verbalize what they have been through. This treatment provider believed this approach was helpful for the women. Further, the treatment providers used the storytelling method by sharing their personal experiences of healing from experiences of violence. They also showed the women movies (documented stories) to generate discussion around the topic of violence.

Some of the treatment providers explained how they educate the women about the generational cycle of violence. They try to stress to the women that they can stop the cycle of violence and it is possible to live a different life with their children. The treatment providers also work to connect the women to community supports that the women can access after they have completed treatment. In order to prevent the women from future violence, some treatment providers develop a safety plan with the women. For example, the treatment provider and the woman will designate a shelter or other safe place for the woman to go if her partner is violent in the future.

The practices that the treatment providers use are important in helping the women build healthy self-esteem. According to the treatment providers, using specific care practices, such as empowering and encouraging their clients, focusing on their strengths, are important, but the use of Aboriginal healing practices is critical in strengthening their connection with who they are.

7.2 Discussion of treatment practices

The treatment providers used client-centered treatment approaches and individualized the women's treatment plans. Research demonstrates that treatment plans tailored to clients' needs enhances their likelihood of success in treatment (Miller et al., 1999; Sellman, 2009). Many of the qualities demonstrated by the treatment providers (non-judgmental, caring, supportive) align with gender-informed approaches, which emphasize the importance of offering care to women using strengths-based practices (National Center on Addiction and Substance Abuse at Columbia University, 2006). Further, using a multitude of therapeutic approaches that centre on an individual's needs has been shown to promote healing (Covington, 2002).

In order to help clients overcome their addictions, the treatment providers must address the reality of the women's lives, which includes addressing past experiences of trauma. It is important to examine Aboriginal women's life histories in order to understand the circumstances

that lead to their present health status (Browne et al., 2007). Research indicates that creating a safe environment for trauma survivors means validating past experiences of violence, rather than ignoring them (Markoff et al., 2005). Studies indicate that addressing trauma symptoms while women are in treatment is linked with a lower likelihood of a drug relapse (Farley et al., 2004; Hien et al., 2009). The treatment providers' practices fit well with these research findings, as the providers stressed the importance of treating and validating the women's trauma histories. The research participants expressed how it is important to give the women tools to confront their experiences of trauma while simultaneously focusing on their strengths and guiding them towards the future. Trauma research indicates that allowing survivors to set the pace and goals of treatment is paramount for empowering treatment practices (Markoff et al., 2005).

The treatment providers used both one-on-one counseling and group sessions. Research indicates that group experiences are important to provide support for survivors while allowing them to see commonalities between themselves and other women (Markoff et al., 2005). The treatment providers indicated that they view the group sessions as vital in establishing connections between women, which results in the recognition that they are not alone. Covington (2007a) argues that connections with others are crucial for women who have psychological problems stemming from disconnections or violence within their relationships. According to the treatment providers, the women also identified these connections as important in their healing journeys. It is significant to note that group therapy can also be problematic, as some women feel forced to disclose their trauma histories before they are ready or can be re-traumatized by listening to the trauma histories of other women (Markoff et al., 2005). These are significant concerns, and those facilitating therapy groups should be aware of them.

7.3 Trauma-informed and trauma-specific approaches

The approaches of the treatment providers align with trauma-informed approaches. The practices of treatment providers (e.g., encouraging their clients, creating a safe space, maximizing clients' choices over her own recovery, and recognizing the impact of trauma and its connection with addiction) are linked to the principles of trauma-informed care. Connections to trauma-informed approaches were not as strong involving the lack of inclusion of survivors in aspects of service design, implementation, and evaluation of treatment services. Additionally, the treatment providers often did not understand how experiences of trauma are connected with mental illnesses. While they understood the connection between trauma and problematic

substance use, they lacked the understanding and qualifications to address mental health disorders. When they recognized that they could not address certain mental health illnesses, some of the treatment providers referred clients to other services. These findings indicate that treatment providers need education about applying trauma-informed approaches with women who have mental health disorders. Further, treatment providers should gain comfort in referring women to the next stages of trauma-specific treatment, such as local mental health professionals specializing in helping women with trauma concerns.

In the literature review I presented five models that were developed to address the trauma-specific needs of women with substance use concerns. Certain aspects of the models align well with Aboriginal healing approaches. For example, the *Addictions and Trauma Recovery Integration Model* (ATRIUM), which is based on the premise that trauma impacts an individual's mind, body, and spirit, strongly reflects Aboriginal healing approaches (Finkelstein et al., 2004). This approach integrates cognitive-behavioral treatment while emphasizing the effects on all three levels (Finkelstein, et al., 2004). In addition, the *Trauma Recovery and Empowerment Model* (TREM) addresses problematic substance use throughout the intervention and consists of three major parts: empowerment; a focus on trauma and its impact on the individual; and skills building (Finkelstein et al., 2004).

