THE ROLE OF SPIRITUALITY AND SELF-DETERMINATION IN RECOVERY FROM DRUG AND ALCOHOL ADDICTION AMONG INDIGENOUS PEOPLE

by

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ABSTRACT

Three-quarters of Indigenous adults living on reserve report that addiction to alcohol and other substances leads to problems within families and other violence. Over the last 40 years, there has been a growing body of evidence linking an individual’s spirituality with health outcomes, especially in the prevention of and recovery from addictions. Indigenous peoples have traditionally viewed spirituality as an integral part of health. Alcoholism and other addictions are self-soothing ways of numbing the “soul wounds” many Indigenous people have experienced as a result of colonialism.

The purpose of this report is to examine the literature on the role of spirituality and self-determination in successful recovery from addiction among Indigenous Peoples. Accordingly, the literature on traditional cultural ways of being of the First Nations of eastern Canada has been reviewed together with the effects of colonialism on their wellbeing. The spiritual and cultural influences apparent in addiction recovery have been reviewed in relation to Indigenous Self-Determination, a social determinant of health among Indigenous people. The psychological Theory of Self-Determination, which has been developed in Western therapeutic and academic locations, and tested and used by some Indigenous scholars, has been reviewed in relation to Indigenous Self-determination, as well as spiritual and cultural influences on recovery from addiction. The question that has emerged from this discussion is whether there is room for individual choice of healing approach within the cultural imperative of collective self-determination. Finally, the implications of these findings for nursing practice, research and education are identified.
DEDICATION

To the God who knew and knows the plans He has for me

And

To the memory of Kenny “Munster” & Davey
ACKNOWLEDGEMENTS

Those who have loved and supported me through this journey—

You know who you are.

I can no other answer make…

but thanks…thanks; and ever, thanks.

*Shakespeare*
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Chapter 1: Introduction to the Health Situation of Indigenous People

The plight created by drug and alcohol misuse among some Indigenous people has been used to stereotype the whole population. Statistics have highlighted the problem of addiction without providing insight into the factors that lead many Indigenous people in Canada to addiction. While addiction contributes to many physical and social problems, it is important to critically reflect on the factors that lead to the development of addiction, as well as those factors related to recovery.

Over the last 40 years a growing body of evidence has shown a relationship between an individual’s religiosity/spirituality and positive health outcomes (Crawford O'Brien, 2013; Koenig, McCullough, & Larson, 2001; Moreira-Almeida, Koenig, & Lucchetti, 2014). This notion is not new to Indigenous peoples who have always viewed spirituality and health as one (Garrett & Carroll, 2000). Many Indigenous scholars contend that a return to Indigenous Self-Determination and traditional views of spirituality are the only hope for the recovery of their people (Archibald, 2006b; Brave Heart, Chase, Elkins, & Altschul, 2011; Cole, 2008; Marsh, Coholic, Cote-Meek, & Najavits, 2015; Smith, 2012; Szlemko, Wood, & Thurman, 2006; Umeda, 2006; Wesley-Esquimauz & Smolewski, 2004).

Purpose

The purpose of this report is to examine the literature on the role of spirituality and self-determination in the successful recovery from addiction among Indigenous Peoples. No interviews were conducted; recommendations are based on interpretation of the literature through the lens of my clinical experience; therefore, there was no need for
ethics approval. However, in keeping with the principles of self-determination, I consulted and sought permission from Chief Candace Paul of St. Mary’s First Nation about the need to examine this topic. Thus, I ask that no reproduction or dissemination of this report take place without permission from the community of St. Mary’s First Nation in Fredericton, New Brunswick, Canada.

**Objectives**

The objectives that will lead to attainment of the purpose of this report are as follows:

1. To review the literature related to the following:
   
   (a) The worldview and ontological approaches of Indigenous people and culture;
   
   (b) The effects of colonialism on the health and wellbeing of Indigenous peoples;
   
   (c) The definitions of spirituality and its role in healing from addiction;
   
   (d) The definitions and theories of the causes of addiction;
   
   (e) The concept of Indigenous Self-Determination (ISD);
   
   (f) The psychological theory of self-determination (SDT) by Ryan and Deci; and
   
   (f) The spiritual approaches that support the recovery of Indigenous people battling addictions.

2. To examine these approaches according to how they support ISD at the community and individual levels; and the components of SDT—autonomy,
relatedness, and competence—at the individual level; and

3. To discuss the implications of these findings for nursing education, practice, and research.

In this chapter, I will present statistics to demonstrate the great health disparity that exists for Indigenous peoples globally and within Canada, while presenting the scope of the lingering problem of addiction that has resulted. The chapter also serves to situate the researcher.

**Indigenous Health Statistics**

The declining health of Indigenous peoples is a global health concern (Holtz, 2010; Jacobsen, 2008). “Indigenous peoples remain on the margins of society: they are poorer, less educated, die at a younger age, are much more likely to commit suicide, and are generally in worse health than the rest of the population” (Health Canada, 2014; International Work Group for Indigenous, 1994, p. 10).

On a global basis, there are significantly higher rates of the many health problems among Indigenous peoples compared to the general population. These include the following conditions: (a) tuberculosis (Al-Mouaiad Al-Azem, 2006; Herce, Chapman, Castro, Garcia-Salyano, & Khoshnood, 2010; Holtz, 2010; Robertus, Konstantinos, Hayman, & Paterson, 2011); (b) HIV/AIDS (Brown, 2006b; Firestone, Tyndall, & Fischer, 2015; Powers, 2007); (c) diabetes (Collier, 2008; Danks, 2006; Dutton, 2010; Firestone et al., 2015; Oster et al., 2011); (d) maternal and child mortality (Holtz, 2010; Kildea, Kruske, Barclay, & Tracy, 2010; Smylie, Fell, & Ohlsson, 2010); (e) heart disease (Douketis, Paradis, Keller, & Martineau, 2005; Firestone et al., 2015; Hiratsuka,
2007); and (f) mental health disorders (Andersen et al., 2015; Cain, 2007; Evans, 2009; Li, Sun, Marsh, & Anis, 2013; Saddichha, Linden, & Krausz, 2014). In fact, mental health and addictions rates among Indigenous peoples globally far outweigh those of non- Indigenous people, and this trend shows no sign of declining (Andersen et al., 2015; Kirmayer, Tait, & Gracey, 2009; Maranzan, 2008; Reading & Wien, 2009).

According to Turner and Statistics Canada (2013), there are 1.3 million people who identify themselves as Indigenous in Canada representing approximately 4% of the total population; Indigenous people are Canada’s fastest growing population, doubling between 1986 and 2001; and this rate was more than five times the population increase among the Canadian population as a whole. Further, despite the higher birth rates, fewer Indigenous people live to older ages compared to the population of Canada. On average, Indigenous women live three to five years less than other Canadian women, and Indigenous men live five to six years less than other Canadian men (Turner & Statistics Canada, 2013). Maranzan (2008) claimed that the rates of preventable deaths among American Indian adults are mostly alcohol-related, and are 133% higher than among the American population as a whole.

One factor that contributes to the higher mortality rate among Indigenous peoples in Canada is the higher level of completed suicides; five to seven times higher among Indigenous individuals than for non-Indigenous peoples in Canada (Firestone et al., 2015; Khan, 2008). In Canada’s non-Indigenous population, approximately 4% of females and 2% of males have attempted suicide; but, among the Indigenous population, 19% of females and 13% of males, have made suicide attempts (Firestone et al., 2015; Khan, 2008). Most of the suicides occur in young adults who, potentially, have many years of
productivity (Firestone et al., 2015; Khan, 2008). In fact, the leading cause of death among Indigenous people less than 44 years of age is suicide (Harder, Rash, Holyk, Jovel, & Harder, 2012). These rates vary from community to community, some having endured ‘epidemics’ of suicide (Harder et al.; Lakaski, Martin, & Bobet, 2006) while other communities have had few or no suicides for several years. Many of these suicides are closely linked with drug and alcohol abuse (Evans, 2009; McLoughlin, 2007; Rehm et al., 2008). Fournier and Crey (2000) reported that 74% of suicides were enacted while the person was intoxicated. “Alcoholism in the Native American population is an epidemic, causing several other smaller epidemics [such as suicide and accidents]” (Cole, 2008, p. 5; National Collaborating Center for Aboriginal Health, ND).

Surveys have revealed that three-quarters of members of Indigenous communities see alcohol abuse as a problem in their community (Firestone et al., 2015; Khan, 2008; McLoughlin, 2007; Rehm et al., 2008). According to Khan (2008), one third of the population report that alcohol abuse is a problem in their families and twenty-five percent own the problem themselves. However, only 66% of Indigenous adults living on reserves consumed alcohol, compared to 76% of the general adult population in Canada (Stade, Ungar, Stevens, Beyene, & Koren, 2006; Statistics Canada, 2006). Unfortunately, 63.6% of those who drink alcohol, imbibe five or more drinks in one session at least once a week, leading to a myriad of problems (Firestone et al., 2015). Figures drawn from hospital records in BC and Alberta show that Indigenous people, especially men are admitted to hospital for problem substance use, which includes alcohol, more often than other residents of these provinces (Firestone et al., 2015; Khan, 2008).

Studies have shown that alcoholism among Indigenous people is related to an
increased risk of the following conditions: (a) sexually transmitted diseases (Brown, 2006a; Powers, 2007; Szlemko et al., 2006; Wynne & Currie, 2011); (b) teen pregnancies (Jacobs, 2007; Rehm et al., 2008; Szlemko et al., 2006); (c) hypertension and diabetes (Self, 2007; Szlemko et al.); and (d) physical, emotional, and sexual domestic violence (Richard, 2010). Moreover, the intersection of alcohol and drug addiction with these health issues may create self-perpetuating cycles. For example, when larger numbers of youth drink heavily, there are more teen pregnancies (Jacobs, 2007; Rehm et al., 2008; Szlemko et al., 2006), in turn leaving their children at higher risk of being born with Fetal Alcohol Syndrome (FAS). FAS causes a child to have an increased chance of social and other learning challenges, so that she/he fits poorly into the environment, resulting in an increased risk for alcohol abuse (Richard, 2010; Stade et al., 2006). In Atlantic Canada, the rates of FAS are almost five times higher in the Native population (29.9 births per 10,000) compared to the general population (6.7 births per 10,000) and that the average annual direct and indirect economic cost is estimated to be $160.7 million for FAS, and $1.17 billion for alcohol (Rehm et al., 2008).

Alcohol consumption is often a gateway to other drugs. The use of cannabis is common among Indigenous youth (32%) and adults (27%) (Khan, 2008; Rehm et al., 2008) and inhalant drug use (gas, glue, and solvents) is rapidly becoming a problem among Indigenous youth in some locations (Godel, 2006; Richard, 2010; Tyndall et al., 2006). Studies have found that individuals who use solvents are eight times more likely to make a suicide attempt (Kirmayer, Tait, & Simpson, 2009). Asbridge et al. (2013) surveyed Nova Scotia students from grades 7-12 and found that 7% had used non-medical stimulants (e.g. Ritalin), 16% had used opioids in the form of non-prescribed
prescription painkillers (e.g. OxyContin), and 5.8 % had used cocaine in the previous 12 months. These statistics among Indigenous youth are estimated to be much higher (Fischer & Argento, 2012; Richard, 2010). However, these statistics emphasize the negative behaviors of a minority of persons. A better approach would be to state that 93% of youth had never used stimulants.

As mentioned earlier, this emphasis on the negative minority has been used as evidence to stereotype all Indigenous peoples. This statistical practice is harmful, misrepresenting the reality of Indigenous peoples’ lives. For example, from my first connection with the St. Mary’s First Nation in Fredericton, it was obvious that the community was thriving, with success in economic development, educational attainment, cultural renewal and healing from the soul wounds imposed by colonial practices. For example, some of the thriving businesses in St Mary’s community include the following:

1. Specialty Maples supplies wood to Gibson and Fender, world leading manufacturers of professional guitars.

2. Wolastoq Wharf is a band-operated fine dining seafood restaurant that has been given the distinction of “where to eat in Canada,” and awarded the Certification of Excellence by Trip Advisor.

3. Bear Construction received the Canadian Homebuilders Association Best 2014 Single Detached Under $500,000 New Home Award.

4. St. Mary’s Entertainment Centre, which houses the largest Bingo facility in Atlantic Canada is enjoyed by thousands of New Brunswickers and others

5. The Kchikhusis Supermarket is a service leader in its sector. It is the only supermarket in Fredericton that still has carryout service for its customers,
which can be essential for persons with disabilities, the elderly, and for mothers with young children.

6. Many artisans and crafts persons, that live on the reserve, create beautiful Native designs with beading, weaving, sewing, painting and carving that are sold internationally.

Some community members, who have recovered from addiction, run groups to support addiction recovery for Indigenous and non-Indigenous people alike. Members of St. Mary’s First Nation, like many other Indigenous communities, are not only courageous survivors, but “creative thrivers” (Kirmayer, Tait, & Simpson, 2009, p. 55), using their cultural strengths and values as the foundation for their healing, and economic development and successes.

**Situating the Researcher**

My interest in this research stems from my personal belief in spirituality as an essential component of health, and the right of every individual to equitable and dignified healthcare. It is important that the reader identify potential biases that can affect interpretation of the data. Patton (2002) wrote that “any personal and professional information that may have affected data collection, analysis and interpretation—either negatively or positively” (p. 566) should be reported. Nowhere is this more important than in working with people living in vulnerable situations whose voices are suppressed. Thus, it is essential that the researcher make clear her position from inception.

I am a White Anglo-Canadian female registered nurse who has worked with marginalized people with mental health problems, both in acute care and the community
settings, for over 20 years. My personal and clinical experience has helped me to hone such skills as understanding the humanity and diversity of clients. These will be important assets when interpreting the literature and making recommendations on behalf of people who are underserved and living in vulnerable circumstances.

I was born into a low-income family of an alcoholic father, and of a mother who had suffered severely at the hands of an alcoholic brother who became head of her home upon her father's death when she was an infant. Alcoholism and its ravages surrounded me until I left home to attend university. I attribute the role of spirituality in my own life with having produced my resilience and ability to abstain from substance use and recovery from childhood trauma. In this way, I bear some personal understanding of the complexities of trans generational, psycho-social traumas that addictions produce. As a researcher, these experiences bring strength to me in my ability to connect with Indigenous people despite my whiteness.

My spirituality is grounded in a strong Biblical worldview, and I am a practicing evangelical Christian who attempts to worship and meet regularly with others who are of a like mind in a nondenominational group setting. Both my spiritual beliefs and whiteness could produce areas of risk in writing this report. I have been very open about my position with those I sought to partner: Dr. Grace Getty and Dr. Janice Thompson, my supervisors; the Atlantic Aboriginal Health Research Program (AAHRP), my funding organization; and the local First Nation community of St. Mary’s First Nation. This openness serves as a checkpoint to minimize bias within my report. Traditional Indigenous culture centers around the authenticity—or the concept of *truthing*—which refers to the “strong expectation that everyone will share his or her truth” (Bear, 2011, p.
As Switlo (2002) and others (Gustafson, 2007; Haney-López, 2006) remind us, my 
whiteness affords me a position of unearned privilege and power. For this reason, I feel 
extremely honoured to have been allowed by St. Mary’s First Nation to examine this 
topic. Being aware of one’s own stance and how one arrived at this knowledge are 
important factors in maintaining an open attitude toward interpreting the literature in light 
of my clinical and life experience (Kelly & Howie, 2007).

Summary

This chapter has identified the overall purpose and objectives of the report. It has 
provided a glimpse into the health disparities that exist for Indigenous people, the scope 
of the lingering problem of addiction, and the situation of the researcher. The balance of 
this report is laid out in the following sections: Chapter 2 contains a literature review, to 
provide some understanding of the traditional ways of being of Indigenous people in 
eastern Canada and the strengths that have enabled them to survive in the midst of the 
systemic and enduring racist actions of colonization, which have led to addiction. 
Chapter 3 is focused on a discussion of the role of self-determination at both societal and 
personal levels. In Chapter 4, the spiritual approaches used in addiction recovery 
programs is discussed in relation to ISD and the Theory of SD. Finally, in Chapter 5, the 
implications of the findings relative to nursing practice, research, and education, are 
identified.
Chapter 2: Literature Review

In this chapter, I will present a review of the literature on the following topics: (a) the traditional cultural values of Indigenous peoples and the experiences of colonization, (b) spirituality, and (c) addictions. I begin by examining traditional ways of being and traditional spirituality. The history and knowledge of Indigenous peoples has been transmitted by oral tradition; therefore, the following information is based on classic historical books, either written or acknowledged by Indigenous scholars as being accurate. The databases: Academic Search Premiere, CINAHL, PsychInfo, Medline, and ALTA were searched using the search terms spirituality, traditional spirituality, addictions, in combination with the terms First Nations, Aboriginal, Indigenous and Native American.

Indigenous Traditional Ways of Being

Prior to European contact, more than two million Indigenous people lived in Canada in numerous distinct tribes, with their own language and belief systems (Dickason & Calder, 2006). In eastern Canada, the Mi’kmaq and Maliseet peoples were healthy, self-sufficient, long-living people, with organized and vibrant social and political systems (Dickason, 1992; Dussault et al., 1996; Henderson, 2011b; Wallis & Wallis, 1955). Their lifestyle was about balance and living at one with the land. For example, Wolastoqiyik, presently referred to as Maliseet, means ‘People of the Beautiful River’ (Elder M. Paul, personal communication, October 2010). The land, referred to as Mother Earth, was held in reverence (Henderson, 2011b).

The Maliseet people were nomadic, traveling on a seasonal basis to obtain food
and other needs through hunting, fishing, and gathering according to their knowledge of their environment (Dickason & Calder, 2006; Wallis & Wallis, 1955). Men and women worked together contributing equally within their gendered roles (Bull, 1991; Lavell-Harvard & Lavell, 2006). Fathers taught their sons these gendered roles along with the chores implicit in these roles, as mothers did with their daughters (Dickason & Calder, 2006; Wallis & Wallis, 1955). Children were held accountable to carry out these chores before being able to play (Fournier & Crey, 1997; Safarik, 1997; Wallis & Wallis, 1955). Children were viewed as a beloved resource of the community, not only the family, so that everyone in the community was responsible for the children’s learning and discipline (Bull, 1991; Castellano, 2009; Morrissette, 1994; Safarik, 1997). To this day, the perspective of Indigenous people focuses on the family and community versus the individual (Getty et al., 2001; Royal Commission on Aboriginal Peoples, 1996). Smith (2011a), writing about Indigenous peoples, noted: “one fundamental value [of Indigenous societies] is that of the collective solidarity, embedded in notions of family, cultural traits, values, and practices” (p. 215).

Among Maliseet people, the goal of life was to respect and maintain harmony between themselves, others and their environment (Dickason & Calder, 2006; Henderson, 2011b; Wallis & Wallis, 1955) resulting in peaceful social systems (DeGagne, 2007; Wallis & Wallis, 1955). Everything was valued for its part in maintaining the intricate web of life. To hurt one of these aspects would be harming oneself. Thus, it is not surprising that corporal punishment of children was not accepted. Instead, behaviour that was consistent with traditional values was rewarded (Bull, 1991; Miller, 2006a; Morrissette, 1994).
Individuals were considered autonomous, and, therefore, different opinions and behaviours were respected (Bear, 2011). Each person was expected to attend to his or her own balance and needs for knowledge (Bull, 1991; Safarik, 1997) while still contributing to the collective whole (Bear, 2011; Smith, 2011a). The traditional decision-making process was one of consensus building (Bear, 2011).

In summary, prior to the arrival of Europeans to the east coast of North America, the Maliseet people had a worldview that enabled them to adapt to ecological, social, and other changes to maintain a healthy social way of living based on the choices they were able to make freely in their own society and physical environment. However, their way of life and health status began to change with the advent of colonialism.

Colonization: Marginalization Through Collective Trauma and Racism

According to the Oxford English Dictionary (2014), colonization means to settle among and establish control over (the Indigenous people of an area). In the mid-1700’s, French explorers began to arrive on the east coast of Canada, surviving the Canadian winters through the help of the Mi’kmaq and Maliseet people (Dickason & Calder, 2006; Grzybowski & Allen, 1999). Despite the kindness shown to them by the Mi’kmaq people, these explorers held to their beliefs in the superiority of their own white cultures and chose to view Indigenous people as deficient. Colonists declared that the land belonged to the European country from which they had emigrated, and began to impose their own system of government (Anderson, 2004; Dickason & Calder, 2006; Henderson, 2011a). This began the process of colonialism by the denial of worth of the Indigenous people and their social systems (Archibald, 2006a), and the stealing of their lands. This
pattern of colonization of Indigenous people was similar to that followed in the USA, Central, and South America, Australia, New Zealand, and Africa (Kildea et al., 2010; Nóbrega et al., 2010; Smith, 2006), suggesting a planned political course of action (Kirmayer, Tait, & Simpson, 2009).

The French colonial governments benefitted from their allegiances with Indigenous people whose knowledge about the use of the land for medicines, fur trade routes, hunting, and trapping and whose help in defending the French colonies from the British were important assets to the survival of the French settlements (Dickason & Calder, 2006). However, this military collaboration with the French created feelings of enmity with the conquering British (Umeda, 2006).

