URBAN NATIVE WOMEN IN RECOVERY FROM ADDICTIONS: AN ARGUMENT FOR THE HOLISTIC INTEGRATION OF TREATMENT AND AFTERCARE SERVICES

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INTRODUCTION

The purpose of this exploratory study was to determine the adequacy of current addiction services for Vancouver’s urban Native women in recovery from addiction. It is evident that urban Native women continue to be at risk of recidivism, due to a multitude of issues that directly affect their ability to maintain a healthy addiction-free lifestyle. If recidivism is to be reduced, there needs to be a dramatic reconstruction of current addiction services. In fact, there is a need to integrate treatment and aftercare services, in conjunction with systemic changes that provide a holistic approach to addressing the issues faced by this population. Certainly, First Nations women are recovering from addiction, in spite of the failure to meet their needs. Regardless, as this study indicates, urban Native women experience unique difficulties in their efforts to find a new way to live, difficulties that could be mitigated by providing holistic and integrated services.

Of particular relevance is the fact that urban Native women comprise a very diverse group; they come from many different cultures, in addition to having differences related to family status, sexual preference, and degree of acculturation to the dominant society. For example, as regards culture, Vancouver’s Native population spans a large variety of cultures from across Canada, with over 40,000 Native people in the Vancouver/Richmond area (Vancouver Richmond Health Board (VRHB), 1999). As well, the diversity of Vancouver’s urban Native population includes those from highly traditional communities such as Alert Bay, on the West Coast, to those who have lived off reserve in Vancouver since birth.

Also pertinent is the historical impact of colonization, which is reflected in the health and socio-economic status of
Vancouver’s urban Nations women. First, generations of Native people have been abused through colonization, the policies of which have led to traumatic intergenerational effects on the family, a fundamental aspect of Native society (Ing, 2000, Royal Commission on Aboriginal People (RCAP), 1996). Secondly, the health status of First Nations women, living in Vancouver, is indicative of the ongoing colonial oppression they face. For example, prominent are the alarming statistics regarding HIV/AIDS; 31% of all new HIV/AIDS cases diagnosed by the B.C. Center for Disease Control are Aboriginal women (VRHB, 1999).

Thus, the reconstruction of addiction services needs to include integration with programs and policies geared towards addressing the inequities stemming from colonialism. Currently, the value system underlying current programs leads to services which tend to be fractured at best, as addiction is addressed in isolation from the complicated issues facing this population. In fact, as mentioned in the RCAP, “tackling addictions is like grabbing the tail of a tiger - family violence, suicide, self-injury, accidental deaths all being stripes of the same animal” (Vol.3, Part 3). Since existing addiction services focus on the individual, with little or no attention to the family, the community and the larger society, an individual’s environmental concerns are not addressed, and the status quo is not challenged.

Importantly, Urban Native women are faced with complex issues that cross lines of history, culture, class and gender, factors which are not considered in mainstream programs. Paramount is the need to facilitate changes to First Nations women’s status as it relates to issues of poverty, racism, heterosexism, lack of education and employment, under-employment, isolation, lack of housing, health needs, lack of family or community support, and a lack of societal support. Furthermore, a lack of follow-up (post-treatment) services for this population perpetuates the vulnerability to recidivism.

In fact, this exploratory study of five urban Native women in long-term recovery from addiction in Vancouver found that these women are still faced with problems associated to relationships; self-identity/concept; education; oppression; culture; and, service provision. As well, the impact of these
issues leads to the perpetuation of issues related to fear; difficulty connecting with self and others; grief and loss; identity/esteem issues; depression and anger and safety and comfort. As such, there is a need for integrated and holistic services to overcome the challenges that continue to place them at risk.

Lastly, the failure to make significant changes in the provision of services to this group amounts to nothing less than the perpetuation of the colonial oppression faced by First Nations women. Substantial efforts must be made to reduce the stigma, racism, poverty, and sexism experienced by Native women; fundamentally, restoring First Nations women to a respected, visible, and valued role in their families, in their communities, and in society must be a priority. Similarly, the RCAP mentions that “if the Aboriginal and non-Aboriginal people of Canada are to share a future characterized by peace and creativity, that shared future must accommodate openly and generously the cultures and values that Aboriginal people are determined to retain. Anything less will be a continuation of the oppressive practices of the colonial past” (Vol. 1, Part 3, Chap.15).

**COLONIZATION: UNDERSTANDING HISTORY**

Colonization has had a devastating impact upon First Nations, generally, and on First Nations women specifically. Native societies across the lands now called Canada have suffered severe multigenerational losses including loss of land, of resources, of language, of culture, and of the economic and political structures that sustained them for thousands of years. “Gathering strength” (RCAP, 1996), identifies the symptoms of colonization which “include, but are not limited to: poverty, unemployment and under-employment, access to health care, health concerns generally, alcohol and substance abuse, sub-standard housing, high suicide rates, child care, child welfare and family violence” (Vol.3, Part 3).

