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ALCOHOLISM, GROUP THERAPY AND SELF-ESTEEM:
RESIDENTIAL GROUP TREATMENT IN THE NORTH

by

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B.S.W. The University of British Columbia, 1982

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

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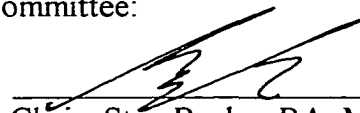
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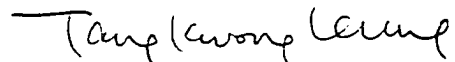
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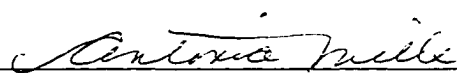
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Abstract

This thesis examined residential group therapy treatment for alcoholism at Nechako Centre, Prince George. It looked at financing, programming and clientele characteristics of eighty clients. Additionally changes in self-esteem amongst the clients were recorded and analyzed. Combined methodology using qualitative and quantitative measures were used to analyze data collected from four groups of men and women in 1990, 1992 and 1995. Fifty-two percent of the clients were First Nations. The question was asked "Does self-esteem increase after group therapy treatment?" Self-administered self-esteem results for 47 participants were analyzed and showed an increase in self-esteem. A second measure, Hudson's Index of Self-Esteem, was given to a women's group in 1995 and a statistically significant improvement in self-esteem was noted. Two First Nations women were interviewed. Themes of sexual abuse were present in these interviews. Suicide connected with the use of alcohol was present in one of the interviews. In one woman, the researcher noted an increase in self-esteem with a minimal improvement in the other. A further question was asked "Is group therapy helpful for the clients?" Some therapeutic experiences proposed by Yalom were observed during group therapy, i.e. interpersonal learning, self-understanding and existential changes. Group therapy also appeared to be an effective way for First Nations people and others to come to know and appreciate one another. A First Nations couple was interviewed thirteen years after initial treatment. From the interview it was learned that two hundred people from their reserve followed this couples' example and sought treatment for alcoholism.

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Dedication

I dedicate this thesis to my parents, Arthur and Lillian Fisk, pioneers of Prince George, who despite the depression, managed to clothe, feed and buy books for my brother and I.

I also would like to dedicate the thesis to the late Bridget Moran, my friend. Her books were inspirational for me. They showed me that stories of everyday lives can be the most important stories we read.

Finally, to my daughter Sheralee Elizabeth (Parker) Thibault whose love and admiration helps me to keep growing and stretching my limits.

Chapter One

Introduction

Alcoholism (substance abuse, substance misuse or chemical addiction) affects many lives. It is one of the most serious social problems in industrialized nations. Europe and North America have experienced the largest increases in per capita alcohol consumption: 86% and 79% respectively in 1988. In Canada studies report an alarming figure of 78% of adults using alcohol and the economic costs were estimated to be \$6.0 billion dollars in 1984 (Addiction Research Foundation, 1988). Recent estimates from Smart and Ogborne (1996) indicate that 73% of Canadians are drinkers compared to 79% in 1990. Although alcohol consumption has declined since 1990, the number of drinkers is still substantial. According to the 1993 General Social Survey, nearly one in 10 adult Canadians (9.2%) said that they have problems with their drinking. The most common problems affect physical health (5.1%) and financial position (4.7%). A study done by Statistics Canada in 1978 reported that 139 males and 31 females (out of 1,000) are considered to be problem drinkers. Even more worrying is the incidence of problem drinking among youth. Health and Welfare Canada report that in 1992, 86% of British Columbia youth aged 15 to 24 were drinking. The percentage of problem drinkers amongst youth is not given. This finding is confirmed by the Canadian Centre on Substance Abuse (1997) which has documented that young adults, males and those with higher incomes drink more than other Canadians.

The estimated economic and social costs of substance abuse are high. According to Single and his associates (1996), substance abuse costs more than \$18.4 billion in

Canada in 1992, representing \$649 per capita or about 2.7% of the total Gross Domestic Product. Alcoholism is associated with violence towards women, violence in general, sexual abuse and death. There were 33,498 deaths attributed to tobacco, 6,701 deaths due to alcohol and 732 deaths due to illegal drugs in 1992. Taken together, this represents 21% of the total mortality for that year (Single et al, 1996). In the same year, there were 86,076 hospitalizations attributed to alcohol.

Alcohol-related deaths are many: Canada reported 10,122 fatal alcohol-related accidents in 1985. Impaired driving is largely alcohol-related: The Ministry of Supply and Services, Canada report that it was estimated in 1992 that more than 1600 people lost their lives in alcohol-related motor vehicle accidents. The Traffic Research Foundation reported that in the same year (1992) 48% of drivers killed on Canadian roads had been drinking. There were 201 alcohol-related homicides in 1985 (Statistics on Alcohol and Drug Use, 1988). Furthermore, alcoholism impacts all those who over-use and affects their families, their communities and the well being of our nation. It particularly preys on First Nations people as they adapt to their ever changing conditions.

Treatment of Alcoholism in Canada

Until the end of the Second World War, most Canadian governments provided few resources for the treatment of alcoholism. Private sanitariums that were available catered to the middle classes and some charity cases (Smart & Ogborne, 1996). New treatment services were established in the 1940s and 1950s thanks to the lobbying efforts of Alcoholics Anonymous (AA). From the 1960s to the 1980s a remarkable growth in specialized treatment programmes was noted. The different types

established were detoxification centres, outpatient services and long-term residential services. Alcoholism is considered a provincial problem and most of the direct costs of specialized services are borne by the provincial governments (Smart & Ogborne, 1996). The misuse of alcohol and other drugs continues to be a significant problem in British Columbia. According to another study by Single and his associates (1996), the per capita cost of alcohol misuse in British Columbia is estimated at \$272. The provincial government has recognized the severity of the problem and in partnership with non-profit agencies offers the following services: outpatient counselling, residential treatment, supportive recovery services, community-based prevention programmes and school-based prevention programmes (Kaiser Youth Foundation/B.C. Ministry of Health, 1997). Private companies and public agencies have their own employee assistance programmes and mutual support groups such as AA are organized by local recovering addiction users.

Needless to say, researchers and practitioners (Kooyman, 1993) have endeavoured to find effective substance abuse treatment approaches. Some suggest that one of the best solutions for alcohol problems is the need for expansion of residential treatment services. However, existing literature on residential treatment in the northern and rural regions of British Columbia is scant. Moreover, there is not sufficient research on First Nations and other cultures working together in an environment dedicated to the recovery of both.

This study was undertaken with a view to providing an understanding of what occurs in an alcohol and drug residential group treatment programme in northern British Columbia known as the Nechako Centre. My interest in this study comes from

thirteen years spent as an addictions counsellor and therapist working with the clients in this residential treatment programme. The majority of people that go through the centre are First Nations. I found this work challenging, rewarding and moving. I began this thesis seeking to study and document the growth I had witnessed many clients make by describing: (1) the structure of the program, (2) the group therapy offered and (3) the impact of group therapy on participants through the use of self-esteem measures and intensive interviews.

Types of Groups

Perhaps the best differentiation between types of groups is that given by Turner when he suggests that it is the purpose of the group that defines the group (Turner, 1999, p 213). Historically, Canadian social group work emerged in the 1930s. Following the Industrial Revolution and the resultant social upheaval that produced inhumane working conditions and widespread poverty, social action groups were formed. Since that time, aftercare groups, cancer support groups, eating disorders groups, groups for patients with myocardial infarct, paraplegia, diabetic blindness, renal failure, etc. have proliferated.

Social work practitioners are associated with treatment groups and tasks groups. Each type of group has several subtypes. Treatment groups have the purpose of increasing the satisfaction of member's socioemotional needs. Task groups are established to accomplish a task. They differ in that treatment groups focus on self-disclosure and confidentiality while in task groups self-disclosure may be low and the meetings may be public or private (Hepworth, Larsen & Rooney, 1997, p. 318).

Treatment groups may encompass support groups, education groups, growth groups, therapy groups and socialization groups. Self-help groups are distinguished from treatment and task groups in that they have central shared concerns such as coping with addiction, cancer, or obesity (Hepworth, Larsen & Rooney, 1997). An example of a self-help group is Alcoholics Anonymous which was founded in 1935 in Akron, Ohio. The Big Book of Alcoholics Anonymous states “each group was to be autonomous and there was to be no professional class of therapy” (Alcoholics Anonymous, 1976, p. xix).

Group therapy which falls under the treatment group category emerged in the mid-1920s (Corsini & Wedding, 1995). There are many models of group therapy and because it is such a complex phenomenon to-date there is no unified theoretical approach to small group therapy (Ephross & Greene, 1991). Because group theory is not unified, groups can be as unique as the counsellors who lead them.

Residential Treatment and Group Therapy

Residential treatment for substance abusers provides a laboratory for studying human behaviour and observing factors that can effect change. Group therapy has been a powerful tool for effecting change and is easily carried out when clients are living in a residential setting for a period of twenty-eight days as they do at the Nechako Centre. There is a major difference between group counseling and group therapy. One of the major differences is that group counseling focuses on growth, development, enhancement, prevention, self-awareness and releasing blocks to growth whereas group therapy deals with the present and the past. Group therapists help group members re-experience traumatic situations so that catharsis can occur.

The experiences are relived in groups and working through unfinished business from the past is a primary characteristic of group therapy (Corey, 1995, pp. 10-11).

The combination of a residential setting and group therapy provides a microcosm of life. This can be interpreted by using social microcosm theory which regards the group as a miniature social universe in which new interpersonal skills may be developed (Yalom, 1970; Corey, 1995). Yalom (1970) identified twelve therapeutic experiences in group psychotherapy:

1. Altruism
2. Group Cohesiveness
3. Universality
4. Interpersonal Learning - input
5. Interpersonal Learning - output
6. Guidance
7. Catharsis
8. Identification
9. Family Re-enactment
10. Self-Understanding
11. Instillation of Hope
12. Existential Factors

These are often considered as factors or mechanisms through which group members find their group experience rewarding and helpful. Yalom sees them as “curative factors.” His framework of “therapeutic factors” for facilitating outcomes in group work has been accepted by psychologists (Lese et al., 1997). Consequently his framework has been applied to various social work groups and settings; outpatient older women’s group (McLeod, 1993); group members having childhood incest (Bonney et al., 1986); support groups for women with breast cancer (Weinberg et al., 1995); and HIV patients (Burke et al., 1994).

Studies looking at the empirical validation of Yalom's therapeutic experiences are growing. There are some preliminary findings. Many studies have found that interpersonal factors to be the most therapeutic in group psychotherapy. There are some studies which arrive at different results. Weinberg and his associates (1995) conducted a support group for six women with breast cancer and they identified the following therapeutic experiences to be helpful: instillation of hope, universality, group cohesion, catharsis and altruism. In McLeod's (1993) study of eight members of an outpatient therapy group for older women, results showed that existential awareness was seen as the most therapeutic. Durall (1997) recently identified three factors in group psychotherapy that can be applied to the camping experience: group cohesion, interpersonal learning, and altruism. Obviously, the composition of the group, the characteristics of clients, and the nature of the presenting problems affects which therapeutic factors are found to be helpful (Bonney, et al., 1986).

Studies have established the relevance and applicability of Yalom's therapeutic experiences in various group settings and groups but we do not know if these experiences are found in group therapy for people with substance abuse. Additionally, most of these studies do not look at a cultural variable. Thus there is a gap in the existing literature pertaining to the First Nations. It remains to be seen if therapeutic experiences are shared by those who come from different cultural backgrounds. Whether such experiences will be shared by First Nations people living in the remote North is a question worthy of analysis.

Social microcosm theory postulates that group members will display maladaptive interpersonal behaviour in the group and it will be acted out before the

other group members (Yalom, 1970, p. 30). From Yalom's theory we may hypothesize that individual therapy does not present the same potential for observation as does the group therapy process. Yalom further suggests that not only is the maladaptive interpersonal behaviour displayed but also that the event that triggers it is observed by others. The response of other group members to the triggering event allows group members the opportunity to tell the client what it is about the behaviour that is not helpful to his/her recovery. A sequence of how this could lead to change is summarized as follows:

- Pathology display - member displays his or her behaviour
- Through feedback of other members and self-observation one:
 - (i) becomes a better observer of one's behaviour
 - (ii) appreciates the impact of that behaviour upon -
 - (a) the feelings of others
 - (b) the opinions others have
 - (c) the opinion one has of oneself
- As a result of increased awareness the client may take personal responsibility to change the way he/she interacts with others. Change will be gradual as new ways of being with others are experimented with.

Barrie (1990, pp. 153-168) believes that problem drinkers benefit from group therapy; research has shown that group therapy is at least as effective as, and less expensive than, individual treatment. Individual therapy does not provide the same richness of experience that group therapy can provide. Working with individual clients as well as groups, some researchers have found that it is relatively easy for a

client to tell a counsellor what s/he wants you to hear but that it is very difficult to fool a whole group.

Barrie suggests a number of benefits which can be derived from this approach:

- attitudes and behaviours are largely formed in group settings and should be amenable to change in such a setting.
- members do not feel alone and are not stigmatized by other members.
- members can practise interactive behaviours in a protected setting.
- both negative and positive feedback can be given in a group.
- in giving feedback members increase belief in their own abilities.
- the group provides a context for role playing and behavioural rehearsal.

The Benefits of Residential Treatment

The benefits that I have witnessed from residential treatment are many. Issues that arise for clients living together on a twenty-four hour basis are issues that also arise when clients leave treatment and can be constructively dealt with using the help of professional counsellors and feedback from other group members. Clear communication and conflict resolution are two new interpersonal skills which clients can learn and practise. The residential setting serves as a safe place for these skills to be practised; it is possible to avoid verbal communication in a home but it is very difficult to avoid verbal communication in a residential treatment setting.

Adler and Towne (1996 p.iii.) suggest “that even impersonal or adversarial interactions often have the best chance for success when they are handled in a constructive, respectful manner”. In the residential treatment programme, many conflicts have been resolved by communication skills taught and used in a

constructive and respectful manner. Often in the past the recovering person would have simply walked away or been involved in a physical fight. As well, in alcoholism, many social skills are lost as the alcoholic leads an isolated life with the bottle as his/her best friend. When recovering from a chemical dependency the most constructive learning that can occur on an everyday basis is simply that of being able to communicate with others. Sleeping, waking, eating and being together twenty-four hours a day gives a client the opportunity for learning and practising communication skills.

Residential treatment provides a social microcosm where new learnings may be practised and group therapy provides a setting for therapeutic catharsis of earlier events that were hurtful to the client. Peck (1993) believes that is where the wounds and scars are and those are the areas that need healing. Peck further states:

And so I would tell my patients that we cannot really forget about anything. The best we can do is to come to terms with it, to such a degree that we can remember it without pain. Therefore, the first step in the safety of the therapeutic alliance is to remember the crimes that were committed. Then comes the anger. It must come, as must the trial and the naming of the crimes. But beyond a certain point, the longer you hold on to that anger, the longer you will continue to hurt yourself (Peck, 1993, p.46).

Alcoholism and self-awareness are negatively linked. Hull's self-awareness model of alcohol use postulates that the consumption of alcohol allows the addict to avoid painful experiences with the ensuing loss of self-awareness (Hull, 1981). Based on this Yablonsky (1989) finds that because addicts practise some form of self-deception, a small group situation provides a setting whereby others in the group can point out their self-deluding behaviour. Kaufman (1994) believes that individual therapy alone is not enough to help the addict and that a combination of group

therapy, individual therapy, Twelve-Step (AA) work and family therapy are needed for successful treatment.

Self-Esteem and Substance Abuse

In the treatment process, one of the main objectives is to help the substance abuser develop a better sense of self-esteem. Self-esteem has been considered by many practitioners to be an important treatment goal. Corsini and Wedding (1995, p. 158) state emphatically: "Two frequent results of person-centered therapy are increased self-esteem and greater openness to experience." Moreover some studies have found self-esteem to be an important factor affecting the treatment outcome. Yablonsky (1989) describes the substance abuser as having intense feelings of low self-esteem. Alcoholics frequently come from a background where there is a lack of nurturing resulting in low self-esteem. Jacoby (1994) believes that feelings of self-esteem are based on care and affirmation received from significant others in childhood. Schutz (1994) suggests that self-esteem begins in childhood and is based on the messages one receives from others. Satir (1988) emphasizes that self-esteem is developed in the first five or six years of a child's life and that children brought up in families where they are made to feel worthless are at high risk for developing destructive behaviour. When the therapy involves family of origin issues and the client becomes aware that there was a lack of nurturing in their childhood, then change can occur and self-esteem will be augmented (Bradshaw, 1990).

Active participation in group therapy where the client looks at issues arising from lack of nurturing in childhood can lead to heightened awareness. This new awareness is conducive to the client's feeling better about himself and leads to

increased self-esteem. If a client is accepted as a member in a group therapy setting by other clients as actively participating in the group (if that is a group norm) then change will occur and self-esteem will be augmented (Yalom, 1970). Because of the importance of self-esteem, residential programmes tackling substance abuse problems have in their treatment goals the enhancement of self-esteem.

Adult Children of Alcoholics (a mutual aid group) in North America uses family systems theory in attempting to recover lost self-esteem. They make it plain that alcoholic or chemically dependent parents do incalculable damage to their children and affect their self-esteem (Abrams, 1990, p. 8).

Why Study Nechako Treatment Centre?

I have a special interest and understanding of the Nechako Treatment Centre and insight into the treatment values that effect change. Initially I was one of the designers of the programme and I have spent fifteen years in the field, two as a detoxification worker and thirteen as a counsellor at the Centre. I have observed clients change and become happier people. One of the most important observations I made is that both First Nations peoples and others are the same when it comes to change. Factors such as becoming aware of the grieving process within the family atmosphere of the Centre are valued by both First Nations people and others as grieving is a universal process. My personal observation regarding the factors that influence change is valuable but it is also important that it is backed up by a study of the literature. As a dedicated long-time worker in this field it should be illuminating for me to step back and analyze how change occurs and hopefully it will be illuminating for the readers.

Purpose of the Study

The purpose of the study of Nechako Centre is as follows:

1. To provide a description of the Nechako Treatment Centre and to answer the primordial question “what is going on here?” (Locke, Spirduso, Silverman, 1993, p. 99).
2. To provide descriptive data of profiles of three groups (60 clients) which span a five year period. The profiles include employment rates, aboriginal ratios, age, educational level and sex ratios. Self-administered self-esteem results are available for the three groups.
3. To provide descriptive data of the profile of a fourth group of 24 clients including employment rates, aboriginal ratios, age, educational level. To further examine whether self-esteem has improved after treatment a self-esteem pre-test and posttest was administered by the author of this thesis to this fourth group (Women’s Group, October , 1995). It is hypothesized that when self-esteem improves, recovery is more likely.
4. To examine and explore treatment experiences of two clients that attended the Women’s Group. To examine the helpfulness of group therapy, two interviews were analyzed utilizing Yalom’s (1970) therapeutic experiences. The intensive interviews of these cases are unedited. As argued by Kirby and McKenna (1989) it is important to enter the world of the speaker.
5. A further interview is provided of a couple who attended the treatment centre in 1984.