Exposure to the European immigrants was dangerous for the health of the Indigenous people who had no immunity to the infectious diseases brought from France and England. Diseases such as influenza, measles, smallpox, scarlet fever, pertussis, and chickenpox are estimated to have killed 90% of Indigenous people in Canada (Kirmayer, Tait, & Gracey, 2009). Whole villages died from these epidemics, leaving the land unoccupied so colonial forces could seize it (Dickason & Calder, 2006). Colonization and marginalization of Indigenous peoples occurred through the actions and policies of church and state in the three ways (Chrisjohn, Young, & Maraun, 2006; Milloy, 2006; Thira, n.d.).

**Legal.** Legislation was enacted to identify those Indigenous people who were to have ‘status’ as registered Indians and to control them by limiting their rights. This was founded on the belief in the superiority of the European systems and the inferiority of the Indigenous ways, viewing Indigenous society as ‘savage’ and ‘uncivilized’ (Dickason &
The British monarch, King George III, recognized Indigenous rights and title to the land on which they lived in the Royal Proclamation of 1763. Colonial authorities interpreted this law as confining Indigenous people to one of the areas they had formerly lived for part of the year. However, rather than give them title to this land, the ownership of this land remained in the hands of the crown and was reserved for the use of Indigenous peoples. Indigenous communities agreed to move to the reserve areas in order to isolate themselves from the colonists and their infectious diseases (Switlo, 2002).

The colonial government assigned White Indian Agents to represent the Government of Canada and to supervise Indigenous communities. The Indian Agent heard the requests of reserve members and decided whether to grant their requests or not. However, the racist attitudes of some of these Indian Agents led to abuses of power (Miller, 2000).

The other areas that were traditionally inhabited and cared for according to seasons in which food was gathered by these nomadic people were seized by the colonial authorities and apportioned to incoming colonists who received title to this land (Miller, 2000). In this way, the land, on which the Indigenous peoples had lived for thousands of years, was seized without recompense. Thus, it can be argued that this Royal Proclamation, established to recognize the land rights of Indigenous peoples, in reality served colonial interests. Reserve lands were selected because they were less valuable, essentially considered to be “wild and waste lands” (Switlo, 2002, p. 107) that had no perceived economic or trade value to the colonial forces.

The marginalization of Indigenous peoples continued as further laws were
developed. These laws forbade Indigenous people from moving off their reserve, even for the purposes of hunting or fishing (Anderson, 2004). As the people could no longer follow their food source, food became scarce and starvation ensued (Dickason & Calder, 2006; Henderson, 2011a). As Getty et al. (2010) stated, “this outlawing of their traditional way of life sentenced Indigenous people to poverty and disease, and led to many of the health problems currently abounding in Aboriginal communities” (p. 29). Many others agree (Archibald, 2006a; Barney, 2005; Barton, Thomamasen, Tallio, Zhang, & Michalos, 2005; Brave Heart & DeBruyn, 1998; Braveheart - Jordan & DeBruyn, 1995; Caron, 2005; Castellano, Archibald, & DeGagney, 2008; Chansonneuve, 2007; Dinges & Joos, 1988; Duran, Duran, & Yellow Horse Brave Heart, 1998; Hunter, Logan, Goulet, & Barton, 2006; Kelm, 2004; Kirmayer, 1994; Lowery, 1998; Paul, 2000; Pepper & Henry, 1991; Safarik, 1997; Seth, 2004; Slattery et al., 2009).

In 1867, the Indian Act gave government absolute jurisdiction over all aspects of life for Indigenous individuals, including the determination of who is deemed to be a ‘status Indian’ (Cole, 2008). One of the most damaging components of this Act was the criminalization of Indigenous cultural and spiritual practices. To this day, the Indian Act continues to be one of the most powerful pieces of legislation, despite amendments intended to undo its harms (Lakaski et al., 2006).

**Administrative.** Native people in eastern Canada were first introduced to alcohol in the 1670s by the French fur traders as part of the ceremonies that preceded negotiations for sales, in order to decrease the astuteness of the Indigenous negotiators and win better bargains (Gray, Saggers, Sputore, & Bourbon, 2000; Jilek-Aall, 1981; Waldram, 1997). Incorporating alcohol into the ceremony ensured that Native
negotiators would participate out of respect. Historical accounts described extremely heavy drinking by early traders, military personnel, trappers, miners, soldiers, and lumbermen (Beauvais, 1998) as well as the colonists (Maracle, 1993).

As alcohol use among Indigenous people escalated, alcohol abuse began to permeate the Indigenous community. Gradually, a paradox developed for the colonial government: “liquor lured Indians to the British, but drunken binges undermined Indian communities and made individual Indians less reliable hunters and allies” (Mancall, 1995, p. 159). Binges resulted in some children being neglected (Cole, 2008). Eventually, Native political leaders demanded political action to stop the use of liquor during trading practices (Waldram, 1997). Colonial authorities responded with a prohibition of possession or use of alcohol by Native people. However, evidence of the government’s goal of establishing control by abolishing the rights of Indigenous people was revealed with legislation that asserted that if an Indigenous person agreed to give up his/her status as a registered Indian (enfranchisement) he or she would be free to drink alcohol and enter a drinking establishment (Maracle, 1994; Thira, n.d.).

**Ideological.** The government abandoned its obligations to negotiate treaties, as guaranteed in the Royal Proclamation of 1763, and set a new goal of complete assimilation of Indigenous peoples (Arnason, 2009; Dickason & Calder, 2006; Getty et al., 2010; Richard, 2010). Residential schools and foster parent care were established to separate children from Indigenous communities and assimilate them into the non-native mainstream, based on the view that Indigenous peoples and their communities were spiritually ‘heathen’ and ‘deficient’ (Chrisjohn, Young, & Mauraun, 2006; McCormick 2002; Milloy, 2006; Thira, n.d.).
**Residential schools.** The strategies to assimilate the Indigenous people in Canada began in 1923 with the introduction of mandatory attendance for all Indigenous children between the ages of 5 and 17 in Indian Residential Schools across Canada. With a goal of ‘civilizing’ Indigenous peoples, 130 residential schools were established throughout Canada (Chrisjohn, Young, & Maraun, 2006). In these schools, children were immersed in a Western way of life and were expected to renounce all Indigenous ways of life—language, cultural beliefs and practices, and anything associated with their history (Hare & Barman, 2001). Most poignantly, they were separated from their families (Chrisjohn et al., 2006; Getty et al., 2010; Hare & Barman, 2001). Milloy (2006) suggested that as many as 60% of students died while in these schools, as a result of the severe beatings, sexual abuse, the rampant spread of infectious diseases facilitated by malnutrition and overcrowding, attempted escapes, or suicide.

Stories are told by Residential School Survivors about being ‘snatched’ and swept away with no ‘goodbye’, or removed in front of parents, or being sent or taken to the schools by their parents (Hare & Barman, 2001; Truth and Reconciliation Commission of Canada, 2012). These children felt abandoned in the strange environment of the schools, a feeling heightened by being forbidden to associate with their own siblings at the school. According to Attachment Theory, children require secure attachment to parents to develop mentally and socially (Fraley, 2010). Secure attachment requires that the attachment figure is nearby, accessible, and attentive; a protector. Colonial law and social structure rendered this impossible, even for the most determined parents. According to the theory, the child will exhibit intense psychological distress and activity directed towards reconnection to the attachment figure (Fraley, 2010). Unbearable
images come to mind here, as one can imagine the scenes of beatings, since residential school caregivers, believing they needed to rid the children of ‘all things Indian’, would attempt to beat the children into submission (Stout & Kipling, 2003). According to the theory in prolonged separation or loss, eventually the child “wears down” (Fraley, para. 4), experiencing profound despair and depression and an inability to form natural and trusting bonds in adulthood (Fraley, 2010; Holmes, 1993). This impaired ability to have healthy relationships often leads into socially aberrant behaviors, such as violent actions and addiction in adulthood (Holmes, 1993).

Many Residential School Survivors patterned their parenting on the role models from the residential school. These practices in turn were passed onto the next generation (Castellano et al., 2008; Vaughn et al., 2007). The result of these colonial acts is the perpetuating cycle of poor mental health and addictions that we see today. Studies show that Indigenous people who had a parent who attended a residential school were more likely to have experienced suicidal thoughts (Getty, 2010; New Brunswick Office of the Child and Youth Advocate, 2010; Rehm et al., 2008). Brave Heart (2003) states, “The historical losses of Native peoples meet the United Nations’ definition of genocide” (p. 8). Some have described assimilation as the genocide of the Indigenous people, and have equated residential schools with concentration camps for Indigenous children (Ryan et al., 2008). Indeed, there is evidence of intentional annihilation of Indigenous people here in Eastern Canada. In 1744, a law in Nova Scotia awarded “a scalp bounty of 100 pounds of silver...for every male Indian over twelve” (Getty, 2013, p. 28; Paul, 2000; Perley, 2001).

One must have an understanding of the colonial history that Indigenous peoples
endured in order to understand present addiction issues. Kirmayer, Tait, and Simpson (2009) state, “the history of the European colonization of North America is a harrowing tale of decimation of the indigenous population by infectious disease, warfare, and active suppression of culture and identity, an undertaking that was tantamount to genocide” (p. 7).

The inter-generational effects of the collective trauma that occurred because of colonialism, including the residential school experience of Indigenous people, are widely acknowledged. These are referred to as Historical Trauma (Brave Heart et al., 2011) or transgenerational Post-Traumatic Stress Disorder (Lee, Harrison, Mills, & Conigrave, 2014; Wesley-Esquimauz & Smolewski, 2004). These terms, describe the suffering that resulted from the epidemics of infectious diseases, military defeats, loss of lands, culture, and language. This continuing trauma has brought about the dysfunctional relationships, violence, and addiction that are transmitted from one generation to the next (Brave heart, 1998; Brave Heart & DeBruyn, 1998; Braveheart - Jordan & DeBruyn, 1995; Ing, 2006; Lonczak, Fernandez, Austin, Marlatt, & Donovan, 2007; Whitbeck, Adams, Hoyt, & Chen, 2004).

Substance abuse is common among adults who were physically, sexually and emotionally abused as children in the residential school system (Brasfield, 2001; Cahill, Kaminer, & Johnson, 1999; DeGagne, 2007; Duran et al., 1998; Edwards, 2005; Hurdle, Okamato, & Miles, 2003; Jacobs & Gill, 2002; Martsolf & Draucker, 2008; Morrissette, 1994; Palacios & Portillo, 2009; Samson, 2003; Springer, Sheridan, Kuo, & Carnes, 2003; Stout & Kipling, 2003; Wesley-Esquimauz & Smolewski, 2004). Corrado and Cohen (2003) found that 90.9% of residential school survivors in British Columbia...
abused alcohol as adults. Indeed, the phrase ‘Residential School Syndrome’ has been used to describe the effects of post-traumatic shock symptoms experienced by former students of residential schools, including: (a) dysfunctional relationships, (b) fatigue, (c) diminished interest in and participation in cultural activities, (d) addiction, and (e) anger management problems (Brasfield, 2001). It has also been noted that children of residential school survivors have high suicide rates (Stout & Kipling, 2003).

Getty and associates (2010) study on the health and social support needs of descendants of residential school survivors found that parenting issues of the survivors emerged as central to the health of the descendant participants. Similarly, Claes & Clifton (1998) stated, “child-rearing patterns have been indelibly marked by residential schools in ways that will last for generations” (p. 43). They noted that the inability of many children, grandchildren and great-grandchildren of former students to offer praise or demonstrate affection is a sign of the effects of the residential school experience in subsequent generations. It is hardly surprising that many descendants of former students inflict verbal and physical abuse when disciplining their children because they learned their parenting skills from their own parents, who copied the abusive style of discipline that they had experienced in residential school (Haig-Brown, 1988; Milloy, 2006; Stout & Kipling, 2003). In this sense, violence became perpetuated from one generation to another as victims inflict violence on their descendants (Firestone et al., 2015; Jacobs & Gill, 2002; Libby, Orton, Beals, Buchwald, & Manson, 2008; Niccols, Dell, & Clarke, 2010; van der Woerd & Cox, 2005).

**The Sixties Scoop and foster home programs.** The Sixties Scoop was another racist government program that blamed Indigenous peoples for their poverty, rather than
recognizing the effects of the policies established by government departments and
institutions. Indigenous children were and continue to be taken from their families,
communities and traditions and placed in a series of White foster and adoptive families
(Milloy, 2006). In these White homes, Indigenous children were taught that their
Indigenous parents’ ways were degenerate. They were forbidden to speak their own
language or practice their own culture (Duran et al., 1998; Stout & Kipling, 2003;
Wesley-Esquimaux & Smolewski, 2004). As a result, for many, their Native identity was
lost and they grew up feeling they did not belong in either community (Haig-Brown,
1988).

Summary. In summary, before contact with the white population, Indigenous
peoples had little exposure to alcohol. The use of alcohol was a powerful tool in trade
negotiations with Natives, and enabled trappers, fur traders, and governments to use
alcohol to exploit Indigenous people. Infectious diseases such as whooping cough and
smallpox wiped out whole populations. Due to the new laws, Indigenous hunters could
no longer provide food in sufficient quantities to promote good health and nutrition.
With their spirituality outlawed and alcohol readily available, the road to addiction and
deteriorating health was paved. Indigenous society was beginning to break down.

Colonization brought devastating and permeating effects on the health of
Indigenous peoples. It robbed people not only of their land, their livelihood and their
possessions but also attacked their very spirit—their ability to relate to each other, their
environment, and their Creator. In the next section I will examine the literature related to
spirituality and health, particularly as they relate to the experience and practices of
Indigenous peoples.
**Spirituality**

The key word *spirituality* yielded over 17,000 results in the Cumulative Index to Nursing and Allied Health Literature (CINHL). Oldnall (1996) argued that one’s spirituality is anything that brings meaning to one’s life, such as art, food, and relationships. Because of this broadness, a search on the topic of spirituality is very difficult (Cohen, Holley, Wengel, & Katzman, 2012; Moberg, 2008). The concept of spirituality appeared to be almost limitless; for instance, there are studies that define spirituality as broadly as any activity that improves personal diet and sleep patterns (Pardini, Plante, Sherman, & Stump, 2000). Far fewer studies measure spirituality, compared to religiosity, because of the difficulty in defining and operationalizing the term. Commonly identified aspects of spirituality included ideas of connectedness—with oneself, others, nature and/or a higher power that gives meaning and purpose to one’s life (Baldacchino, Borg, Muscat, & Sturgeon, 2012; Cohen et al., 2012; Tanyi, 2002). This higher power may or may not be in a Supreme Being, or force such as God (Cohen et al., 2012). For example, Tanyi (2002) posited that, instead of a belief in God, “a strong belief in significant relationships, self-chosen values and goals” (p. 503) is the spirituality of atheists and agnostics. Burkhardt (1989) stated:

> In nursing practices, attentiveness to spirituality goes beyond a focus on religiosity. Spiritual care needs to be based on a more universal concept of inspiring rather than focusing around religious concepts. Spirituality is a broader concept than religion or religiosity. Spirituality involves a reflection on and coming into relationship with one's experiences. Spirituality is of the essence of one's human nature, whether or not it is expressed through religious beliefs or practices. (p. 71)

Several nursing authors have described spirituality as the integrative force or energy that exists within individuals (Baldacchino & Draper, 2001; Blasdell, 2015; Burkhart &
Hogan, 2008; Cohen et al., 2012; McSherry, Cash, & Ross, 2004; Oldnall, 1996; Tanyi, 2002; Watson, 1989). This is in keeping with traditional Indigenous views of spirituality. According to Garrett and Carroll (2000), traditional Native Americans define spirituality as “Good Medicine” (p. 381):

In Native American culture, the term Medicine refers to ‘the essence of life or an inner power’ that creates every living being’s particular way of life and presence, a way that is chosen in spirit and lived out in physical form so that person may learn in mind, body, and spirit. Our choice of the way in which we focus our time and energies in each of the directions [mind, body, spirit, natural environment] reflects our values and priorities and is the manifestation of our own vision. (p. 381)

In this sense, life, spirituality, and creation are of one essence — creation (the Creator) gives us life and through spirituality, we connect to creation (the Creator). Medicine is the circular relationship between creation and people. ‘Good’ medicine brings life to people, because it enables an uninterrupted flow of spiritual power (life). In this way, our religiosity is an outward flow of our spirituality. Concurring with this, Moberg (2008) stated that while there is a growing impetus that the two terms, ‘spirituality’ and ‘religiosity’ should be pursued as distinct concepts, “that nevertheless [they] are so interrelated that they can also be studied together as Religion/Spirituality” (p. 102).

Although Western medical and nursing literature since the early 1990s acknowledge that there is a difference between spirituality and religion (Blasdell, 2015; Crawford O'Brien, 2013), a search of the literature revealed much conceptual confusion and debate about the need to differentiate between the two concepts. Many argue that the terms are inseparable (Lyons, Deane, Caputi, & Kelly, 2011; Miller & Saunders, 2011; Moreira-Almeida et al., 2014; Russinova & Cash, 2007; Saunders, Lucas, & Kuras, 2007). This is evident in most of the instruments used within research. For example,
Bussema and Bussema (2007), who were primarily examining the benefit of religion in recovering from mental illness, used Paragament’s Five Coping Functions of Religion—the first of which is spirituality. Similarly, Kelly, Stout, Magill, Tonigan, and Pagano (2011) found that “spirituality/religiousness was assessed with the religious background and behavior instrument” (p. 456). Corrigan and associates separated the two concepts, but found there were more similarities than differences in how participants defined the terms (Corrigan, McCorkle, Schell, & Kidder, 2003). As well, over 60% of participants (n=1783) saw themselves as both spiritual and religious. In yet another attempt to discern between the two terms, Wilding, Muir-Cochrane, and May (2006) conducted a qualitative study with an in-depth look at the perceptions of religiousness and spirituality for six participants. While participants did not clearly differentiate between the concepts of spirituality and religiosity, they agreed that spirituality was something more than religion. Several researchers have questioned the need and ability to differentiate between the concepts of religion and spirituality (Baldacchino & Draper, 2001; Corrigan et al., 2003; Fitzpatrick & Kazer, 2012; Wilding et al., 2006). In summary, it was obvious that most studies did not separate these terms. Discourses frequently overlapped, and the terms spirituality and religion were often used synonymously (Carroll, 2001; Kelly et al., 2011; Miller & Saunders, 2011). However, generally speaking, within these discourses, spirituality was a much broader, more inclusive term (Burkhardt, 1989; Dyson, Cobb, & Forman, 1997; Goddard, 1995; Krippner & Welch, 1992; Lyons et al., 2011; Malinski, 2002; Miller & Saunders, 2011; Oldnall, 1996).

Religion is much easier to define because it has boundaries that can be delineated by particular beliefs, practices and rituals (Tanyi, 2002). Religiosity is generally
measured by adherence to a common set of beliefs and practices that have been established by an organization (Dyson et al., 1997; Miller & Saunders, 2011). For many people religion is a way to express spirituality, but belonging to a religion is not a requirement for being spiritual (Cohen et al., 2012; Tanyi, 2002). Malinski (2002) pointed out that religion has little to do with spirituality when it is divisive. Musgrave, Allen, and Allen (2002) state that traditionally spirituality is defined as “one’s acknowledgment of and relationship with a Supreme Being” (p. 557). However, there is no universal definition for the word spirituality (Carr, 2008; Cohen et al., 2012). Umeda (2006) states, “There are as many concepts of spirituality as there are people on earth” (p. 58). Thus, one can argue that spirituality is inherent to being human, and, therefore, it is common and important to all people. Robinson, Cranford, Webb, and Brower (2007) contend that forms of spirituality include the following: (a) religious spirituality (or a structured connection to an ultimate being), (b) theistic spirituality (an unstructured connection to an ultimate being, or (c) existential spirituality, a nontheistic search for meaning and purpose. Researchers are currently more likely to view religiosity as part of the concept of spirituality (Cohen et al., 2012; Hood Jr, Hill, & Spilka, 2009).

Positive relationships between spirituality/religiosity and health. Despite debate in the literature over how the terms are distinguished, the relationship between good health and religion/spirituality is remarkable. Studies have linked higher levels of spirituality and/or religiosity with longevity, enhanced quality of life, decreased psychiatric problems, as well as better success rates in drug and alcohol treatment programs (Cohen et al., 2012; Koenig, 2009; Moberg, 2008; Robinson et al., 2007). So much work has been done on this topic that at least 15 reviews on the topic of spirituality
and health exist from the years 1993-2010 (Cohen et al., 2012). In particular, a large body of work, culminating in the 1990s, found there was a positive relationship between spirituality/religiosity and length of life (Koenig, 2009). Critics argued that the link between religious and spiritual activity and longer life can be explained by the social support and healthier lifestyles of individuals who engage in these activities. However, studies that controlled for confounding variables, such as social support, still found a positive relationship between spiritual activities and longer lives of participants (Helm, Hays, Flint, Koenig, & Blazer, 2000; Koenig et al., 1999; Oman & Reed, 1998; Strawbridge, Cohen, Shema, & Kaplan, 1997).

A large number of research studies and several meta-analyses of the literature have shown that spiritual practices are often associated with increased health and ability to cope with life’s traumas. For example, Koenig, McCullough, and Larson (2001) conducted a meta-analysis of over 1200 studies that investigated the relationship between religion and health, concluding that religious involvement was positively correlated with longer lives, and was comparable to other psychosocial factors, such as social support. However, critics argue that the link between religious and spiritual activity and longer life is explained by the social support and healthier lifestyles of individuals who engage in these activities. McCullough, Hoyt, Larson, Koenig, and Thoresen (2000) conducted a meta-analysis of published and unpublished studies examining religious/spiritual activity and death by any cause. They excluded studies that only looked at religious affiliation and instead focused on studies that had some level of religious activity, such as how often individuals engaged in such activity, how important one ranked his or her faith beliefs, or the degree to which one found strength or comfort from God. Controlling for
confounding variables, such as social support, higher socioeconomic status, or better initial health status and lifestyle, the only factor that approached the protective effect of religious involvement was lack of obesity.