Furthermore, in a discourse on the family as central to Aboriginal life, The RCAP Report claims that,

Aboriginal families have been at the center of a historical struggle between colonial governments.... which set out deliberately to
eradicate the culture, language and world view of the First Nations, Métis and Inuit children over whom they assumed control, and Aboriginal parents....who believe wholeheartedly that they have a sacred responsibility to maintain balance in the world for their children... Many Aboriginal adults have lived through this struggle and come out as whole human beings. Others, however, are serving time in a dead end from which they see no way out (Vol. 3, Part 2).

Rather than the individualistic values inherent in Western society, the values of Native people tend to be rooted in the family and community; importantly, the destruction of family and community has undermined the health and well-being of Native people, overall.

In addition to the destruction of family systems in First Nations communities,” there has been a denigration of First Nations women in contemporary society due to the impact of colonization” (Sayers and MacDonald, 2001).

What was observed by European settlers was the power Aboriginal women enjoyed in the areas of family life and marriage, politics and decision making, and the ceremonial life of their people.... the Jesuits, steeped in a culture of patriarchy, complained about the lack of male control over Aboriginal women, and set out to change that relationship (RCAP, Vol.4, Part 2, Chap.1).

Sayers and Macdonald also quote Absolon et al. (1996): “The erosion of First Nations women’s traditional roles has gone hand in hand with their contemporary devaluation. Not only are First Nations women devalued by White men, First Nations men (and women) have arguably internalized the white devaluation of First Nations women” (p. 45).

ABORIGINAL WOMEN IN SOCIETY: CURRENT STATUS

“Colonization has severely affected the health...of Aboriginal women” (Deiter and Otway, 2001). For example, according to Health Canada (online, 2003), Aboriginal women:
- have a lower life expectancy than non-Aboriginal women (76.2 years versus 81.0 years)
- experience higher rates of circulatory and respiratory problems, diabetes, hypertension, and cervical cancer
- represent 15.9% (versus 7%) of HIV cases, nationally
- have 3 times the mortality rate of their counterparts
- are hospitalized for alcohol related accidents 3 times more
- are 3 times more likely to commit suicide

Compounding these health issues is the social status of Aboriginal women. For example:

Aboriginal women tend to be better educated than men, [but] are no more likely to find jobs. Their participation rate in the labour force is much lower than Aboriginal men's — 53.4 per cent versus 72.4 per cent. Their unemployment rate is 21.1 per cent, versus 27.6 per cent for men...[and] the average annual income of Aboriginal women is about $11,900....far behind their non-Aboriginal counterparts, for whom the average annual income is about $17,600 (RCAP, Vol 4. Part 2).

These statistics are indicative of the ongoing oppression Aboriginal women face in Canadian society, and provide the background for a discussion regarding the need for significant changes in the structural framework that guides addiction services to Aboriginal women. Importantly, tackling these issues, which are rooted in colonialism, is pertinent to ensuring the success of Aboriginal women in recovery from addiction.

PERSPECTIVE ON ADDICTIONS AND FIRST NATIONS IN VANCOUVER, B.C.

Mainstream theories and programs disallow meaningful resolution of the concerns related to addiction within the urban Native community; therefore, other ideas and approaches must be considered. Many authors address the need for a holistic approach to addiction services for Native people (Anderson, B.M. 1993; Cummins, E. 1992; Duran, E. and Bonnie Duran 1995; McCormick, R. 1995; Royal Commission on Aboriginal Peoples (RCAP) 1996). “The Vancouver Urban Indian Needs Assessment Study” (ADP, 1989) also reinforced the need to incorporate a holistic approach. The implications of the study
suggest the need to develop a continuum of services, and, the need for family, community and societal participation in the process of overcoming addiction within the urban Native community.

Significant, as well, is that, according to “Healing ways” (Vancouver Richmond Health Board (VRHB) 1999,p.vi), “...families often live in a state of unresolved grief resulting from losses that include frequent deaths in the family or neighborhood” This study also attests to the challenges faced by urban Native women, highlighting the need for more services for Aboriginal women in Vancouver. Seen as an area of priority, the report mentions that “women’s health concerns relate to consequences of poverty, substance abuse, being a single parent, having a history of sexual abuse, being isolated, and living in an environment of domestic violence,” (p.19). Primarily, recognition and acknowledgment of the devastating effects of colonization, both historically and in contemporary society, can facilitate understanding regarding the importance of developing a more holistic approach to services for this population.

Also significant is that mainstream addiction theories, as well as mainstream programs and services, fail to address the politics of Native peoples’ experience of colonization. This represents a huge gap in the way services are developed, as the larger society, which can provide resources and other support, remains unchallenged. As such, criticisms of existing programming, as well as alternative and feminist theories on addiction will be briefly considered, as each implies the need for a new approach to services for urban Native women seeking recovery from addictions.