Significance of the Study

This thesis is being prepared for a Master's Degree in the Social Work Program at the University of British Columbia. The motto of the University is "en cha' huná", a saying of Carrier elders, with a direct translation "he/she also lives". It was used by Elders when an individual was being critical of another and served to remind that the other was a living being with a voice and a viewpoint. The motto encapsulates respect for others.

This thesis deals with a drug treatment programme that serves a high ratio of First Nations people. It is the author's wish that, through this thesis, a greater understanding will develop regarding how treatment for addiction works not only for the general population but for those First Nations people who attend the Centre. My understanding and regard for First Nations people has developed over the thirteen year period working at this Centre.

My first contact with First Nations people is described in Chapter Two when I was travelling during summer holidays. My father worked for the CNR so summers were spent travelling to Prince Rupert. I was eight years old at the time and it was not until close to fifty years later that I had the privilege of interacting in a meaningful way with First Nations people while at the Nechako Centre. As children we were segregated from one another and so I did not have the opportunity to know their heritage or to know them. At Nechako Centre my eyes were opened to a world that I had missed within my birth country as I witnessed their open-hearted and sincere sharing. I learned of the trauma of residential schools through their voices and

witnessed their anomie in the loss of their own society. Their personal stories have touched me deeply.

I would like non-Native people to have a deeper understanding of the personal struggles of First Nations people. Through the discussion of the history of alcoholism of First Nations people and through their personal interviews, I hope non-Native people are able to appreciate First Nations people with their rich and deep stories. This thesis is about sharing and learning respect. One of the advantages of Nechako Centre is that it teaches non-Natives to respect First Nations people.

Methodology

This thesis is a descriptive/exploratory study of Nechako Residential Treatment Centre. The study is both quantitative and qualitative in its approach.

The qualitative portion of the study follows the contextualized-consequentialist model that requires the researcher to build relationships of respect and trust that are noncoercive and that are not based on deception. It further involves the personal values held by the researcher and those studied. The model presumes that the researcher is committed to an ethic that stresses personal accountability, caring, the value of individual expressiveness and the sharing of emotionality (Collins, 1990, p.216; Denzin & Lincoln, 1998, pp 38-39). The phenomenological principle of *verstehen* is applied in that we are trying to understand the feelings and views of reality of the interviewees. In other words we are applying a social work concept of *empathy* in entering the world of the client through their own words (Rubin & Babbie, 1993, p. 362).

In this post-colonial era, it is important to have respect for First Nations people we interview and to privilege their voice being heard. Story telling to First Nations people is as old as their culture and not straight-forward and crisp as is the European way. Story telling weaves, twists, turns and takes time. I want the reader to walk the journey and weave, twist, turn and have a relationship with the story teller. Furniss (1998, p. 13) points out that the life histories and oral traditions of First Nations people are exceedingly scarce. Research is conducive to looking from the outside in and remaining objective. Kirby and McKenna (1989) state people who live on the margins are those who suffer injustice, inequality and exploitation. They further state that one of the characteristics is the necessity to translate their experience into acceptable and understandable terms for the status quo (Kirby & McKenna, 1989, p. 33). Rather than interject my voice into the stories, I have guided the reader with headings of important themes.

The qualitative portion of the study is naturalistic as the researcher has entered the world of the participants in the interviews and as counsellor in one of the groups (Rubin & Babbie, 1993, p. 361). Qualitative research is described as a systematic, empirical strategy for answering questions about people in a bounded social context. (Locke, Spirduso & Silverman, 1993, p. 99). Inductive logic was used in that observations were made, a pattern was found and a tentative conclusion was reached (Rubin & Babbie, 1993). Deductive logic was also used to analyze Yalom's therapeutic experiences and Hudson's self-esteem testing.

The first part of the thesis gives a background of the history of alcoholism in British Columbia as it applies to First Nations and other cultures. This is necessary to

explain why the Nechako Treatment Centre exists. Then the study goes on to describe what happens in the centre. This is accomplished through my insight as counsellor of the centre from its inception in 1981 to 1992, together with a return to the Centre in October of 1995 as a counsellor.

Data Collection

Often it is useful to combine qualitative and quantitative methods of data collection. For this study, a two-stage strategy was adopted. First, the profiling of the programme's participants is best approached by using quantitative data collection since it will generate a more comprehensive view of the reality. The analysis of the self-esteem scores is done by inferential statistics since it is important to compare the pretest and post-test results against the chance factor.

This kind of quantitative analysis is followed by in-depth interviews of selected group participants. In essence, this second stage relies on qualitative analysis. Qualitative techniques are important when human beings are studied in context (Palys, 1992). Palys puts emphasis on an approach that attempts to understand the reality from the perspective of the participants. Generally, he extols the virtues of an exploratory attitude; this matches the nature of the present research.

I am aware of the current debate between qualitative and quantitative research. I take a pragmatic view of the issue and would favour the combination of both approaches if they can serve better to unearth the social reality. The statistical data that was collected on eighty clients becomes richer when four of the clients come alive through interviews.

There are several sources of data. The first data that was collected derived from client files, which provided the profile of participants in three groups who had attended the programme. This was accomplished by receiving permission from the Centre to pull client files. The three groups selected from the agency's archives for profiling were sampled randomly from groups that had completed self-esteem questionnaires. These groups covered a five year time period from June/July 1990, May/June, 1992 and January, 1995. The clients remained anonymous as room numbers were used and not client names. They were analyzed as to age, gender, education, employment, self-esteem assessment and whether they were First Nations. The data from the Women's Group, October, 1995 was obtained using the same method.

Additionally, Hudson's self-esteem test was administered during the Women's Group (October/November, 1995). Informed written consent of all the clients attending the October 1995 group was obtained. To administer this self-esteem study, pre-test and post-tests were given and the data from the self-esteem questionnaires was analyzed. This gave a range from 0 to 100 with higher scores giving more evidence of the presence of problems with self-esteem. These self-esteem measures have been tested for reliability and validity by other researchers. As far as reliability is concerned, the Index of Self-Esteem (ISE) has a mean alpha of .93, indicating excellent internal consistency and an Self-Esteem Measurement of 3.70. The ISE also has excellent stability with a two-hour test-retest of .92. The ISE has good known-groups validity, significantly distinguishing between clients judged by clinicians to have problems in the area of self-esteem and those known not to

(Corcoran & Fischer, 1987 , p. 188). The self-esteem scores were further statistically analyzed by paired sample T-test.

At the end of the Women's Group in October 1995, intensive interviews were conducted with two First Nations' women. These interviews were taped and later transcribed and analyzed. These two interviews were further analyzed utilizing Yalom's twelve therapeutic experiences. I read the transcriptions and applied the concept of therapeutic experiences. The categories were used only for analysis and interpretation. A third intensive interview was conducted in April of 1996 with a First Nations couple who had attended the program in 1984. This interview was taped and later transcribed and analyzed.

Chapter Two

Introduction

This chapter deals with the history of alcoholism in British Columbia as it relates to First Nations and those from other cultures. Alcohol is widely accepted in society today. However, alcohol was unknown to the first natives of British Columbia and this is important as we try to understand why such a high percentage of First Nations people use this particular Centre. I felt it necessary to describe a history of alcoholism in British Columbia from both an Aboriginal and European perspective to set the background for the establishment of this treatment centre. It is important to look at both aspects when studying Nechako Treatment Centre because of the high rate of First Nations people that attend the Centre.

The Problem of Alcohol in British Columbia

Considering the lengthy history of alcoholism in British Columbia, treatment for alcoholism is fairly recent. Campbell (1991) tells of European fur traders first bringing alcohol to First Nations people in the late eighteenth century and that at first they were not too interested but by 1800 had acquired a taste for rum. There were two sets of rules for drinking in British Columbia, one for First Nations people and one for the rest of the population. The two histories will be dealt with separately.

Spanish ships first visited the coast of British Columbia in 1774. In 1778, Captain James Cook's third voyage explored the northwest coast of British Columbia. Cook had the opportunity to spend the winter in British Columbia but decided to travel on to the Polynesian Islands. The irony of Cook's preference played

itself out when Cook was killed by the Islanders on February 14th, 1779. Cook gave us our first glimpse into the First Nations people of Nootka Sound “where the natives traded fish and fur and practised thievery on a professional basis” (Villiers, 1967 p. 246). It should be noted that Villiers describes Cook’s impression of the Polynesian Islanders in the same way and it was because of “thievery” that Cook met his final end (Villiers, 1967).

In 1849 Vancouver Island was proclaimed a Colony of the British Empire. British Columbia was declared a Colony in 1858. James Douglas was a senior member of the board of the Hudson’s Bay Company and was appointed as the Governor of Vancouver Island in 1851. He left the Hudson’s Bay Company and was appointed as Governor of the new colony of British Columbia in 1858. In 1853 Governor Douglas and his council (then the Governor of Vancouver Island) established wholesale and retail liquor outlets in British Columbia. Like future government leaders, Douglas said that liquor licensing was for the control of consumption of alcohol and that the resulting steady source of revenue had nothing to do with the government’s action.

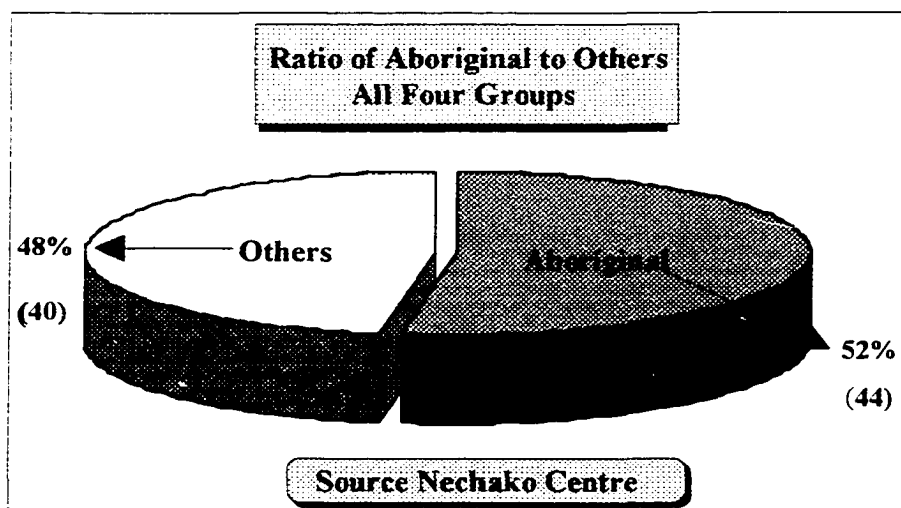
After sixty-four years of the government profiting from the sale of alcohol a referendum was held and prohibition was established in October of 1917. In 1918 Canada “under the authority of the War Measures Act banned the manufacture, transportation and sale of any ‘intoxicating liquor’ stronger than 2.5% proof spirits....” in those provinces which had prohibition (Campbell, 1991, p. 22). Thus prohibition had come to British Columbia. Soon afterward this course was reversed. Campbell (1991, p.1) noted that “In October of 1920 the voters of British Columbia,

for the first time including women in their number, abandoned prohibition for the regulated sale of liquor in government stores.” Part of the rationale for abandoning prohibition was to effect control over the sale of liquor and to eliminate bootlegging.

The first government liquor store opened in 1921 when prohibition was repealed. By 1922 there were liquor stores in 32 of the province’s 39 electoral districts and by 1923 liquor revenue accounted for over 15 percent of the provincial government’s income (Campbell, 1991). Meyers advises that in 1998 there were 220 provincial liquor stores in British Columbia and liquor revenue in the fiscal year 1997-98 accounted for 2.97% of the provincial government’s income with the net income being 5.42 million. The per capita costs for alcohol misuse in British Columbia in 1996 were estimated at \$272 (Leslie Meyers, March 23rd 1998, Alcohol & Drug Services, Vancouver, personal communication).

First Nations Alcohol History

Looking at participants who attend the Centre it is of significance to the author that the majority of people represented in my study are of First Nations origin. The ratio of First Nations to others in Nechako Centre populations included in this study is illustrated in the following graph:



First Nations had prophecies about the coming of whites and the coming of alcohol:

Some day you will meet a people who are white. They will try always to give you things, but do not take them. At last I think that you will take these things that they offer you, and this will bring sickness to you.

Sweet Medicine (Cheyenne Prophet)
(Ballantine & Ballantine, 1993 p. 230)

It is important to understand when we are looking at the problem that First Nations people had with alcohol that we understand the history of what happened to them when the Europeans came. Jenness (1958) states "In British Columbia the canneries that sprang up at the mouths of the Columbia, Fraser, and Skeena rivers depleted the salmon on which the Indians had depended for their daily food" (p. 256). As a Canadian I personally never received any insight into the devastation that occurred to First Nations people when the Europeans came. I do not recall being taught anything at school about the epidemics or abuse they experienced. I remember traveling through the canneries with my father on the Canadian National Railways along the Skeena during the 1930s. My father worked for the CNR so

summer holidays were spent traveling from Jasper, Alberta to Prince Rupert in British Columbia. The train would stop at Kitwanga so the passengers could go to the local school and view the art done by First Nations children at the school. We would then travel on to Prince Rupert and as we passed through the canneries at the mouth of the Skeena River our impression was one of the smell of the fish, and clothes hanging out to dry on lines. Little did I know that the people were being used as labour for profit and that their way of life had been taken away from them and that they were prohibited from selling salmon in 1885. Ballantine and Ballantine (1993, p. 203) said the society along the Skeena River was stabilized in the first century, A.D. and that economic territories were claimed by specific royal houses. The entire region blended into a system of compatible beliefs and practices. This system continued unchanged until the arrival of the Europeans in the 18th century. It is of historic significance for us to know that a well organized stable society was thrown into disarray by the beliefs and values of the incoming Europeans. I later learned of the Kwakiutl poem to the salmon:

When a man *eats* salmon by the
river, he sings the salmon song. It is
in the river in the roasting in the
spearing in the sharing in the shoring
in the shaking shining salmon. It is
in the song too.

Kwakiutl Poem
(Ballantine & Ballantine, 1993, p. 44)

The spearing and sharing of the salmon was the way of life for the Coastal First Nations people prior to European contact. It was not until the career phase of my

life some fifty years later that I came to know my First Nations friends at a deeply meaningful and personal level. I have gratitude and am richer for this experience.

Past Government Attitude Towards First Nations People

Indian policy was firmly fixed on a national foundation based unashamedly on the notion that Indian cultures and societies were clearly inferior to settler society. The annual report of the department of the interior for the year 1876 expressed the prevailing philosophy that Indians were children of the state:

Our Indian legislation generally rests on the principle, that the aborigines are to be kept in a condition of tutelage and treated as wards or children of the state. ... the true interests of the aborigines and of the State alike require that every effort should be made to aid the Red man in lifting himself out of his condition of tutelage and dependence, and that it is clearly our wisdom and our duty, through education and every other means to prepare him for a high civilization by encouraging him to assume the privileges and responsibility of full citizenship. (Report of the Royal Commission on Aboriginal Peoples, 1996 Volume 1, Looking Forward, Looking Back).

Their total way of life was taken from them and they were given the status of children. We learn that the government wanted First Nations people to become part of what was called a “high civilization.” Their own civilization was to be obliterated by government policy. Until we can appreciate the devastation that happened to them and their way of life, we can never comprehend the reasons for the misuse of alcohol. Their civilization was to be no more and they were to become “white.” Even today there are many who regard First Nations people “less than themselves.” This is ignorant and disrespectful and not terribly surprising considering the original government policy.

Post-Contact References

“The Indians, unlike many other primitive peoples, had no alcoholic beverage in prehistoric times” (Jenness 1958, p. 253). “Canada was bone dry and its inhabitants were totally abstinent” (Smart & Ogborne, 1996, p.1) when the Europeans came to Canada. Yet soon Jenness would say “from the earliest days of settlement they abandoned every restraint in their frenzy for the white man’s firewater.” (Jenness, 1958, p. 253).

Contrary to Jenness’ preceding statement there is more substantive evidence that the Indians of the Northwest coast did not like the taste of alcohol and that the traders had to teach them to drink and become drunk (Smart & Ogborne, 1996). Captain George Vancouver described three Indians who came to a ship’s dinner party and drank sparingly and he further described Ross Cox writing in 1833 that the Campbell River Indians had an aversion to spirits and said that “drunkenness is degrading to free men” (Howay, 1942).

To single out First Nations people is not fair. Daniel Harmon, a British fur trader who had reason to know, said he would rather deal with fifty drunken Indians than five drunken Canadians (Ballantine & Ballantine 1993, p. 261). Jenness (1958) pointed out that European disease (small pox, measles, influenza and consumption) to which they had no resistance devastated and demoralized First Nations people when they needed their energy to cope with the coming of the Europeans and the change in their lives. Hundreds of thousands sickened and died as a result of their encounters with Europeans. Many Europeans arrived suffering from illnesses they brought with them from the slums of Europe and from the effects of the voyage

(Royal Commission on Aboriginal Peoples 1996, Chapter 3, Health and Healing, p. 5). Before contact with Europeans, the native population of the Americas were portrayed as remarkably healthy because they lived an open, uncrowded life. They also knew about herbal remedies and medications and practised cleanliness in sweat baths. (Ballantine & Ballantine, 1992, p. 137).