In this chapter, I presented the treatment practices used by providers in helping Aboriginal women with trauma concerns and described how the practices of the treatment providers align with the trauma-informed and trauma-specific approaches. It is important to mention that the trauma-informed and trauma-specific approaches do not discuss the role of trauma for Aboriginal women specifically and were not developed to take the impact of colonization into account. This research provides evidence for the implementation of trauma-informed and trauma-specific approaches for Aboriginal women; however, it needs to be employed in a way that incorporates Aboriginal healing into the treatment plan. Strengthening Aboriginal women's connection to their culture and sense of identity is a critical component of healing, and mainstream trauma-informed approaches need to be altered in order to fit the specific needs of Aboriginal women.

Chapter 8: CONCLUSION

The purpose of this research was to explore women's healing in Aboriginal drug treatment centres in Canada from the perspectives of treatment providers. This study offers unique insight into this understudied area. Treatment providers are the individuals who are listening to Aboriginal women in drug treatment centres. Thus, the focus of this study is unique, as it explored the knowledge of treatment providers; it "listened to the listeners." A number of distinct but interrelated findings resulted from exploring their perspectives, which can be used to offer recommendations to improve existing treatment practices in drug treatment centres. In this final chapter, I offer suggestions for improving the quality of care at drug treatment centres for Aboriginal women across Canada based on the findings of this study. In addition, I present the treatment providers' recommendations on how to improve drug treatment for Aboriginal women. These recommendations were not set in the context of the research questions in this study, but rather focus on making drug treatment services more effective for Aboriginal women in general. Finally, I discuss the need for future research in this area and advocate for policy changes.

8.1 Implications of the research findings

The findings of this study support the need to integrate drug treatment programs with trauma services. Women's addictions should not be addressed in isolation from other issues their lives (Briggs & Pepperell, 2009). Women's experiences of trauma were found to highly impact their pathway to problematic substance use and subsequently influence their healing journey from problematic substance use. Violence, mental health concerns, and socio-cultural influences (primarily colonization) should be addressed in combination with substance use concerns in drug treatment centres. Integrated care can help women draw connections between their experiences of trauma and their substance use and can minimize their chances of re-traumatization (Aston, Comeau, & Ross, 2007).

This research and extant literature identifies the need to continue focusing on culture and self-esteem-building treatment practices, as they have been identified as critical for Aboriginal women healing from violence, drug use, and intergenerational trauma. Literature reveals that the benefits from Aboriginal healing practices accrue not only for those who are healed, but also for

the broader community (Williams, et al., 2011). For example, Aboriginal cultural approaches emphasize that "a person's inner spirit is intertwined with their family, community, and the land, and it cannot be understood apart from them" (Dell et al., 2011). In contrast to most Western models, this model suggests that an individual's healing cannot be disentangled from their community (Dell et al., 2011).

In order for Aboriginal women to heal from violence and trauma, treatment approaches need to include the role of the community and focus on implementing healing approaches that include both men and women as well as their respective communities. The Native Women's Association of Canada (2010b) notes:

> Ending violence against Aboriginal women and girls lies with both men and women, with both Aboriginal and non-Aboriginal communities, as well as all levels of government. It ends with recognition, responsibility and cooperation. Violence against women ends with restoring the sacred position of Aboriginal women as teachers, healers and givers of life. (pp. 39-40)

The findings from this thesis provide support for this statement and stress the importance of culture-based approaches to heal Aboriginal women in drug treatment as well as their communities.

In most cases, the practices of treatment providers examined in this study align with trauma-informed models; however, treatment providers could benefit from clear guidelines on how to approach trauma and create safe healing environments for their clients. Many of the treatment providers' existing trauma-care practices result from their experiential knowledge and past experiences with violence. This experiential knowledge is important and allows the treatment providers to build a trusting and healing relationship with their clients. However, drug treatment personnel should also receive enhanced training to ensure that they are aware of trauma concerns among their clients. Specific protocol should be put in place in which treatment providers screen women for trauma and make referrals to trauma-specific supports in that treatment centre or in the larger community. This protocol would ensure that treatment providers are sensitive to trauma concerns and would likely improve existing trauma care services.

Presently, service providers in Ontario have developed an integrated model of care called *Ontario Woman Abuse Screening Project* (2012). They are leading the movement to implement routine screening for violence and trauma in addictions and mental health service sectors. This integrated system of care will prevent women from "falling through the cracks" and will help service providers create a culture of safety. Addiction and mental health agencies in Canada,

including the NNADAP treatment centers could consider expanding their existing mandates in support of integrating support for addiction, mental illness, and trauma.