Firstly, the recent publication by the Kaiser Foundation (May 15th, 2000) provides a succinct description of existing addiction-related services. The publication states that

In short, British Columbia’s attempt to provide an appropriate “continuum of services” for the users and abusers of alcohol, drugs and gambling is today a broken chain. Inconsistent and under-funded education and prevention efforts. Wasted opportunities for intervention. Fragmented components for counseling and treatment. Inadequate data collection and research capacity
on which to base good decisions. Waiting lists for counseling and treatment. The province’s Alcohol and Drug Services (ADS) continuum, despite the best of intentions, has become a “discontinuous” continuum (p.20).

As well, research by Griffiths, Glackman, Esperson and Davies (1989) presents a number of factors that impede adequate provision of services to Native people struggling with addiction. A brief summary of this research will validate the need to consider a more culturally appropriate approach to the development of addiction theory and practice for Native clients. Issues presented by Griffiths et al include concerns regarding:

- lack of a clear understanding of the “etiology of Indian drinking”
- lack of research on substance abuse among urban natives
- failure to consider cultural, psychological and socio-economic factors or the differential needs of target groups based on patterns of use, gender, age, etc...
- lack of applicable data or appropriate methods for gathering data
- lack of adequate evaluation materials or appropriate models for evaluation
- lack of empirical research on non-alcohol substance abuse among urban Native Indians
- politics of research funding
- funding available for treatment programs
- treatment strategies based on assessment of the treatment needs of Native clients
- most programs are community or reserve-based
- lack of aftercare/post-treatment services (pp.vi-94)

As regards the theoretical underpinnings of addiction services, alternative theories regarding substance abuse in the Native community are also described by Griffiths et al.:

- Social organization/Cultural approach – suggest a lack of cultural norms and folkways to control substance misuse/abuse,
- Biological explanation-Firewater Myth-idea that native people metabolize alcohol differently and have greater risk in becoming alcoholic; reinforces stereotypes and obscures role of history, social structures and economic factors
- Cultural disintegration theory – colonization, oppression have undermined traditional Native culture, leading to disintegration of communities; evidenced by over-representation in social service system, justice system, and higher rates of substance abuse, suicide, violence, accidental deaths (pp.4-9).

Duran (1995) points out the tendency to blame the individual, as well as culture, which he views as fundamentally harmful to Native people, since this leads to reinforcing the idea that dominant values are superior. Of relevance here is the cultural disintegration theory, in that it acknowledges both the importance of culture and the impact of colonization.

Also relevant, particularly in the case of First Nations’ women, are feminist theories of addiction, which focus on the fundamental features of the patriarchal society as relevant to the issue of addiction. Specifically, Van den Bergh (1991) wrote that:

The social, political and economic forces associated with patriarchy create conditions conducive to the development of addictive behavior. This is because the primary process associated with patriarchy is one of control and domination, whereby a few have power over the many (p.19).

Furthermore, Van den Bergh (1991) elaborates on power and powerlessness, dichotomous thinking, valuing outcome at the expense of process, and the invalidated self. Without elaborating at length on these theories, of relevance is the need to look at how recognition of these factors can enhance support for the development of comprehensive programs.

First, power distribution within families, communities and society needs to be addressed. Within the family, issues of violence and sexual abuse, for example, can perpetuate problems of addiction. At the societal level, local, provincial and federal governments need to facilitate activities, services, and resources to overcome the complex and varied factors which affect the overall health of the urban Native community. The Royal Commission on Aboriginal Peoples (1996) states that poverty and housing are among the most pressing issues that affect health.
Also, there is a need to overcome dichotomous thinking. Inherent in the moral approach, as well as the ideology which determines how services are developed, are the underlying issues of superiority/inferiority that represent the dichotomy between deserving versus undeserving clientele, such as urban Native people struggling with addiction. Absolon (1993) uses the Medicine Wheel framework to discuss service provision and the need to determine what constitutes healing, as well as considering the negative influences. “The presence of behaviors that contribute [to] and sustain ‘harmonious and cohesive’ relationships is essential” (p.5). In reference to dichotomous thinking, much work needs to occur to overcome such impediments to the development of at least adequate services, not the least of which is the stigma attached to being Native and being addicted.

Further, recovery is a process not an event. Existing services are evaluated according to outcomes, such as completion of programs, yet the high rates of recidivism among Native people (McCormick, 1995) fails to validate the effectiveness of addiction programs. “Healing is a process, characterized by the continuum inherent in the Medicine Wheel....the healing process requires time and patience from all involved; the healing relationship is an important factor in allowing for this process to evolve” (Absolon, p.12).

In reference to the invalidated self, a failure to include Native people in the development of structures and ideology that are culturally sensitive and inclusive, invalidates this population. Yet, “the healers’ openness to change is a key element in the healing process” (Absolon, p.14), and research shows the need to include Native people in all aspects of the development of health related services (ADP 1989, Griffiths et al. 1989, Health Canada 1998, RCAP 1996, VRHB 1999). This would, at the very least, include participation in research, program planning and development, and evaluation.