Jenness (1958) mistakenly thought the problem of alcoholism was solved when he said “Of shorter duration than diseases, because Europeans finally awoke to its menace, but, while it lasted, almost equally destructive, was alcohol” (Jenness, 1958, p. 253). The problem of alcoholism still exists today and it is still destructive. In 1860 in British Columbia (then the Colony of Vancouver Island) an act was passed to prohibit the sale or gift of intoxicating liquors to the First Nations people (Fisher, 1992). This was difficult to police and between 1858 and 1864 there were 240 convictions of Europeans selling liquor to the First Nations people. In 1860 it was thought that selling liquor to First Nations people was one of the most profitable businesses in Victoria. Maracle (1993) gives us insight as to how drinking patterns emerged in First Nations society. In 1876 Parliament passed the first Indian Act. Western First Nations people were excluded from the operation of most sections of the Act as they were not considered as advanced as First Nations people who lived east of Lake Superior (Tobias, 1983). By advanced Tobias is referring to the fact that Eastern First Nations people with their longer European contact were more advanced in the way of European culture. Tobias further states that the Indian Act subsequently contained amendments for the western First Nations people which attacked traditional Indian sexual, marriage and divorce mores and furthered the

Christian-European values (Tobias, 1982). The act made it illegal for status Indians to buy or possess alcohol. The penalty for being intoxicated on or off reserve was one month in jail and a further fourteen days if the seller of the liquor was not named (Volume I, Looking Forward, Looking Back, Royal Commission on Aboriginal Peoples, 1996). The law did not stop Indians from drinking but it changed the way they drank. They were not allowed in bars or beer parlours and could not have it in their homes so they became furtive with their drinking, drinking in bushes, back alleys or wherever they would not be seen. They learned to ‘guzzle’ their alcohol so they would not be caught and arrested. Despite this, thousands were caught and arrested (Maracle, 1993). Prohibition for First Nations people lasted until 1951 (Dickason, 1992 p. 251). Since that time all Indian reserves are “wet” (alcohol is allowed) unless a band council votes to make it “dry” (no alcohol is allowed on the reserve).

The First Nations customs, values, and beliefs were unknown to the Europeans and the First Nations peoples were stereotyped as dishonest, lazy and deceitful (Fisher, 1992). Particularly when the question of settlement started in the 1800s, the First Nations peoples were devalued even more as their land became attractive to European settlers. The picture of the “drunken Indian” began to emerge as the First Nations people had to consume liquor illegally. They also resorted to making up batches of “home brew” and drinking substances such as rubbing alcohol, canned heat, hair tonic, vanilla extract, shaving lotion, listerine and perfume (Leland, 1976).

In working with both First Nations peoples and others over thirteen years I have seen no differences in the way intoxicating substances are obtained. When alcohol cannot be obtained due to monetary restraints, other intoxicating substances are used.

When alcohol is available, the one main difference from personal observation is that the First Nations people tend to “binge” drink. A contributing factor for binge drinking was that First Nations people had to obtain their alcohol illegally so they began to drink furtively. Large amounts had to be consumed so there would be no left-over evidence of the alcohol. First Nations people were not allowed to go into beer parlours or have it in their homes like the rest of the population until 1951. So where were they to drink?

Looking at the oral history of one of the women who has gone through Nechako Centre (Chapter 6), we observe that this First Nations person learned to drink when she was very young. Some First Nations children clean up after their parents or relatives parties. Due to enactment of the Indian Act, in which reservations were set up, the homes that were built are smaller and the children upon awakening see the results of the party held the previous night. Some First Nations children learn to drink early and drink heavily, cleaning up the left-over alcohol from bottles left by their parents from the previous night. While this may happen in European families it appears to be a more prevalent story amongst First Nations people. (See Chapter 6, First Interview).

Clearly there was no understanding of the highly organized society nor of the culture of First Nations peoples. No-one took the time to understand the original peoples of the land and so there was a complete lack of respect for the First Nations people from the beginning.

Proposed Principles for a Renewed Relationship

The Royal Commission on Aboriginal Peoples (1996) recommends mutual recognition, mutual respect, sharing and mutual responsibility between Aboriginal

and non-Aboriginal People. Mutual recognition on the part of non-Aboriginal Canadians encompasses the reality that Aboriginal people are the original inhabitants and caretakers of this land and have distinctive rights and responsibilities that flow from that status. Mutual recognition calls on Aboriginal people to accept that non-Aboriginal people are also of this land, by birth and by adoption, and have strong ties of affection and loyalty. In short we need to regard one another as equals, co-existing each with our own laws and institutions (Report of the Royal Commission on Aboriginal Peoples, 1996, Volume 1, The Principles of a Renewed Relationship).

Had this respect been given in 1876 and before, the First Nations peoples would not have suffered for over one hundred years. They would not have lost their culture, their children to residential schools, their language and their pride. Perhaps alcohol would not have become so prevalent had their pain not been so great.

Action Against Alcoholism in British Columbia

There was early recognition of alcohol as a social problem. Proposals to curb alcohol were not lacking. A Liquor Inquiry Commission was conducted in 1952 headed by Harry H. Stevens later known as the Stevens Commission. It recommended a provincial programme of alcohol education, an alcohol research foundation at the University of British Columbia, and a rehabilitation centre for habitual drunkards and alcoholics, all to be financed from liquor revenue. Stevens and fellow commissioner George Home were disappointed that liquor reform did not occur and their recommendations were not implemented. In the late 1950's Stevens criticized the W.A.C. Bennett government (Social Credit) for having done little to help the province's 20,000 alcoholics (Campbell, 1991, p. 126).

Some seventeen years later, the Morrow Commission was appointed in February, 1969 and in March 1970, the Commission report was released. It recommended that a cabinet member be appointed to aid in the prevention,

education, treatment and rehabilitation of those suffering from substance abuse. The Morrow report also contained many of the recommendations which were given in the Stevens report. Once again the recommendations were not implemented and Judge Morrow expressed his disappointment in 1971. In 1972 the federally appointed LeDain Commission stated that “alcohol was a major factor in traffic accidents, violent crimes, suicide and family disruptions” (Campbell, 1991, p.155). In 1973 the government of British Columbia (New Democratic) established the Alcohol and Drug Commission under the chairmanship of J. Peter Stein who had been a member of the LeDain Commission. The purpose of the Alcohol and Drug Commission was to bring order to the provinces’ alcohol and drug programmes overseen by eighty private agencies and five ministries.

Paralleling the growth of drinking in British Columbia, Prince George was known as a “drinking town.” Service for substance abusers began in 1972 when the Salvation Army opened a centre called Harbour Lights. Harbour Lights provided care and counselling for those who needed help due to drinking. Alcohol and Drug Services (run by a private society) provided outpatient counselling in the 1980’s. St. Patrick’s Halfway House was established during the 1980s. “St. Pat’s” is still running and provides shelter for those waiting to return to society. Treatment North opened in 1976 under the auspices of the hospital and was a residential treatment centre founded by members of Alcoholics Anonymous. Nechako Centre (under the auspices of the Prince George Hospital) took over Treatment North in 1981 and hired professional staff as well as keeping on some of the Treatment North staff.

Chapter Three

Introduction

This chapter presents a brief history of the Nechako Centre and includes the programmes and information that are offered to clients. It provides the main core of the treatment model and the therapeutic techniques that are utilized in group therapy. It describes a day in the life of a Nechako Centre client.

Nechako Centre: A Fighter Against Alcoholism

Nechako Centre was founded in Prince George in October of 1981 and is located on the grounds of the Prince George Regional Hospital. The Nechako Centre serves a population of 309,852 (Directory of Substance Abuse Services in British Columbia, 1994-95). Referrals are made by Alcohol & Drug Outpatient Clinics, Native Alcohol & Drug Abuse Counsellors, Employee Assistance Programmes, Family Doctors, Social Service Workers and Detox Assessment Units. It was estimated in 1995 that 4,675 people have passed through the centre since its inception.

As well as serving Prince George, the Nechako Centre receives referrals from many parts of the Province. Clients have come from Vancouver, Vancouver Island, the Okanagan, the Kootenays, Bella Coola, Williams Lake, Quesnel, McBride, the Peace River, the Yukon, and Queen Charlotte Islands. Many reserves in the province have used the services of Nechako Centre.

Nechako Centre offers intense group therapy in a residential setting wherein close ties are developed and a sense of community evolves. Nechako Centre offers an opportunity for First Nations people and others to come together and know one

another in a supportive environment. It validates First Nations culture through the use of the Medicine Wheel and values the visits of a Medicine Man as a guest lecturer. Many lasting friendships have been formed between First Nations people and others and a greater understanding has developed. I recall one First Nations man from the Queen Charlotte's speaking at a closing ceremony in 1990 and he said "but we are all the same, whether we are white or native."

Nechako Centre Treatment Model

Nechako Centre uses a biopsychosocialspiritual model. The theory behind the model is that substance misuse is the result of complex interactions between biological, psychological, social and spiritual determinants. Like the Adult Clinical and Addictions Services Branch, the Nechako Centre believes the determinants listed below are part of the cause. However, Nechako Centre believes that causality remains elusive:

- substance misuse embraces a variety of syndromes including dependency syndrome and substance misuse related disabilities
- substance abuse lies upon a continuum of severity.
- the development of substance misuse follows a variable pattern over time and may or may not progress to a fatal stage depending on the type of syndrome and/or degree of severity.
- there is no one superior treatment for all substance misuse as the elements in the experience of addiction will differ between individuals.
- the population of substance misusers is heterogeneous and defies stereotyping.

- successful treatment is contingent upon accurate and comprehensive assessment and matching of affected individuals to the most appropriate treatment.

(Adult Clinical and Addictions Services Branch, Alcohol and Drug Services, B.C. Ministry of Health and Ministry Responsible for Seniors, 1996).

Funding

Nechako Centre is funded by the Provincial Ministry for Children and Families and is administered by the Prince George Regional Hospital. An agreement was signed on the 13th of September, 1993 between the Province of British Columbia and the Prince George and District Hospital Society. The Prince George and District Hospital Society is named as the “Contractor” and funds are given quarterly to the hospital for the administration of Nechako Centre.

Nechako Centre Programmes

Nechako Centre offers residential treatment programmes for clients who have substance abuse problems. Group work is the norm. It serves twenty to twenty-four clients in each group. The following groups are three weeks in length and are followed by a one-week relationship program with the significant other:

- Co-education Programme
- Women’s Programme
- Men’s Programme

It also periodically offers:

- Refresher Programmes
- Programme for Violent Men (Men Against Violence)
- Teen Programmes

- Co-Dependency Programme

The Co-Education Programme, Women's Programme, and Men's Programme all have the following commonalties:

They are three weeks in length and the day begins at 7:00 A.M. with the clients making and serving breakfast. Breakfast ends and is cleared up by 8:00 A.M. The serving and clearing of breakfast are tasks that the clients take on. It produces certain interesting dynamics as there can be those that are late, those who do not clear up behind them and general confusion can occur. The very serving of breakfast produces the first group dynamic for the clients. Following breakfast, clients are introduced to the concept of "learning partners." The methodology of learning partners is that the partners get together from 8 - 8:30 A.M. and mutually discuss a topic that has been posted for them. The learning from "learning partners" is not just the topic discussed, there are times when partners become fast friends and are close after leaving the centre. Of course, the opposite happens and some partners just cannot get along. When this happens, counsellors instruct the clients how to communicate resentments to each other. This is invaluable as communication skills are very often lacking in the treatment centre as they are in life outside of the centre.

Following breakfast and learning partners, the clients come together for a "warm-up." Warm-up consists of tai chi, yoga, meditation, stretching, relaxation techniques or just plain fun games. The purpose is to make a connection with the clients and have some fun as well. The other purpose is to have the clients relax without the use of alcohol or drugs. "Smudges" are also offered if there is a predominance of First Nations clients. The smudges I have participated in are

described as follows: a circle is formed and one person will be selected to conduct the smudge. Sweet grass or sage is lit and placed in a shell. The sweet grass or sage is generally made into a rope. When the sweet grass or sage is alight a smudge of smoke arises. The person conducting the smudge will then gently waft the smoke with an eagle feather in front of each person in the circle. As the smoke wafts over the person they will cup their hands and seemingly wash the smoke over them. In one smudge in which I participated, the women were from the Arctic and they each called upon their ancestors to bless them and guide them in their work. That particular smudge was a spiritual experience for me as I respected the sincerity of the participants.

There are four counsellors in a co-educational group, two male and two female and they participate in all the warm-up activities. After warm-up a circle is formed and discussion ensues regarding disputes amongst group members and tasks that need to be done in the Centre. The group is responsible for keeping the Centre clean and how well this is done sometimes reflects the enthusiasm and success of group interaction. Again, differences may occur amongst members and this provides another opportunity for learning communication skills. Adler and Towne (1996) suggest that communication is not a natural ability and that effective communication takes practise. In general, effective communication skills are lacking amongst the majority of clients. Teaching basic communication skills gives the clients some insight into how to approach others in problem solving situations. Also the group members may wish to offer appreciation. Criticism comes easy, teaching appreciation skills can prove more difficult but can enhance gratitude for simple acts of kindness

between the clients. The simple act of appreciation can be taken from the Centre and applied to everyday living when the clients return home.

Clients are also encouraged to share any skills they may have. Some of the skills that have been shared are: playing a musical instrument, hairdressing, different types of dancing, poetry, or native art. Clients are introduced to journal writing and this may be their first experience of keeping track of their feelings and what is happening for them as they go through treatment. Journal keeping can take many forms and if writing is not a skill then pictures can be drawn or pictures pasted. Whatever appeals to the client's creativity is supported. The journals are private and are never seen by counsellors or other group members unless the keeper of the journal wishes to share with others. It is also encouraged that recurring dreams be recorded in the journal.

Information Sessions

The Counsellors will follow a group warm-up with informational inputs on:

- The nature of chemical dependency: clients are given information on how substance abuse affects every aspect of their lives, i.e. physical, mental, emotional and spiritual. For First Nations people the Medicine Wheel is an important concept of these four areas and the client learns that continued substance abuse can result in death and that the process of substance abuse can be reversed by the client.
- A discussion of how feelings get lost in the abuse process: When heavy drinking is involved the full range of feelings can get lost. To re-experience joy in living the clients need to have an understanding of how feelings can be re-gained and how important feelings are to their emotional health.

- Self-esteem: Very often clients have little understanding of how self-esteem is formed. Information is given on the development of self-esteem.
- Assertiveness and communication skills: This is an interesting part of the program for the clients that includes role playing using actual life events. Counsellors model role-playing and this is always a highlight for the clients.
- Family dynamics and the homeostasis of families: The clients learn about the systems of families and the various roles that are played by family members. Very often they will identify some of the roles they have played to keep the family functioning.
- Grief and loss: The clients learn that grief is universal and that there are stages in grieving that everyone goes through. Understanding the grieving process allows them to share their feelings of grief in a supportive environment. The model that is used is based on Worden's Normal Grief Reactions (Worden, 1991, pps. 21-30).

Group Therapy

Following the informational inputs, the participants will be divided into two groups, with two counsellors (one male and one female) leading each group. Group work is the basic tenet of the programme. There are two group rooms at the Nechako Centre and group members get possessive about *their* room and *their* group and *their* counsellors. Groups run both morning and afternoon and are two to three hours in length.

Several models of therapy are utilized. The therapy that is offered is discussed with each client before it is conducted and can vary from client to client depending on

the counsellors' assessment of the clients' needs. Agreement of the client for the therapy selected is essential as respect for the clients is one of the values of the programme. It is also empowering for the client to have control over what s/he will or will not do. So often, as in the case of battering or sexual abuse, the client has had little or no control over the situation. Part of the therapy is for the client to know that they are in control of their own therapy. Also, growing up in a family, children are not in control and many traumatic experiences can come from the family of origin. Even if there are no traumas, self-esteem and self-concept are based on early childhood experiences.

A Variety of Techniques

Counsellors each have their own preference for the therapy they like to work with and some of the models offered are:

Family Therapy

Family therapy is both a theory and a treatment method. It offers a way to view clinical problems within the context of a family's transactional patterns. Family therapy also represents a form of intervention in which members of a family are assisted to identify and change problematic, maladaptive, self-defeating, repetitive relationship patterns. Unlike individually focused therapies, in family therapy the identified patient (the family member considered to be the problem in the family) is viewed as a symptom bearer, expressing the family's disequilibrium or current dysfunction. The family system itself is the primary unit of treatment and not the identified patient. Helping families change leads to improved functioning of individuals as well as families (Goldenberg and Goldenberg, 1995, p. 356, *Current Psychotherapies*).

Gestalt

A form of psychotherapy associated with the work of Frederick (Fritz) Perls (1893-1970). It is based loosely on the Gestalt concepts of unity and wholeness. Treatment which is usually conducted in groups, focusses on attempts to broaden a person's awareness of self by using past experiences, memories, emotional states, bodily sensations, etc. In short, everything that could contribute to the person forming a meaningful configuration of awareness is an acceptable part of the therapy process (Reber, 1985)

Transactional Analysis (TA)

Members of TA groups learn how their life scripts influence their feelings, attitudes, and behaviour in the present. Once early decisions have been made, through a variety of therapeutic techniques group members can experience early childhood scenes, can relive situations in which they made certain self defeating decisions about themselves and about life, and eventually can make *new decisions* on both an intellectual and emotional level (Anastasia, 1994).

Psychodrama

A psychotherapeutic technique developed by J.L. Moreno in which the individual acts out certain roles or incidents in the presence of the therapist and, often, other persons who are part of the therapy group. The procedures are based on the assumption that the role-taking allows the person to express troublesome emotions and face deep conflicts in the relatively protected environment of the therapeutic stage. Common variations are *group psychodrama* in which all the actors are in the therapy groups, and *family groups* in which difficult domestic scenes are enacted (Reber, 1985).

Nechako Centre has an eclectic approach and allows counsellors to use various techniques. The strength of this liberal approach is that counsellors can keep developing and learning. The weakness is that unless counsellors are monitored it could be harmful to the clients. If professional standards are not met, counsellors have been asked to leave the Centre. The monitoring that I have witnessed comes through continual staff meetings. There are meetings at the conclusion of each day and a meeting at the conclusion of the week. Thus the counsellors are able to give one another feedback on a daily and weekly basis where both positive and negative feedback is encouraged.