In Koenig’s (2009) review of research on religion, spirituality, and mental health, spirituality was found to enhance overall quality of life, even in the gravest of circumstances. For example, spirituality has helped individuals cope with uncertainties associated with living with chronic illness (Baetz & Bowen, 2008; Baldacchino et al., 2012; Gould, Wilson, & Grassau, 2008), including chronic pain (Baldacchino et al., 2012), and death and dying (Baldacchino et al., 2012; Penman, Oliver, & Harrington, 2013). These situations are statistically more prevalent among Indigenous people and add to the complexities of their lives (Kirmayer, Sehdev, Whitley, Dandeneau, & Isaac, 2009).

Also noteworthy among these findings is that spirituality decreased psychiatric symptoms, such as depression and anxiety (Aukst-Margetić, Jakovljević, Margetić, Bišćan, & Šamija, 2005; Daaleman & Kaufman, 2006; Kilbourne, Cummings, & Levine, 2009; Koenig, Larson, & Larson, 2001; Kristeller, 2010). For example, in Wong-McDonald’s (2007) study examining the results of a spirituality group offered in a psychosocial rehabilitation center, 100% of participants were able to meet all treatment goals. The sample was very small, and, as such, statistical significance was only for the wellness goal, but the results were astounding. For instance, a woman with a 30-year history of agoraphobia (fear of open spaces) and daily panic attacks, and who had been unresponsive to treatment, was able to walk down streets and control symptoms to bimonthly occurrences.
Bellamy et al. (2007) showed that mental health care consumers who endorsed spirituality had higher levels of hope, quality of life, and sense of community. Consistent with this were Daaleman and Kaufman’s (2006) findings that greater spirituality was found to be independently and inversely associated with depressive symptoms. As well, research focused on identical twins who have been separated at birth has provided strong evidence that there is a positive association between spirituality/religiosity and reduced prevalence of DSM-III-R diagnoses of depression and substance use disorders (Kendler et al., 2003; Tsuang, Simpson, Koenen, Kremen, & Lyons, 2007). Some researchers have hypothesized that these effects may be related to spirituality’s meaning-making ability (Diaz, Horton, McIlveen, Weiner, & Williams, 2011; Hood Jr et al., 2009; Neff & MacMaster, 2005; Rasic et al., 2009; Warfield & Goldstein, 1996). The inherent hope that religion and spirituality bring has also been shown to enable people living with serious and chronic mental illness to reject suicide (Crawford O'Brien, 2013; Rasic et al.; Wilding et al., 2006). These are important findings given the high rates of serious chronic mental illness and suicide among Indigenous communities (Chandler & Lalonde, 1998; Kirmayer, Tait, & Gracey, 2009; Tanner, 2009). While spirituality and/or religion have many positive effects on health, spiritual distress has been related to negative health outcomes.

**Negative relationships between religion and health.** Researchers have identified a positive association between spiritual distress and increased risk of poorer health outcomes, such as early death (McCullough et al., 2000; Pargament, Koenig, Tarakeshwar, & Hahn, 2001; Penman et al., 2013). For example, McCullough et al. found that spiritual distress, such as feeling abandoned by God, or that one’s illness was
from the devil, increased the risk of dying by as much as 28%.

An individual’s beliefs about God may provide insight into why spirituality and religion can have a negative outcome for some (Ano & Vasconcelles, 2005; Phillips & Stein, 2007). Phillips and Stein found that those who believed that their illness was a punishment from God, or who lost trust in their God due to perceived unanswered prayers for healing, showed a negative adjustment to their illness one year later. In contrast, individuals who believed in a benevolent deity showed positive adjustment to life after a myocardial infarction, as did those dealing with the reality of their children’s illness with Cystic Fibrosis (Baldacchino, 2010; Baldacchino et al., 2012).

Krause and Wulff (2004) found that people who had doubts about their theological beliefs were generally less satisfied with their physical and mental health. In particular, the ones who had the most difficulty were those who had religious doubt, yet were actively involved in religious activity. This may be a particularly relevant consideration in regards to Indigenous individuals who are caught between the mainstream religious beliefs, which were entrenched through residential schools, and traditional spiritual beliefs being taught by Elders in the community (Adelson, 2009).

Research has shown that rigid parenting practices, bordering on abuse, that were rationalized through religious beliefs, produced clinical mental health problems among children (Bottoms, Goodman, Tolou-Shams, Diviak, & Shaver, 2015; Bottoms, Shaver, Goodman, & Qin, 1995; Marsden, Karagianni, & Morgan, 2007). This type of rigid-discipline parenting of Indigenous children, justified by the religious beliefs of the governing nuns and priests, took place in residential schools. God was presented as a punitive, intolerant judge (C. Paul Sr., recovered alcoholic and Residential School
In summary, there is no definitive agreement about the definition of spirituality. While it is often linked to religiosity, spirituality is a much broader term and can be independent of religiosity. Nevertheless, there is a plethora of evidence about the connection between both spirituality and religiosity, and health. Overall, the literature demonstrates the benefits of spirituality to the physical and mental well-being of individuals. Although the majority of the studies are Western, and therefore it must be acknowledged that the findings cannot and should not be imposed on Indigenous peoples, Indigenous world views have always held health and spirituality to be one (Garrett & Carroll, 2000).

**Traditional Indigenous spirituality, health, beliefs, and practices.** Irwin (1996) pointed out that understanding traditional Indigenous spirituality, from the perspective of a non-Indigenous person, is very difficult, as it is a very complex concept and written interpretations are not readily available. Traditional Indigenous spirituality is not an entity that is identifiable by a clear list of beliefs or doctrines that exist outside of an individual, as one might see in traditional Judeo-Christian spirituality. Rather, it is an all-encompassing way of being and existing with one’s universe (Kirmayer, Tait, & Simpson, 2009). This is evident in the lack of words for the concepts of spirituality and religion in most Indigenous languages (Garrett & Carroll, 2000; Kasee, 1995).

Traditional Indigenous spirituality sees “humans as part of a cosmological order, depending on a balance of reciprocating forces to keep the universe functioning in harmony” (Dickason & Calder, 2006, p. xii). In the Indigenous worldview, all of creation, the seen and unseen worlds, animate and inanimate objects alike, are universally
interconnected life forces (Bear, 2011; Cajete, 2011; Henderson, 2011b), within a circular relationship in which all are equal (Coyhis & Simonelli, 2008; Gone, 2011). As Henderson (2011b) points out, in Indigenous culture everything has a spirit, even a seemingly inanimate rock, and because all things are connected, they are equally significant. Everything is part of a common cosmos that is constantly in flux as these life forces are continually interacting. For example, Henderson (2011b), referring to the Mi’kmaq wrote:

To them [the Mi’kmaq] every stone, tree, river, coastline, ocean, and animal is a discrete mntu [spirit]. They strive to respect and live in harmony with these intelligible essences. Within their space, a respectful and sacred relationship between all life forms is the highest form of existence. Such relationships are not always achieved but they are at the purpose of life. (p. 257-258)

These relationships between spirits and the ‘Creator’ are fundamental to the health and spirituality of Indigenous peoples.

Garrett and Carroll (2000) state that among Indigenous peoples, health beliefs and spiritual beliefs are really one and the same things. While there are many distinctions between different Indigenous peoples, traditional Indigenous perspectives generally share a common understanding of health and wellness based on their worldview. Historically, Indigenous people perceive that relationships between people, animals, the environment, and the Creator are directly related to a person’s well-being (Lakaski et al., 2006).

Euro-Canadian society tends to view an individual’s health as distinct from the earth, animals, and others. This is in sharp contrast to the Indigenous peoples’ traditional beliefs of spirituality as the essence of the “web of sustaining relations” (Lakaski et al., 2006, p. 162). In this web, which can be thought of as concentric circles, humans are not distinct from the earth, animals or anything else in creation, but instead are part of inter-
connected life forces (Garrett & Carroll, 2000). These forces affect one another, referred to as the natural “law of circular interaction” (Henderson, 2011b, p. 260).

The Medicine Wheel is a depiction of the interacting dynamic spheres of health. There are various models of the Medicine Wheel, all of which include social and environmental health, and depict the individual’s health within that of the family and community. Typically, quadrants on this wheel represent four dynamic interacting health dimensions: emotional, mental, physical, and spiritual. If one dimension is weakened, inevitably the other three will be affected. For example, when a person has a physical illness, their spiritual dimension may become stronger to stabilize the whole.

Many have described the traditional Indigenous concept of person as ecocentric (Dickason & Calder, 2006; Henderson, 2011b; Kirmayer, Tait, & Simpson, 2009; Sioui, 1992; Tanner, 1979). This means Indigenous peoples see everything (other people, land, animals) as aspects of reality to which they are connected—a “relational self” (Kirmayer, Tait, & Simpson, p. 23). Responsibility and consideration for animals, the earth, and people are embedded in cultural spirituality. When one of these relationships is strained, all dimensions of health may be compromised (Lakaski et al., 2006).

These relationships between people, ancestors, animals, the earth and the Creator—were regularly celebrated and honored in Indigenous communities (Henderson, 2011b). Even informal gatherings and meetings often begin and end in ceremonies, which include at least prayer, acknowledging the Creator, ancestors, and the earth.

For this reason, traditional Indigenous spirituality is founded on the concept of “Mother Earth” and has been described as a “living relationship with the land” (Henderson, 2011b, p. 260). Cajete (2000) speaks of a “spiritual ecology” which
underlies Indigenous spirituality around the world. He describes spiritual ecology as “the intimate relationship that people establish with place and with the environment and with all of the things that make them or give them life” (p. 184). Sioui (1992) contended that continued destruction and misuse of land in the promotion of commerce, constitutes a direct assault on a person’s health. Tanner (1979) pointed out that traditional hunting did more than maintain physical sustenance. It maintained the social, moral, and spiritual health of the individual and the community. Indigenous peoples traditionally shared their worldview, including their perspectives on spirituality, through the modelling and teachings of Elders, who consistently demonstrated that they lived according to the spiritual and cultural values of their people, as determined by their community (Grandbois & Sanders, 2009, 2012). Elders were perceived to be more complete or refined in ways of being and spiritual knowledge (Archibald, 2001; Cajete, 2011), and were shown ultimate respect as teachers and keepers of the community’s history, customs, and knowledge (Archibald, 2001; Grandbois & Sanders, 2009, 2012).

The above body of works supports traditional Indigenous beliefs that spirituality and health are inseparable. Several Indigenous scholars believe that the outlawing of traditional spirituality has contributed to the epidemic of addictions that exist today and that recovery occurs through a return to traditional values (Brave Heart et al., 2011; Garrett, 1999; Gone, 2011; Hunter et al., 2006; Jacobs & Gill, 2002; McCormick, 2000).

Addictions

In this section I will outline the definition that the literature has widely used for addiction, theories related to the causes of addiction, and addiction as a spiritual disease.
Because these theories have been informed from Western research methods with the
general population, which has largely excluded Indigenous peoples, whenever possible
Indigenous writers’ comments on these theories have been given preference. The
majority of the studies are Western and therefore it must be acknowledged that the
findings cannot and should not be imposed on Indigenous peoples.

**Definition.** A thorough search of the literature confirms that there is no static
definition of what constitutes an addiction (Korhonen, 2004; Sussman & Sussman, 2011).
Perhaps this is because there are many factors to consider. Khantzian (2001) commented:

> For some, addictive illness takes an unrelenting devastating course with all the
> characteristics of malignant disease; for others dependency on substances seems
to be symptomatically related to a stressful or distressful phase of a person’s life
> and the reliance on drugs or alcohol is transitory and a temporary aberration; and
> yet for others they simply choose to stop for reasons that are not always clear. (p.
> 1)

A wide range of problems can occur from the misuse of drugs and alcohol—from use that
is causing mild problems in one’s life, to severe physical dependence that can have life-
threatening consequences (Hammer et al., 2013; Korhonen, 2004).

The American Psychiatric Association (APA) and the World Health Organization
have developed specific criteria to differentiate between the many levels of substance
abuse problems—from harmful use, to dependence, to addiction—but these criteria
continue to change (Korhonen, 2004; Sussman & Sussman, 2011). For example, in the
fifth edition of the APA’s Diagnostic and Statistical Manual of Mental Disorders (2014)
harmful use, dependence, and addiction are now combined under a single category—
*substance use disorders.* A diagnosis of mild, moderate, or severe is based on the
number of symptoms present. The American Society of Addiction Medicine defines
addiction as:

Addiction is a primary, chronic disease of brain reward, motivation, and related
circuitry. Dysfunction in these circuits leads to characteristic biological,
psychological, social and spiritual manifestations. This is reflected in an
individual pathologically pursuing reward and/or relief by substance use and other
behaviors. ("ASAM issues new definition of addiction," 2011)

This definition is inclusive of spirituality but basically emphasizes addiction as a disease
beyond one’s control. In comparison, the National Native Addictions Partnership
Foundation (2000) describes addiction as:

Any habitual behaviour pattern involving substance ingestion that affects central
nervous system activity, which creates a psychological and/or physiological
dependency that is preoccupying to the point of disadvantage in other aspects of
one’s life, and is perceived as extremely difficult to overcome. (p. 67)

In this definition the biological disease aspect is again acknowledged but lessened by
stating that addiction is perceived as extremely difficult to overcome. This could give a
sense of hope, implying that it can be overcome. Korhonen’s (2004) seminal report for
the National Aboriginal Healing Organization defined addiction as “the uncontrollable,
compulsive craving, seeking, and use [of the addictive substance], even when the person
is experiencing negative health and social consequences” from this use (p. 5).

Overall, in the literature, addiction criteria seem to be marked by the point at
which an individual shows all of the following: (a) tolerance, the need to use more to
achieve the same effect; (b) withdrawal symptoms, when the substance is abruptly
stopped; and (c) an all-encompassing focus on using, despite dire, even life threatening
circumstances (Sussman & Sussman, 2011).

Over time, there have been several theoretical viewpoints about the causes of
addiction. The following section will briefly review the literature related to these
theoretical approaches to the issue of addiction.

**Theories related to the causes of addiction.** Clinicians and researchers have agreed that addiction is a complex interaction of an individual’s inner makeup, such as genetics, biological processes, thoughts, feelings and beliefs, with the environmental factors that surround and interact with them (Firestone et al., 2015; Sussman & Sussman, 2011). I will comment on those aspects within these broad-based themes that I believe may be most applicable to understanding Indigenous people living with addictions. My primary elaboration will be on addiction as a spiritual disease, since this is in keeping with the Indigenous views on addiction (Coyhis & White, 2006), and the focus of this report.

Because the social and economic costs of addiction have driven extensive research on the subject, thousands of studies about addiction are available. Thomason (2000) stated that there are more than forty contrasting theories about the causes and courses of alcohol addiction. Robert West, who is editor-in-chief of the journal Addiction, published a book in which approximately three-dozen theories of addiction were summarized (West & Brown, 2013). Broadly speaking, most of these theories cluster around the following main theoretical perspectives:

1. Moral theories, in which addiction is viewed as a choice stemming from a weak-willed or morally deficient character.
2. Disease theories, where substance abuse is thought to trigger an innate disease that makes it impossible for the individual to control the use of that substance.
3. Biological theories in which genetic and chemical factors are said to influence the development of addiction.
4. Psychosocial theories, where social, environmental, and learning circumstances, as well as personal psychological factors, are hypothesized to produce addictions. (Korhonen, 2004; West & Brown, 2013)
In the early days of addiction theory, moral theories were the standard (Chansonneuve, 2007), which is perhaps why disease theory was such a breakthrough concept. The idea that substance abuse is, at least in part, the result of uncontrollable factors commands a compassionate, rather than a condemning approach to dealing with addicted individuals. Over time, research confirmed more aspects of these theories, but no singular theory or model was found to predict addiction. It became obvious that addiction was a complicated interplay of aspects from all of the models. Today, the biopsychosocial theories have emerged and become the most prevalent explanation of addiction because they combine the important premises of the biological, psychological, and social theories to address the body, mind, social environment and, sometimes, spiritual needs of the individual (West & Brown, 2014).

There has been much debate in the literature about whether or not addiction is an incurable, progressive, primary (inborn) disease (Korhonen, 2004). Many researchers argue that addiction is the expression of social suffering, which suggests that the cause of addiction lies as much within society as it does within the individual (Adelson, 2009; Tanner, 2009). However, others question why some individuals, such as in siblings who are exposed to similar detrimental social and environmental parameters will develop an addiction while another may not. Korhonen (2004) stated,

For more than 40 years, one of the strongest beliefs among medical professionals in North America has been that addiction is a primary (caused by an inborn physical abnormality, not some other physical or psychological problem), chronic (ongoing, always present), progressive (gets worse), incurable, physical disease that can be fatal. (p. 8)

This view was first articulated by E. M. Jellinek (1960) in his description of the progressive disease of alcoholism (Fitzpatrick & Kazer, 2012; Korhonen, 2004). In this
conceptualization of alcoholism, the chronic abuse of alcohol triggered the disease of
drug seeking behavior that is beyond the control of the individual’s willpower. Within certain individuals, a biological predisposition will result in unavoidable abuse once that individual’s substance use begins (Korhonen, 2004). However, this theoretical approach does not explain all of the variance in addiction among different people.
(Korhonen, 2004). Despite this, the majority of current mainstream Western treatment approaches view addiction as an incurable disease unless the individual completely abstains from the addictive substance (Korhonen, 2004; West & Brown, 2014).

However, critics of this disease approach contend that addiction encompasses a wide scale of problems with a variety of causes. Furthermore, they note that many people with addictions, especially those addicted to alcohol, have been able to stop or control their addiction without medical intervention, thereby defying the idea that the problem is an innate, uncontrollable, progressive disease (Hammer et al., 2013; Korhonen, 2004).

Many Western and Indigenous scholars have pointed out that this view of addiction as an incurable disease is especially detrimental to Indigenous people who have already learned to feel powerless and without hope following colonization (Chansonneuve, 2007; Korhonen, 2004; Leland, 1976). Leland (1976), in her book “Firewater Myth,” explained that Indigenous people have internalized the idea of addiction as an incurable disease. These internalized beliefs are particularly important, because people have been found to react to alcohol according to their preconceived beliefs of how it will affect them (Baetz, Bowen, Jones, & Koru-Sengul, 2006; Spillane, Greenfield, Venner, & Kahler, 2015). Studies have demonstrated that alcohol-related violence is a learned behaviour, rather than a universal response to drinking (Barnwell, Borders, & Earleywine, 2006; Exum, 2006; Fitterer, Nelson, & Stockwell, 2015). Additionally, the disease theory supports an abstinence only recovery model. Increasingly, however, research has demonstrated that harm reduction models are more in keeping with traditional Indigenous ways of thinking, including: recognizing equal
worthiness in all human beings, encouraging respect of every individual’s choices rather than passing judgment, learning through experiences, including mistakes, and accepting that each individual will continue at his or her own pace (Chansonneuve, 2007).

Nevertheless, to say that addiction is not a disease does not mean that there are not important biological factors involved. Mancinelli (2013) and May (1994) point out, however, that genetic aspects of alcohol metabolism are more individual or sex-related than characteristic of a particular ethnic group or nation. For example, studies have shown that low levels of dopamine and serotonin are associated with increased risk of alcohol abuse (Nutt, Lingford-Hughes, Erritzoe, & Stokes, 2015; West & Brown, 2014). In terms of sex differences, women generally have less body fluid than men, which affects their ability to dilute the alcohol they consume (Mancinelli, 2013). In addition, some women seem to be deficient in a certain enzyme involved with alcohol metabolism (Korhonen, 2004; Mancinelli, 2013). These are all genetic factors that are linked to sex or individual differences, rather than group predispositions. Generally speaking, “all experts, including those who believe in the disease model, agree [that] psychological, social, and environmental events are important elements in the development of problem drinking patterns” (Korhonen, 2004, p. 9). Certainly, the most prevalent and undisputed dynamic accounting for addictions among Indigenous peoples is the massive collective trauma caused by the process of colonization, such as residential schools. Wesley-Esquimaux and Smoleski’s (2004) study examining the intergenerational transmission of historic trauma from the time of European contact in 1492 to the 1950s clearly demonstrates the negative impact in all areas of life: physical, economic, cultural, social, and psychological (Korhonen, 2004). They apply the model of Historic Trauma
Transmission developed by Maria Braveheart (1998). This continuing multiple cumulative impact on dimensions of health, with no opportunity to recover from traumatic events before the next one is experienced, is thought to have created many psychopathologies (Braveheart - Jordan & DeBruyn, 1995; Kirmayer, Tait, & Simpson, 2009; Stout & Kipling, 2003; Wesley-Esquimaux & Smolewski, 2004). As a result, addictive behaviours have become a means of self-soothing (Chansonneuve, 2007).