**METHODOLOGY AND FINDINGS**

Within the context of colonization and its impact, of the perspectives related to Aboriginal women’s health and social status, and of the issues identified regarding the mainstream approach to services in Vancouver, the experiences of
Vancouver’s urban Native women in recovery from addiction constitute the focus of this study.

Specifically, a qualitative case study, using semi-structured interviews, and a grounded theory analysis of the data show that the current services available to Aboriginal women in long term recovery from addiction are inadequate, at best. The use of grounded theory allowed for an open-minded approach to the data: rather than imposing a predetermined hypothesis, the data could reveal patterns and themes (Huberman and Miles, 1994, as quoted in Creswell, 1998, p. 141) important to the participants.

The purpose of the study was to learn about the experiences of Aboriginal women in recovery from addiction. Specifically, understanding their life experiences, and their perspective on service delivery were sought. The two questions that were asked are: “what’s life been like since you got out of treatment?” and “what do you think about existing services?”

Initially, letters inviting participation in the research were given to Aboriginal women known to meet the criteria for participation –criterion sampling (Creswell, 1998, p. 120). These criteria included Aboriginal women, who live in Vancouver, B.C., were over the age of 21, and were out of treatment for at least one year, with continued abstinence since treatment. Of those approached, five agreed to participate in the study.

Importantly, the participants were quite heterogeneous. At the time of this research: their ages ranged from 35 to 48 years old; they had between 8 and 12 years of abstinence from drugs or alcohol; three were single mothers, one was married with children, and one did not have children; three worked full-time, one worked part-time, and one was in school; one is a lesbian; two had no connection to their cultural history due to growing up away from their community; one was Metis; two were from eastern Canada, while two were from B.C., and the the 5th participant was from North Saskatchewan. Based on the small sample, and on the diversity of the participants, these findings cannot be generalized to all urban Native women in recovery from addiction.

Most significant was the fact that, at the time of the interviews, one woman had just attended a treatment program for residential school survivors, and two were seeking a
secondary treatment program, although they had no idea where they could go to address their current needs. Another had been to treatment five times in ten years, as she was unable to find any other services available to address her ongoing needs.

Certainly, the negative effects arising from a lack of adequate services is reflected in the articulate and knowledgeable responses of participants during the interviews conducted for in this study. “Analysis of the interview data provides a definitive case for the argument that this population’s [after-care] needs are not being met” (Harris, 2002).

Data analysis involved transcription of the data, which was reviewed by the participants for accuracy. General themes had been written in the right margin, and the respondents had the opportunity to add, remove or change the initial themes that were identified, allowing for validation of the findings. The initial categories from the data analysis include: relationships, self-identity/concept, education, oppression, formal services, culture (see appendix), and factors affecting risk of recidivism – this category was derived from reflections of the emotional impact of dealing with the aforementioned issues, and is the basis of my conclusions. The first five categories will be briefly discussed within the framework of individual, family, community and society, and precede the latter two topics: factors affecting risk of recidivism, and culture. The factors affecting risk of recidivism included the topics: fear, connecting with self and others, dealing with grief and loss, self-concept, depression and anger, and safety and comfort. Ultimately, it is the impact of the external factors mentioned previously that serve to perpetuate an internal state that leads to ongoing vulnerability.

In terms of analysis, the theme of ‘self-identify/concept’ is not only a concern, but also represents an aspect of the factors affecting risk of recidivism; thus, this category represents both a cause for internal conflict, and an effect of their interactions with the outside world. Also of relevance is the fact that the issues were not all presented by all of the participants. For example, one participant does not have children, and did not mention concerns regarding child-care while in treatment.
THE NEED FOR INTEGRATED AND HOLISTIC SERVICES: A CRITIQUE

From an individual perspective, the research showed that the respondents face ongoing challenges that affect positive movement in their own lives. Rather than facilitating growth and freedom, much of their experience is characterized by stigma and ongoing isolation.

“There were a lot of issues...issues of discrimination against First Nations, First Nations in recovery......simple things we take for granted...things like shopping in a shopping mart, or even getting hired on....facing poverty issues, being a single mother... parenting skills, having to learn how to parent and nurture your child...And on your own especially, another kind of isolation...”

In fact, the overwhelming lack of support, compiled with ongoing racism and discrimination, lack of education and culturally appropriate services, makes the prospect of feeling as though they really can make the changes they would like seem a formidable task, and progress is far slower than need be.

From a family perspective, the respondents talked openly about the need for education and support for their families. Relevant were issues related to the need for healing among family members, resistance of family members in accepting change, and the dilemma of trying to maintain recovery in spite of family members addictions and/or violence in the home.

“Me and my son was going there [treatment program] because obviously, I had damaged my son in my drinking...emotionally, physically, and mentally probably...he got to the point where he was hating me as a mom, so it helped him heal through that”

“family violence, that’s another issue I face as well. And learning how to cope with a dysfunctional family unit. I lived through that as well.”
Also mentioned were a multitude of issues relating to intergenerational impact of the residential school system and foster care, to men’s loss of roles as providers, and to ongoing internalized oppression as Aboriginal people.