Chapter Four

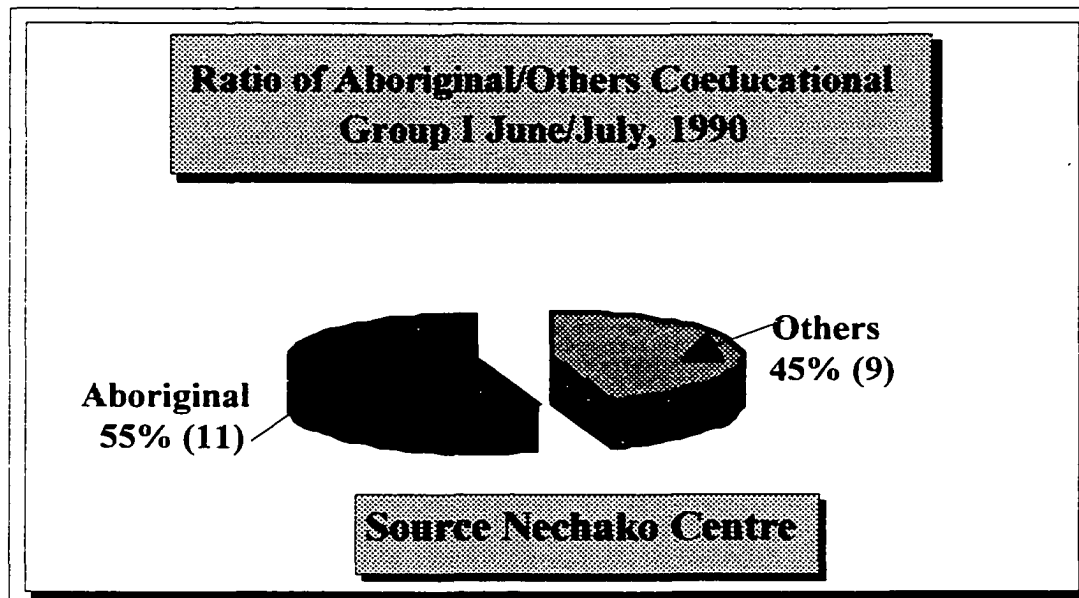
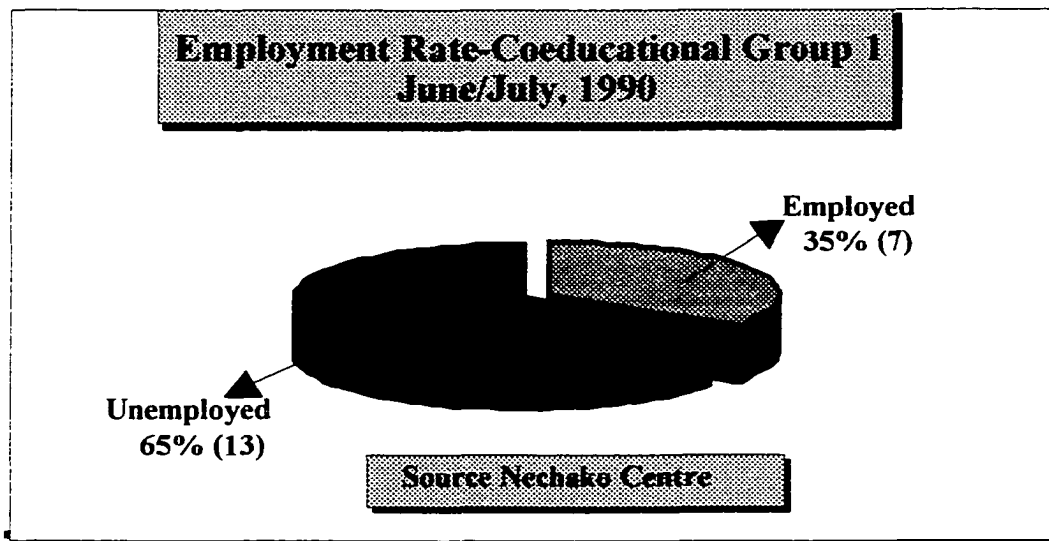
Profiling Groups: Clientele Characteristics at Nechako Centre

This chapter examines three groups that attended the programme from June 1990 to January, 1995 in order to provide background information as to participants' age, gender, education, employment and ethnicity. Each group is studied separately and toward the end of the chapter, self-esteem and ethnicity are examined on the basis of aggregate data from the three groups. Self-esteem is measured by a self-evaluation scale at the end of treatment. The estimated number of people that have passed through the programme in this time period would be around 400. A total of 60 participants are included in the following three profiles. Although this is a small sample of the total number, it gives a snapshot picture of those who attend the programme. The Centre included a self-esteem measurement on an evaluation form completed at the end of the program.

Group I: Co-Educational Group, June 19th to July 20th, 1990

Twenty clients entered the program. Eleven were female, seven of whom were First Nations. Nine were male, four of whom were First Nations. The age range was twenty to fifty-seven. The females ranged in age from twenty to forty-one and the males ranged in age from twenty-two to fifty-seven. Education ranged from Grade 7 to 12 for females and from Grade 8 to 12 for males. Four females were employed and three males were employed. Two males and one female left the programme before completion, all of First Nations origin. Three of the group attended Relationship Week, all were First Nations females. Homemakers are not categorized

as employed. The following graphs give a visual picture of the make-up of the group.

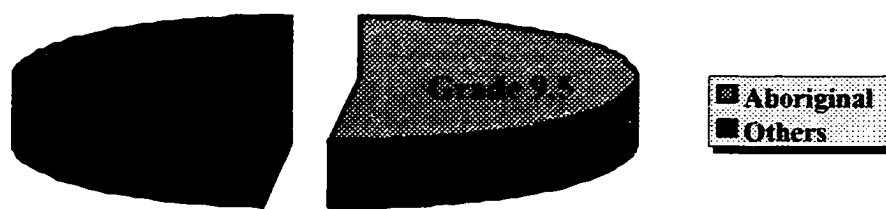


**Ratio of Male/Female Coeducation Group I
June/July, 1990**

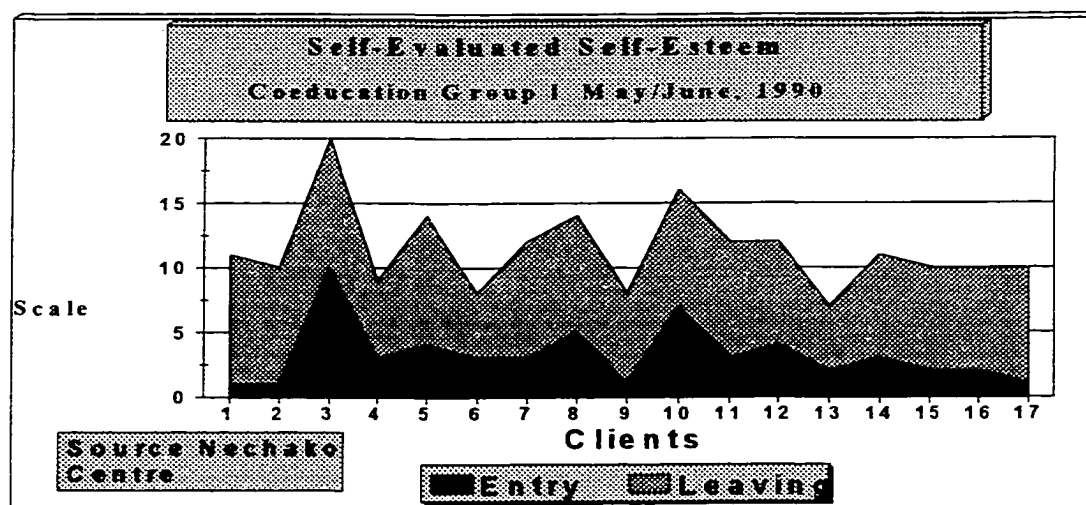


Source Nechako Centre

**Education Level Aboriginal/Others
Group 1, June/July 1990**



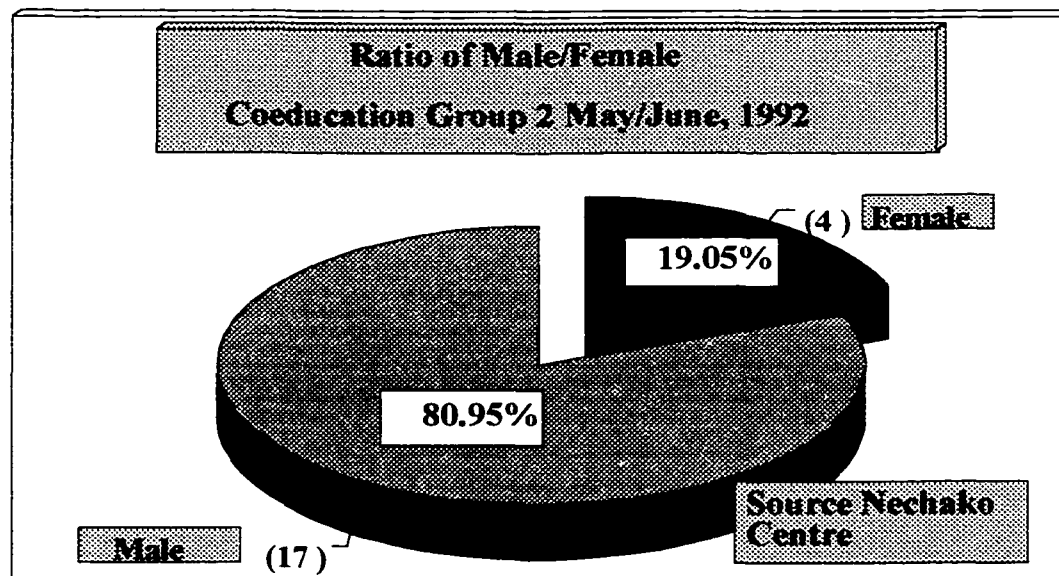
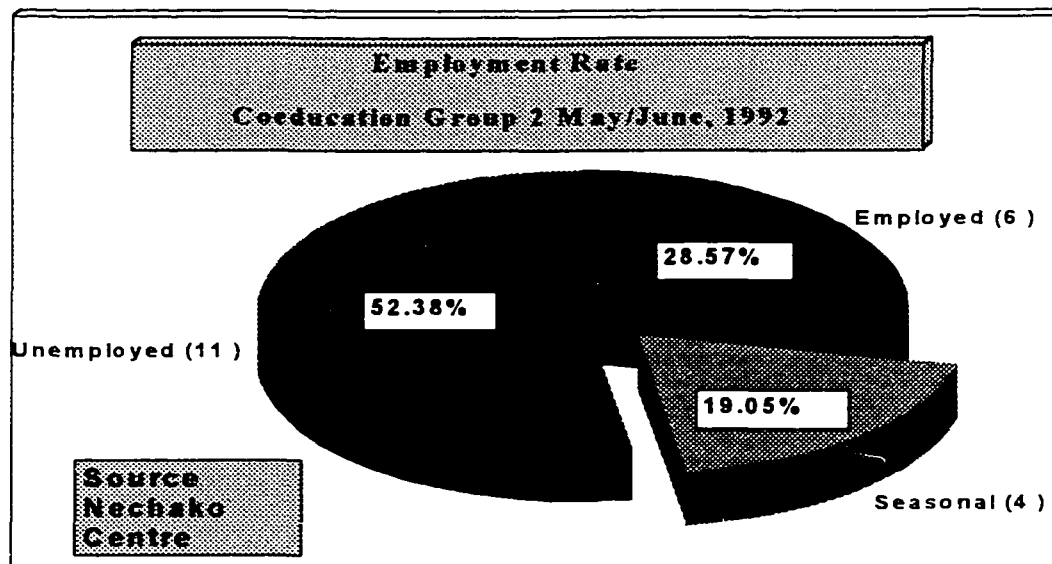
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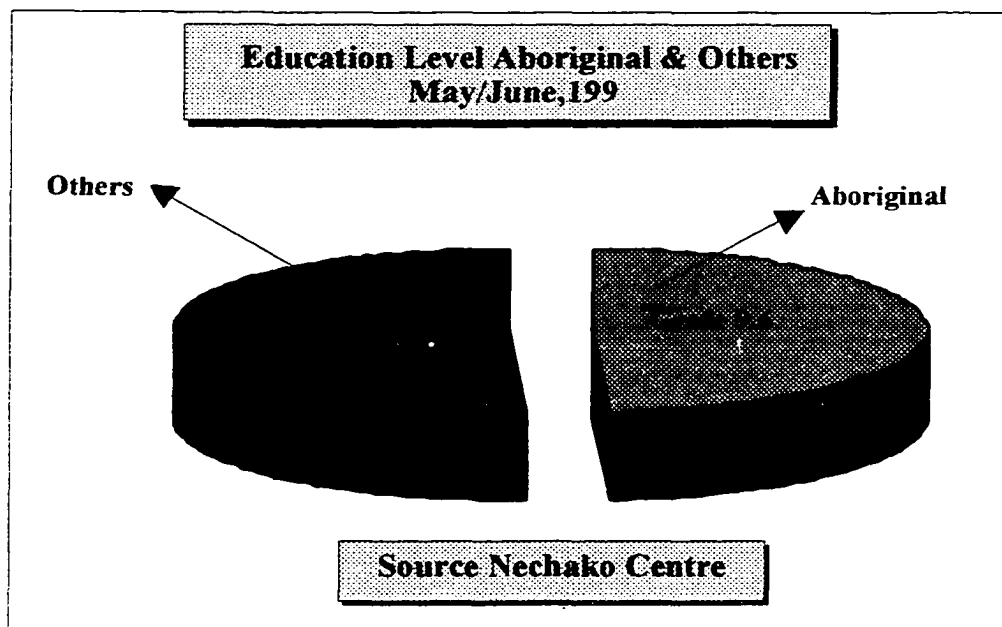
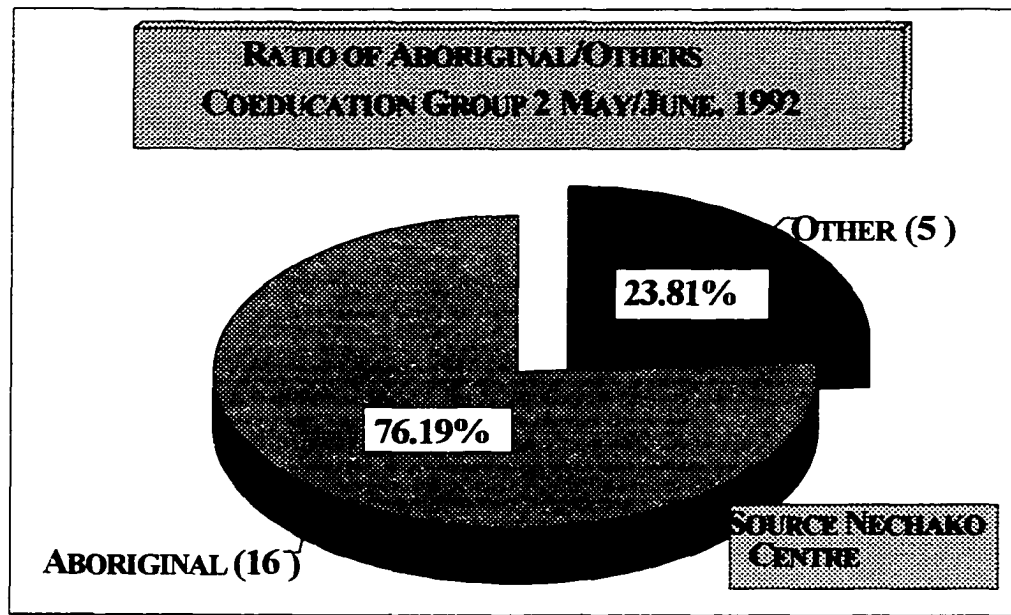


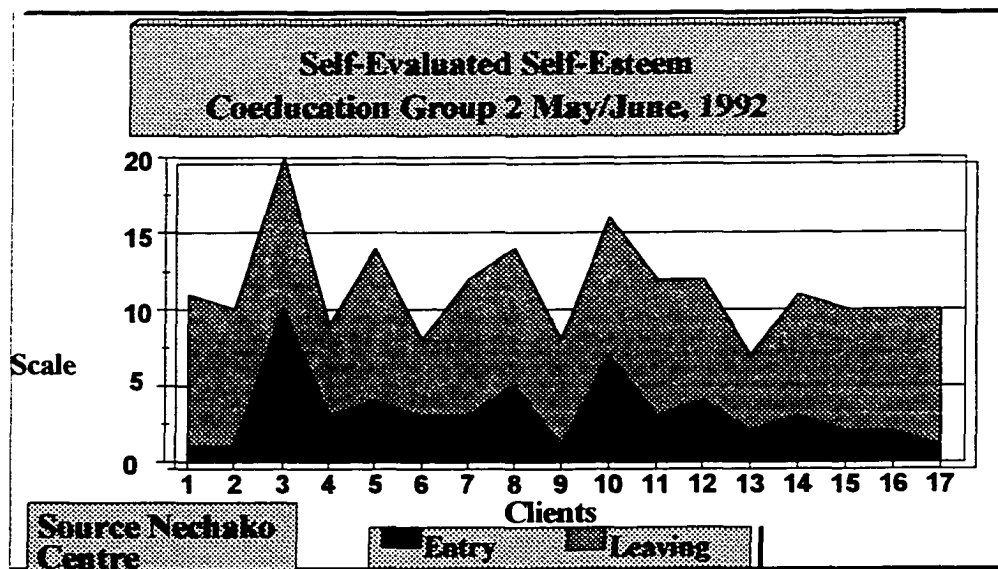
Group 2: Co-educational Group, May 19th to June 20th, 1992

Twenty-one clients entered the program comprised of four females, all of First Nations origin and seventeen males, twelve of First Nations origin. They ranged in age from twenty-one to sixty-four. The females ranged in age from twenty-four to thirty and the males ranged in age from twenty-one to sixty-four. Education ranged from Grade 11 to 12 for females and from Grade 4 to 12 for males. One female was employed part-time and five males were employed full-time. Four males were seasonal or part-time. There was one retired male and eight males were unemployed. One male left the programme before completion and he was not of First Nations origin, three others did not complete the self-evaluated self-esteem form. Six of the group attended Relationship Week and five were males of First Nations origin and one female of the white race.