Many qualitative studies have examined addiction in relation to the traumatic effects of residential schools. Fournier and Crey’s (1997) book, Stolen from our Embrace, uses powerful personal accounts to underscore how systemic racism and ignorance among non-Indigenous child welfare authorities led to the desolation of Indigenous communities (Chansonneuve, 2007). In fact, Chansonneuve reports that employees of Indigenous treatment centers see “alcohol and drug addiction merely as symptoms” of the abuse suffered while attending residential schools (p. 116). Although qualitative research does not prove causality, the consistent findings of numerous reports leaves little room for debate about the links between residential schools and causes of addiction (Kirmayer, Tait, & Simpson, 2009).

Perhaps the most widely applied model to addiction recovery is Prochaska and DiClemente’s (1982) stages of change, which include pre-contemplation, contemplation, determination, action, and maintenance. Morjaria & Orford (2002) critiqued this theory, stating, “Despite the complex relationship between religion/spirituality and addiction/recovery the leading paradigm in change processes in addiction, the Stages and Processes of Change…does not address the spiritual element of change in recovery from addictions” (p. 228). After conducting a study testing the applicability of the change
model to Alcoholics Anonymous members, Snow, Prochaska and Rossi (1994) concluded that “spirituality was difficult to conceptualize within their model, indicating a need for the further development of this model if it is to encompass the spiritual/religious element of change in the recovery process” (Morjaria & Orford, 2002, p. 228). The role of spirituality in the recovery process is an essential concept to Indigenous peoples’ traditional beliefs, which view spirituality as the fundamental essence of life, wellbeing, health and healing (Coyhis & White, 2006; Lakaski, Martin, & Bobet, 2006).

**Addiction as a spiritual disease.** MRIs and CAT scans have been utilized to demonstrate the link between the physiology of addiction and spirituality. It has been shown that spirituality, like addiction, is mediated by the limbic circuitry and the temporal cortex (Vaillant, 2005, 2014). As early as 2003, Borg, Andree, Soderstrom, and Farde found that those who scored higher on spiritual transcendence had an increased activity in the limbic system (Dermatis & Galanter, 2016; Kelly, 2016). This activity is the same type that is characteristically seen with addictive substance use. Some researchers have suggested that spiritual practices can substitute the high produced by mind-altering substances (Borg, Andree, Soderstrom, & Farde, 2003; Dermatis & Galanter, 2016; Galanter, 2007; Kelly, 2016; Vaillant, 2014).

Indigenous scholars define addiction as a crisis of the spirit (Brave Heart et al., 2011; Cajete, 2011; Cole, 2008; Coyhis & Simonelli, 2008; Duran & Duran, 2011; Firestone et al., 2015; McCormick, 2000; Morjaria & Orford, 2002). This idea has been supported overtime, even in mainstream Western literature. Morjaria & Orford note, “several writers of the past have argued that in the Western world, individuals have become detached from their ‘inner life’, because they have become too materialistic,
believing that outside sources will bring happiness” (p. 227). As long ago as the 1800s, William James, an influential philosopher, psychologist, and physician, referred to addicted individuals as “divided” souls, contending that addiction and spirituality may be interchangeable, but cannot exist together (James & McDermott, 1967; Morjaria & Orford).

Others argued that addiction is a form of idolatry (Jung, 1987; Morjaria & Orford, 2002). Psychiatrist, Carl Jung, believed that the “craving for alcohol was the equivalent, on a low level, to the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God” (Jung, 1987, p. 5). Morjaria and Orford (2002) argued that the search for God is what ultimately gives us meaning in life. Miller (1998) reported that more than a dozen studies have found that alcohol and drug abuse is associated with a lack of a sense of meaning in life. McCormick (2000), an Indigenous psychologist and researcher, used this explanation to describe alcoholism among Indigenous peoples. He contended that drinking alcohol is a survival mechanism, used to deal with existential anxiety, a state of being powerless and hopeless, due to the devastation of traditional cultural values and ways of life. This perception is in line with Victor Frankl’s Existential Theory of Human Motivation (Frankl, 1975).

Victor Frankl, an Austrian neurologist, psychiatrist, Holocaust survivor, and founder of existential therapy, claimed that a lack of meaning in life causes an existential vacuum (Chen, Cheal, Herr, Zubritsky, & Levkoff, 2007). Essentially, an existential vacuum is a metaphor; if meaning is what we need, then meaninglessness leaves a hole, or vacuum (Boeree, 2006). Wherever there is a vacuum, things rush in to fill it, but they are never enough (Boeree, 2006). Frankl asserted that addictions would not be
understandable unless we recognize the existential vacuum underlying them (Frankl, 1975). Frankl saw spirituality as transcendence (Boeree, 2006). He spoke of this transcendence and of the “unconscious God.” According to Frankl, a God void is within each of us: “This unconscious religiousness, revealed by our phenomenological analysis, is to be understood as a latent relation to transcendence inherent in man” (p. 61), and it is merely a matter of our acknowledging that presence that will help us understand the meaning of life. Conversely, he noted that turning away from God is the ultimate root of all evils: “Once the angel in us is repressed, he turns into a demon” (Frankl, p. 70).

Boeree (2006) who is self-admittedly not of a religious inclination states: “There exists, beyond instincts and ‘selfish genes,’ beyond classical and operant conditioning, beyond the imperatives of biology and culture” (para. 81), referring to moral theory, disease theories and psychosocial theories; “a special something, uniquely human, uniquely personal” (para. 81). This is the spiritual aspect of addiction. “For much of psychology’s history, we have, in the name of science, tried to eliminate the ‘soul’ from our professional vocabularies. But perhaps it is time to follow Frankl’s lead and reverse the years of reductionism” (para. 81). In keeping with this line of thinking, this report examines addiction as a spiritual disease and explores spiritual influences and approaches to healing and their relevance for Indigenous Peoples, expounding upon the impact of self-determination.

**Summary**

The reviewed literature has clearly identified colonization as the backdrop to many of the addictions we see today among Indigenous people in Canada. It has been
illustrated that the collective trauma, racism, and attempts at annihilation have left lasting patterns of thinking and living, yielding battles with addiction. The role of spirituality and religiosity among Indigenous people has been reviewed in both positive and negative lights in relation to overcoming addiction. Lastly, theories about addiction have included spirituality as an essential component of healing.
Chapter 3: Self-Determination

This chapter explores the concept Indigenous Self-Determination (ISD) as it applies to Indigenous peoples locally and globally. It also critiques the Western self-determination theory (SDT) by Ryan and Deci as a possible lens through which to support ISD, two-eyed seeing, and Indigenous wellbeing on the individual level. To do this, a search was performed through the databases Academic Search Premiere, CINAHL, PsycINFO, Medline, and ALTA using the search terms self-determination in combination with the terms First Nations, Aboriginal, Indigenous, and Native American. This yielded 135,078 results. The scholarly and professional practice literature, media, organizational websites, Indigenous program development, and lay conversations about Indigenous Health and Indigenous Peoples abounded with calls for Indigenous Self-Determination.

The Canadian Assembly of First Nations defines ISD in this way:

Self-determination refers to the right of a people to freely: (1) determine their political status and freely pursue their economic, social, and cultural development; and (2) dispose of and benefit from their wealth and natural resources. Under international treaty law, Canada is obligated to respect the First Nations’ right of self-determination. (First Nations, 2017).

Grande (2000) articulated that self-determination is as important to Indigenous people as democracy and equality are for Western Canadians. Among Indigenous scholars, self-determination is at the core of all knowledge development and translation strategies (Denzin, Lincoln, & Smith, 2008; First Nations, 2017; Keddie, 2011; Neeganagwedgin, 2013; Smith, 2012; Strickland, 1999; Willow, 2013). Dr. Marlene Brant Castellano, a leading Indigenous scholar and Mohawk Elder stated that “Fundamental to the exercise of self-determination is the right of peoples to construct knowledge in accordance with self-determined definitions of what is real and what is
valuable” (Castellano, 2014, p. 277). Essentially, ISD refers to the right of Indigenous people to decide what is best for them, and how to achieve this.

In recent policy initiatives connected to the recommendations of the Truth and Reconciliation Commission (2012), principles have been articulated that address ISD. Touchstone Principles are a set of principles that focus explicitly on ISD by addressing values, commitments, and guidelines for ways of honoring and respecting ways of being and knowing among Indigenous peoples (Blackstock, Cross, George, Brown, & Formsma, 2006). The Touchstone Principles have been adopted as expectations for culturally safe practices with Indigenous peoples in various areas of policy and community level engagement. For example, the principles clearly articulate the importance of ISD in relation to child welfare. The first principle “concerns self-determination and requires that all reform efforts begin with an acknowledgement that Indigenous people themselves are in the best position to make decisions that affect Indigenous children, youth, their families and communities” (Blackstock et al., 2006; Richard, 2010, p. 16). Other touchstone principles include: the need to take a holistic approach towards child welfare; respecting Indigenous cultures and languages; the need for structural intervention to address systemic disadvantage; and non-discrimination (Blackstock et al., 2006).

**Indigenous Self-Determination as a Fundamental Global and Local Goal of Indigenous Peoples**

Several charters and declarations for Indigenous peoples center around the primacy of ISD (Smith, 2012). Smith listed at least nine national and international
charters and declarations, demonstrating the global reach and deep detail of international consensus to address ISD. Since 2007, this consensus has emerged in significant ways internationally and nationally. Many of the national and international statements regarding ISD have been based on the United Nations Declaration of the Rights of Indigenous Peoples (2007). This declaration was finally signed by the Government of Canada in 2010, as the framework for Truth and Reconciliation in addressing human rights violations of Survivors of Residential Schools in Canada (Indigenous and Northern Affairs Canada, 2017). This literature clearly indicates that all efforts to address the lived experience of Indigenous peoples must be guided by the principles of ISD.

Smith (2012) clearly addressed the importance of respecting principles of ISD in any research that seeks to produce knowledge about Indigenous peoples. In her comprehensive review of transnational commitments to ISD, Smith described the historical significance of work from New Zealand, as follows:

> The Mataatua Declaration on Intellectual and Property Rights of Indigenous Peoples signed in Whakatane, New Zealand (1993) addresses these issues by declaring that ‘indigenous peoples of the world have the right to self-determination and in exercising that right must be recognized as the exclusive owners of their cultural and intellectual property. (Smith, 2012, p. 123)

This means that knowledge regarding Indigenous culture should only be produced or translated with Indigenous peoples’ authorization.

Indigenous and non-Indigenous people who are committed to work together on the cultural, historical, social, and political principles of ISD agree that self-determination is a fundamental and universal goal of Indigenous people worldwide (Barelli, 2011; Brayboy, 2006; Getty, 2013; Henderson, 2011a; Hirsch, 2015; Mansberger et al., 2005; Reading & Wien, 2009; Smith, 2000; Smith, 2011b). Article 3 of the United Nations
Declaration on the Rights of Indigenous Peoples (2007) affirms the right of Indigenous peoples across the globe to self-determination of their social, economic, cultural and political directions and systems. Article 34 reinforces this, stating:

Indigenous peoples have the right to promote, develop and maintain their institutional structures and their distinctive customs, spirituality, traditions, procedures, practices and, in the cases where they exist, juridical systems or customs, in accordance with international human rights standards. (Assembly, 2007, para. 34)

Yet, Indigenous peoples in Canada live in a context of laws and systemic practices that inhibit the exercise of many of these rights. While the term self-determination is often used synonymously with sovereignty and self-government among Indigenous peoples (Ah Nee-Benham, 2008; Barelli, 2011; Denzin et al., 2008; Grande, 2000; Kirmayer, Tait, & Simpson, 2009; Salois, Holkup, Tripp-Reimer, & Weinert, 2006; Smith, 2012; Willow, 2013; Willows, Veugelers, Raine, & Kuhle, 2008), it encompasses related existential components that are part of its meaning as a political construct; it is a fundamental and ontological way of being.

Several authors explain that ISD extends the meaning of sovereignty and self-government in that it deepens the ideology of political autonomy and political self-determination to include culture and religion (Deloria & Lytle, 1984; Hirsch, 2015; Smith, 2012; Willow, 2013). In this kind of meaning, Indigenous scholar, Neeganagwedgin (2013), contends that ancestral knowledges, spirituality, and self-determination (in the political and cultural sense) are so intricately linked that they are inseparable concepts essential to Indigenous peoples’ well being. Thus, ISD is central to the decolonizing process of preserving and respecting Indigenous culture, beliefs, spirituality, knowledge, traditions, and practices. Some researchers of Indigenous issues refer to self-determination as a
determinant of health (Chandler & Lalonde, 1998; Getty, 2013; Murphy, 2014a; Reading & Wien, 2009).

**Indigenous Self-determination as a determinant of health.** Dr. Charlotte Reading, an accomplished scholar of Mi’kmaq ancestry, and Dalhousie University professor Fred Wien, who works closely with the Indigenous peoples of eastern Canada wrote, a report, entitled, “Health inequities and social determinants of Aboriginal peoples’ health.” This document, funded by the National Collaborating Centre for Aboriginal Health has been used nationally. They divided the social determinants of health for Indigenous peoples living in Canada into three categories: *proximal*, *intermediate*, and *distal*. ISD is one of the *distal* determinants, which involve the historic, economic, and political contexts of all of the other determinants of health for Indigenous peoples living in Canada.

Several authors have stressed that ISD undergirds all of the other social determinants of health (Getty, 2013; Kirmayer, Tait, & Simpson, 2009; Liu, Aho, & Rata, 2014; Murphy, 2014a; Reading & Wien, 2009; Smith, 2012). Understanding the impact of colonization on the loss of self-determination is integral to understanding the effects of all determinants of health in Indigenous communities (Adelson, 2005; Coyhis & Simonelli, 2008; Gone, 2011; Portman & Garrett, 2006; Richard, 2010; Smith, 2012; Young, 1989; Yurkovich & Lattergrass, 2008). Indeed, as long ago as 1998, Chandler and Lalonde identified a significant inverse relationship between the levels of suicides among youth in Indigenous communities and the levels of self-determination of those communities.

The connection between *distal* determinants of health—for example ISD—and
relevatively decontextualized analysis of proximal (individual or family related) determinants of health is complex, contradictory, and not always clearly analyzed in research (Reading & Wien, 2009). This absence of clarity—moving between the distal principles of ISD and more psychological explanations for self-determination, for example self-determination theory, must be monitored carefully to ensure that its interpretations preserve the principles of ISD.

Sir Michael Marmot, working with the World Health Organization, has written about the global situation of Indigenous peoples. Meta-analytic and epidemiological research by Marmot and colleagues showed that inequities in the social and economic status among Indigenous communities were significantly correlated with decreased physical and mental health status (Marmot, 2004, 2016). In further epidemiological research, Marmot identified that heart, lung and kidney disease, diabetes, mental illness, and deaths by suicide, accidents, or violence were directly associated with autonomy—or perceived control (Lynch, Smith, Kaplan, & House, 2000; Marmot, 2004, 2005, 2016). As presented in Chapter 1, these conditions are the leading causes of mortality and morbidity among Indigenous peoples (Firestone et al., 2015; Holtz, 2010; Khan, 2008; Kildea et al., 2010; Smylie et al., 2010). Such research should only be interpreted as relevant to ISD if it is confirmed by Indigenous peoples to be relevant to their lived experience and linked to the goals of ISD. When we consider how colonization eliminated the autonomy of Indigenous peoples, and continues to do so through present policies and lack of recognition of ISD principles, we see how the absence of ISD continues to force Indigenous people into ill health.

As a cautionary note, as is the case with much of Western research, Marmot’s
research may be used in contradictory ways to suggest that Indigenous people generally have poorer mental and physical health than those of higher socio-economic status, due to their own efforts rather than their history of colonization. It is important to recognize that this decreased socio-economic status among Native people, has resulted from many losses imposed by the process of colonization. These include their loss of ISD, lands, resources, languages, and culture, leading to increased poverty and social exclusion for Indigenous peoples. It is problematic to reduce ISD to psychological self-determination through simplistic reference to social and economic status.

Marmot argues that people with higher perceived control over their lives tend to be physically and mentally healthier, while those with lower perceived control suffer negative health outcomes from living in chronic stress, resulting in detrimental behavioural health practices choices such as smoking, alcohol consumption, and inactivity (Marmot, 2000). The key words here are choice and perceived control over their lives. One must be careful with assumptions about choice as we are not all equally located in terms of choice. Having lived through the process of colonization, Indigenous people are not satisfied with having control over their lives mediated by the colonial state and other Canadians’ perceptions of their abilities. Indigenous peoples demand that ISD be honoured, so that they have not only the perception of control but also are able make decisions that are right for their people.

However, while some of Marmot’s work had been focused at a meta-analytic and epidemiological level on Indigenous peoples across the globe, his unit of analysis was geared to the individual. Rather than prioritizing the importance of culture as a primary unit of analysis for understanding individuals, psychological explanation basically evades
the question of how culture and loss of culture influences individual behavior. There remains a need to articulate the relevance of the meaning of self-determination on an individual level as this is determined by cultural influence. One possible and speculative approach to linking ISD to psychological theories of self-determination has been suggested by Ryan and Deci’s (2008) psychological theory of self-determination.

**Ryan and Deci’s Self-Determination Theory.** From a Eurocentric individualistic perspective on self-determination, Deci and Ryan (2008) identified a basic needs theory of self-determination. Because SDT has been clearly derived primarily from the knowledge and experience of Western scholars with Western populations, the imposition of this theory as a lens for cross-cultural understanding can be problematic and contrary to Indigenous Self-Determination. However, Dr. Michael Murphy, Canada Research Chair in Comparative Indigenous-State Relations, whose research focuses on the moral and legal foundations of ISD, uses Ryan and Deci’s theory of SDT to support and advocate for ISD to be fully recognized by Western governments and others (Murphy, 2014a, 2014b).

According to the theory, three basic psychological needs are identified: (a) competence (feeling that you are good at accomplishing something), (b) autonomy (freedom to make your own choice), and (c) relatedness (a sense of connectedness and belonging with those around us) (Belik, 2008; Deci & Ryan, 2008; Ryan, 2014).

Essentially, the theory posits that individuals are able to successfully make major changes in their lives when they have the autonomy to make their own choices, reinforced by the ability to be successful in achieving their goal, combined with having a sense of support and relatedness to others (Bell, 2010; Bontempi, 2006; Johnson, 2007; Ryan, Huta, &
Deci, 2008; Strickland, 1999; Williams et al., 2006). SDT purports that it is “an empirically derived theory of human development and wellbeing” (Murphy, 2014a, p. 37). This reference to human beings as undifferentiated decries the massive body of knowledge about the differences created by the ontological perspectives of different populations, especially those from a western or Eurocentric background versus those of Indigenous people (Smith, 2012). If these “universal” basic psychological needs can be re-interpreted through a non-Eurocentric lens of understanding, we would need to hear from Indigenous Peoples as to how this can be done. But in the spirit of being an advocate for ISD, it is possible to consider how the perceived universal psychological needs were missing from opportunities for self-determination among Indigenous Peoples after colonization.

Self-determination as described by Ryan and Deci (2008) has been anything but the experience of Indigenous people since colonization. According to SDT, individuals’ sense of competence is increased when their efforts lead to successful outcomes, including having their strengths and accomplishments acknowledged by others (Weinstein & Ryan, 2011). The processes and policies formed under colonial governments did not build autonomy, relatedness, or competency; it did exactly the opposite. In history, we see no acknowledgment of the strengths of Indigenous peoples or culture (i.e., competence), but rather a racist focus on their perceived inadequacies to the point of declaring them incompetent, and removing their individual and collective autonomy through annihilating Indigenous culture.

Prior to colonization, these basic psychological needs were met by Indigenous culture. There was little need to increase relatedness, for example, because Indigenous
culture modelled relatedness on every level: with each other (hunting, fishing, building and gathering were done collectively); with their environment and the Creator (rituals and ceremonies to the Creator existed around all activities); through the passing on of stories, and carrying out traditional hunting, fishing, gathering, and building as families and communities together; and through time spent together as a way of life, rather than spending time in isolation. Parents and grandparents taught their children and grandchildren, and leaders taught communities. This way of living not only maintained relatedness with each other, but also Indigenous peoples’ relatedness with the land.

Competence was taught and experienced as individuals learned skills necessary for living with a knowledge about their environment: from understanding how plants provided healing remedies, to constructing portable dwellings, developing proficient tools, protecting their families and communities, and providing food and clothing for each other through skilled hunting, fishing, and gathering (McMillan & Yellowhorn, 2004). The ability to observe the land, watch the seasons, and migrate to obtain seasonal foods, reinforces a strong level of competence. Based on their living off the land, Indigenous peoples were able to make decisions about where they lived, when they moved, and how to respond to both the availability of food and to threats within their environment; these all illustrated their autonomy.

By 1927, the 1867 Indian Act was revised to make it illegal for Indigenous peoples (Dickason & Calder, 2006) to practice their culture. The Act outlawed Indigenous peoples’ practices in the following ways: (a) to gather in groups (removal of relatedness), (b) to plan (removal of competency), (c) to protest (removal of autonomy), (d) to hire legal counsel in treaty negotiations (removal of autonomy and competence),
(e) to practice Indigenous spiritual rituals (removal of relatedness to God and to the land),
(f) to practice cultural ceremonies (removal of relatedness to each other), and (g) to
practice cultural activities (removal of competence). Parents were rendered completely
helpless through removal of their children to Indian Residential Schools (removal of
relatedness and competence), and traditional Indigenous governments were totally
disregarded and legally replaced by a Western type of competitive political process
(removal of autonomy and competency)—the elected band council system (Dickason &
Calder, 2006), which sets community members into a competition with one another
(removal of relatedness).