From a community perspective as well, education and support were mentioned as critical, as is the need to develop reciprocal relationships aimed at providing ongoing support between community members.

“Finding emotional support...peers or friends was a really difficult task...and I was still harming myself so that it made it really difficult to connect with other people...People would say and do really inappropriate and hurtful things to me”

Additionally, lack of understanding about history, and about the recovery process, as well as stereotypes, and the lack of education and awareness relating to parenting and communication skills are augmented by the need for improved access to employment and education generally. Also mentioned was the need for more activities within safe and sober environments, and the need for childcare supports.

From a societal perspective, already mentioned are the ongoing racism and discrimination, factors which are exemplified by the failure to act on the priorities mentioned in studies such as the “Healing Ways” document previously referred to here. Regardless, it is important to consider the critique of services described in this study. The respondents spoke to the lack of culturally appropriate services, including the lack of First Nations service providers, and the culturally inappropriate use of an individualistic approach to services. In terms of the inadequacy of services, mentioned is the lack of funding in order to access services; the lack of treatment matching – referrals to services that meet their needs; inappropriate referrals, the gate-keeping process to access services; and the lack of flexibility of services. Gaps in services include lack of resources for single mothers, and the lack of gender and culture sensitive services. Last but not least is the inadequacy of service providers the respondents have dealt with; of mention was the failure to acknowledge positive changes, the need to educate the service providers about First Nations, and the unwillingness to address trauma that clients were trying to cope with.
This summary of concerns of five of Vancouver's urban Native women in recovery from substance abuse provides an overwhelming glimpse of the factors that affect, and often impede, the healing process, in addition to placing urban Native women at continuing risk of recidivism. What is worse, the impact of failing to address these issues is often paralyzing, a fact that was expressed by the participants.

IMPACT OF FAILURE TO PROVIDE INTEGRATED AND HOLISTIC SERVICES

Significantly, most of the difficulties expressed are associated primarily with the historical and ongoing oppression of Native people generally, as reflected here by the failure to provide even adequate services. In addition, it is this oppression which continues to perpetuate the cycle of abuse, leading to fundamental issues of fear; connecting with self and others; grief and loss; self concept in terms of identity, esteem and worth; depression and anger; and safety and comfort. These themes, which constitute the factors affecting the risk of recidivism, represent an undercurrent of internal challenges for these women, and are a resounding testament of the failure to meet their needs.

*Fear* (for example, of violence or other abuses, of relapse, of harming self or others, of trusting others, of making mistakes):

"I went to treatment because I was having a hard time with my kids. I didn’t know how to cope with their fighting. I had a lot of anger issues and I was really freaked out....I didn’t want to abuse them...hurt them...I didn’t want them to hurt each other. I had so much memories coming back from my own childhood and all the violence there...any normal childhood disagreement freaked me out to the nth degree...I felt like I was going crazy and I didn’t want to drink, but I just didn’t know what to do."

The respondent was able to reflect on the connection between the past and the present, but at the time it was happening, she was very scared, and unfortunately, the support needed was
not there to assist her, so she went to treatment. That was the only solution she could come up with.

“I think I started going to the abuse group…at about a year and a half clean…They recommend that…you wait until two years anyway, but you know, I just knew that if I didn’t start to work on some of the really deep issues…I wasn’t going to live…I was still having some pretty serious suicidal thoughts and still hurting myself pretty seriously.”

Terrified of her circumstances, this respondent was reaching out, and being told it wasn’t time. This is a case of invalidating her existing needs.

Connecting with self and others (issues include needing support, isolation, desperation, loneliness, stress):

“The isolation part of it was really overcoming. I had to overcome that in order to trust other people and I had to reach out for help. And how was I going to do that? How am I going to take that initial step and get through that barrier…and say “yeah, I do need help with this addiction and my kids.”

The stigma and isolation facing this client hindered her ability to make the connections she needed. Shame is also a key factor in getting help, and efforts to help clients work through their shame is critical.

“Sometimes they’re astounded that I’m eleven years clean and sober and when I say I’m going to an AA meeting they say ‘oh, you still have to go to those meetings?’ People think that after being eleven years…I should have it all together.”

The lack of understanding of the process of recovery, and of the challenges faced by urban Native women lead to negative messages about their efforts to obtain ongoing support.

“I’m continually reminded through pain that I have abandoned myself again…a big issue for me to self acceptance and trying to stick with me and
not eliminate parts of myself in order to fit into relationships like my present one...issues about just learning how to like people...how to reconnect with my son, who didn’t live with me for ten years....When I came in [to recovery] I had no idea how to have real friendships or relationships, intimate, romantic, physical...Yet I didn’t have enough of me to participate so I would find these broken people...and have these shattered little encounters that of course would result in some sort of pain and shame...”