The following graphs give a visual picture of the make-up of the group:

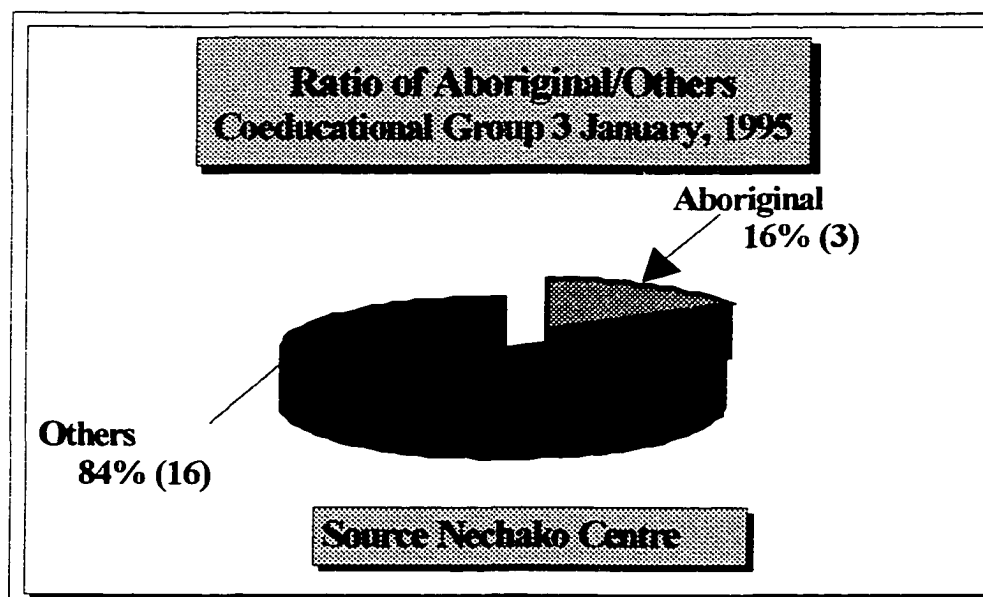
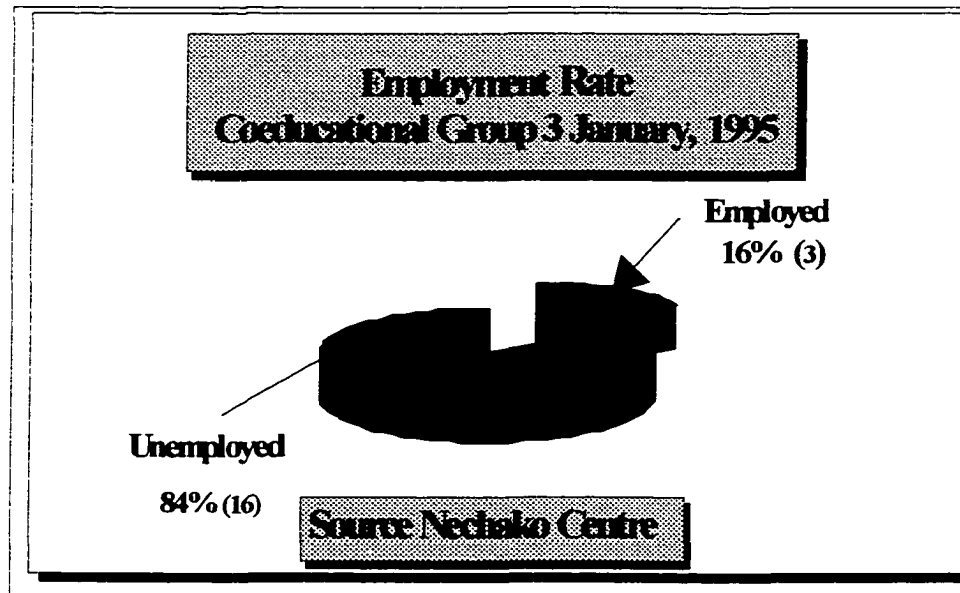


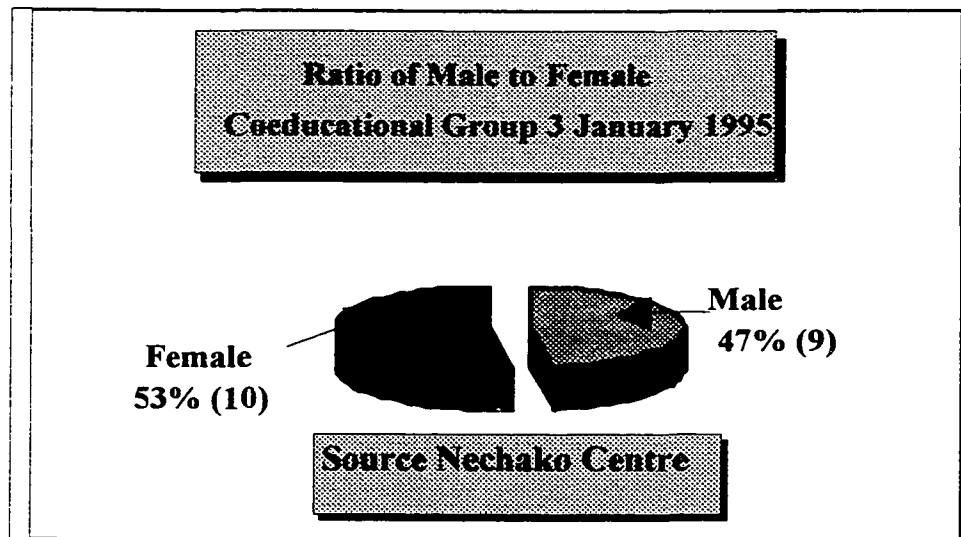
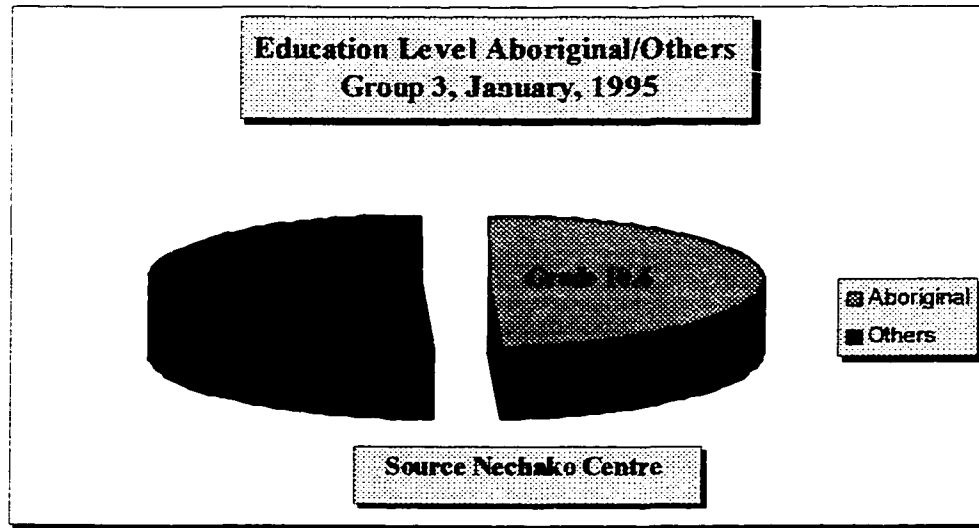


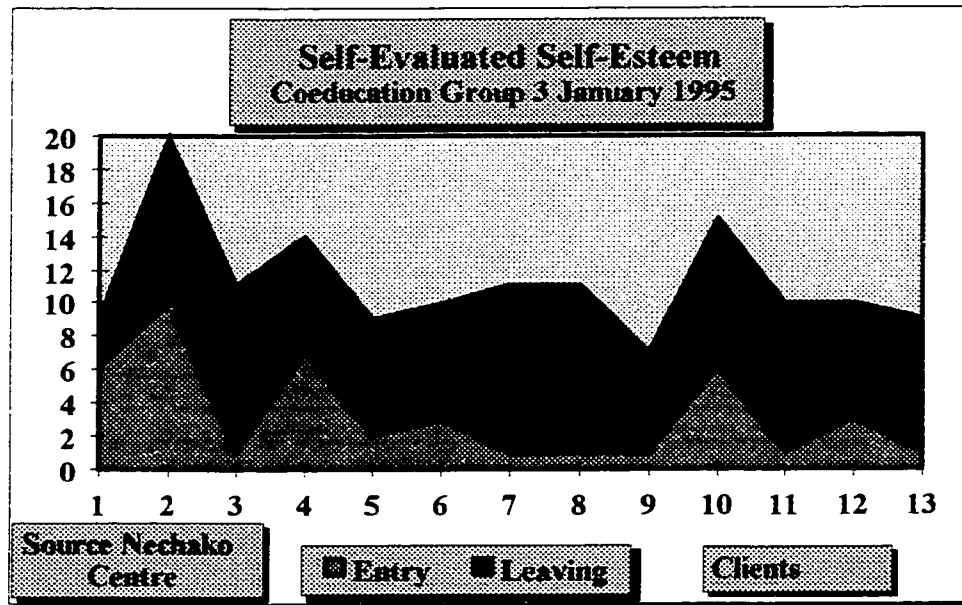


Group 3: Co-educational Group January 3rd to January 27th, 1995

Nineteen clients entered the program comprised of nine males and ten females. One female and two males were of First Nations origin. They ranged in age from sixteen to sixty-six. The females ranged in age from sixteen to forty-three and the males ranged in age from twenty-seven to sixty-six. Education ranged from Grade 7 to two years of university for females and from Grade 8 to Grade 12 for males. Two males were employed, neither were of First Nations origin. One female was employed, not of First Nations origin. Seven couples attended relationship week, one of which was of First Nations origin. Five people left the programme, two were of First Nations origin. One person did not complete the self-evaluated self-esteem form. The following graph gives a visual picture of the make-up of the group:

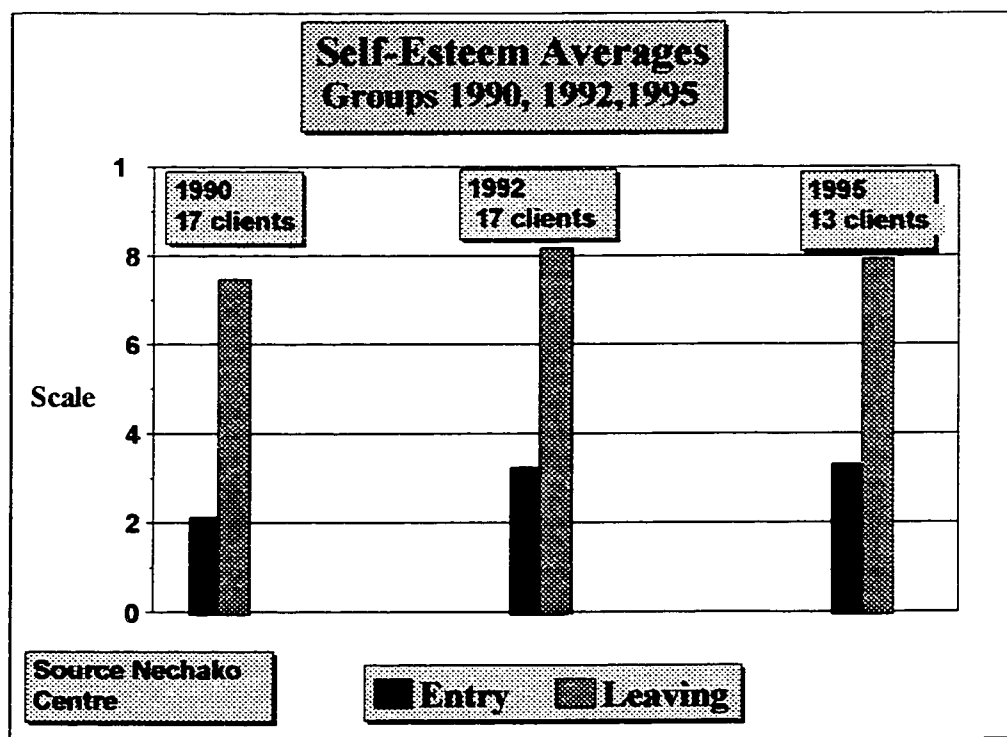






The original group comprised 19 clients. Five left the program and one did not return their self-evaluation form.

Comparison of Self-Esteem averages between the three groups



Of the three groups that were profiled in this study we observe that their average self-esteem increased significantly. In Group 1 the increase was from just over the average of 2 to close to an average of 8. Group 2 increased from 3.5 to just over 8 and Group 3 increased from an average of 3.55 to 8. There was no pre-test and the retrospective self-evaluated scores at the completion of treatment were on a scale from 1 to 10.

It is interesting to analyze the aggregate data from the three groups. There are 47 cases to analyze because 13 either left the program before completion or did not complete the self-esteem assessment forms. For the group, their average age is 33.4. Their average years of education is 10.1. Collectively, for the self-esteem measures, the pretest average for the 47 cases is 2.85 and the posttest average is 7.85. In order to test whether the difference in means from the pretest and posttest is statistically significant, a paired-T test was performed (Table 4.1) based on the sample of 47 participants. The two-tailed test results indicates a significant increase in self-esteem from pre-test to post-test. Also each group individually gained in self-esteem and the three groups pooled together show that they all gained at the about the same level.

Table 4.1
Pretest and Posttest Self-Esteem Scores
(n=47 pairs)

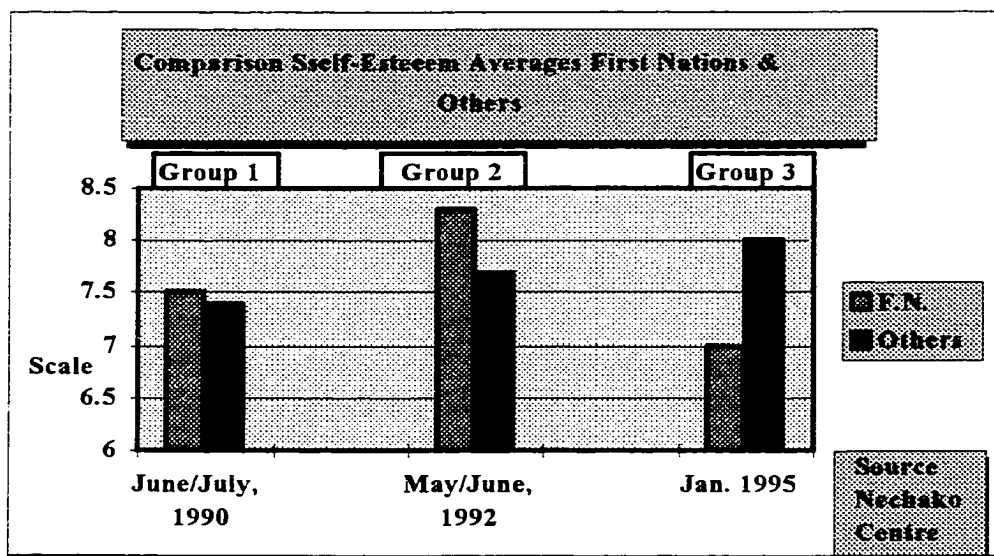
	Mean	S.D.	Df	t-value
Pretest	2.85	2.25	46	12.92*
Posttest	7.85	1.74		

*p < .001

Note: Self-esteem measures derive from self-evaluation of clients at Nechako Centre

Comparison of average of self- esteem First Nations and non-First Nations

for the three groups



The clients who completed self-esteem forms at the end of the programme:

Group 1 (the June/July, 1990 group) was comprised of eight First Nations and nine white.

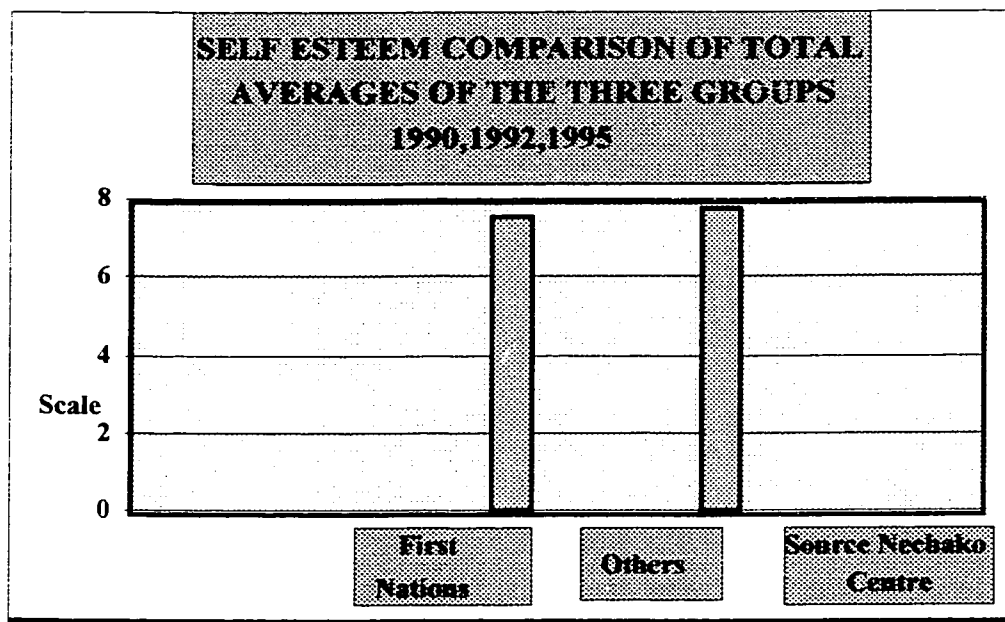
Group 2 (the June May/June, 1992 group) was comprised of thirteen First Nations and four others.

Group 3 (the January, 1995 group) was comprised of one First Nations and twelve others.

The self-esteem was self-evaluated and in June/July 1990 we observe that First Nations scored themselves a little higher than the others. In May/June, 1992 the First Nations clients have a higher self-esteem than the others and in January of 1995 the non-native clients have a higher self-esteem than the Native population. There was only one First Nations in the latter group and this may account for the difference.

Also in the May/June, 1992 group the First Nations outweighed the other cultures significantly. In Group 1 (June/July group) First Nations and others were more closely balanced in numbers and in increase in self-esteem.

Comparison of total averages of Self-Esteem for First Nations and Non-First Nations for the three Groups



The First Nations' percentage for the three groups was 7.5% as compared to 7.7% for the non-First Nations. From the foregoing graph for the three groups that were profiled we may conclude that the increase in self-evaluated self-esteem was comparable between First Nations and non-First Nations. However the score was higher when First Nations were the majority, comparable when the First Nations and others were comparable and less when there was only one First Nations person. This suggests that self-esteem for First Nations will be higher if the ratio of First Nations to others is at least balanced.

Chapter Five

Personal Interaction and Observation of the Group Process in October and November, 1995

The writer was called back to work at Nechako Centre on October 10th, 1995. This presented a unique opportunity to study the group process. I began my research on Nechako Centre during the Spring of 1995 while taking my post-graduate courses at UNBC. The knowledge gained from post-graduate courses enabled me to use a better scale in measuring self-esteem.

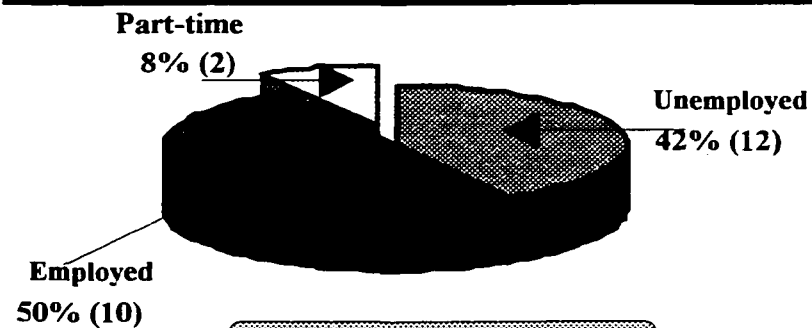
I worked in the Women's Programme from October 10th to November 4th, 1995. I counseled a group of eight women for three weeks and then counseled the relationship portion of the programme during the final week. The relationship portion of the programme is the fourth week when partners of clients come into Nechako Centre.