Here we see the gradual breakdown of self-determination to the point of
annihilation through policy development. In the above we see how the Indian Act
affected Indigenous peoples’ sense of competence and autonomy in every way: people
could no longer fulfil their roles, they could not hunt and fish as they did before, because
of confinement to reserves—thus they could not pass these skills on to their children, nor
could they feed their families adequately. They could not teach their children traditional
ways of knowing because the children were removed from their influences by being sent
to Indian Residential Schools. Being confined to reserves meant that Indigenous people
could not use their knowledge (competence) about the seasons and food sources because
they could not migrate to feed their families, and they suffered great hunger for some
seasons. This led to their abject poverty and powerlessness (decreasing their autonomy).
It is this intersection of losses that increased the removal of self-determination. As a
result, their feelings of competence, relatedness, and autonomy were decreased.

Studies based on SDT have demonstrated how when any one aspect of
competence, autonomy or relatedness is weak, mental health suffers (Ryan & Sapp, 2007; Ryan & Deci, 2011; Wichmann, 2011). We must then question: With colonization’s decimation of all three components, such as in the case of Indigenous peoples, what is the extent of the emotional damage? In spite of the actions of the Canadian government Indigenous people have held onto their culture, rebuilding and strengthening it in the face of oppression. It is a strong testimony that ISD represents a fundamental way of being that has contributed to their survival as nations.

Although the three basic need tenets of self-determination theory may appear to be valid constructs in terms of Eurocentric understanding, there are important contradictions in applying these constructs to Indigenous Peoples through a lens that is devoid of any understanding or analysis of the history of colonization of Indigenous Peoples. For example, it is deeply contradictory to ignore the centuries old distrust and betrayal that has occurred in the context of ongoing effects of colonization, by expecting that Indigenous people will welcome praise for their accomplishments by Western persons. According to SDT, when individuals are genuinely praised for their strengths and accomplishments, their self-esteem and self-confidence improve, their stress is lowered, and they develop a sense of competency (Weinstein & Ryan, 2011). However, unless non-Indigenous people are trusted allies, working with Indigenous partners, to address distal determinants of health, praising can be experienced as paternalistic. To further explore this risk, an exploration of the meanings of Indigenous autonomy, relatedness, and competence yields additional contrasts and insight.

**Indigenous autonomy.** Whether at the individual, family, or community level, the definition of autonomy among Indigenous people, is a matter that should be judged
and defined by Indigenous peoples. This includes a process of addressing incompatibilities contained in the theories of non-Indigenous researchers. In other words, the definitions of Indigenous peoples are primary and take precedent.

For Indigenous peoples, the tenet of autonomy as articulated by SDT, has had verbal, yet little practical support from colonizing states. Early uses of SDT have not been guided by the principles of ISD. As was stated earlier, if it were possible to tend to an ISD perspective on autonomy, this would emerge as an Indigenous definition, as has recently happened in the concept of related-autonomy (Roche, Haar, & Brougham, 2015).

Within the worldview or ontological perspective of Indigenous peoples, individuals are held accountable for their own actions and are expected to contribute to the whole (Dickason & Calder, 2006). There were approaches to disciplining individuals whose enactment of their own autonomy resulted in negative outcomes for the whole (Dickason & Calder). In other words, rather than the unfettered, Eurocentric perspective of autonomy, Indigenous peoples always placed the emphasis on the wellbeing of the family and community—related-autonomy.

When an Indigenous person is not allowed to make his/her own decisions, the message that is conveyed is the same colonizing approach as in the Indian Act—that Indigenous people are like children and have to be cared for, as if they are incapable of making wise choices for themselves. An Indigenous definition of related autonomy is important in that it recognizes everyone’s rights and abilities to make their own decisions, in relation to the wellbeing of their family and community. In other words, it is even more important for Indigenous peoples to be autonomous as they define this, because to
not allow this is a colonizing, racist action and attitude. In this sense, related-autonomy may perhaps be the most relevant among the three elements in the psychological theory of SDT.

**Indigenous relatedness.** Similarly, the psychological definition of relatedness may be understood as something that Indigenous People themselves have defined, and it may, within the context of ISD be understood as having similar elements to the experience of feeling accepted by and connected to those around us. Relatedness is a fundamental value of Indigenous peoples, who focus on community rather than the individual (Battiste, 1997; Bear, 2011; Dickason & Calder, 2006), and on the interconnecting relationship of all things (Henderson, 2011b). This interconnecting relationship is not easily understood by Eurocentric Canadians. While Indigenous people are focused on the collective and believe in the relatedness with seven generations, they also have a oneness with the land (Martin, 2012). Unless this is fully understood, even well-meaning attempts to support Indigenous peoples are misplaced. For example, Indigenous people believe that water is pure and has life-giving qualities, thus relatedness with the water is necessary for their well-being (Gkisedtanamoogk, personal communication, November 24, 2011). This relationship with water has led to Indigenous peoples ability to protect the water in stand-offs like that at Standing Rock, an example of autonomous actions (Press, 2017). Definitions of relatedness on an Indigenous level are much deeper than the Eurocentric psychological theory affords.

**Indigenous competence.** Likewise, in addition to its SDT definition, a term for competence more in keeping with Indigenous thinking is better stated as *related-competence* (Grande, 2008; Roche et al., 2015). In traditional Indigenous communities,
individuals were commonly expected to gather the knowledge and skills necessary to contribute to the community’s well-being, contributing to a personal sense of competence in relation to the collective well-being of others (Battiste, 2008; Bear, 2011; Dickason & Calder, 2006). In a Eurocentric view, leadership and competence are closely linked with the focus being on achieving an external, materialistic, or power-related goal (Roche et al., 2015), whereas leadership in an traditional Indigenous sense would be focussed on building and nurturing relationships through reciprocity with people and the environment; the goal being to keep the balance of all things within the universe (Roche et al., 2015; Spiller, Erakovic, Henare, & Pio, 2011). Roche et al. (2015) found that in New Zealand, Maori leaders do not focus solely on their own competence attributed to them through their leadership roles or position within their communities, but rather focus on the success of the relationships among those they lead. For example, one Maori leader explains in the context of leading a public forum:

It’s also about allowing them to have their say and be acceptable to think that their say might be right, more right than yours! ...now that is scary standing up like that being all smart and then being small so others can stand tall (laughing) …that still scares me, looking stupid…but I do it [be small] cause others need to come forward…need to develop…that is what Maori do, make sure others also get to stand tall. (Roche et al., 2015, p. 8)

This statement shows how the emphasis on relationships infuses Indigenous thinking, such that even personal competence is developed within this context (Roche et al., 2015).

Given the importance of contextualizing SDT within, and as dependent on ISD, it is very important to exercise great care in making claims about how autonomy, relatedness, and competence as psychological elements are relevant to Indigenous peoples. If empirical theory, derived from non-Indigenous populations, is used to make
claims that autonomy, relatedness and competence can productively support Indigenous individuals—it must be understood as largely speculative until it is demonstrated to be relevant. In the context of ISD, this speculative use of theory may actually be challenged in terms of its cultural congruence and safety. In the context of this report, unless claims from a psychological theory have been fully supported empirically among Indigenous peoples and are consistent with principles of ISD, the relevance of SDT research should be questioned. While SDT has been used in treatment approaches to locate motivational factors with Indigenous peoples (Bontempi, 2006; Wild, Yuan, Rush, & Urbanoski, 2016), it has not been established that this was done in a culturally congruent way: recognizing the fundamental prerequisite of ISD.

In short, although Ryan and Deci (2011) and (Ryan & Sapp, 2007) purport that SDT has been substantiated across a wide range of countries, such as China, Japan, Russia, Turkey, South Korea and the USA, unless this empirical testing conforms to the principles of ISD, and has emerged from an Indigenous perspective, it contradicts ISD: it commits the very error that ISD has challenged (Denzin & Lincoln, 2008; Smith, 2012). In recent months, it appears that there is a beginning body of empirical evidence that supports an ISD informed perspective on autonomy, relatedness, and competence in Indigenous communities (R. M. Ryan, personal communication, February 19, 2017).

**Empirical evidence of emerging perspectives on SDT in the context of ISD.**

Dr. Maree Roche, an Indigenous researcher (from the New Zealand Maori Ngati Raukawa tribe), and Dr. Jarrod Haar (who is of Ngati Maniapoto and Ngati Mahuta descent), have carried out a study along with Dr. David Brougham among 18 New Zealand Maori leaders. This research team began with identifying the values of Maori
people and examined how these Indigenous peoples’ work demands and wellbeing were connected. In considering measures of wellbeing, they chose to use SDT, a Western psychological theory that was said to address the basic psychological needs related to wellbeing. It is important to recognize that this choice was made by Indigenous researchers, not White scholars, connecting it to ISD on an elementary basis. The findings of this study, identified that the components of SDT, autonomy, competence, and relatedness were congruent with Maori values. “However, in contrast to SDT, autonomy and competence are developed within relationships” (Roche et al., 2015, p. 1). In this study, it was clear that the participants’ autonomy or ability to make choices was dependent on the influence of these choices on the wellbeing of the people with whom they worked. In this same way, their sense of competence depended on the success or competence of the Maori people whom they led. They found that, “based on an understanding of positive psychology but weaved, understood, and developed within indigenous culture, we can gain an understanding of Maori leaders’ positive psychological resources that aid in well-being” (Roche et al., 2015, pp. 11-12).

**SDT viewed through the lens of Indigenous Self-Determination and Two-Eyed Seeing.** Emerging work provides evidence of the relevance of self-determination theory through the lens of Indigenous Self-Determination (Craven et al., 2016; Roche et al., 2015). The juxtaposition of Indigenous and Western constructs for the development of knowledge has been found useful in working in the Western world while maintaining traditional points of view and practice among Indigenous peoples. This approach has been referred to as *two-eyed seeing*, introduced by Mi’kmaw Elder Albert Marshall in 2004 who wrote,
We often explain *Etuaptmumk*—Two-Eyed Seeing by saying it refers to learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing ... and learning to use both these eyes together, for the benefit of all. (Health, 2017, para. 3)

Like the work of Roche et al., another example of two-eyed seeing can be found in the work of Craven et al. (2016), where three Indigenous and four non-Indigenous authors have created a research approach called the *Reciprocal Research Partnership Model (RRPM) of Indigenous Thriving Futures*, utilizing the Western approach of Ryan and Deci’s theory in combination with Australian Indigenous worldviews and research methodologies. In this model, focused on understanding Indigenous thriving, the four values of responsibility, reciprocity, relationships and respect are defined in relation to research partnerships. It identifies four interrelated research programs which are all focused on a strength-based approach to research and are aimed to understand how Indigenous peoples can thrive and achieve their goals in the future. In this way, this research model draws together Indigenous values and worldviews with Western values and approaches to life in a strength-based research agenda, in order to understand how Indigenous people thrive, i.e., achieve a state of wellbeing.

**Summary**

The concept of Indigenous Self-Determination (ISD) has been reviewed. As well, the Western self-determination theory (SDT) by Ryan and Deci has been examined as a possible lens through which to support ISD, two-eyed seeing, and Indigenous wellbeing on the individual level.

In the next chapter, I will use the construct of ISD to explore the relevance of
contemporary “two-eyed” approaches to self-determination (SDT)—relating these to addiction treatment programs. The purpose of the next chapter is ultimately to consider the role of spirituality in various treatment approaches and how or why these agree with or conflict with the principles of ISD. In drawing a connection between the history of colonization and addiction (as has been suggested in previous chapters), it is important to consider whether various approaches to the treatment of addiction are well suited to reversing the long-term effects of colonization. There has been some suggestion, especially among non-Indigenous psychologists, that the psychological theory of self-determination (SDT) may be relevant to the treatment of addiction among Indigenous peoples. This suggestion warrants careful consideration. By placing the psychological theory of self-determination (SDT) within the wider international context of ISD it may be possible to consider whether this theory can be helpful as a treatment approach in this population—based on its ability to address the long-term effects of colonization.

In the next chapter, through the lens of Indigenous Self-Determination and adjustments in SDT, I will:

1. Examine the literature about the different spiritual approaches to treatment of addiction among Indigenous people; and

2. Appraise these treatment approaches to recovery regarding their integration of ISD and the components of self-determination theory (autonomy, competence, relatedness) as well as ISD.
Chapter 4: Spiritual Approaches to Addiction Through the Lenses of ISD and SDT as Adapted by Roche and Associates

Indigenous scholars define addiction as a crisis of the spirit (Firestone et al., 2015). A search of the following databases: Academic Search Premier, Bibliography of Native Americans, Dissertations and Thesis, PsycINFO, Medline, and ALTA, using the terms addiction treatment, recovery, spirituality, and traditional spirituality in combination with the terms First Nations, Aboriginal, Indigenous and Native American provided evidence that support this theory of addiction as a spiritual disease (Eshkibok, 2014). In this chapter, I will examine the spiritual approaches found in the literature that have been successful in facilitating recovery from addiction among Indigenous people:

1. Alcoholics Anonymous with various levels of traditional cultural adaptations,
2. Traditional Indigenous spirituality/religion (i.e. ‘culture as treatment’), and
3. Traditional Christian spirituality/religion.

Then I will critique these three broad approaches through the lens of: (a) ISD, a community level, and (b) the individual level, through the previously discussed adaptation of SDT.

I have chosen to begin with a review of the literature on Alcoholics Anonymous (AA) because to date, the AA 12-step program is the predominant approach to recovery from any type of addiction worldwide, including drug and alcohol addiction among Indigenous peoples (Coyhis & White, 2006; Dermatis & Galanter, 2016). AA is built on the belief that the cause of addiction is a spiritual void (Dermatis & Galanter). It focuses on sharing personal stories, victories and challenges with a group of peers, which is in
keeping with Indigenous traditional ways and has been proven to yield successful outcomes (Coyhis & Simonelli, 2008; Kelly, 2016). The AA program has been effectively modified and applied to a vast array of addictions to: substances (Narcotics Anonymous, Smokers Anonymous); behaviors (Codependents Anonymous, Spenders Anonymous, Child Abusers Anonymous); activities (Gamblers Anonymous, Debtors Anonymous, Workaholics Anonymous); and even attitudes and emotions (Rageaholics Anonymous, Emotions Anonymous). AA has engaged over 2.1 million members and a total of more than 100,000 groups worldwide (Pagano et al., 2013). It has also been modified by many Indigenous peoples (Galanter, Dermatis, Post, & Sampson, 2013), a point I return to later in this chapter.

Alcoholics Anonymous

Background and program design. The Alcoholics Anonymous organization was formed in 1935 by Bill W., a New York stockbroker, after he had failed to achieve sobriety on his own. He found refuge in a spiritually-focused organization—the evangelical Oxford Group—who counselled him to: (a) look within himself, (b) ask forgiveness from God, (c) face personal defects, (d) seek restitution for harm to others, and (e) share his experiences with a group of similarly-challenged individuals (Dermatis & Galanter, 2016). This led to a spiritual awakening (a change in thinking that recognized the need for the connection to a Higher Power).

Bill W. designed the AA program to include the following components: (a) the importance of anonymity in the meetings, (b) the expectation that a person addicted to alcohol would be expected to acknowledge his/her identity as an “alcoholic” to the group
at the AA meetings, and (c) the access to a sponsor; an individual who has been successful in remaining sober for a period of time and has stabilized his/her life (aa.org, 2017). He developed the 12 Steps of Alcoholics Anonymous (AA) to help others achieve this same spiritual awakening.

The 12 steps of Alcoholics Anonymous state:

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs (aa.org, 2017).

Essentially, Steps 1 to 3 focus on the process of becoming humble through speaking of, and acknowledging one’s addiction, surrendering to a Higher Power, and admitting one’s lack of ability to heal oneself. Steps 4 to 9 focus on asking a Higher Power to remove one’s shortcomings and making amends for the harm one’s addiction has produced. Finally, Steps 10 to 12 focus on continued self-correction through the use of prayer, meditation and helping others (Smith & Wilson, 2015).
Bill W. also developed methods of operation known as the 12 Traditions to act as guidelines for operating each local chapter. These 12 Traditions state:

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose, there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA, as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities (aa.org, 2017; Anonymous, 2001).

The 12 Traditions promote anonymity and equal status of all members. This is to prevent individual egoism (Umeda, 2006). Hierarchies, experts, or exclusive leadership are forbidden in AA. The anonymity of its attendees enables individuals to be more comfortable acknowledging that she is an alcoholic and will always remain an alcoholic, even after many years of sobriety.

**The AA formula.** After reviewing research on Alcoholics Anonymous, it became obvious that its strength is found not in one isolated component but in the
combination of many. This might explain why some researchers (Galanter, Dermatis, & Sampson, 2014; Kelly, 2016; Tusa & Burgholzer, 2013) point to the value of spirituality (in its full definition) as AA’s vital tenet, including meaning making, which is finding purpose in our existence. Kelly (2016) contended that the supportive nature of group sharing and accountability undergird its success. There is a likelihood that spirituality may interact with factors like motivation, social support, and elements of self-determination in supporting an individual’s growth in overcoming addiction (Kelly). Without intending to diminish the role of spirituality in any way, I would propose that AA is greater than the sum of its parts, and simply put, it is built on a formula that, without each of its elements, would not be as effective.

“Several state-of-the-art analyses” (Kelly, 2016, p. 3) have tied improved outcomes to the AA formula. This formula seems to contain several synergistic elements: honor and humility towards a Creator, social connectivity, appreciating life, and serving others. The importance of both social support and spirituality were especially pronounced among those with greater levels of addiction (Kelly). The level of attention to spirituality appears to be the determining factor in success (Dermatis & Galanter, 2016; Ranes, Johnson, Nelson, & Slaymaker, 2017).

**The role of spirituality in AA.** One of the primary elements of AA is its reference to a Higher Power, referred to as ‘God’ in Step 2. Within the AA framework, God is referred to as any Higher Power, or the God of one’s understanding, encompassing all belief systems. Alcoholics Anonymous World Services purports that substance abuse is a symptom of a spiritual disease, in which one displaces the role of a Higher Power in one’s life (Smith & Wilson, 2015). Thus for advocates of AA, “to play
“God” (Anonymous, 2001, p. 62) in your own life results in an arrogant reliance on self, rather than on submission to God. For the founder, Bill W., and advocates of AA, the answer to addiction was in a Christian based spiritual awakening; realizing that “every day is a day when we must carry the vision of God’s will into all of our activities. How can I best serve Thee—Thy will (not mine) be done” (Anonymous, 2001, p. 85).

The empirical evidence on the efficacy of the spiritual mechanism of behaviour change has been challenged because the nature of spirituality is so multifaceted (Blasdell, 2015); thus there is no way to do a truly controlled study isolating the component of spirituality (Ranes et al., 2017; Vaillant, 2005). Further, the AA program has many different variables that are happening simultaneously, including the following: (a) providing and receiving social support, (b) learning more about the addiction process and assessing his/her situation in a more constructive manner, (c) developing one’s spirituality, and (d) finding a purpose in life. Kelly (2016) examined results from 25 years of mechanisms of behaviour change (processes that produce change) in Alcoholics Anonymous. While Kelly (2016) argued that the empirically supported mechanisms of AA were found in the social, cognitive, and affective elements, in referring to the social aspects, he acknowledged that spirituality “may be” a mobilizer, catalyst or the spiritual scaffold, “the binding securing many pages of [AA’s] multifaceted milieu” (p. 5). In other words, spirituality is the vital change agent, undergirding the sobriety of individuals engaged in the AA program.

In AA, all forms of spirituality are respected (Dermatis & Galanter, 2016), such as Indigenous spirituality, as acknowledged in Steps 3 and 11. Several scholars argue that all individuals have spirituality because it is the essence of being human (Baldacchino et
al., 2012; Cohen et al., 2012; Kelly, 2016; Miller & Saunders, 2011), and has to do with relationships between people (Kelly, 2016). Studies show that AA works for both atheists and agnostics (Dermatis & Galanter, 2016; Kelly, 2016; Kurtz & White, 2015) for several reasons, highlighting the common aspects of spirituality shared by people with or without the role of religion (Kelly, 2016; Kurtz & White, 2015; Ranes et al., 2017).

**The interplay of spirituality and attendance at AA.** While the spiritual component of AA is vital, attendance at meetings is also important. There is compelling evidence that long-term abstinence has been associated with attendance at AA meetings, where the social support of peers, and accessing personal sponsors is available (Dermatis & Galanter, 2016; Kaskutas, Turk, Bond, & Weisner, 2003; Kelly, 2016; Tonigan, Rynes, & McCrady, 2013; Vaillant, 2005, 2012, 2014; Young, 2013). According to Kelly (2016), the interplay between spirituality and attendance at AA meetings became more important with the severity of the addiction. The Grant Study of 268 Harvard college men and 456 socially disadvantaged Boston inner-city men, who were followed for more than 60 years, found that about half the men in both groups abused alcohol until death, or were still doing so (Vaillant, 2003, 2014). Interestingly,

There were few clear premorbid differences that distinguished the men who achieved stable abstinence from those who remained chronically alcoholic. Poor education, low IQ and multi-problem family membership did not identify the men who would fail to achieve stable abstinence. Nor did an abundance of risk factors for alcoholism, like alcoholic heredity, hyperactivity in youth and sociopathic behaviour predict chronicity. Nevertheless, it was noteworthy that the men in the good outcome groups reported attending about 20 times as many AA meetings as the men in the poor outcome groups (Valliant, 2005, p. 433; 2014).