The issue of connection is significant. If, for example people can’t connect to themselves in such a way as to recognize their own value/worth, what would be the driving force that keeps them going, in spite of the challenges? How would they get to a place of having hope and wanting something better for themselves?

“Recently, I went on a retreat with First Nations women...When I went there I felt there was some connection...and some healing. It was good being able to do that with other women.”

Here, the respondent speaks to the value of being able to connect with the world in a meaningful way, through identification with her peers.

Grief and loss:

“I see Native men and then can’t connect. They are so beautiful, but they’re resigned to their position...being stripped of their roles as providers...and they take it out on Native women.”

This respondent is making reference to how internalized racism, and the oppression of Native people, plays out in today’s Native community. Family violence is a reaction to that oppression.

“It really makes me angry that social services is more willing to put money into...foster-care. My son should have stayed with me...the amount of money they spent to have him in a foster home,
they could put that into services for...making it easier for us to live together.”

When this respondent went to treatment, she placed her son in care temporarily, but it took four years to get him back. She is still grieving that loss.

“The thing that caused me to enter recovery was the suicide of my partner...The pain I felt around my partner’s suicide was so huge and so immense and the places I went to around it...how much I wanted to die and how much I hated myself...[even after a few years clean] I used self harm because that would make the pain go away.”

Having internalized guilt about the suicide, this respondent needed support in grieving the loss of her partner. At two years clean, she was still slashing her wrists. Evident is the lack of services critical to her being able to heal from this loss.

*Self concept* re: identity, esteem, worth:

“I was afraid because I’m so part Native and what does that mean and where do I fit and do I have any right to go into ceremonies...it was really scary.”

The issue of identity is, for many Aboriginal people, at the root of many of their challenges. “Coming home,” or repatriation is often particularly difficult, without support in that area.

“I used to call myself stupid a lot, without even realizing it. Like, ‘I’m so stupid...oh shit I’m stupid’...Getting my grade 12 and ESW were definite stepping stones in giving me new information and helping me be with other women...[and] going on to places of employment, knowing that if they let me stay there a week I couldn’t be as bad as I thought I was.”

Internalized negative self images are reinforced for Aboriginal women who are addicts. Efforts to destigmatize addiction, as well as identity as First Nations, underscore the need for services that validate urban Native women as valuable
members of society, and as people in need of assistance to overcome the negative self perceptions they experience.

“I [was] really being judgmental towards myself that I should be at a better place [at 8 years sober]...Looking at my mom and dad, and how they stuck things out...[and how] I ended up kicking this guy out and I was alone and feeling inadequate...I feel that being a woman...being First Nations...and a single mom, I feel all those things are against me.”

Again, validating the experiences and struggles of urban Native women in recovery is lacking, and needs to be addressed within the family, community and larger society.

“The father was around but not supportive...really destructive, actually. [He was] always telling me I was crazy, telling me that I shouldn’t even be raising the kids anyway. He just had me convinced that I couldn’t do the job...and I believed him. I believed I was really too nuts to do the job so I called social services and asked them to take the kids.”

Compounding the lack of validation are the family dynamics, which through lack of awareness of family members reinforces negative self-perceptions.

“Right now we have a situation where it’s normal and natural for Native women to be in poverty and it’s normal and natural for them not to have a place that supports them being moms...So, the thinking is that we are poor and that’s normal, and we are not good mothers and that’s normal and that’s not right! That really has to change and there has to be a moral outcry for that to happen. That thinking has to be challenged, not only by us, but by the whites...The traditional Native way of raising children is much more humane, and more healthy for the children.”

This poignant quote speaks directly to the ignorance rampant in society regarding this population. Furthermore, the effects of such ignorance are the normalization of the oppression faced by
this population, and the perpetuation of the stereotypes that insidiously undermine meaningful changes in meeting the service needs of these women.

*Depression and anger*

“[In] the nine years I’ve been clean, there’s been...little fleeting moments of joy...but basically, every day is a struggle...I don’t know if I’ve ever really come out of the depression...There’s times when the depression has been just bordering on debilitating and pretty scary and with the depression comes isolation...”

Indicated here is the fact that, regardless of the tenacity of this respondent, her struggles with depression are not being addressed adequately. Whether the depression was a pre-existing disorder seems a moot point. What is relevant is that at nine years clean, she is still very much at risk.

“I went to an anger management group which was so dumb. I wanted to know how to express my anger (laughter) and...everybody else wanted to stop being angry and acting out...It was very hard because I knew very well how to stop my anger.”

Still slashing her wrists at two years clean, this respondent’s way of controlling her anger was to use self harm, while other group members were dealing with issues of violence towards others. These issues are not one and the same, suggesting a need to consider a range of programs that are reflective of the specific needs of clients.

*Safety and comfort*

“For me it’s very important to have women in my life. I have a woman doctor...a woman dentist...a woman counselor. And I work with women...I just find it more comforting to be with women at this time in my life.”

Safety and comfort are topics which permeate the interviews repetitively, while the themes of gender and culture are also
consistently mentioned. Specifically, First Nations women service providers are lacking.