Profile Of The Women's Group, October 10th to November 4th, 1995

Twenty-four women entered the program and seven left before the completion of the program. Four of the women who left were of First Nations origin. They ranged in age from twenty to forty-eight. Education ranged from Grade 7 to Grade 12. Ten of the group were employed. Fourteen of the original group were of First Nations origin. Six couples attended Relationship Week. Three of the couples were of First Nations origin.

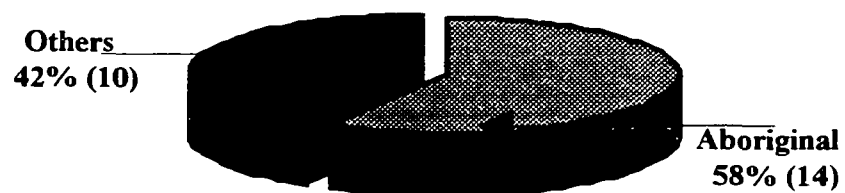
The following graphs give a visual picture of the make-up of the group: Homemakers are not considered as employed.

**Employment Rate
Women's Group Oct./Nov., 1995**

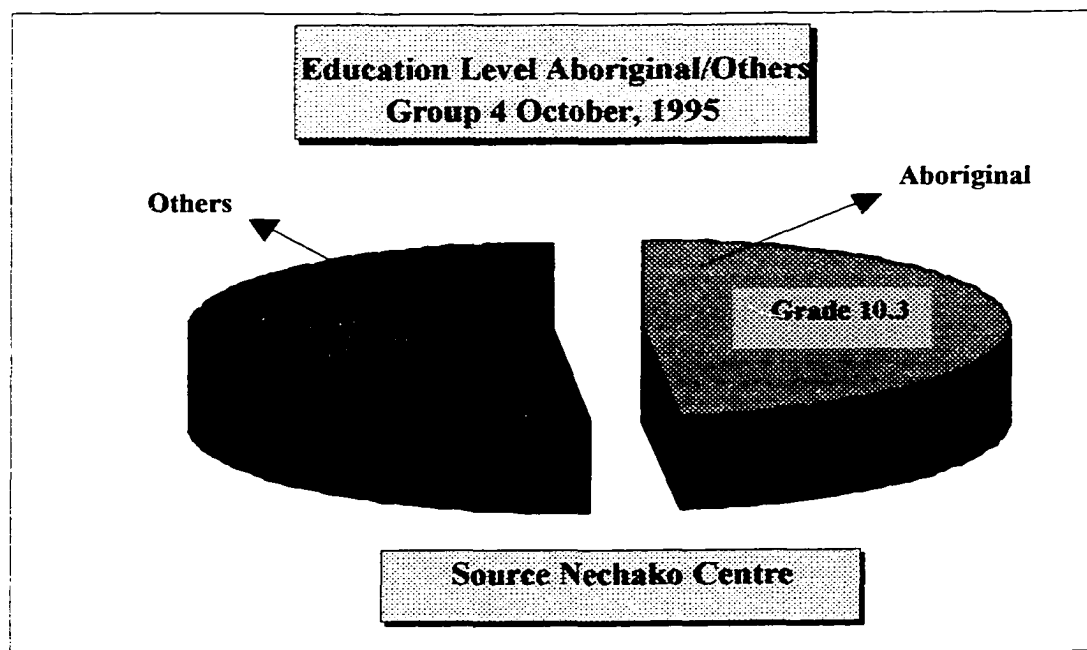


Source Nechako Centre

**Aboriginal/Others, Women's Group
Oct./Nov., 1995**



Source Nechako Centre



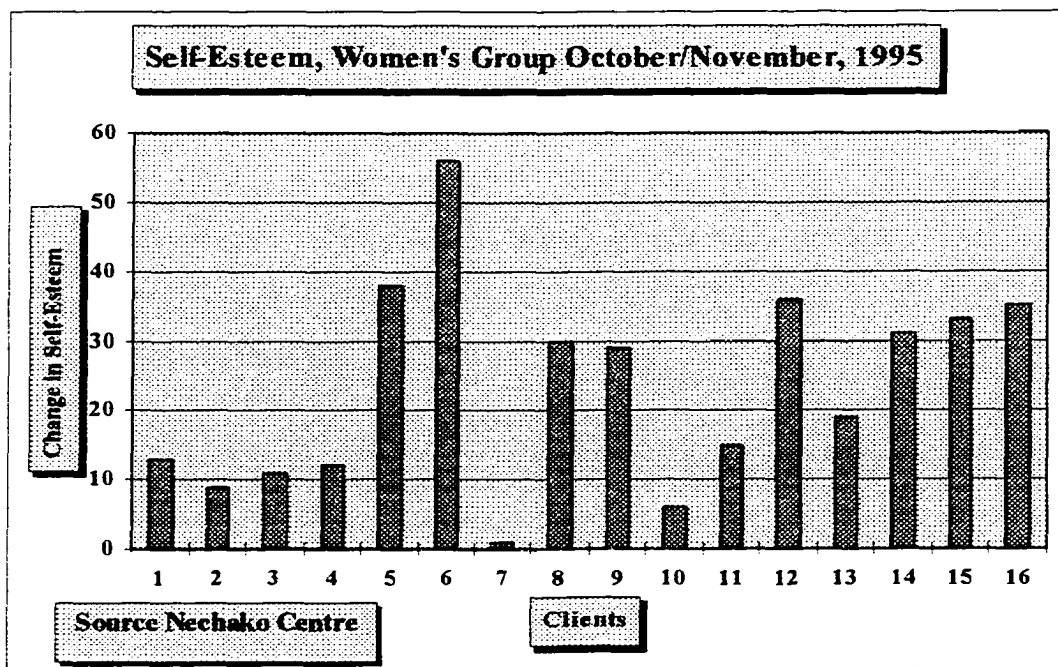
Introduction to Index Of Self Esteem

The Hudson's Index of Self-Esteem was administered to the clients on October 10th, 1995 and the same Index was administered again on November 3rd, 1995 (See Appendix B for reliability and validity). To avoid confusion it should be noted that the self-esteem Index administered to the Women's Group is different to the self-evaluated self-esteem for the previous three groups. In the previous groups the higher the score the greater the improvement; in the Hudson Index the lower the score the greater the improvement.

SELF-ESTEEM OF WOMEN'S GROUP

October 10th, 1995	November 3rd, 1995
49	36
60	51
75	64
78	66
53	15
81	25
45	44
42	12
41	12
17	11
33	18
49	13
46	27
68	37
52	19
48	13

On October 10th, (the day after arrival at Nechako) we observe that the scores ranged from 33 to 81, all above 30 indicating a significant problem with self-esteem. On November 3rd, (the day before completion of the programme) we observe that 10 of the respondents scored under 30 while 6 of the respondents ranged from 36 to 66 indicating significant problems with self-esteem. Self-esteem had improved in these 6 but there is still cause for concern because the lower the score the greater the improvement. Sixteen of the clients had shown increased self-esteem during the intervention of the three-week program. Eight of the original twenty-four clients did not complete the programme. The following graph indicates the changes in self-esteem from entry to leaving:



Self-Esteem Scores: Pretest and Posttest

In the pretest, the group average is 52.3. This is decreased to 28.9 in the posttest. In order to test whether the difference in means between the two time intervals is statistically significant, a paired T-test was conducted on these scores. The results can be found in table 5.1. There is a highly significant increase in self-esteem after the participants have undergone group therapy in the programme.

Table 5.1
Women's Group
Pretest and Posttest Hudson's Self-Esteem Scores
(n= 16 pairs)

	Mean	SD	Df	t-value
Pretest	52.31	16.91	15	-6.32*
Posttest	28.94	18.74		

* $p < .001$

Women's Group Process, October/November, 1995

The women went through the usual three week programme and six of the women brought in their partners for the final week of the programme. I worked with three couples, two of whom were First Nations. The following short description of a unique outcome of relationship week is as follows:

Relationship Week, October/November, 1995

There were three couples in the group, two of the couples were of First Nations' origin and the third couple was Caucasian. What was interesting about this particular group was that at the end of the programme two couples decided to renew their wedding vows. It was a first for the Centre and, to my knowledge, there has not been one since. On graduation day a priest came in and re-married the two couples. One couple was of First Nations' origin and the other was the Caucasian couple. The Caucasian couple had been married for forty years and the other couple for under twenty years. The Caucasian couples' adult children attended the ceremony.

The couples had become very close during the therapy sessions, particularly the males. As one male watched the other talk about the mistakes he had made in his relationship, the other male listened and tears began to fall from his eyes. It was a connection that touched his heart as he had made the same mistakes. This perhaps is one of the unique values of a residential group therapy programme, the colour of the skin does not matter, it is the feelings that go on between people that makes the connection. It is not so much the expertise of the therapist as it is the absolute honesty that can be shared between members of the group. It is also interesting to

note that usually the partners come in to therapy to support the one who has been in the programme and find out that it is they, themselves, that need to do some work.

Chapter Six

Introduction To The Qualitative Data

The self-esteem testing indicated a change in self-esteem for some participants. In order to understand when this happens I conducted two interviews. The interviews were also conducted to give insight into the lives of these clients. To fully understand the nature of alcoholism the causal factors may be disclosed in the uninterrupted dialogue of clients.

My philosophical position favours a subjective rather than an objective approach to understanding the world of the people who are interviewed. I take a broadly phenomenological humanist view that their world can best be understood through their own perceptions (Payne 1991, p 66). Proponents of phenomenological research argue that human behaviour can best be understood through the viewpoint of the people involved. vanManen (1997, p. 42) suggests that we ask what something is really like and what is the nature of the lived experience.

Two open-ended interviews were conducted the day before the end of the programme. All but one of the clients had signed the consent form agreeing to be interviewed at the completion of the programme. The client for Interview One came forward and wanted to be interviewed. This was interesting as I had not been a counsellor in her small therapy group. I personally selected the client for Interview Two as I had worked with her previously in 1990 and wanted to observe changes that occurred from that time to 1995. The clients were not selected on the basis of the self-esteem scores. The self-esteem scores were not analyzed until some time later. The interviews were taped and transcribed. I did not wish to be intrusive and

influence the interviews so I simply asked “tell me about your life and your experience at Nechako Centre.” Kirby and McKenna (1989, p. 68) rightly argue that more insight will be gained into the client’s life when an intensive interview is conducted so as to discover information in the language of that person. Structured interviews seek to ask questions in a uniform way and are controlled whereas intensive unstructured interviews are guided by the need and intent of the participant (Kirby & McKenna, 1989). Marshall and Rossman (1995, p. 80) suggest the assumption fundamental to qualitative research is that the phenomena should unfold as the participant views it and not as the researcher views it. I also believe that intensive interviews are more egalitarian which is the way I like to work with people. In allowing the client to speak without confining them to a series of structured questions and without interrupting them, I think we are in a more equal position.

The following interview is presented verbatim. I thought it was important to the thesis that the interview was not abridged or edited. I want the reader to see into the mind and heart of this young woman. The interview goes back and forth into her life and does not always follow in sequence. It is, however, the sequence which she presented. I have interjected my comments which are highlighted in bold type. I have done this to help guide the reader through important highlights of the interview.

This young woman is twenty-eight years old and is Métis. She goes on to describe her ethnic background in the interview.

First Interview

I was borne in Peace River, Alberta (1957) and raised there until I was four years of age. My background is Metis, predominantly Cree, part Iroquois, part Slave and French. I am the youngest of twelve children. In 1961 my father died and we moved to Dawson Creek, B. C. After my father's death my mother started drinking. She drank quite heavy and so from the age of four until I was sixteen I was raised in an alcoholic home.

In the following paragraph we can follow the interviewee as the drinking process starts.

There were a lot of house parties, a lot of fighting, a lot of things I didn't understand. I remember waking up in the morning to go to school and having to clean up things from the night before. People were passed out all over. A lot of bottles were lying around and we would take whatever was left over and put it in one bottle and drink whatever was there.

Sexual abuse is mentioned and then the client moves on quite quickly to other parts of her life. We will return to the sexual abuse issue later in the narrative.

I had sexual abuse between ten and eleven years old. I was left home alone a lot because my older brothers and sisters had left. I started drinking when I was about eleven. I started with drugs when I was fourteen or fifteen, minor things like hash but I preferred to drink. I started going to bars when I was fifteen. Once I started going to bars it became routine to go out. Then I moved down South that's where I met my first husband. I was seventeen but he didn't know that, we were going to

bars and cabarets. We had a three-year relationship and out of that relationship I had a son. Basically then my only chemical dependency was still drinking. We separated when I was twenty years old.

I went on a year-long drunk because of the break-up. I had the dream that everything would be okay once I had my son but when that dream was shattered that's when I drank heavily and started experimenting with other drugs, like acid and mushrooms. I had gone back North and there weren't any heavy drugs like cocaine or heroin, it was mainly mushrooms and speed. That year I gave up on everything and almost lost my son. I was living with my Mom by then she had quit drinking.

Here we have our first mention of suicide. The issue of a sibling's suicide is left very quickly and the narrative moves on to talk about her relationship with her Mother.

She was raising my son along with a niece and nephew as my sister had committed suicide. I guess that was when my Mom decided to quit drinking. She came to get me at the bar one night and I wouldn't leave so she told me to come and get my stuff and not to touch the kid, just get out. That sort of brought me out of it and I sorta slowed down after that, I had quit school in Grade ten so I didn't have much of an education and working wasn't a big deal for me.

A relationship develops in which drinking and drugs are involved. Cocaine and marijuana become part of a chemical addiction pattern.

In 1980 I decided to go back to school, I wanted to straighten out my life. I had met another man and we started a relationship. I did go back to school but in our relationship we drank quite a bit. I used to blame it on him, follow him, do whatever,

then the last three years I started using drugs again. I used a lot of cocaine. I didn't believe I would get addicted to it, I just didn't believe I would get addicted to anything but then when I started getting feelings of being cheated out of drugs when I was dealing with other people then I knew it was becoming important. So I stopped doing cocaine. From there I just smoked marijuana, I did that for the last three years, from the time I woke up in the morning until I went to bed. I never believed I would get addicted to that. My drinking had slowed down.

Anger begins to manifest itself and fights would ensue. She becomes aware that it is too dangerous to continue drinking because of the possibility that she could get hurt or could hurt someone else.

The reason I slowed down on drinking was that I was becoming a very angry person. I wasn't myself anymore whenever I drank. A lot of my anger would come out and if anyone looked at me I would challenge them or whatever. I was starting to fight with girls, guys, it didn't matter. I realized that there was too much anger there that I was becoming too dangerous that I could get hurt or that I could hurt other people.

Other addictions enter her life as marijuana and bingo become addictions. When the client was not high anger and paranoia would ensue.

I slowed down on the drinking but I was smoking five to eight joints a day, sometimes more, depending on how much money I had. When I wasn't high I was angry, I was angry at everyone, my family, my kids, my husband. I was becoming paranoid, I wouldn't even go to the store to buy a loaf of bread, I would send someone else. The other addiction I had was bingo, it was somewhere I could go

where I felt comfortable. When I would walk in I would put on my mad look because I was stoned and I didn't want anyone talking to me. If I didn't win, I would be mad so I would smoke a joint so I wouldn't be mad.

Dreaming becomes a difficult issue as she didn't like the dreams and marijuana would cover up the feelings in the morning.

When I went to bed I would smoke a joint so I wouldn't dream. I didn't like to dream. Then when I would wake up in the morning I would smoke another joint. This went on for three years until one day I woke up and didn't want to live that way anymore. I got fed up with it because everything was falling apart on me. My marriage, my kids.

The legal system enters the family as the children begin having problems with alcohol.

My oldest son was having trouble with drinking and getting into trouble with the law, fighting. My step daughter had a baby and didn't want the baby. I tried to take the baby. It was really hard to maintain everything by being stoned all the time because eventually when I would come down, I would have too much anger. It was hard to keep the money coming to buy the marijuana. One day I woke up and realized I didn't want it anymore. I was losing my husband, he was getting back into coke, drinking, the fights were worse, arguments. Then my two younger kids, my son is twelve, my daughter is three and my grandson is four months. We were fighting in front of them, yelling, screaming, their nerves were getting bad. By then my oldest son and step-daughter weren't living with us anymore.

She becomes aware that she is blaming everyone for her problems and decides to go into treatment. The client is aware that she cannot control her husband's drinking.

It's just like my eyes opened I could see what I was doing to everybody, to my family, to my kids. I thought at that time I didn't want my marriage either. Instead of blaming myself and my husband for what was happening, I was blaming it on alcohol and drugs. Blaming everybody else so I left, it was my easiest thing to do was to leave to get away thinking it was all his fault. Because he wouldn't give up the drinking and the drugging by this time he was back into doing coke, I wasn't. So I decided to leave it all and then I left got my head cleared up for a few weeks and decided that I would like to go to treatment to learn ways to cope. To cope with my anger, to find out where it was coming from.

After treatment she becomes aware that situations in her childhood that had not been dealt with were causing the anger and hurt. Issues of abandonment and grief are looked at.

After being in treatment and looking back on my childhood I can sit back; the anger wasn't at my husband or my kids or the situation I was in, it was situations I hadn't dealt with in the past. Looking at abandonment issues and things like that. I always figured my abandonment issue came from my father dying at four years old. That may be part of it but it was losing my Mom at the same time due to her drinking, she was never home. She was working trying to support the six younger ones at home, she was trying to support us. Between working and drinking I hardly

ever saw her, it was my three older sisters who basically raised me and the abuser in my family that was sexually abusing me was one of my brothers.

The client now looks at the sexual abuse that happened to her and begins to understand why she ran from home.

He was abusing me and my sisters, I didn't know that till later on. He was just taking his turn as we grew up or whatever, I don't know. A lot of time that was why I started running away from home, I started running away from home when I was 11 years old because the abuse came in at age nine, ten or eleven. I remember at ten and eleven that was when I started running away. A lot of times my sisters would be out and I ended up being alone in the house with him and I didn't want to be so I would just leave. I would go for days, weeks. I never went to cities, thank gawd. I didn't like the city life, I would go to the nearest reserves to be with my own people. I would live with friends who had big families and stuff like that. Mind you, the kids, too, wherever I went, were allowed more freedom. They were allowed to go out and stuff like that so we would party around and stuff like that. Between eleven to thirteen I ran around quite a bit and at thirteen my Mom started coming down on me quite a bit. She came and looked for me a few times and she would come and get me.

The client realizes that her mother does care about her but her physical condition has deteriorated so her mother doesn't recognize her.