The proponents of AA (Galanter et al., 2014) would certainly advocate that is was the spiritual aspect, in particular, the spiritual awakening and growth that their attendance
produced. For several years, researchers have been trying to tease out the different components that are part of spirituality in AA. For instance, McKellar, Stewart, and Humphreys (2003) did a prospective two-year study of 2,319 alcohol-dependent veterans. At the two-year follow-up, they discovered that attendance at AA was found to predict change. They questioned if the precursor of motivation for recovery, rather than spirituality, could be at play here. However, they found that the effect was independent of the participant’s previously measured motivation for change, concluding that spirituality was the key mechanism that produced change.

Another relevant and seminal work, Project MATCH, was a landmark eight-year study that compared three different approaches to treatment for alcohol addiction: cognitive, motivational, and spiritual. The spiritual program was an independent design based on 12-step AA philosophy, and participants were encouraged to also attend AA meetings. The research found that the 12-step program was just as effective as the evidence-based cognitive and motivational approaches (Group, 1998). In the years that followed, secondary analysis studies showed that scores on spirituality were predictive of a positive outcome at 10 years (Tonigan, 2003) and beyond (Vaillant, 2014). These findings give credence to the argument that spiritual approaches are evidence-based.

Attending AA has been associated with increases in spiritual practices, and significantly associated with better subsequent alcohol outcomes for both outpatient and hospitalized patient samples (Kelly et al., 2011). AA involvement (practicing the philosophies in daily life, such as forgiving) was found to be a stronger predictor of drinking outcomes than merely AA attendance (Krentzman, Cranford, & Robinson, 2013). Indeed, AA involvement was found to predict increases in daily spiritual
experiences, religious practices, and the ability to forgive others (Krentzman et al., 2013).

In order, to objectively identify the utility of 12 step programs in residential substance abuse programs, Ranes et al. (2017) conducted a multiple regression analysis examining the role of spirituality in treatment outcomes following a residential 12 step program. The authors concluded that spirituality is a dynamic construct that is expressly connected with a person’s emotional responses and meaning in life. This underscores the vital role spirituality plays in the program, yet it does not appear to act alone:

Although there was no support for a direct association between spirituality and abstinence following treatment, AA participation appeared to play a mediating role between the two variables, which suggests that increased spirituality can have an indirect positive effect on abstinence through its association with increased AA participation. (p. 16)

This in part is confirmation that the AA formula is multi-faceted, with spirituality playing a role that is a common link among many of its parts.

In summary, believing in the spirit of God, or the Creator, or other Greater Power, staying connected to this Greater Power, and ministering as a sponsor are factors that predict positive outcomes, such as abstinence from alcohol use (Dermatis & Galanter, 2016). There is little question that AA works for many because it encompasses several aspects of a person’s life in one demarcated approach to overcoming addiction. In light of this, AA will now be examined through the lens of ISD and subsequently through an adapted version of the psychological theory of self-determination in light of the wisdom of Indigenous knowledge.

**Congruence of AA with ISD and Indigenous worldviews and values.** The long-lasting nature of the Alcoholics Anonymous program and its various applications to other addictions has been understood as a measure of its success in helping those battling
addictions of various kinds. In many Indigenous communities, AA was begun and led by Indigenous people who have themselves benefitted from AA (Coyhis, 2006). The values of the AA leadership are those of humility and respect for those who choose to attend. Congruent with Indigenous worldviews, the AA meetings are held in an area on reserve that is private and not supported financially or by contributions of work by the professional programs and staff, such as the Health Center. In this way, it is evident that AA on reserve has the potential to both meet the traditions of AA and of Indigenous worldviews and that it may contribute to Indigenous Self-Determination.

Each tribe of Indigenous peoples has its own unique language and customs developed in relation to its land base, leading to autonomy within the community. This community level autonomy is similar to the autonomy of AA groups, which are expected to respect the independence of other AA groups and the organization as a whole. Likewise, some of the priorities, strengths, and values associated with Indigenous Self-Determination (ISD) are congruent with AA’s 12 Traditions. The overall thrust of the AA Traditions is the safety, unity, and wellbeing of the group, or community as established in Tradition 1: “Our common welfare should come first; personal recovery depends upon AA unity” (aa.org, 2017; Anonymous, 2001). Spiritually, the AA Traditions and steps focus on the recognition of a Higher Power, and recognizing this spiritual entity in all aspects of life as the key to recovery. Traditional Indigenous spirituality has always recognized that respect, humility, and acknowledgement of the Creator is essential to all aspects of health.

Autonomy is valued by the traditions of both Indigenous peoples and AA. Indigenous traditional ways of individual autonomy, with individuals held responsible for
the effect of their choices on others within the social determinants of Indigenous Self-Determination are congruent with the traditions of AA. This is evident in Tradition 4: “Each group should be autonomous except in matters affecting other groups of AA as a whole” (aa.org, 2017; Anonymous, 2001).

**Congruence of AA with SDT in the light of Indigenous worldviews and values.** *Autonomy, relatedness, and competence,* the three core elements of SDT (Ryan, Curren, & Deci, 2013), are integral parts of the AA program. For instance, in AA, *autonomy* is reinforced in that the individual alone is the expert in his/her recovery, and is responsible for his/her choice beginning with the decision to attend AA each time. *Relatedness* is evident in participants’ attendance at and participation in group meetings. This tenet is further reinforced by the anonymity of members, decreasing the barriers between social classes, and focusing on a collective purpose (to stop drinking). Additionally, AA encourages relatedness between individuals through the use of mentors known as “sponsors.” Relatedness also extends to one’s sense of connection with a Greater Power, not only in meetings, but also in daily living. According to AA, being sober means to be at peace with God, oneself, and others (aa.org, 2017; Smith & Wilson, 2015). Peace in relationships is viewed by many as the goal of relatedness. This goal is very much in keeping with traditional Indigenous relations (Cajete, 2011), which would expand the concept of the ultimate goal of relatedness beyond a linear relationship with God/Great Spirit and others, to include all of creation (animate and inanimate objects) and the interconnectivity and interdependence of all things. Lastly, *competence* is built through achieving sobriety, becoming a sponsor, and leading meetings.
Incongruence of AA with ISD and Indigenous worldviews and values. One must be constantly aware of the individualistic nature of Eurocentric thinking, which can unconsciously contribute to continued colonization. Privileging this Eurocentric perspective by clinging to the original format of AA may prevent Indigenous participants from fully benefitting because it does not recognize the validity of Indigenous perspectives, the source of their addictions, or their ability to decide for themselves what is in their best interests, the foundation of Indigenous self-determination (Castellano, 2014). This loss of Indigenous autonomy—or right to express oneself through cultural thinking and customs—has been associated with greater stress and the use of inadequate coping mechanisms that have been shown to lead to a loss of health and an increase in addictive behaviours (Firestone et al., 2015; Greenfield & Venner, 2012; Marmot, 2004, 2016; Owen, 2014). Indigenous traditions can bring much healing without the help of Eurocentric programs such as AA (Gone & Calf Looking, 2011). Nevertheless, many Indigenous communities have adapted the AA program to reflect Indigenous thinking (Coyhis & White, 2006; Eshkibok, 2014). Indigenous people have defined Indigenous Self-Determination for themselves and applied two-eyed seeing, to those features within AA that have been helpful to them, in ways that will be reviewed next.

Incongruence of AA with SDT in the light of Indigenous worldviews and values. While AA exemplifies many of the key tenets of SDT, there are several disparities. Although AA points to one’s fundamental weakness and powerlessness to change, SDT underscores the value of discovering competencies, reinforcing one’s inner strengths, and therefore contending that one possesses all one needs to overcome challenges successfully (Ryan et al., 2013). While AA focuses on the individual’s
willingness to give up autonomy to a higher power, SDT is focused on the individual’s ability to be autonomous (Wilson, 2015). SDT does not incorporate spirituality in the way that AA does; SDT relatedness is directed towards people rather than towards a Greater Power and spiritual connections between all things. This would also be contrary to the world view of Indigenous people where spirituality is central to health and wellbeing (d'Abbs & Chenhall, 2013; Marsh et al., 2015; Roche et al., 2015).

**Adaptations of the AA movement to Indigenous populations.** Some Native scholars, such as Eshkibok (2014), argued that the effectiveness of AA for Native people is limited by its origin among White colonial Christian elite, whose beliefs and rules for living tended to be “black and white” in many ways. Spicer’s (2001) study quoted one Native American articulating this incongruence:

… Most of the treatment programs, they’re geared more towards White people. Because White people are used to being programmed, like getting up, going to school at a certain time, you’ve got to say please, thank you, and all this and that. Indian people aren’t like that. (p. 234)

This quote articulates the importance of treatment approaches being respectful of Indigenous ways such as Indigenous perceptions of time (Duran & Duran, 2011). Some Indigenous scholars have contended that the AA 12 step program “one size fits all” (Walle, 2008, p. 3) compounds an Indigenous participant’s feelings of worthlessness, failure, and helplessness, all of which have been produced by the colonial process (Eshkibok, 2014). As well, the AA program expects that participants will acknowledge their status as an ‘alcoholic’, even after being sober for many years (Anonymous, 2001). This has been interpreted by this group of Indigenous scholars and leaders to affirm that AA reflects a Eurocentric worldview of the medical disease model in that a person is
placed into a classification or label tied to the addiction he or she is battling; that his or
her identity is that of the addiction.

In contrast to the critique of Indigenous scholars, such as Eshkibok and Spicer, Cherokee scholar and medicine teacher, Dr. Michael Tlanusta Garrett is a university professor and an active certified counsellor. His scholarship combines Western and Indigenous theory into pragmatic use through everyday clinical practice. He expounded that the interrelatedness of all things is a delicate balance. When this balance is interrupted, he argues, addiction and other problems may occur. As well, addiction leads to imbalance in the components of health, such as physical, emotional, social and spiritual wellbeing. Garrett & Carroll (2000) wrote the following: “To enter the cycle of substance dependence is to step away from the Sacred Circle and to bring destructive energy to the Circle, to oneself, one’s family/client, and all one’s relations by not living in a Good Medicine way” (Garrett & Carroll, 2000, p. 381).

Some sacred teachings and perceptions are shared by most Indigenous peoples. One common belief, across different Indigenous peoples, is the belief that all life is interconnected (Garrett & Carroll, 2000; Owen, 2014) in the Circle of Life, as described earlier in this report. In other words, through the Indigenous concept of the relatedness of all things, the cycle of substance abuse imbalances the lives of individuals, families and communities.

Garrett and other Indigenous authors teach that the practices of AA can be compatible with the spiritual values of Native Americans (Coyhis & Simonelli, 2008; Jilek-Aall, 1981; White Bison, 2016). They contend that when AA is not perceived to be appropriate for Native people, it is due to misconceptions about underlying philosophies.
Garrett and Carroll (2000) note that “twelve-step programs do not define any particular way as being the best path to a spiritual life” (p. 384). They defended each of the 12 steps, noting that only Steps 6 and 7 (asking God to remove character defects and shortcomings) may be incompatible with some native traditional spiritual principles, as they involve asking the Creator to do something. Some traditionalists would view asking the Creator for favors as arrogant and disrespectful. Thus, there has been a movement within Native communities, especially in the American Native communities, to make the AA program more congruent with Indigenous ways of knowing and worldviews; an example of supporting the process of political and cultural Indigenous Self-Determination. The following will describe the adaptations of the AA program by different American Indian and Indigenous communities.

It is important to remember that there are many cultural differences and languages between different tribes of Indigenous people, so that one community’s approach to adapting the AA program may not be applicable to another. As early as 1981, Jilek-Aall described how the Salish Indigenous peoples of British Columbia had successfully modified Alcoholics Anonymous by disregarding one of the basic tenets of AA—anonymity—by using full names, and by including nondrinking family and community. In 1993, Maracle noted that the AA program had been successfully adapted in most Indigenous treatment centers across Canada.

However, later authors began to differ. Abbott (1998) noted that Hopi and Alaska Natives had little use for AA, asserting that the confession-like disclosure of personal problems, religious emphasis, and exclusion of non-alcoholics was not in keeping with traditional ways of being (Abbott, Prussing, & Gone, 2011). As well, Christian ideology,
found in the AA principles of powerlessness and dependence on God, and customs, such as formal procedures and limited meeting times, were deemed incongruent with Indigenous practices (Eshkibok, 2014; Gone & Calf Looking, 2015; Stubben, 1997).

Eshkibok (2014) rewrote the 12 steps of AA with other Indigenous traditionalists to create Eshkibok’s 12-step program. For example, Step 1 in Eshkibok’s program states, “We admit/acknowledge we are out of control over our addiction, and have the power to take charge of our lives” (Eshkibok, 2014, p. 21), in contrast to AA’s Step 1: “We admitted we were powerless over alcohol—that our lives had become unmanageable” (aa.org, 2017; Anonymous, 2001). Eshkibok’s Step 12 states: “Because of these steps, we grow in awareness that we are sacred beings, interrelated with all life, and we contribute to restoring peace and balance to the world” (Eshkibok, 2014, p. 22). This is contrasted to AA’s Step 12: “Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs” (aa.org; Anonymous).

This movement is known as the Indianization of Alcoholics Anonymous (White Bison, 2016). Perhaps one of the best-known leaders of this movement is Don Coyhis of the Mohican Nation. He is credited with further developing the 12 steps of AA through the medicine wheel and many other culturally specific healing programs, the most notable of which is the Wellbriety Healing Movement (Coyhis & Simonelli, 2008). These adaptations are presented in a book entitled The Red Road to Wellbriety: In the Native American Way, sometimes called the Indian Big Book, authored by the White Bison Organization that he founded in 1988 (White Bison, 2002). Despite the underlying Christian principles, Coyhis says:
Time and again our Elders have said that the 12 Steps of AA are just the same as the principles that our ancestors lived by, with only one change. When we place the 12 Steps in a circle then they come into alignment with the circle teachings that we know from many of our tribal ways. When we think of them in a circle and use them a little differently, then the words will be more familiar to us. (White Bison, 2002, p. 1934)

Unlike Eshkibok, Coyhis and Elders identified a congruency between AA philosophies and Indigenous thinking. The difference is that Indigenous thinking presents these steps and traditions in a more holistic and integrated manner.

The Wellbriety Movement, which is also referred to as the Sacred Path and the Red Road, grew from the initiatives of the Passamaquoddy people (White Bison, 2002). The Passamaquoddy people, who belong to the same Abenaki Confederacy as do the Maliseet and Mi’kmaq people (McMillan & Yellowhorn, 2004), applied traditional Indigenous wisdom and ways to the AA program. Through the formation of local gatherings called Firestarter groups, the movement has spread throughout all of the United States, and there are also groups in Alberta and British Columbia (2016). The term wellbriety is a combination of the words wellness and sobriety. It implies a deeper level of overall wellbeing, one that goes beyond simply sobriety or absence of addiction, and can produce healing from intergenerational trauma (Coyhis & Simonelli, 2008; White Bison, 2016). The program essentially superimposes the 12 Steps of Alcoholics Anonymous with traditional teachings, such as the medicine wheel. From the earliest work Simonelli (1993) teaches that,

The medicine wheel is a symbol of the four directions and the life cycle of a human being. It expresses the holism, interconnectedness and circularity of all life, identifying certain qualities of growth and change with each of the four directions, and certain “essences” of life with the center. (p. 42)

The process of recovery from addiction is represented by the combination of east, south,
west and north. Coyhis and Simonelli (2008) explain that, utilizing the medicine wheel, AA Steps 1 to 3, which involve honesty, hope, and faith, are placed in the East; Steps 4 to 6—courage, integrity and willingness—are in the South; Steps 7 to 9—humility, forgiveness, and justice, in the West; and Steps 10 to 12, which involve perseverance, spiritual awareness, and service, are found in the North (Coyhis & Simonelli, 2008; White Bison, 2016). In the circumference of the Medicine Wheel, the East represents the life stages of childhood, the South that of adolescence, the West is adulthood, and finally the North represents the life stage of old age (Marsh et al., 2015; Owen, 2014; Prussing & Gone, 2011). The treatment goal is to achieve a balance between the quadrants, since addictions and postcolonial distress reveal a life out of equilibrium (Marsh et al., 2015; Prussing & Gone, 2011).

There is a long history, or series of movements where Indigenous people responded to problems of addiction by utilizing wisdom from traditional knowledge (Coyhis & Simonelli, 2008; Wesley-Esquimaux & Snowball, 2010). Coyhis and White (2006) recorded these movements as: The Handsome Lake Movement of 1799, the Indian Prophet Movements of 1805 to the 1830’s, the Indian Shaker Church of 1882; the present day Native American Church, the “Indianization of Alcoholics Anonymous,” the Red Road, and the Native American Wellbriety movement. In each of these movements Indigenous people did as their ancestors had always done. They integrated the new knowledge they were receiving from their environment, in this case about the twelve steps of the AA program, with their traditional wisdom to make it their own—another example of two-eyed seeing. Indigenous people were living out the principles of the psychological self-determination theory the best they could under colonial rule. They
were coming to their own conclusions, experiencing autonomy; by integrating their findings and experiencing levels of success, they were rewarded with a sense of competence; by acting on the community level to put these various approaches in place, Indigenous peoples maintained relatedness as collectives.

In keeping with the spiritual thrust found in AA, much of the literature showed that culturally relevant religious practices such as the implementation of the medicine wheel were powerful elements in the role of spirituality in recovery (Bezdek & Spicer, 2006; Flannelly, Weaver, Smith, & Oppenheimer, 2003; Gone, 2011; Gone & Calf Looking, 2015; Moghaddam & Momper, 2011; Nebelkopf & Wright, 2011; Tousignant & Sioui, 2009). The ability of Indigenous scholars and practitioners to adapt the Western AA program to incorporate Indigenous ways of being is an example of the work toward achieving ISD.

**Relationship between the Indigenous adaptations of AA and SDT.** The first word in self-determination theory is *self*, which focuses primarily on the individual versus the Indigenous focus on the broader, community perspective, with individuals being responsible to contribute to the whole (Bear, 2011). In this way, it may be out of step with many of the world views foundational to ISD. On the other hand, the 12 step program, as adapted to Indigenous ways of knowing such as in the Sacred Path, also celebrates the following individual accomplishments: (a) *competence* in the accomplishments achieved in overcoming addictions; (b) *autonomy* in choosing to participate in the program, and (c) *relatedness* in recognizing the importance of this participation for the family and community as a whole. For example, in some Indigenous communities the group meetings are adapted to use full names and include other family
and community members (Coyhis & Simonelli, 2008; Eshkibok, 2014).

The reorientation of the AA program to become Indigenous in framework is a valuable demonstration of two-eyed seeing, explained earlier in this report. Indigenous peoples have been able to implement methods of overcoming addiction that have been useful from a Eurocentric lens, but have added their own cultural perspectives, practices, and spirituality. Rather than ignoring successful approaches to overcoming addiction simply because they are Eurocentric—through two-eyed seeing, the best of Western and Indigenous ways has been combined (Marsh et al, 2015). However, success in overcoming addiction is not dependent on a Western program, particularly for Indigenous peoples. Indigenous culture has included many traditions that predate colonization—traditions that bring healing without any outside influence.

**Traditional Culture as Treatment**

While AA is a clearly defined program, and the “Indianization of AA” or the Wellbriety Movement is similarly recognizable as a treatment for addiction, some Indigenous peoples have found that the pain that leads to addiction is better addressed by an immersion in the healing practices of traditional Indigenous spirituality (Gone & Calf Looking, 2011). These traditional approaches have yielded recovery and enhanced spiritual health for some Indigenous peoples in a manner that is consistent with ISD.

**Enculturation.** There is a consensus between contemporary Indigenous authorities and scholars that the return to traditional ways (*enculturation*) is essential to healing, and has been referred to as the “‘Culture is our treatment Hypothesis’” (Gone, 2011, p. 291). Cole (2008) concurs, stating, “many Native American substance abuse
counselors believe that the incorporation of cultural and spiritual values into treatment programs is the only lasting solution to the substance abuse problems” (p. 37).

However, little empirical evidence of the efficacy for “culture as treatment” exists because empiricist approaches to evaluation are typically not congruent with Indigenous ways of knowing, and there are no culturally sensitive, well-validated empirical instruments available (Schellenberg, 2015). Thus, most of the literature is based on qualitative observational studies, or from first-hand experience from working with Indigenous peoples. Two empirical studies investigated the therapeutic effectiveness of participation in the sweat lodge ceremony on the mental, physical, emotional, and spiritual health of Indigenous individuals. Schiff and Moore (2006) in Canada found a direct relationship between participation in the sweat lodge and the participants’ wellbeing in all four domains. Schellenberg (2015), at a residential substance abuse treatment center in San Francisco, replicated the Schiff and Moore (2006) study. She found an increase in participants’ emotional and spiritual wellbeing following the Healing the Spirit (Sweat Lodge) Ceremony.