“One guy...within the first 2 or 3 visits, he started almost attacking me about sexual abuse in my past when I had not said a word but...we had not established any sort of relationship...he was a chronic nose picker and would pick his nose and play with his snot...He’s got a really good reputation and still does.”

“I saw this woman on Broadway...within the first few visits she had three chairs set up and I was supposed to go in that chair and be the parent or adult, and go in that chair and be the little child...but we hadn’t established any kind of safety...I haven’t even got comfortable with her...So, I did try bouncing around in these chairs for a bit and I thought ‘I just can’t do this.”

Both of these quotes peak to the inappropriateness and inadequacy of service providers the respondents have had contact with. Yet a failure to return to service providers such as these often leads to labelling as ‘non-compliant,’ ‘resistant,’ or ‘not ready.’ Meanwhile, as private practitioners, consideration of accountability also needs to be addressed.

The internal experiences reflected in the above comments validate the critique of services discussed by these participants. These internal experiences constitute a symptomology rooted in the failure to meet this population’s aftercare needs. As such, the continuing risk of, or vulnerability to, recidivism for Vancouver’s urban Native women, even after years of abstinence from addiction, is evidenced by their experiences as shared here.

In fact, by failing to integrate addiction and aftercare services with programs geared towards assisting urban Native women to overcome the barriers to the societal arenas such as education, employment, housing, and childcare, they face a daunting challenge in making meaningful changes in their lives. As well, the colonial oppression underlying these concerns must be addressed. Certainly, service approaches must be expanded to integrate services to address all of their needs, providing aftercare services that are both holistic and long-term.
Furthermore, the importance of culture cannot be understated. McCormick’s research on healing among 50 Native people living in British Columbia found that

Healing can be facilitated in the following ways: participation in ceremony, expression of emotion, learning from a role model, establishing a connection with nature, exercise, involvement in challenging activities, establishing a social connection, gaining an understanding of the problem, establishing spiritual connection, obtaining help or support from others, self care, setting goals, anchoring self in traditions, and helping others (p.251).

Ultimately, culture must not be ignored. Participants of this research also discussed the importance of cultural ceremonies and activities; the need for cultural teachings, in addition to the need to pass these on to children; and the need for role models in the native community. Some of the remarks regarding spirituality and culture included:

“A cultural lifestyle has helped me quite a bit in my recovery...knowing those traditions and culture and teachings and keeping them alive. And of course teaching them to my children. I think residential schools have left many scars.”

“I went to a Medicine Wheel ceremony...and really...that was the start of my healing...It took such a profound shift. Then I went to my very first sweat and in that sweat I found my voice of pain and it was a totally awesome, absolutely agonizing experience.”

“To be able to go to a church that had sweet grass, and the smudge ceremonies and the Medicine Wheel. That was like the church saying no this isn’t bad and...it was just such a spiritual healing experience...It was...a crack in the doorway where I could get in and do some healing around all the racism, resentment I had around the cultural genocide.”
Culture is fundamental to overcoming many of the challenges mentioned previously, such as issues of identity, connecting to self and others, and relationships. Additionally, the spiritual aspect of culture is often absent from models and types of services available, unless the services are run by Aboriginal people. Efforts to design programs that incorporate culture are often ignored, which also hampers the ability to provide even adequate services to this population.

As a final reflection, it is important to mention the significance of self help groups such as Alcoholics Anonymous and Narcotics Anonymous. All of the respondents relied extensively on these programs as a resource which has been of significance in helping them maintain recovery in spite of the challenges they face. Importantly, however, even this option presents challenges:

“I went into a detox and got back out and...got loaded again, and then came...into a 12 step program and went for a month doing quite well and then had some comments that were said to me that I took to heart, and ended up in the psychiatric ward that night...”

“Self-esteem stuff...seemed to be so deep that I really couldn’t talk to anybody about it.”

“There’s times when I want some other sort of help, or just someone to talk to....that’s not involved in my life, someone completely objective.”

These comments allude to the limitations of self-help groups and are not meant to minimize the importance or significance of such groups. Instead, it points to the complex issues and therapeutic needs faced by urban Native women, who require extensive ongoing support from the professional arenas.

CONCLUSION

While far from exhaustive, this study gives life to the voices of urban Native women in recovery from addiction. The data poignantly illustrate the ongoing vulnerability of the participants, regardless of the fact that they have between 8 and
14 years of recovery, and indicates that the lack of adequate services and supports leads to the risk of recidivism, or other self-destructive behaviors. Overall, significant from the data is that:

a) Native women are still challenged by internal struggles related to factors such as fear, connecting with self and others, grief and loss, self-concept, depression and anger, and safety and comfort, making them a vulnerable population, regardless of having had treatment and having years of recovery;

b) These internal struggles are associated with difficulties related to relationships, self-identity, education, oppression, gender, culture, and service provision.