I remember one time she didn't recognize me. There was a bunch of kids staying in this little house and I was sleeping. I pulled the blankets over me and she went around to all the kids. She pulled my blanket up and said "no, she's not here." I had

cut my hair and lost so much weight she didn't recognize me. I really wanted to go home. It wasn't that much fun, I was always hungry and cold. She left but then someone had told her I was there and she came back, she said she did recognize me.

The trust issue with her mother arises as her mother did not believe her when she first shared her sexual abuse.

Before that she used to yell at me when she'd pick me up, she'd yell at me and call me down. I didn't trust her because I remember when I was eleven I confronted her about my brother sexually abusing us and she called me a liar. She was drinking, there was a party going on, my brother was sitting there.

The oldest sister is the one she trusted. The oldest sister is also the one that committed suicide. Suicide and sexual abuse are recurring themes and she couldn't trust as her mother didn't believe her.

My older sister is the one who asked me and I told my older sister, the one who committed suicide. She asked me if it was bothering me and I said "yeah" and I told her who it was. So she took me out in the living room where the party was to confront my mother and brother and my mother stuck up for my brother. She called me a lying little bitch, I was lying that he wouldn't do anything like that so it was like I lost all my trust in her so when I used to run away she would accuse me of all kinds of things but I wasn't doing it. I used to be accused, I didn't trust.

She talks about how important home was to her and how the nurturing was lacking.

It's strange when you are away from home you really miss it you know there's nothing there but they say there's no place like home. When I'd be gone a few weeks

I really wanted to go home but I was scared to because I didn't know what I was going back to. She'd yell at me when she'd pick me up but the last time when she didn't recognize me all she said was "come on, let's go home baby". She called me baby and that made me feel good so I went home with her but nothing changed. Two weeks later I left again and she left me she didn't come looking for me but I got that feeling that I wanted to go home again. By this time I was twelve years old and I knew she wasn't going to look for me. So I went home and when I got home my brother was home and he said well you are going to get it Mom is looking for you, she left this morning, she is getting fed up with it. She's going to send you away. My sisters came in and said you look gross, they told me how bad I looked and that all I heard, nothing about, oh, it's good to see you, I'm glad you're safe.

When the pain becomes too great she tries to commit suicide. Once again the theme of suicide re-emerges.

They all said, oh you look awful and whatcha doing here, and so I went and tried to O.D. (overdose). I took a bunch of pills, I took everything that was in the medicine cabinet I didn't know what it was. I guess I didn't really want to die because I told my sister next to me that I had done this but don't tell Mom. By this time the effects of all the pills I took, I don't really know what kind of pills, I took everything that was in there, it started to effect me because I was starting to get dizzy and everything. I laid on the bed and the last thing like I could hear what was going on around me but things were fuzzy. I heard my Mom come in and all she did, like she came in the bedroom and sat on the bed and just started yelling at me, telling me she was going to send me away. I just looked at her and didn't say anything and

finally she looked at me and wanted to know if I was drunk, or stoned, what was the matter with me. I didn't say nothing and then my sister stood behind me and I could hear her tell Mom that I had taken some pills. Then my Mom got all nervous and I could just hear a commotion around me. They took me to the hospital and got my stomach pumped out.

No-one in the family ever talks about the attempted suicide. This is part of the problem in alcoholic families and is summed up by the slogan used in ACOA (Adult Children of Alcoholics) literature - "don't trust, don't feel, don't think".

I was in there three days and it's kinda funny now but no-one ever talked about it. No-one ever asked me why I did it. The doctors, the nurses, my Mom, my sisters, my brothers, everyone, no one ever talked about it. No one ever asked me why I wanted to do it. It was like when I got out of the hospital, it was over, it was done. No one, not one person. I remember this nurse she was a native lady when I woke up in the morning after they had pumped my stomach she was just standing there holding my hand but she didn't say anything. There was pity or sorrow or something in her eyes and I didn't know why she was looking at me like that. But she didn't say nothing, she was just standing there holding my hand. Today I think she is probably praying for me but she didn't say nothing, I guess she felt she shouldn't get involved, or whatever. Now when she'd seen that I woke up she just patted my hand and walked away.

Mother changes and she knows mother loves her but running away is becoming a pattern.

No-one ever asked me why I wanted to do away with myself, so when I got out of the hospital like my Mom had changed toward me and just let me sorta do what I wanted. I left again not long after that even though she was trying to make me feel good. She started letting me smoke in front of her although I was twelve, she knew I smoked and she just bought me cigarettes. She just sorta let things go and when I look back today I know she was scared, she didn't want to deal with anything, she didn't want to talk about it. It was her way of sorta comforting me so I wouldn't talk about it, I dunno. I kinda let myself down because I know she loves me because she's not getting mad at me, she's treating me older and things like that but I left again and I really felt let down myself. I kept leaving, whatever happened, I would leave anyway.

I always tried to figure out why I left and I didn't know. I just knew that I didn't want to be alone anymore. My brothers, too, they had a band and my sister next to me used to sing, they used to go on tours sorta thing and I would always be left with whoever could take care of me and I just got tired of it, I wanted to be with people. Friends were really important to me. A lot of my friends had big families too, but they had like more closer family than I had. I dunno, I used to just go, I would just go when I didn't like something.

The running away stops and the bar and party scene begins. It is noteworthy that running away was all within a sixty mile radius.

Then finally I quit running away but I started staying in town and staying with friends in town, like I didn't have to leave town anymore because I had my friends in town. I would party around with them and stuff like that. I started going out with

boys and guys and I would hang around bars and go to parties. So when my Mom knew I was starting to go with boys she told me I was going down South. I remember not wanting to leave but yet part of me did want to leave. When I went down South I used to keep in touch with everybody. Like being in a small town it seemed like I was on the other side of the world and it never occurred to me to run away to go back. I had never been out of my community really. The places I ran to were maybe sixty miles away. I never went like over a hundred miles so it seemed like too far to try and hitch hike.

A geographical change is recommended as Mother decides it is time for her to move to Penticton where an older brother lives.

So when I got to Penticton I settled down a lot because I didn't know anybody. I tried to live the other way of life, like go to school, stay straight. The home I was in with my other brother, I thought was better because they had nice things and they never lacked for anything. Like I remember cheese, block cheese, my Mom could never afford to buy cheese or yogurt. Like I never ate those things before and they had steak all the time. We never had steak, we'd just eat hamburger and things like that because we had no money. I thought it was really great, like it was a new start for me.

The geographical change is not working as alcoholism has affected her brother and the themes of anger and physical abuse re-emerge.

Until my brother started drinking and it was no different, sure he had nice things and money and stuff like that but whenever he drank I didn't know that he beat up my sister-in-law. That started happening, they would go out and drink then they'd

come home and he'd beat on her and I would have to protect her and the kids, like keep them in a room. Like the same thing was starting to happen all over again. He was real angry all the time, too. Like he'd go to work and me and my sister-in-law would have fun. She was the only person that would ever talk to me, listen to me, that I could communicate with without ever having to worry about being told to shut-up and not to say anything. We became really good friends but as soon as my brother would come home, it would all have to stop, everybody just quiet, like he'd come in really mad looking and everybody just sitting there, scared to move, scared to say anything. We were just glad when he would leave again cuz everybody could have fun and be who we wanted to be. But then he started hitting my sister-in-law and she told me that it was all through their marriage. I didn't know him, he always lived away from us so he never was close to our family.

When the client witnesses physical abuse in her new location she leaves for the big city of Vancouver. That doesn't work and she returns to Penticton.

When he started beating her up and I had to witness that again, I couldn't handle it and so I did start running from there too. I did end up going to Vancouver, finding friends that would run with me. I checked out Vancouver but I didn't like it. I didn't like the City, I didn't like it at all so I went back to Penticton and started going to the reserve there and finding friends there and partying there and stuff like that.

The first serious relationship ensues and alcohol is involved as her husband drank a lot.

When I was seventeen that was when I met my first husband and thought that would be great because he didn't hit me or nothing like that, he just liked to drink

lots and he liked women. That was what broke up our relationship and he liked lots of women and not just one woman, he liked lots of women.

The client has her first child at 18 years of age and more problems ensue as her husband didn't want the baby.

I ended up having my son and that was another thing I had to deal with because (I was eighteen when I got pregnant) and when I told him, he wasn't very happy. He said you'd better tell your Mom and when I told my Mom the first thing that came out of her mouth was, "well, you'd better have an abortion". That just floored me, it didn't even cross my mind. I dunno why she wanted me to have an abortion so I talked to him about it and he said it sounded like a good idea. I thought, what, where did this come from? I should have known, that was my first sign that we weren't going to make it. Then I just told them both "no" whether or not youse guys want me to I am having this baby. When I told my doctor that they wanted me to abort the baby he wanted to know why and asked me to bring my husband in. So we went in and after the doctor talked about it, he looked at me and wanted me to have the baby. That made me feel more comfortable, more secure. I had the baby against my Mom's wishes but once the baby came she accepted him and so did my husband.

Having the baby didn't make the marriage work and so they separated.

The client once again returned to alcohol as a solution.

We separated when he was ten months old because of his running around and drinking. I just had dreams that once the baby was there everything would be fine. Of course, I know that now and I try and tell other girls now but they won't

listen to me. After we separated I went on a drunk for about a year and I sorta came out of it and moved here and met my husband that I am with now.

A different relationship begins and the second husband sells drugs, is street wise and alcoholic.

We've been together fifteen years but it's been on and off, a lot of drinking because he lived the streets. He's a lot younger than my first husband and that sort of life excited me because I didn't really live the streets, like the drug trade, the selling, the dealing, ripping off people, knowing prostitutes. It was exciting to me to know somebody that knew people like that. We got together anyway but I never really got to that scene because he was protecting me because he knew I hadn't lived that way so he moved me out of town right away.

The first year we were together we left the City and he took me to his hometown and we lived there for six years. There was lot of alcoholism in that community too. I left there because he was going back to jail, he spent a lot of time in jail and stuff. I didn't want that life, so I left him there but we got back together a month later. He said he quit and everything like that. We did good for quite a few years, like I went back to work and so did he. The drinking still kept coming up and coming up all the time and then the drugs started coming in, just like we could never leave it behind. We had never took a look at why we drank or why we drugged, what was the real problem.

He had a way worse childhood than I ever had and we never started talking about those things until a few years ago by then it was already thirteen years that we had been together. We had good times and bad times and when the bad times

happened they would be really bad. The good times were really good too but there was never even ground there. It was always from one extreme to another, there was no even ground.

The client goes to treatment and awareness develops that a lot of the marital problems they experienced were due to childhood experiences.

Now I am realizing going through treatment that it has a lot to do with what we went through, it has never really left us. It is really hard for two people to try and have a relationship when each one of you has never looked at the real issues and never dealt with them. I always wanted to blame everybody else for making me mad. It was everyone else's fault for making me mad, if they didn't make me mad I would be happy or if they gave me what I wanted I would be happy. I didn't know it was in myself to give myself what I needed to be happy. I think of this poem "don't wait for someone else to bring you flowers, decorate your own garden". "Kisses aren't contracts" and things like that.

The client experiences spirituality and a re-connection with her Creator as awareness develops and her attitude changes.

Now I realize I have to decorate my own garden to be happy for myself, including those around me. I was always expecting someone to magically come up and just make me happy. Now I don't think anyone ever could of made me happy, I have to do it myself. Sure you can dream but you'd better watch what you dream for because some of it might come true. You have to make it happen yourself. With going through treatment I learned a lot about learning to have to love myself, respect myself and honour myself before anyone else can do that. Being alone doesn't bother

me, I don't think it will bother me again because I know I am not alone anymore I was scared to be alone that was why I tried to hang on in my relationships right to the very end. I've got myself and my Creator and that makes me feel good. I never was really alone but I didn't have enough spirituality and believing there was a Creator.

The narrative returns to painful memories of deaths in the family due to alcohol. The theme of suicide and traffic fatalities re-emerges.

In my family a lot of deaths were due to alcohol. I lost a brother due to alcohol. He drank too much and the doctor told him he couldn't drink anymore and then on his last drunk it was almost like he committed suicide he had alcohol poisoning. My sister committed suicide at twenty-five years old from drinking. My other sister, they said it was a car accident but we don't know if it was suicide or a single vehicle accident. She was at a party, some say she was run off the road. None of us really know what happened but I think she committed suicide. Three major deaths that I remember. I lost a nephew through alcohol, he was riding with a drunk driver and got killed. There were so many bad things around my memories of so much drinking.

The client's concluding thoughts revolve around the decision to break the cycle of alcoholism and to work on establishing trust in her family.

I think now that it is in my control to stop it, I can't control others, but I can be there for them sober and straight. When my children come to tell me things are wrong, I won't deny it and I will speak out against it. If my daughter should come and tell me she's been molested I am not going to tell her she's a liar. I'll believe her

and I'll confront the person. I'll stand by my kids. I want to break the cycle, I don't want to be silent.

Is Group Therapy Helpful?

Yalom (1970) identified twelve therapeutic experiences that are derived from group therapy. A powerful example of the helpfulness of group therapy is supplied by applying the twelve therapeutic experiences in the clients' own words. The table following each women's interview give these twelve experiences in the two women's own words. The presence of these therapeutic experiences illustrates that group therapy is helpful in the treatment of chemical addiction. The third interview was conducted fourteen years after group therapy treatment and so it would be difficult to apply Yalom's therapeutic experiences to this subjective recollection.

The following table illustrates Yalom's therapeutic experiences for this first interview.

Table 6.1 Analysis of the first client's group experiences using Yalom's framework

12 THERAPEUTIC EXPERIENCES	DEFINITION OF EXPERIENCES	CLIENTS' OWN WORDS (as shared in group)
ALTRUISM	giving part of myself to others.	not observed.
GROUP COHESIVENESS	revealing embarrassing things about myself and still being accepted by the group.	not observed.
UNIVERSALITY	learning I'm not the only one with my type of problems: "We're all in the same boat."	not observed.
INTERPERSONAL LEARNING -Input	other members telling me what they think of me.	not observed.

INTERPERSONAL LEARNING -Output	feeling more trustful of groups and other people.	not observed.
GUIDANCE	the leader advising or suggesting something for me to do.	not observed.
CATHARSIS	being able to say what was bothering me instead of holding it in.	not observed.
IDENTIFICATION	seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.	not observed.
FAMILY RE-ENACTMENT	being in the group somehow helped me to understand how I grew up in my family	after being in treatment and looking back on my childhood . . . looking at abandonment and things like that.
SELF-UNDERSTANDING	learning that how I feel and behave today is related to my childhood and development (there are reasons in my early life why I am as I am).	now I am realizing going through treatment that it has a lot to do with what we went through, it has never really left us. It is really hard for two people to try and have a relationship when each one of you has never looked at the real issues and never dealt with them.
INSTILLATION OF HOPE	knowing that others had solved problems like mine.	not observed.
EXISTENTIAL FACTORS	(1) learning that I must take ultimate responsibility for the way I live my life (2) recognizing that no matter how close I get to other people, I must still face life alone.	now I realize I have to decorate my own garden to be happy for myself, including those around me. I have to do it myself . . . with going through treatment I learned a lot

		about learning to have to love myself, respect myself and honour myself before anyone else can do that. Being alone doesn't bother me . . .
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Discussion of therapeutic experiences

This interview was done at the conclusion of the programme. I neglected to ask the client if she had shared everything that was in the interview with the group she was in. I was not the leader of the group and cannot verify if all of the interview was previously shared in group. Therefore I am only able to extract the items that the client shared with me as taking place during treatment. From her own words we can note that the group experience was helpful under “Family Re-Enactment” when she looked back at her own childhood and faced the issue of her abandonment as a child. Under “Self-Understanding” she realizes that it was difficult to build a relationship until both she and her partner looked at their childhood and development. Existentially she has become aware that she has to take responsibility for her own life and that she still must face life alone. I was unable to present data from the interview (shared in group) regarding “Instillation of hope” yet we can observe that hope is present when she says “I want to break the cycle, I don’t want to be silent” and that she will “stand by her kids.”

General Discussion

Upon entry to the program this client's self-esteem rating was 45 and upon leaving the program, the rating was 44. The self-esteem chart is reproduced so that we observe all the participants. At entry her self-esteem was above eleven out of sixteen of her cohort. She showed the least amount of improvement of the whole group with an increase of 1. Three other clients had less self-esteem at the end of the treatment programme but they had increases of 11, 13 and 14. Also as indicated in Chapter Five those with scores above 30 had a clinically significant problem with self-esteem. We could speculate that the client made little progress while at the Centre as far as self-esteem is concerned.

Table 6-2 Changes in Hudson's Self-Esteem Scores for First Interviewee

Rank of Self-Esteem Oct. 10, 1995	Score at Outset (Low=better)	Score at End	Amount of Change	Rank of Change	Rank of Self-Esteem Nov. 3, 1995
8	49	36	13	12	5
5	60	51	9	14	3
3	75	64	11	13	2
2	78	66	12	11	1
6	53	15	38	2	11
1	81	25	56	1	8
12	45	44	1	16	4
13	42	12	30	7	15
14	41	12	29	8	14
16	17	11	6	15	15
15	33	18	15	10	10
9	49	13	36	3	13
11	46	27	19	9	7
4	68	37	31	6	6
7	52	19	33	5	9
10	48	13	35	4	12

Upon analyzing the interview, we note that the bulk of the interview deals largely with her past life and very little had to do with her experience at the Centre. It is not

until near the end when she suggests that she has to decorate her own garden and that she will never lie to her kids that we begin to observe a change. She also talked about loving, respecting and honouring herself before anyone else can give that to her.

In talking to the client after the interview she revealed that she had done the bulk of her work with her counsellor before she came to the Centre. My evaluation is that the tragedies in this young woman's life were so severe that while she was at the Centre, she detached herself from the experiences. She lost three brothers and a sister due to suicide. She suffered sexual abuse at age ten or eleven. She lost her father when she was four and she talked about her mother becoming an alcoholic at that time. When life experiences are so overwhelming, becoming detached from the experiences is a survival technique. A marked change of some kind can occur during the process of treatment in the client's attitude to the world around them. I do not believe that this client was able to come to grips with some of the tragedies in her life and was continuing to be detached. There were no changes in her voice and as she talked about her life, it was a one-toned monologue.

As a counsellor in a four-week experience with clients I must always honour what I cannot see and acknowledge that despite my observations changes do occur. I felt it would be of interest to the readers to know this client's life. It gives insight as to how difficult life can be at this time in the history of First Nations people. In this client's life we learn of sexual abuse at a very young age and we learn of suicide. These are major traumas as well as the trauma of no-one being there for her to help her deal with these issues.