The research findings in this project support the development of childcare programs in drug treatments centres. This research emphasizes the important role that children play in their mother's healing journey. Given the fact that trauma survivors often experience parenting challenges resulting from their trauma histories (Covington, 2007b), treatment parenting programs should provide opportunities for enhancing positive parenting practices, thereby diminishing the cycle of addictions and abuse. If it is not possible to have child-care programs in the treatment centres, treatment providers should make appropriate referrals for the women in treatment; for example, the women could potentially attend day treatment programs. Although this thesis did not intend to set out to examine the role of children in their mother's healing journey, it was a recurrent theme throughout the interviews with treatment providers. It is particularly important to examine this relationship when attempting to make changes for existing and future generations in the addictions and mental illness fields. The Native Women's Association of Canada (2010b) explains:

> We must not overlook those who may be affected by multiple layers of violence or trauma: the children. For this reason, measures created to improve the situation of Aboriginal women will have a similar and positive impact on their children and families. (p. 34)

8.2 Treatment provider's recommendations

Throughout the interviews, the treatment providers often made recommendations on how to improve drug treatment for Aboriginal women. Most of the treatment providers are on their own healing journey. Some have attended treatment programs and all work with the women in the treatment center on a regular basis. Therefore, they have immense knowledge about what works and what does not work.

Length of treatment was a topic that was frequently raised in the interviews. Treatment providers consistently stressed that treatment should be longer, as healing is a long, slow process. The treatment providers believed that treatment should be longer in order to address all the different concerns in the women's lives, including their experiences of violence. Further, they argued for increased accessibility and widespread awareness of the programs. Moreover, they explained that the waiting lists for the centres are too long; women who want treatment are sometimes forced to wait for weeks or months.

In order to make treatment more effective, treatment providers recommended certain programming changes and increased programming options. Some of the suggested changes included: (1) an outreach worker in the community to help the women after they attend treatment; (2) life skills, job search programs, and education programs in the treatment centre to help the women become more financially independent (also help them leave abusive relationships); (3) develop family treatment centres in their communities to help prevent children from growing up with the same problems as their parents; (4) more preventative programs to help youth; (5) programs to help keep women and their children together (rather than in the care of child welfare services); and (6) increased use of Aboriginal healing practices within drug treatment centres, and treatment counselors with greater knowledge about the traditional healing practices of Aboriginal people.

In addition, the treatment providers expressed that there should be more harm-reduction practices in treatment centres. They view harm reduction services as providing a place for women to talk openly about their addictions without being judged and giving them a chance to use drugs in a safe environment while learning about treatment options. When discussing the lack of harm-reduction options in treatment centres, one treatment provider expressed: "I think a lot of service agencies are limiting themselves and further marginalizing women who are already marginalized" (Treatment Provider no. 19).

The treatment providers advocated for enhanced community supports and aftercare programs for the women when they complete treatment and return to their communities. They suggested, for example, that women's addiction support groups should be established in Aboriginal communities. In addition, they believed that a transition centre or transition house would help women post-treatment. Currently, many women are going home to unsafe environments where there may be pressure to consume drugs and/or alcohol; this is especially the case for women who do not have their own housing.

Moreover, treatment providers would like to see enhanced support services for treatment providers and counselors. Many of the treatment providers discussed how they were overwhelmed at times, pointing to the need to improve self-care procedures in their specific treatment centre. When the treatment providers are unable to care of themselves, they cannot provide adequate supportive care to their clients. One way this could be

accomplished is by having a separate room for treatment staff, where they can take time for themselves.

8.3 Recommendations for future research

The findings from this study highlight a number of areas for future research. This study directs our attention to further research on the application of trauma-informed and trauma-specific approaches in the context of drug treatment for Aboriginal women. Studies should examine how trauma-informed approaches can better meet the needs of Aboriginal women and how these approaches can take into account the impacts of intergenerational trauma as well as gender-based violence.

Future research projects may want to look at the past experiences of treatment providers in mainstream treatment centres throughout Canada. It is likely that the past experiences of treatment providers would be different from those in Aboriginal specific centres, and therefore the treatment providers care practices would also be different. In addition, future research must continue to examine the effectiveness of Aboriginal healing practices in drug treatment centres. Further research in this area could improve existing holistic healing practices used to help Aboriginal women and could bring additional funding supports to existing cultural healing options.