Given that these findings cannot be generalized to all urban Native women in recovery from addiction, there is a need to do further research into whether such themes are common among urban Aboriginal women in recovery. Over and above all the barriers spoken of, the risk of recidivism relates to the provision of services and supports in such an inconsistent, and at times inappropriate way.

Ultimately, even with long-term recovery, the respondents still find themselves struggling with a multitude of issues, many of which could be mitigated through the provision of services to meet their needs. Urban Native women need to be forefront in the development of policies and programs, as well as in determining funding priorities, as they have the wealth of experience required to develop programs and services that might actually facilitate a better quality of life, and lead to a meaningful movement away from their current status as the most invisible, isolated and marginalized group in Canadian society.

Apparent is that addiction needs to be addressed within the environmental and cultural context of Native peoples’ lives. Furthermore, when we speak of environmental context, we need to consider the family, the community, and the wider society, to avoid a short sighted approach to resolving the longstanding impediments to achieving health and social status equivalent to that of mainstream Canadians.

For example, in the family, ongoing abuse, suicides, and addiction among family members can hamper the limited
progress made in a treatment setting. Brown (1994) points out that the family may still be subject to an out-of-control environment, that stability may also take years to develop, that unhealthy patterns continue as the family resists change, and that children may have tremendous difficulty adjusting to the recovery process. Thus, programs need to be accessible to both the individual and the family to help reduce the risks of recidivism, and/or addiction among other family members.

Within the wider community, competition between agencies for funding, peer pressure and a lack of activities aimed at prevention can also hinder recovery. Duran points out that “Community work is an integral part of delivering psychological services in Native American country...The reality of the situation...is that therapeutic relevance can only be accomplished by implementing a model that encompasses the whole community”(pp.186-86).

Lastly, in reference to societal issues, lack of program funding, and ongoing discrimination and prejudice relating to employment, access to housing, and mistreatment or misdiagnosis by professionals facilitate the continual abuse of Native people (VRHB 1999). ADP (1989) spoke of the need for access to education, funding, employment and housing, as well as coordination between municipal, provincial and federal governments in the development of services for the urban Native population.

As such, the argument for the need to provide services that are both holistic, and integrated, is evidenced by the results of this study of 5 urban Native women in recovery from addictions in Vancouver, B.C. The risk of recidivism is prevalent among urban Native women, in spite of the fact that they may have eight to twelve years of abstinence from addictions. In order to counteract the symptoms relating to fear, difficulty connecting with self and others, grief and loss, identityesteem issues, depression and anger, and safety and comfort, drastic changes need to take place. Importantly, there is a need to address the inappropriateness and inadequacy of existing services, as well as providing a continuum of care that is holistic, including an integration of services to address barriers related to education, employment, and childcare, as well as attending to culture, gender and history. Foremost is the need to deconstruct the racism and discrimination that lies at the root of these problems.
APPENDIX: INITIAL THEMES FROM THE DATA ANALYSIS

Relationships
- destructive or unhealthy relationships in recovery, and dealing with violence, addiction and abuse
- inability to connect with others – other women, family, community
- child-care services, and support for children’s healing
- impact on children of separation from parents seeking treatment
- role expectations within the family
- men’s loss of roles as providers and internalization of the oppressor
- generational impact of and parallel between the residential school system and foster homes
- reciprocity important – need to be able to share experience with and get support from others to reduce risk of relapse
- need for social setting that is safe – sober activities

Self identity/concept: re: internalized racism – denying heritage as Native; confusion regarding Native and non-Native values

Education: need to understand addiction and process of recovery, history of First Nations and how it relates to present life: need for more skills in parenting/communication; need for employment skills and ongoing support in this area: need to educate community re: addiction to overcome lack of understanding/stereotypes

Oppression: racism, classism, sexism, discrimination, prejudice, paternalism; double standards, stereotyping, assumptions of pathology; stigma as Native women faced with poverty, addiction, single parenthood; being constantly reminded of who they are; control – need to stop perpetuating abuse of First Nations through enforcement of the dominant values; marginalization due to sexual orientation as a lesbian

Culture: importance of cultural ceremonies and activities; need for cultural teachings, in addition to the need to pass these on to children: need for role models in native community
Formal services:

- need holistic approach to services and more resources for women – pre-treatment, treatment, post- treatment services and second stage recovery programs;
- need for gender sensitive and gender specific services, for First Nations women service providers;
- need to be able to connect with the service provider, service providers need to acknowledge positive changes; don’t want to have to educate the helper about First Nations’ issues, need to address, not ignore, trauma due to residential school system
- need funding to access services, housing, transportation, childcare, should redirect funding to parenting skill development instead of placing children in foster-care,
- need to decrease barriers to services, including alternatives to abstinence models, need flexible services that are available when needed – no wait lists, or appointments for a later time – window of opportunity may be just a few minutes; need to make appropriate referrals for services
REFERENCES


Vancouver Richmond Health Board (October 1999). Healing ways: Aboriginal health and service review. Vancouver, B.C.