Perhaps the ultimate application of culture as treatment has recently taken place in Browning, Montana, at the Crystal Creek Lodge a culture immersion treatment camp. In this study, four Indigenous men from a residential substance abuse treatment program lived in a cultural immersion setting, i.e., lived off the land, according to traditional ways of hunting, fishing, and gathering in the manner of pre-colonization. “Given a variety of logistical and methodological constraints, the pilot offering of the culture camp primarily served as a demonstration of ‘proof of concept’ for this alternative indigenous intervention” (Gone & Calf Looking, 2015, p. 83). Although in this small number of
participants it was not possible to find empirically measured evidence of efficacy, Gone
and Calf Looking note that:

It would be difficult to overestimate the sacred and sociopolitical significance of
turning to and relying on indigenous traditional principles and practices as a
primary source of therapeutic recovery. In the context of a bitter postcolonial
legacy, this home-grown iterative synchronized efforts to assist program clients
with the broader project to advance community revitalization and self-
determination. (p. 87)

Earlier, Gone and Calf Looking (2011) investigated the cultural, therapeutic
activities behind a nationally accredited Indigenous controlled substance abuse treatment
center in a northern Manitoba Indigenous reserve, and found that cultural activities
provided a supportive asset in recovery. This treatment program was built on universally
acknowledged teachings of the medicine wheel and the Seven Sacred Values (the
Grandfather Teachings), which are Courage, Honesty, Humility, Respect, Truth, Love,
and Wisdom (Bouchard, Martin, Jones, & Jones, 2011). According to traditional spiritual
Indigenous teachings, every individual must embrace and develop these principles to live
in peace and harmony with the cosmos (Bouchard et al., 2011; Wesley-Esquimaux &
Snowball, 2010). In a similar vein to the Wellbriety Movement in the United States,
Wesley-Esquimaux and Snowball (2010) articulated a Wise Practices healing model in
Canada. It is based on the Seven Sacred Values that goes beyond the treatment of
addiction, providing a foundation for total wellness.

Other studies also supported the importance of traditional spirituality and culture
in the prevention and treatment of addiction. When Western substance-abuse programs
were modified to include traditional healing elements (such as occurs in the Wellbriety or
Red Road programs), decreased substance use was evident immediately after the program
was completed, and continued to be significant six months later (Moran & Bussey, 2007). Two factors have been credited for this success. These include:

1. Inclusion of Indigenous staff provided role models and a level of comfort, especially if these staff were former substance abusers (Legha & Novins, 2012; Peterson, Berkowitz, Cart, & Brindis, 2002).

2. Culturally specific integrations, such as classes on culture, traditional healing, and engaging in ceremonies, like talking circles, smudging, sweat lodge ceremonies, praying and visiting with spiritual leaders were found to be beneficial (Leghan & Novins, 2012).

**Cultural and spiritual practices.** The *talking circle* is a ceremony in which participants sit in a circle to denote egalitarianism and enhance communication between the members of the group. Customarily, a spiritually meaningful object, such as an eagle’s feather or shell, is passed to the person whose turn it is to speak, symbolizing that they may talk without interruption. The meetings start and end with smudging, prayer, or both (Coyhis & Simonelli, 2008; Moghaddam & Momper, 2011).

*Smudging* is a purification practice that involves sacred herbs and plants that are burned so the smoke may provide a spiritual cleansing to the participants. Among other plants and herbs, tobacco, sage, sweet grass, and cedar are commonly used (Coyhis & Simonelli, 2008; Moghaddam & Momper, 2011). These substances are recognized as medicines. For example, sweet grass, and tobacco are used as a relaxant; sage and cedar have antibacterial/antibiotic properties (Ody, 2017). Smudging is used at the beginning of all ceremonies to purify the mind and body prior to prayer (Gundy, 2010).

From a Native perspective, the main purpose of such healing ceremonies is to...
“keep oneself in good relations.” This can mean honoring or healing a relation or connection with oneself, others (relationships; i.e., family, friends, community), the natural environment, or the spirit world. (Garrett et al., 2011, p. 318)

This quote highlights the Indigenous worldview of the role of spirituality in maintaining the delicate balance of the interconnectedness of all things.

A sweat lodge ceremony involves prayers, drumming, and offerings towards the spirits of the ancestors. This is a traditional, sacred ceremony with deep meaning, led by an Elder who is a sweat lodge keeper who oversees the spiritual and physical wellbeing of those present (Getty, 2013). The sweat lodge ceremony can have a direct benefit on one’s mental, physical, and spiritual health. Dr. Tetyana Rogalska, a Harvard Research Fellow and physician at The Ottawa Hospital, found that,

Far from opposing the principles that guide modern clinical practice, the sweat lodge healing ceremony was a testament to the spiritual, emotional and mental dimensions of health that complemented the medical treatments provided in the neighbouring hospital and clinics. It held the potential for a remarkable partnership in healing. (Rogalska, 2016, p. 680)

The sweat lodge is created by tying arched willow poles together to form a small dome, which is tightly covered by blankets or animal skins to prevent light from entering (Rogalska, 2016; Schellenberg, 2015). There is a circle in the middle of the lodge into which the red-hot rocks are placed and water is sprayed on the rocks to provide a hot steam throughout the sweat lodge. The Sweat Lodge Keeper introduces and closes four rounds of prayer, focused on women, those who are ill, the community and world, and finally, the participants in the Sweat (Garrett et al., 2011). This process causes participants to sweat (diaphoresis), which releases toxins from the body (Tjosvold, 2016). The entrance is opened briefly to allow for cooling at the end of each sequence (Getty, 2013). This experience provides not only physical cleansing, but more importantly,
spiritual cleansing and restoration in one’s relationship to oneself, family, others, and the Creator (Schellenberg, 2015).

**Indigenous cultural practices and alcohol cessation.** According to Stubben (1997), Indigenous people who identified both with traditional and mainstream culture were the least at risk for substance abuse, and those who were marginal to both had the highest risk. In contrast to this, Herman-Stahl, Spencer, and Duncan’s (2003) quantitative analysis (N= 2449 on-reserve American Indians) compared multiple culturally relevant indicators with numerous measures of alcohol misuse. They found that bicultural (p. 46) or less traditionally cultured individuals were four times more likely to be heavy drinkers and develop dependency problems. However, Cole (2008) states, “the few studies done specifically on enculturation for Native Americans have shown that spirituality and traditional practices play a large role in sobriety” (p. 37). As mentioned previously, Kulis, Hodge, Ayers, Brown, and Marsiglia’s (2012) study with adolescents found that “following American Indian traditional spiritual beliefs was associated with antidrug attitudes, norms, and expectancies” (p. 444).

Yet, empirical investigations of this culture-as-treatment hypothesis—namely, that a (post)colonial return to Indigenous cultural orientations and practices is sufficient for effecting abstinence and recovery from substance use disorders for many American Indians—have yet to appear in the scientific literature.” (Gone & Calf Looking, 2011, p. 293)

This statement may point to the central role spirituality plays in maintaining abstinence, regardless of whether or not cultural ways are lived or adopted.

**Culture as treatment within ISD.** The practice of using cultural methods of healing is perhaps a clear exercise of ISD. Denying Indigenous people the right to use cultural traditions as a way of healing has had a disastrous effect on individual’s
psychological and physical health (Firestone et al., 2015). Beginning as early as 1963, studies have demonstrated that increased rates of addiction have been linked to the decimation of traditional culture (Whittaker, 1963); further, that inhibiting one’s right and choice to practice traditional healing methods is an act of colonialism, contributing to the resultant struggles that have ensued (Brave Heart et al., 2011; Schellenberg, 2015).

Many Western and Indigenous authors have argued that during early colonization, the loss of culture that occurred through massive deaths from disease, forced assimilation policies, and criminalizing cultural practices, has led to drug and alcohol dependencies (Coyhis & Simonelli, 2005; Eshkibok, 2014; Firestone et al., 2015; Garrett, 1999; Garro, 1995; Gold, 2004; Ladd-Telk, 2001; LaVeaux & Christopher, 2009; Marmot, 2016; Schellenberg, 2015). To help stem the rising incidences of substance abuse, Marsh et al. (2015) contend that community empowerment is a prerequisite to health promotion, both mentally and physically, and cultural healing traditions must be carried out on the community level in the manner and frequency as each community decides.

**Programs Used in Indigenous Treatment Centers in New Brunswick**

An online search using the terms “addictions treatment, New Brunswick First Nations” yielded few results; however, a web site entitled DRS, or Alcohol and Drug Rehab Centers First Nation in New Brunswick, lists four community-based residential treatment centers in the province. Other search results point to the National Native Alcohol and Drug Abuse Program, NNADAP, with links back to the four centers. NNADAP is a federally funded program intended to support initiatives carried out by Indigenous and Inuit communities (Health Canada, 2017). This includes a NNADAP
worker, who is usually a person, recovered from an addiction, as well as prevention and recovery support services. It also funds each of the four Indigenous treatment centers in New Brunswick.

New Brunswick Indigenous peoples utilize the Detox Programs available in each Regional Health Program to enable community members who are addicted to substances to safely withdraw from the addicted state (Health Canada, 2017). Once, the person is free of substance abuse, he/she may enter one of four Indigenous residential treatment programs, such as The Lone Eagle Treatment Center in Elsipogtog. Such healing lodges use traditional treatment approaches, such as sweats, along with alternative healing approaches such as acupuncture, mindfulness, relaxation, and anger management (Health Canada, 2017). Those Indigenous people that don’t offer residential programs may refer individuals to any of the four residential programs in the province of New Brunswick, in Quebec, to non-native treatment centers, and to the NNADAP program for education, prevention, intervention, and after care treatment options (Health Canada, 2017).

Residential treatment programs provide the opportunity for those who are addicted to substances to leave their usual environment with all of its triggers and stressors to focus on their own issues. It engages participants in the process of identifying patterns of living that serve as triggers for their substance abuse. Program participants learn new skills and practices to cope with their lives and stressors when they return home. However, more resources are needed within the community to support people who have completed the residential program and are returning home to the same circumstances that contributed to their addiction in the first place.

Moghaddam and Momper’s (2011) grounded theory study of 19 staff from 10
addiction recovery programs for Native Americans. Fourteen of the 19 staff were of Native heritage, representing several tribes and linguistic backgrounds. Their objectives were to examine how spirituality was conceptualized through the integration of Western and traditional Native American healing paradigms, and the impact of traditional healing activities on client recovery in these urban treatment programs. The role of spirituality in recovery from drug and alcohol addiction was conceptualized in various degrees of acculturation. Some staff reported that Native traditional spiritual healing activities were having a stabilizing and strengthening influence on clients’ long-term recovery. Other staff observed that the spiritual events in the programs taught new coping skills that were appropriate for their native culture (Gone & Calf Looking, 2015; Moghaddam & Momper, 2011).

Some clients Moghaddam and Momper’s (2011) study were closely connected to their Native heritage in their expression of spirituality. Others saw the benefit of maintaining traditional culture while simultaneously holding to mainstream religion such as Christianity. Retaining both mainstream religion and traditional spiritual beliefs was referred to as bispirituality (Moghaddam & Momper, 2011). Still others held exclusively to mainstream religion. Staff who helped in the recovery process found that whether clients used traditional rituals, a dual approach of traditional and mainstream religion, or even a monotheistic spiritual belief system; developing spirituality was significant in long-term recovery from addiction, even long after formal treatment had ended. In all, Indigenous peoples have found their own spiritual path to recovery, speaking to the importance of self-determination for individuals.
NB treatment centres through ISD and SDT lenses. Both traditional cultural approaches and Western treatment approaches are offered with differing balances in different residential treatment centers on New Brunswick Indigenous communities. For instance, traditional healing ways, including the Medicine Wheel and Sweat Lodge ceremony, are taught and practiced in the residential programs. As well, sound healthy living routines, along with a well-balanced lifestyle including a nutritiously sound traditional diet and patterns of living (such as obtaining adequate sleep and exercise), are consistently practiced in each addiction treatment center (Health Canada, 2014). In addition, Western approaches to addressing addiction, such as cognitive and skill based approaches like **mindfulness** and **anger management**, are employed. In this framework, the freedom to blend non-Indigenous knowledge with traditional ways of healing is an exercise in ISD (Craven et al., 2016). Residential treatment programs also provide increased opportunities to develop enhanced relationships with other Indigenous people who have similar challenges with addiction, thus increasing their sense of relatedness to others as well as their culture. The practice of traditional spiritual practices supports their sense of relatedness to their Creator.

Traditionally, individual Indigenous community members were free to make their own choices and were responsible for the effects of these choices on the community (Bear, 2011). This respect for the autonomy of the individual, while holding him/her accountable for the effect of his/her choices on the whole community and environment, may be expressed in one’s right to choose what recovery method is best for him/her/their self. While the traditional AA program has enabled many Indigenous people to recover from addiction, and others have benefitted from programs that adapted the AA program
design to include traditional spirituality, including residential treatment programs, other Indigenous peoples have found their way to recovery through engaging in Christian beliefs and practices.

**Addiction Treatment Programs Founded on Traditional Christian Spiritual Beliefs and Practices—Integrated with ISD**

Much of the trauma inflicted on Indigenous peoples through colonization has been imposed by the Christian Church (Wesley-Esqumauz & Smolewski, 2004). Dr. Naomi Adelson, an Indigenous scholar, who recently worked with Mi’kmaq in Atlantic Canada, and since the late 1980s has collaborated closely with the Whapmagoostui Cree in northern Québec, summarizes it well:

> The colonization of First Nations peoples did not begin with the church, yet that institution’s fervent interest in the process remains one of the most potent symbols of penetration into and eradication of the cultural and spiritual core of Indigenous communities. Despite that history, however, and paradoxically for some, Christianity today is an important and basic aspect of spirituality for many of the Elders whom I interviewed. (Adelson, 2009, p. 284).

Thus, for Indigenous peoples in Canada, Christianity is a deeply sensitive issue. One cannot assert that any one person’s form of spirituality, whether oriented toward Indigenous spirituality or other religions, is accepted or held by all other members of a given community, nor can one method of overcoming addiction be said to be appropriate for everyone (Tanner, 2009). However, Christianity has been associated with long-term recovery from drug and alcohol addiction among some Indigenous people in various countries (Adelson, 2009; d'Abbs & Chenhall, 2013). Since the 1970’s in Australia, for example, evangelical Christianity has produced recovery, and decreased the risk of becoming addicted to substances for some Indigenous people (d'Abbs & Chenhall, 2013).
Indigenous and Western scholars who are also practicing psychologists and psychiatrists working with Indigenous people acknowledge the fundamental role of religion in wellbeing (Garrett et al., 2011; Kirmayer, Tait, & Simpson, 2009; Knox, Catlin, Casper, & Schlosser, 2005). For example, Shafranske and Malony advise that religious affiliation and spiritual beliefs may be “a far more potent social glue than the color of one’s skin, cultural heritage, or gender” (Shafranske & Malony, 1996, p. 546). As explored earlier in this Report in the discussion on the role of attendance at AA meetings, and in the interplay between attendance and spirituality, religious meetings may play an important role in not only helping someone overcome addiction, but also in maintaining sobriety over the long term. As discussed earlier, this may be due to the combined attention to the spiritual part of someone’s life, and the building of relationships with others either through attendance at recovery meetings, traditional ceremonies or church gatherings.

Some Indigenous addiction treatment programs explicitly claim a spiritual focus with a distinctly Christian worldview. In 1992, a few Christian Native leaders came together in a “unanimous resolve that First Nations people need to take the lead in providing help to those who are suffering from the damaging effects of abuse and stopping the cycle of abuse that has destroyed so many of our people” (Walther, 2017a, para. 2). They formed Rising Above, an Indigenous organization initiated and governed by Indigenous peoples. Their motto is First Peoples helping First Peoples. With its headquarters in Thunder Bay, Ontario, they provide a national outreach and resource center to all Indigenous peoples, “offering hope and healing from a biblical perspective” (Walther, 2017b, para. 2), while also practicing some Indigenous ceremonies, such as
talking circles. Inenimowin Circle training provides the needed skills and capacity to deal with personal abuse issues, and lead others through their own healing. Inenimowin, a Cree word for the feelings we have in our heart, creates “a safe place for people to talk about their experiences and feelings of abuse” (Walther, 2017c, para. 3).

The Rising Above program offers individual, couple, family, and community counselling, and provides mentorship and leadership courses, directed at understanding the historical context of addictions and physical abuse and healing through Christian beliefs. This is a clear demonstration of the use of an Indigenous approach to healing that is grounded in Christianity, and points to the ability of Indigenous communities to integrate Christianity into their culture. It is important to remember that culture is a dynamic construct, ever changing according to the changing experiences and needs of the people within a particular culture (Kirmayer, Tait, & Simpson, 2009). In the case of Indigenous people who choose to seek out and practice Christianity, the culture change or articulation that ensues depends to some degree on the ability to combine their new Christian beliefs with their Indigenous culture.

Another such Christian approach to addiction recovery for Indigenous people is the Overcomers Recovery Support Program. Their members purport that this approach has been effective with Indigenous people who are addicted to different substances. This program is delivered through the use of a 90-day recovery workbook, based on the Bible. Several members of this group, who have chosen to follow the teachings of the Bible, have been free from addictions to substances such as drugs and alcohol, for as long as 20 years. Consistent with this group’s experiences, Adelson (2009) noted:

Indeed, fundamentalist (Pentecostal) Christianity is on the rise in some Cree
This increasing engagement with both traditional Native practices and those of Christianity has purportedly been associated with radical lifestyle changes where adherents forsook the use of alcohol and tobacco (d'Abbs & Chenhall, 2013). In claiming a connection between evangelical Christianity and sobriety, d’Abbs and Chenhall recalled, “Becoming Christian was viewed as antithetical to drinking and the act of becoming a Christian was associated with a realization of the degrading effects of getting drunk” (p. 1118). In this way, evangelical Christian practice has been understood to help because it changes the perception of drinking alcohol to the point of drunkenness from being a socially sanctioned behavior to being seen as shameful.

Regardless of their choice of healing strategy, the recovery of Indigenous people from addiction, is worthy of respect. Nevertheless, the choice of evangelical Christianity as a healing strategy has been contentious, resulting in consequences, such as a loss of relatedness for Indigenous people and for their communities (Kirmayer, Tait, & Simpson, 2009). One of the issues that arose from the engagement of Indigenous people in Christianity occurred when their Native spiritual practices were devalued by these churches, leading to subsequent loss of cultural practices and ceremonies. Families have been divided when one member has become a member of a church and others remain traditionalists. This division is evident at times of celebration and change within families, such as the choice of funeral or wedding ceremonies, when decisions may become contentious among family members. Just as the recruitment of Indigenous
people to the Roman Catholic Church during European colonization led to a loss of their traditional beliefs and practices, this new evangelism may separate Native people from their roots.

Over time, the Catholic Church incorporated Native images and traditional practices, such as drumming at weddings and funerals of Indigenous people. It is a testament to the central role of spirituality in the lives of Indigenous people that they would adhere to any Christian denomination that historically played such a significant role in decimating their culture and in abusing their people. Those Indigenous people who have chosen to accept Christianity have demonstrated their ability to forgive past transgressions by the Christian Church against their peoples and way of being, have found spiritual healing in their Christian beliefs and practices and have exerted their individual autonomy.

**ISD and SDT lenses applied to Christian approaches to treatment of addiction.** Rising Above and The Overcomers Recovery Support Program’s goal is to work with the addicted person and his/her family to help them “rise above” the consequences of addiction, including physical and mental abuse, in the end helping individuals gain an increase in mental health, self-confidence leading to competence, and a connection to others who are on the same journey. One of the limitations of these programs is the loss of relatedness with family and friends who do not ascribe to this approach.

A large body of knowledge has clearly identified the loss of ISD that has occurred by the imposition of Christianity in colonial times (Smith, 2012). Many Indigenous individuals, their families and communities have been healed through a return
to traditional spiritual ceremonies and cultural practices which has been interpreted as evidence of and synonymous with ISD among Indigenous peoples (Schellenberg, 2015).

Some Indigenous peoples have been able to integrate Christian and traditional spiritual practices in a way that enhances their spiritual health. Currently, some Indigenous people have found healing and spiritual health through adherence to evangelical Christian denominations, especially the evangelistic denominations, such as Pentecostalism (Adelson, 2009; d'Abbs & Chenhall, 2013). This conversion to Christianity has been seen as a threat to the Indigenous culture and ISD by many Indigenous Elders, based on their colonial experiences (Smith, 2012). This tension between the experience of the Indigenous community that Christianity contributed to a loss of ISD and some individuals’ choice of Christianity continues to decrease the relatedness of members of the Indigenous community. Moreover, the desire of the current federal government to not continue to impose limitations on ISD has led to their support of programs and activities that are congruent with traditional Native spirituality and ISD. This means that resources, such as funding of programs have often been limited to those that are traditional versus those proposing programs founded on Christianity (Aboriginal Corrections Policy Unit, 2006).

Attendance at a church may provide access to social support of the congregation, increasing access to a feeling of relatedness, a fundamental need of humanity according to SDT. This altered understanding of SDT recognizes a combination of benefits that produces related-autonomy—the freedom to choose while considering family and community—that is in keeping with traditional Indigenous ways (Roche et al., 2015). Indigenous people who have engaged in Christianity in order to recover from addiction,
have experienced an enhanced sense of competence (Aboriginal Corrections Policy Unit, 2006). In summary, those Indigenous people who have found their way to Christianity and recovered from addiction to substances have increased their ability to fulfill the needs of autonomy, relatedness and competence—that is, the ability to make their own decisions and determine their own choices (Tribal Trails, 2017).

In spite of the collective efforts to reclaim Indigenous culture and spiritual practices, some Indigenous people have exercised their individual self-determination in choosing to follow Christianity. While traditional ways included respect for the right of the individual to make his/her own choices, individuals were held accountable for the effect of their choices on the community as a whole (Bear, 2011). When Indigenous people choose to follow Christianity, and recover from addiction their capacity to contribute more to their families and community is increased (d'Abbs & Chenhall, 2013). This raises the question: Does the choice of Christianity among individual Indigenous people enhance or threaten the ISD of the Indigenous community and nation? Is there a way that the individual and family can determine his/her/their own approach to healing, even by choosing a form of Christianity without harming the ISD of the Indigenous community?