This research demonstrates the value of applying a post-colonial feminist approach to addiction research with Aboriginal women. Future research studies could benefit by applying a post-colonial feminist framework. This lens was important for situating Aboriginal women's experiences of oppression, and it provided a deeper understanding of the complex and interrelated factors that contribute to Aboriginal women's existing drug use and trauma concerns. It allowed me to remain cognizant of the colonial power relations that exist on numerous levels, including the differences between Westernized health approaches and Aboriginal approaches. Research indicates that Aboriginal women feel marginalized from mainstream health service sectors (Browne, Fiske, & Thomas, 2000). This illustrates the need for critical research approaches that will provide evidence to implement changes in policies and service practices. Research that stands outside of colonial thought and questions existing systems serves to expose the lived realities of marginalized groups.

Lastly, future research with Aboriginal women should focus on integrated health approaches that assess the efficacy of self-esteem boosting through the use of cultural healing

methods. Self-esteem boosting through Aboriginal cultural practices would be particularly significant for young Aboriginal women.

8.4 Policy changes

This study has several implications for treatment providers, drug treatment centres, and society as a whole. The historically based inequities discussed in this thesis cannot be separated from their societal context and are not resolved through simple solutions. It is imperative to situate the high rates of violence and substance use among Aboriginal women within the context of the historical trauma endured by all Aboriginal peoples. Aboriginal peoples were in residential schools for hundreds of years; therefore, changes to the existing situation will take time. The Royal Commission on Aboriginal Peoples (1996) explains that "each problem addressed would be difficult to resolve on its own; the problems are rendered more challenging by their interdependence" (Section 1). Problematic substance use and trauma among Aboriginal women need to be addressed in a comprehensive manner that targets the social determinants of health that are central to the occurrence of these problems. Attention to the social determinants of health, which alter the opportunities of Aboriginal women, must inform policies in order to change the existing situation.

Policies that target violence against women comprise crucial components that can increase women's security and lower the rates of violence towards women. Policy changes that target violence against women can take many forms. Some of the policy changes that should take place, include: public education campaigns that target violence against women; introducing greater sanctions for perpetrators of violence against women (including the use of culture based practices for healing); increasing the amount of support services for violence against women; and violence education for institutional professionals such as health, social support workers, and police officers. Moreover, in order to get to the core of this issue and significantly reduce the rates of violence against Aboriginal women it is important to apply a social/health determinants model that benefits the entire community. A 2007 report by the Ontario Native Women's Association and the Ontario Federation of Indian Friendship Centres expresses that "violence against Aboriginal women is always done within the context of a community, and as such, the community as a whole has a central role to play in addressing the issue".

Lowering the rates of violence against women will likely be a long and slow process. Misogynistic and patriarchal attitudes towards women continue to persist in Canadian society.

These sexist attitudes are often compounded for Aboriginal women due to their social status and the racist attitudes that persist in society. Mainstream media and societal attitudes often perpetuate the belief that violence against women is acceptable. These notions particularly target women who live on the margins of our society, such as Aboriginal women living in poverty and sex workers. The fact that there is over 500 missing and/or murdered Aboriginal women in Canada clearly demonstrates that major changes are needed. Policies that target violence against Aboriginal women could benefit from applying a post-colonial feminist analysis, which emphasizes the influences of gender, race, and class. Moreover, policies that address violence against women should also emphasize the importance of restoring Aboriginal culture to enhance prevention methods (Brownridge, 2003). This could include the use of Aboriginal healing methods to curb the high rates of violence against women. Additionally, workshops could be implemented in which men and women learn about healthy relationships and the impacts that violence has on women and children.

The Native Women's Association of Canada (2002) explains that healing for Aboriginal women needs to be done "within a holistic framework which acknowledges the impact of colonization and resultant socio-economic and health determinates, such as: poverty, violence, and substance abuse" (p. 5). In partnership with Aboriginal people and their communities, it is important to draw upon the strengths and needs of community members. The findings in this thesis underscore the importance of culture to the health and healing of Aboriginal women. Aboriginal culture, beliefs, traditions, and practices should be blended with current and emerging trauma-informed and trauma-specific models to make them as applicable and accessible as possible to Aboriginal women.

8.5 Next steps

I plan to disseminate the research findings from this thesis as widely as possible. As Swift and Levin (1987) note, "Knowledge mobilizes action for change." I will provide copies of my thesis to the *From Stilettos to Moccasins Research Project* team members and will send the findings to the National Native Alcohol and Drug Abuse Program Renewal Leadership Team. I will also endeavor to publish my findings in a peer-reviewed journal and present them at an academic conference.

Moreover, I will decide collectively with the research team on knowledge translation methods. Knowledge translation is a significant component of any community-based research

approach and it is necessary to help improve problematic substance use services. For example, the dissemination methods may include drawing on the success of the music and video production already completed in the parent project. The perspectives of the treatment providers in the *From Stilettos to Moccasins Research Project* made this thesis possible. I hope your lived experiences continue to evoke improvements to the ways that drug treatment for Aboriginal women takes place.

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