Western and Indigenous literature has consistently shown that spirituality is a crucial factor in the recovery from drug and alcohol addiction (Coyhis & Simonelli, 2008; Dermatis & Galanter, 2016; Garrett et al., 2011; Koenig, 2009; Koenig, McCullough, et al., 2001; Lorch & Hughes, 1985; Lyons et al., 2011; Miller & Bogenschutz, 2007; Morjaria & Orford, 2002; Ranes et al., 2017). However, many researchers stress that what has yet to be established is how the spiritual processes occur
on a personal level (Galanter et al., 2014; Geppert, Bogenschutz, & Miller, 2007; Miller & Bogenschutz, 2007); this is especially true for Indigenous individuals.

Kirmayer, Tait, and Simpson (2009) noted that culture is a construct and not static. They agreed with several others (Niezen, 1993; Roosens, 1989; Sissons, 2005) that one’s cultural and ethnic identity is created as that culture responds to its current environment. They stated, “this is not to question the authenticity of tradition but to insist that culture be appreciated as a co-creation by people in response to their current circumstances—an ongoing construction that is contested from both within and without” (Kirmayer, Tait, Simpson, p. 20). For example, Indigenous people have been influenced by, and have integrated Christian values with their traditional beliefs and worldviews through several centuries and movements (Abbott, 1998; d'Abbs & Chenhall, 2013). These movements have become part of the culture of many contemporary Indigenous peoples (d'Abbs & Chenhall, 2013). “Ethnographic and autobiographical accounts of American Indian religion and spirituality suggest a complex mix of at least three sets of beliefs and practices: Indigenous traditions, Christian, and ‘new’ or syncretic faiths that fuse Aboriginal and Christian elements” (Garroutte et al., 2009, p. 482). Spirituality may be unique to each community, if not indeed unique to each individual.

**Summary**

Addiction in Indigenous communities is a response to the social and psychological pain of life that has resulted from the continuing historic practices of colonization. It decreases the individuals’ and community’s ability to make choices in their lives. Alcoholics Anonymous, the Indigenous adaptations of AA, traditional Native
spirituality, and Christianity all may provide spiritual pathways out of addiction. The issue of whether ISD, as a community goal, also applies to individual choices in healing approaches remains contentious.

Among Indigenous peoples, ISD is firmly tied to traditional spirituality that was forbidden on a community-wide basis by colonial powers, yet a question remains about the intersection of ISD and individual autonomy. Does ISD only apply to the right of self-determination for the community as a whole or does it also mean that the choice of healing methods may be determined by the Indigenous person—whether traditional culture or other ways are chosen? Do the spiritual approaches to recovery from addiction need to be dichotomized or are there ways of integrating these beliefs into a functional system that enables individuals to do the following: (a) make their own autonomous choices within and in regard to their relationships in the community and faith community, (b) maintain and enhance their sense of relatedness to their family, communities and Creator and (c) enhance a sense of competence through recovery from addiction and increased mental health enabling them to contribute to their families and community more effectively. In the following chapter I will:

1. Identify issues to be considered in choosing effective approaches to addiction treatment among Indigenous peoples, and finally;

2. Discuss the meaning of the findings of this report in relation to mental health, addiction, nursing practice, and implications for research.
Chapter 5: Discussion

This chapter begins with an overview of this report, followed by a summary of the topic, a discussion of the findings, and finally implications for nursing practice, future research, and nursing education.

Overview of Report

The purpose of this report has been to examine the literature on the role of spirituality and self-determination in successful recovery from addiction among Indigenous Peoples. In keeping with the objectives of the report, I have:

1. Reviewed the literature related to the following:
   (a) The worldview and ontological approaches of Indigenous people and culture;
   (b) The effects of colonialism on the health and wellbeing of Indigenous peoples;
   (c) The definitions of spirituality and its role in healing from addiction;
   (d) The definitions and theories of the causes of addiction;
   (e) The concept of Indigenous Self-Determination (ISD);
   (f) The psychological theory of self-determination (SDT) by Ryan and Deci; and
   (g) The spiritual approaches that support the recovery of Indigenous people battling addictions.

2. Examined these approaches according to how they support ISD at the community and individual levels; and the components of SDT—autonomy,
relatedness, and competence—at the individual level; and

3. Discussed the implications of these findings for nursing education, practice, and research.

Summary

Addictions among Indigenous peoples have had far-reaching consequences that affect not only individuals, but also families and communities. Indigenous people recognize that addictions have resulted from soul wounds generated by the losses implicit in colonialism. Spirituality is integral to Indigenous culture, and as Indigenous peoples regain their own cultural practices, spirituality has emerged as central to healing from addiction.

As Indigenous peoples have begun to regain their self-determination, they have taken a more active role in addiction recovery programs for Indigenous communities. Indigenous people in Canada, prior to colonialism, were collective-based societies of many Indigenous people, where relatedness to family, community, environment, and the Creator was central to their way of being. They were a migratory healthy society in which their autonomy enabled them to freely adapt to the changing seasons and other ecological environments in order to feed their families well. Decisions were made by consensus. The role of the individual was to be autonomous while contributing to the whole.

Colonialism by the French and English imposed many losses, taking away Indigenous peoples’ ability to make autonomous decisions. They lost their land, their way of making a living, and of healing illnesses, their cultural and spiritual ceremonies,
and even their identity as Indigenous peoples through the imposition of the Indian Act.
The loss of their parenting rights as their children were seized and sent to Indian Residential Schools, or were scooped and adopted out of the Indigenous communities, produced intergenerational trauma which continues to be transmitted in many families today. This has resulted in physical, emotional, and spiritual pain and illness for many Indigenous people.

Spirituality has many definitions. However, in this report, I have used the grouping of three categories found in the literature as follows: (a) theistic, which is an unstructured connection to an ultimate being; (b) nontheistic, which is a search for meaning and purpose; and (c) religious, which is a structured connection to an ultimate being. There is a plethora of evidence about the connection between spirituality and health—an understanding that Indigenous peoples have incorporated into their health and wellbeing systems from ancient times. Traditional spiritual practices of Indigenous people include the interconnectedness of all life, including relationships with others, the environment and its inhabitants, the Creator, and the cosmos. The healing efforts of Indigenous peoples in Canada have demonstrated that the losses accrued through colonialism are foundational to the epidemic of addictions.

Addictions are defined by Indigenous people as a crisis of the spirit. There are several theories of addiction, which primarily attempt to explain the causes of addiction. While moral, biological, disease, and psychosocial theories have been articulated in the past, I have presented the spiritual component of a biopsychosocial approach to addiction.

One of the most important goals in the perception of Indigenous people in Canada is the need for Indigenous Self-Determination. Among other things, this social
determinant addresses the need for Indigenous communities to determine their own way of healing. In relation to the individuals within the Indigenous communities, self-determination might be understood through adaptations of the Western psychological theory of self-determination from an Indigenous perspective.

The most pervasive Western spiritual approach to addiction recovery programs is that of the Alcoholics Anonymous program, which incorporates a relatedness to a higher power, with accountability, the social support of the group, and the access to a sponsor as mechanisms of recovery from addiction. This approach has been adapted by Indigenous people to become more congruent with their worldview and perspectives. Another approach to recovery from addiction among Indigenous people is that of culture as treatment approach, or returning to traditional Indigenous ceremonies and spiritual practices. Finally, some individual Indigenous people have chosen to use a Christian worldview.

Discussion of Findings

Just as the research of the terms spirituality and religiosity revealed that these were more inseparable than unique concepts, so did the research revealing the value of Christianity and traditional Indigenous spirituality in the healing processes of recovery. “We cannot presume that any one form of Aboriginal spirituality, or healing for that matter, is commonly and equally shared by all members of any given community” (Adelson, 2009, p. 274; d'Abbs & Chenhall, 2013). However, Adelson and others warned that there is an increasing shift towards a model of care for Indigenous people that is based on a pan-Indian approach of traditional spirituality entirely removed from
their lived contexts (Brady, 1995; Calabrese, 1997; d'Abbs & Chenhall, 2013; Kolig, 2003; Tanner, 2009; Tolman & Reedy, 1998). Moghaddam and Momper (2011) advised that a “cultural renaissance” (p. 136) of federally funded programs—referring to a treatment program that was solely run from the Indigenous paradigm alone—would exclude many urban Indigenous people.

Kirmayer, Tait, and Simpson (2009) cautioned that “assuming a pan-Indian approach of traditional spirituality can both unite and marginalize” (p. 20). It can lead to the privileging of certain groups who are identified as being more authentically Indigenous (Kirmayer, Tait, & Simpson, 2009). This has been my experience in New Brunswick and at several communities in British Columbia, Saskatchewan, and Quebec. Indigenous individuals in these regions who knew the topic of this report would consistently seek me in private, often tearfully expounding on their cognitive dissonance, and on pressures they were receiving from others to honour the ancestors and traditional, spiritual ways. This dissonance was especially difficult for those in leadership positions, their immediate families, and among other Indigenous community members. For instance, there was a need to honour their traditional ancestors, but also to honour their present Indigenous grandmothers who held strong Catholic beliefs. This need was complicated by their own bi-spiritual beliefs. This was more than just an “awkward situation” for them; I would describe this as mental torment. Indigenous writer Dan Isaac (2016) in *Reconnecting With the Spirit*, says that we have to stop separating spirituality into categories of either traditional or Christianity because this separates families and communities.

Many researchers and addiction-focused workers argue for the inclusion of
traditional ways in the treatment of addiction, while conceding that this may not be helpful for Indigenous peoples who are more comfortable identifying themselves with mainstream society (Garrett & Carroll, 2000; McCormick, 1995; McCormick, 2000; Poonwassie & Charter, 2001; Spillane et al., 2015; Stubben, 1997). Spillane and associates wrote the following:

Having a stronger sense of FN identity may be a protective factor and it may be these individuals who would benefit the greatest from a culturally informed treatment or traditional healing. While this study cannot address if there are certain types of help that are more preferred by those with a stronger FN identity, others have found that Christian AIs [American Indians] prefer a 12-step treatment approach while more traditional AIs preferred a more traditional approach to treatment … our results highlight the importance of incorporating cultural identity into prevention and treatment efforts and highlight the importance of taking an individual’s cultural identity into consideration when treatment planning. This may lead to more positive treatment outcomes. Therefore, it is my strong recommendation that the individual’s acculturation level needs to be considered to provide appropriate care. (Spillane et al., p. 8)

These statements identify that the spirituality of the individual must be taken into consideration for successful treatment. The traditional way of respecting the individual’s autonomy is at stake here; honouring ISD on an individual level means giving the treatment recipient the freedom to decide the care path that is most honouring to him/her/them.

Implications for Nursing Practice

In a review of 26 nursing theories, 12 were found to contain spirituality as part of holistic care, and three (Roy, Neumann and Watson, date) presented it as a core issue (Oldnall, 1996). Yet Carr’s (2008) exploration into the use of spirituality by nurses in Atlantic Canada demonstrated the distinct gap that exists between the ideals and the realities in the provision of spiritual nursing care. Health professionals, including nurses,
have been found to be sorely lacking in their knowledge and utilization of spirituality in their care of clients (Bellamy et al., 2007; Blasdell, 2015; Corrigan et al., 2003; Macmin & Foskett, 2004; Moreira-Almeida et al., 2014; Phillips & Stein, 2007; Russinova & Cash, 2007; Wilding et al., 2006; Wong-McDonald, 2007). The literature reviewed in Chapter 2 exposed that when individuals define their spirituality, whether from a theistic, non-theistic or religious perspective it is important in their healing and needs to be acknowledged. Spirituality, as defined by the person should be understood as fundamental to the ways of being of Indigenous peoples, and therefore, their recovery from addictions. Consequently, it is paramount that nurses acknowledge the potential risk connected to deficits in addressing the spiritual needs of clients, and determine to make changes to provide this spiritual care.

“The prevalent belief that spirituality is important in recovery is consistent with findings to date, but the literature is still beginning to discover the ways in which spiritual processes or interventions may help to alleviate addiction and reduce suffering” (Gundy, 2010, p. 58). We must work actively with Indigenous peoples to develop programs for recovery, and advocate for everyone’s spirituality to flourish, to be respected, and to be utilized. Cultural sensitivity in caregivers, or being aware of and ready to learn about the differences that exist between cultures, makes a difference in a client’s healing (Craig Rushing, 2010; Darroch et al., 2017; Doane, Pauly, Brown, & McPherson, 2004; Moreira-Almeida et al., 2014). However, presently there is poor cultural sensitivity in healthcare and there is a significant lack of understanding and awareness about traditional healing (Darroch et al., 2017; Hill, 2008; Moreira-Almeida et al., 2014; Shoucri, 2008; Stewart, 2007).
Mental health policies tend to exclude the perspectives of Indigenous peoples (Johnson-Jennings, 2010; Smye & Browne, 2002). The subjective and political processes embedded in Western colonial methodologies and epistemologies tend to disqualify the voices, knowledge, and epistemologies of Indigenous people as an inferior position (Kim, 2009). Thus, it is imperative that nurses support contemporary Indigenous people to ascribe and utilize spirituality in healing (Adelson, 2009; Kirmayer, Tait, & Simpson, 2009; Tanner, 2009). This is essential to good mental health as demonstrated in the theory of self-determination.

**Implications for nursing practice in program development and research.**

Because the majority of nurses who are developing programs or conducting research are Caucasian (Switlo, 2002), I strongly recommend that nurses first identify issues of white privilege. As a community mental health nurse, I have worked to understand the perspectives of diverse clients. Being aware of one’s own stance and how one arrived at this knowledge are important factors in maintaining an open attitude when working with Indigenous peoples (Kelly & Howie, 2007). Traditional Indigenous culture centers around authenticity—or the concept of truthing (Bear, 2011, p. 80). As Switlo (2002) and others (Gustafson, 2007; Racine, 2003; Tang & Browne, 2008) remind us, I must be aware that as a White individual living in Canada, I have accrued certain privileges simply by the colour of my skin. I share in the colonial dividend, benefitting from the resources and land seized from Indigenous people through the colonial process (Switlo, 2002). My whiteness affords me a position of unearned privilege and power (Gustafson, 2007; Haney-López, 2006). Several scholars believe that one can “choose against whiteness” (McLaren, 2000, p. 66) by challenging the social practices and structures that
create privilege (Getty, 2010; Haney-Lopez, 2006). Frankenberg (1993) describes whiteness as a location of structural advantage which is unmarked and unnamed. She writes about awakening to race cognizance, noting that “white people are raced just as men are gendered” (p. 1). What she means is that the White standpoint is so dominant that it becomes the default from which everything else is measured. Others have referred to whiteness as the generic standard for race (Martin-McDonald & McCarthy, 2008, p. 130). Therefore, anyone who is not white is automatically other. They warn that acceptance of this view of race, where whiteness is unmarked and unnamed, is what maintains the power and privilege of whiteness. Martin-McDonald and McCarthy stress that it is imperative that non-Indigenous researchers be keenly aware of their own racial and social positions to prevent the perpetuation of white dominance. They state that “without doing this we, consciously or otherwise, uphold white hegemony and racialist inequality” (p. 126). Non-native nurses need to be aware of their otherness when working with Indigenous peoples. There is a need not only to make Indigenous people the recipients of public policy and programs, but also to be partakers in the making of these programs and policies, through research, for real change to occur—to determine the questions to be asked, how the knowledge is examined, and the methodological way of knowing that best meets this need. Nurses must advocate for research which preferences the voice of Indigenous peoples and their ways of knowing in determining programs for recovery from addictions.

In the beginning of this work, from my mental health background, I was using the psychological theory of self-determination in counselling Indigenous clients because the clients found it to be clear and useful in working through their issues. For me, this theory
elucidated the effects of colonization on the wellbeing of Indigenous peoples in Canada. In doing the literature review on ISD, I found the work of Dr. Michael Murphy, who was using SDT as a framework to understand the effects of colonization, and to advocate for Western governments to provide resources to support ISD (Murphy, 2014a). Accordingly, I chose to use SDT in an analysis of the effects of addictions programs for individual wellbeing, recognizing that SDT was a Western theory and needed to be carefully assessed for its applicability to and by Indigenous peoples. Subsequently, the work of Roche and associates (2015) and Craven et al. (2016) has provided some evidence for the utility of the SDT model as well as some modifications of the relationships between the elements of SDT for Indigenous people. This experience has demonstrated the importance of partnering with Indigenous peoples in work focused on Indigenous peoples’ issues.

One implication from this report is the need to support traditional Indigenous treatment approaches with resources. For example, Elders and other healers often receive little recompense for their services, in contrast to Western health providers, who receive salaries for the program planning and interventions that they do. This inherently places value on Western professionals versus Indigenous leaders, and has implications for the selection of which programs are funded, and therefore privileged.

Considerations for Future Research

Research has consistently shown that spirituality is an important factor in the recovery from drug and alcohol addiction (Dermatis & Galanter, 2016; Koenig, 2009; Koenig, McCullough, et al., 2001; Lorch & Hughes, 1985; Lyons et al., 2011; Miller &
Bogenschutz, 2007; Morjaria & Orford, 2002; Ranes et al., 2017). Among this body of knowledge, most have only examined spirituality and religiosity as a protective factor against drug use or as a predictor in recovery with the mainstream population, using measures of engagement in religious ceremonies such as church attendance. The research on spiritual assessment and support has shown that nurses may not always address spiritual issues with their clients (Carr, 2008). It is time that nursing researchers begin to research interventions that enable nurses to address clients’ spiritual needs more effectively.

Many researchers stress that what has yet to be established is how the spiritual processes occur on a personal level, and that this is especially true for Indigenous people (Geppert et al., 2007; Miller & Bogenschutz, 2007), yet the well-meaning desire of White academics and government bodies to honour calls for Indigenous Self-Determination has led to funding priorities for research that supports healing through traditional means only (Aboriginal Corrections Policy Unit, 2006). At the same time, these funding groups want traditional healing to be evaluated through Western ways of knowing (Hall et al., 2015). This draws attention to the need for ISD so communities can decide what is best for them, and how this is best evaluated.

It is particularly appropriate that the role of spirituality in recovery from drug and alcohol addiction be examined in a local context, rather than basing policy decisions on a traditional pan-Indian spiritual approach. Given the success of addiction recovery programs that already exist within local communities, it is vital that all stories be told through qualitative community based studies.

Gundy (2010), an Indigenous researcher, stressed that future research must move
“beyond the struggle of how to label a certain behavior, belief, or practice, and continue to explore other aspects of the dynamic interplay between addiction, spirituality, resilience and recovery” (Gundy, 2010, p. 97). The intersections between spirituality, addictions and wellbeing has been well studied. However, there continues to be a dichotomy between traditional Indigenous spirituality and Christianity in terms of individual Indigenous people’s choices. In light of the mental anguish carried by those who identify as Indigenous and hold Christian beliefs, it is prudent that researchers examine the intersections between the Christian beliefs and Indigenous identity and the effects on their wellbeing. As well, a study that examines the intersections between Christian and traditional Indigenous beliefs and ceremonies on the wellbeing of Indigenous people would be useful.

Implications for Nursing Education

During undergraduate nursing education, it is important to support students’ learning about assessment of clients’ spiritual needs and effective interventions to address these spiritual issues within the health care team. In particular, students need to learn communication approaches (how to talk about) or how to address clients’ spiritual issues. It is also important for students to reflect on their own spiritual beliefs and practices in order to identify their assumptions. By making these assumptions visible, the students can prevent them serving as barriers to being able to work effectively with clients in their search for meaning related to illness and change.

Non-Indigenous nursing students need to be exposed to knowledge about Indigenous people’s worldviews, experiences through colonization and its continuing
effects on their wellbeing, as well as their current political and health issues. They need to learn about what is meant by ISD, and learn strategies to partner with Indigenous peoples in their care.

Indigenous students need to be supported in their nursing education process, so as to be successful in the Western health care system while strengthening their Indigenous identity. It is important that an increasing proportion of nurses providing care to Indigenous peoples are Indigenous.

Summary

According to ISD, by working in alliance with Indigenous communities, Indigenous people themselves can determine the relevance of a psychological explanation for self-determination. According to SDT tenets, a person’s wellbeing depends on having a sense of personal competence in addition to autonomy and relatedness. Research by Roche and associates (2015) and Craven et al. (2016) have identified the influence of relatedness on both autonomy and competence in the perspective of Indigenous peoples.

It is important for nurses not to assume a “pan-Indian approach” (Kirmayer, Tait, & Simpson, 2009, p. 26), but to recognize each Indigenous patient as an individual and respect that person’s choice of spirituality. Nurses need to advocate for Indigenous self-determination at both the individual and community levels in working with Indigenous people. Thus, education for nurses about spiritual awareness surrounding all patients, and particularly Indigenous peoples, is essential.

Non-Indigenous nurses need to reflect on issues of White privilege in working with Indigenous peoples, and all practice and research efforts need to occur in partnership
according to the principles of ISD. Overall, this report has identified the importance of spirituality in recovery from addiction among Indigenous people. It has elucidated the challenge of viewing their choice of spiritual practice within the collective ISD perspective, while honoring the traditional self-determination of the autonomy of the individual.
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