The positive outcome for this client may be the acknowledgment that it is within her control to break the cycle of alcoholism in her family. Her self-awareness had increased as she articulated that she would do things differently from her mother, this insight may help her to build self-esteem for her children. The lesson learned is that recovery is very difficult when trying to solve it alone. She needs the support and understanding of others to help her overcome the tragedy of what alcoholism has done to her family. Existentially, she learned the following, "With going through treatment I learned a lot about learning to have to love myself, respect myself and honour myself before anyone else can do that."

Second Interview

This 46 year old First Nations woman is from the Penticton Indian Reserve and this was her second time through Nechako Centre. The client had stopped drinking in April of 1990 and had come to Nechako Centre in June of the same year. She was very shy during her treatment session in 1990 and came again in 1995 to learn more about assertiveness and to lose some of her shyness. The process of the interview is the same as that of the first interview, it is conducted as an intensive interview starting with the simple directive “tell me about your life and your experience at the Centre”.

I was borne on reserve. I’m oldest of six children I have two younger sisters and three brothers. We were eleven months apart, the last one was borne five years later. I went to Indian Day School on Reserve, then I went To St. Joseph’s Catholic School in Penticton then I went to Princess Margaret from Grade eight to ten, I didn’t completely finish Grade ten. It was April of 1966 when my Mom had a stroke and I had to quit school but in the late seventies, I went to College to get my upgrading.

The client describes the discrimination she received when she entered a “white” school.

It was okay for me mixing with white people, my Mom and Dad had friends amongst the whites. I did suffer daily discrimination. Going to the Catholic School in Grade four we wore uniforms and Mom and Dad really enjoyed that because they had gone to Kamloops residential school and she liked the uniform. Tunic, white blouse, tie and I was amazed when I went to Princess Margaret’s I was really looking

forward to it, it was something new. I was really shocked and surprised by the remarks of the other school kids calling us squaws and dirty Indians and when I went to Grade eight my first day in Grade eight, no experience, I had never been to that school. I never forgot the remark of the principal at that time, he said “we’ll guard the bus.”

I was pretty excited because we didn’t have to wear uniforms at that school it was a public school and I felt really good because I dressed the way I wanted to and that made me feel really good. Because how we were raised at home, in a way I was having my own identity because I didn’t have to dress in a uniform, but back to the principal, he raised his voice and told the receptionist to get these Indian kids off to the classes right away and I remember I was scared. A lot of my friends and cousins were on the bus with me and he turned around and told the receptionist to make sure we were divided into different home rooms, not the same, he tried to divide the Indian kids up and I remember standing there and I was surprised because he was yelling and he turned to look at me and make sure you don’t have the girls and guys together because all the Indian girls, we don’t want them to get pregnant while they are in class. I thought, my gosh, that really hurt and I just looked at him, he was a little guy, red in the face and just angry but somehow I remembered that and I didn’t like that. (This was in 1964). I was about fourteen.

When the client suffered grief at the loss of her Mother she started drinking.

I was sixteen when Mom had a stroke. Two months before I would have finished Grade ten, I was looking forward to going to Grade eleven and graduating,

that didn't happen. I had to stay home and look after Mom, she had a stroke at work. I had to keep house for my Dad, I came back from school and when I came home that evening I wondered where Mom was and they said that she was in the hospital and they told us what happened at work. She was at work and just collapsed. They sent her to the hospital and Dad was quite upset he said that as far as the doctors knew she did have a stroke and they weren't sure when she could go to Vancouver so that happened within a day or two. That was real hard, we didn't expect that.

She died on December 28th, 1966. I started drinking then. I was fifteen, from April when Mom had the stroke Dad would go to Vancouver on the weekend, and we were raised so strict and when Dad would go to Vancouver, (he did that all summer till September) we all went haywire, literally. My Dad was easier on my brothers because they were a bit younger but boys can take care of themselves. The boys would go to town and my sisters and I would do the housecleaning. Dad was an alcoholic and we grew up in an alcoholic home. My Mom never drank, ever, in her life.

The client had her first and only child when she was 18 and she started drinking heavily when the relationship ended.

I never married but I had a common-law relationship. My only child was borne on September 12th, 1969. I was eighteen. In January, 1977, the relationship broke up and I started drinking heavily, I just had it. In the summer of 1976 an incident happened and that contributed to the break-up.

Sexual abuse occurs and the client suffers guilt and shame.

I was raped by a close family member, I was twenty-six. That really hurt, I carried a lot of guilt and shame with that until a few years ago. I stopped drinking April 13th, 1990 on Good Friday when I graduated from Long Term Care Course Aid. I got my Certificate, something I did for me. The Graduation was on Thursday and I drank, my first day of sobriety was Good Friday. I haven't drank since and I don't miss it. I came through the Treatment Centre (Nechako) in June of 1990 with two months of sobriety.

The client experiences her second time at treatment and describes how important it was for her to be in a Woman's Program.

The most helpful thing for me the second time around (October, 1995) was getting to know more and growing learning more about me as a person and as a woman. As a woman, until I came to this Woman's Program I had never been to a Woman's Program, this is my first time and I purposefully chose that. I had been in a co-educational program in June of 1990 the first time but this Woman's Group was for me. For me to get in touch with that little girl inside of me and I wanted little (name) to start growing up, rather than be stuck about five or eight.

The client expresses the importance of feedback from other group members. The theme of anger arises and how important it was to work through the anger.

Feedback from other group members was also important to me. The physical part of working on my anger was good for me, experiencing it and doing it. Giving myself permission to do it. It was stronger than the first time I was here, more powerful. Small group therapy was the most important part for me that was where

my facades come down. That's where I am really me. I was scared and shy and that's where my walls came down, that's me when I cry and I am angry these are my feelings and I need help to deal with them.

Self-esteem is an important part of her awareness and as she deals with the past her self-esteem increases.

When I come into small group my self-esteem is low already, that's how I feel. But when I come into small group, I take that step for myself, for the here and now, to deal with the past so I can take that other step to go to the future to gain respect, to gain respect. Taking that first step is hard you know but no-one is going to give it to me, I have to work for this on my own.

Relationship Week - the part of the Program that follows three weeks of group work.

This client's partner came to relationship and she describes that part of the program as follows:

The client did not know her partner was coming and she felt surprised and invaded.

I was quite surprised when he came, I was quite happy single, or thought I was. I tell you, mixed feelings on Sunday, when he phoned on that cellular phone. Sunday I had planned as a free day I was going to go downstairs and watch videos, pig out on popcorn and pop and finish my homework and all of a sudden I get this call from the guy I had broken up with. He was just outside Prince George and wanted to know how to get to Nechako. I tell you! I gave him directions, another group member helped me and he said he'd be here shortly so I hung up the phone and found

myself sweating, shaking. My spirit just went down yet these feelings came up, it was like a thermometer and I felt really invaded.

I felt so invaded, how could he? This is my safe place, this is my home and I didn't want him here and how in the hell did he get the number. I was just furious, I was just all over the place. I just stood in the dining room, the other woman and I and I thank God she was there. I was confused I was frozen, my hands were going up, I couldn't talk and the sweat was just coming down my face. She asked me what was the matter and I told her and we talked and talked and in about an hour I gave myself permission to feel these feelings and it was really weird yet kind of neat.

The client describes the portion of therapy that dealt with listening to the physical manifestation of repressed emotion.

Through this Women's Group I got to know more about paying attention to my body being aware that something is stuck down there and it's gotta come up, you know. I calmed down because I didn't want to be stuck, I had been doing that all my life.

Nechako here and the counsellors and yourself helped me come out of that and that's what I want. It's getting more comfortable with him here and I told him yesterday I was glad he was here. I told him I was happy he was here, I am taking big risks here but I am so afraid of not taking that risk all my life.

During an exercise involving trust the client realizes she had been identifying her partner with her father.

The trust walk. I was identifying him with my father. I've been seeing him for three years and three months. We don't live together, it was okay, the honeymoon

stage sort of the romantic side was okay in the beginning but this summer I had a heck of a time, especially after my Dad died. I was all messed up and I missed my Dad I'd drive down the road and cry then turn my car around and drive back home. Then I had people I talked to there on the healing journey themselves that have come to Nechako that really helped me. Positive, healthy, healing people you know. But dealing with my Dad I started to realize that he resembled him.

To me, he is so much like my Dad and somehow during the summer that inner voice inside me kept telling me you know this is wrong, this is wrong. I thought it was something wrong with him then later on someone told me when you and he are together you act like Mom and Dad. Now I went home with that thinking that's kinda cute, then I started seeing that side of it then all of a sudden at the latter end of the summer I had mixed feelings I was feeling angry, I started resenting him and you know he's a good man, he's got a good heart. Sure he's got problems like we all do but I'd nit-pick at any small thing and I thought he just reminds me so much of my Dad and I took it out on him, my feelings for my Dad I took out on him.

The client is able to separate her partner and her Dad as being separate beings.

In my therapy session, I told myself that he was not my Dad and it was hard for me to look at him in the eyes, you know eye contact and tell him "you're not my Dad," that was really hard. I chose to do that, I surprised myself.

I am glad to share this. The more I share the more it's not so personal to me anymore (laughter), you know. I never thought it would get easier.

Table 6-3 Analysis of the second client's group experiences using Yalom's framework

12 THERAPEUTIC EXPERIENCES	DEFINITION OF EXPERIENCES	CLIENTS' OWN WORDS (as shared in group)
ALTRUISM	giving part of myself to others.	Small group therapy was the most important part for me that was where my facades come down.
GROUP COHESIVENESS	revealing embarrassing things about myself and still being accepted by the group.	I wanted little (name) to start growing up, rather than be stuck about five or eight.
UNIVERSALITY	learning I'm not the only one with my type of problem; "We're all in the same boat."	She asked me what was the matter and I told her and we talked and talked
INTERPERSONAL LEARNING -Input	other members telling me what they think of me.	Feedback from other group members was also important to me.
INTERPERSONAL LEARNING -Output	feeling more trustful of groups and other people.	Then I had people I talked to there on the healing journey themselves that have come to Nechako that really helped me.
GUIDANCE	the leader advising or suggesting something for me to do.	Through this Women's Group I got to know more about being aware that something is stuck down there and it's gotta come up, you know. I calmed down because I didn't want to be stuck, I had been doing that all my life. Nechako here and the counsellors and yourself helped me come out of that and that's what I want.
CATHARSIS	being able to say what was bothering me instead of holding it in.	The physical part of working on my anger was good for me, experiencing it and doing it.

IDENTIFICATION	seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.	Small group therapy was the most important part for me that was where my facades come down. That's where I am really me. I was scared and shy and that's where my walls came down, that's me when I cry and I am angry these are my feelings and I need help to deal with them.
FAMILY RE-ENACTMENT	being in the group somehow helped me to understand how I grew up in my family.	I had been in a co-educational program in June of 1990 but this Woman's Group was for me. For me to get in touch with that little girl inside of me and I wanted little (name) to start growing up, rather than be stuck about five or eight.
SELF-UNDERSTANDING	learning that I have likes or dislikes for a person for reasons which may have little to do with the person and more to do with my hang-ups or experiences with other people in my past.	He just reminds me so much of my Dad and I took it out on him, my feelings for my Dad I took out on him.
INSTALLATION OF HOPE	Knowing that others had solved problems like mine.	The most helpful thing for me the second time around was getting to know more and growing and learning more about me as a person and as a woman.
EXISTENTIAL FACTORS	Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others.	Taking that first step is hard you know but no-one is going to give it to me, I have to work for this on my own.

Discussion of therapeutic experiences

All of the twelve therapeutic experiences were helpful for this client. Under “Instillation of Hope” the hope is implied as it was a women’s group and she said she had “learned more about herself as a woman.” She states that small group therapy was the most important part for her as that is where her facades came down and she was able to give part of herself to others, this is noted under “Altruism” and “Identification.” Also helpful for this client was the “Catharsis” and “Identification” where she was able to express her anger instead of holding it in. The feedback from others was important to her and feeling more trustful of groups from the sharing of others on the same healing journey as herself was contained under “Interpersonal Learning.” Existentially, she learned that she has to “work it on her own” and that no-one else is going to live her life for her.

General Discussion

Upon entry to the programme this client’s self-esteem rating was 78 and upon leaving the program, the rating was 66. The self-esteem chart is reproduced so that we can observe the rating of all the participants. This client had the lowest self-esteem score of the graduates and the second lowest at the beginning of the programme. At the same time there were 10 clients who ranked lower than her in the amount of change in self-esteem. Although she still has low self-esteem, she did make significant progress when compared to her cohorts.

Table 6-4 Changes in Hudson's Self-Esteem Scores for Second Interviewee

Rank of Self-Esteem Score at Outset Oct. 10, 1995	Score at Outset (Low=better)	Score at End	Amount of Change	Rank of Change	Rank of Self-Esteem Nov. 3, 1995
8	49	36	13	12	5
5	60	51	9	14	3
3	75	64	11	13	2
2	78	66	12	11	1
6	53	15	38	2	11
1	81	25	56	1	8
12	45	44	1	16	4
13	42	12	30	7	15
14	41	12	29	8	14
16	17	11	6	15	15
15	33	18	15	10	10
9	49	13	36	3	13
11	46	27	19	9	7
4	68	37	31	6	6
7	52	19	33	5	9
10	48	13	35	4	12

As mentioned in the previous case, those with scores above 30 have a clinically significant problem with self-esteem. In reading this client's story we would expect an increase in self-esteem. There has been improvement but the ISE score indicates a problem still exists.

I was the therapist for both visits to the Centre of this particular client and the leader for the relationship portion of the program and so am in a position to give the following observations:

During the 1990 group the client was shy and soft-spoken and when she spoke it was as a child would speak. She attended all sessions and was a cooperative group member. It was as though she was back in residential school and her aim was to please those around her.

At the outset of the 1995 group the same shy, pleasing soft-spoken behaviour was exhibited. As we note in the interview "... I wanted little (name) to start growing up, rather than be stuck about five or eight." There are two important learnings for those uninitiated in the therapy process to recognize here. The first is that the client herself knew exactly what the work was that she needed to do and the other part of that is that the therapist must listen to what the client is saying. The therapist is a guide in the process of what the client's wisdom is telling them. The other part of the learning is that in group therapy it is vital that the client share what they think their work is so that other group members may help them.

The process that was used to get the client to deal with her anger and her grief is as follows:

Once the group was formed the first task was to establish trust between group members. This can take one and one-half weeks to accomplish. To begin to establish trust the members were asked to share what brought them to treatment in the first place. In the case of alcoholism this is usually a traumatic event. Once this is shared by group members they begin to feel they belong to the group and trust develops.

When trust is established family histories are shared and members begin to identify with each other and share more than they share outside of treatment. Once the counsellor is convinced that the level of trust is sufficient, the actual therapy begins. In this interview with the client we note that she dealt with anger regarding her rape. Using Gestalt techniques of taking the client back to the experience, the client then confronted her perpetrator. With the encouragement of the group and the

guidance of the counsellor she expressed her anger towards him. She was able to do this by striking a bean bag with a bat. Once she had got her anger out she was able to talk to the perpetrator and tell him that he no longer had control over her. Through the physical sensation of expressing her anger she felt her own power come back and that she was no longer helpless before him.

Other group members identified with her almost as though they were having the same experience. At the conclusion of the session, the client was asked how she felt and she replied "more powerful, stronger." Her voice was stronger and she was in charge. Each group member was then asked how they felt and support was given to the client by saying that they respected and admired her for the courage she had shown in taking on the perpetrator.

In dealing with grief the same Gestalt technique was used by taking the client back in time to speak to the person they had lost. This was done by suggesting that perhaps there were things that were left unsaid that could now be said to free the client if she was stuck in the grieving process. The client spoke to the person and then felt freer and more complete. Once again the group identified and supported the client and this, too, led them to do their own work as grieving is universal.

Although the client still has a problem with self-esteem, there is a significant increase in the level she achieved (78 to 66) an increase in 12 points in her self-esteem level. Her voice was stronger and she exhibited more self-confidence at the close of the group. This client stopped drinking in April, 1990 and it was her desire to keep working on developing greater self-confidence. Recovery from addiction can be a slow and evolving process as this client demonstrates.

The client said “. . .no-one is going to give this to me, I am going to have to work for it on my own.” This is a successful part of therapy when the client begins to take responsibility for themselves.

Chapter Seven

Interview of a First Nations' couple thirteen years after attending Nechako Treatment Centre

The following is an intensive interview conducted with two people from the Penticton Indian Reserve who had their initial experience in Nechako Centre in 1984. The couple have been married for many years, are in their 50's and have children and grandchildren and a large extended family. The husband came for the full programme and then the wife joined him for relationship week in 1984. I was fortunate enough to be their counsellor at that time. They were very willing to grant the following interview some thirteen years later (in 1997). The format is the same as the previous interviews, it is egalitarian and started with the suggestion "let's talk about your experience with Nechako Centre, how did that all happen, how long ago was it and how come you chose Nechako?"

Interview Conducted On April 22nd, 1997

(The husband) Well, to begin with I didn't have a choice, it was suggested to me by one of my lawyers so I took a chance and came up and did the program and that was in July of 1984 thirteen years ago. I first went through the programme in 1984 and my wife came up with for relationship week at that time.

The client talks about different treatment centres and how Nechako focuses on personal problems.

About three years after I went through the program other people started getting curious. In 1988 we had fifty-eight people come from Penticton (Indian Reserve) and went through the programme in one year. That's a lot of people and the effects

of that is that there is some two hundred people that have come through Nechako. There is some that have gone through other treatment centres, a good number of our adults have gone through treatment. Other people use Round Lake mostly and one on the Island. They are both Native treatment centres where they are culturally oriented. They go there and do cultural things rather than working on their own issues. In my experience Nechako deals with a lot of your own issues rather than cultural issues. I think now that Nechako is more sensitive to the Native values than it was when I first went through. There are some components, they have smudges and sweats, they didn't have that when I was here.

The wife talks about the Medicine Wheel and its importance in recovery.

(The wife) There is a well-known Elder coming to the Centre tonight who gives talks. His healing is done around the Medicine Wheel. He's very powerful actually, I listened to him several years ago when I came through (Nechako) the last time.

The husband was in constant communication with his wife who was in Penticton.

When my husband went through Nechako Centre in 1984 he phoned every morning and he phoned every night. I always caught through his voice where he was really at and for the first two and one-half weeks he was basically just saying tell me to come home and I'll come home. He was here to beat a rap and go back and tell his lawyer and the judge that he had been through the Centre. He wasn't really doing any work until that one night he had a sort of spiritual awakening and decided that he had better do something about his problem. He realized it was a problem. The change in his voice from the first phone call that evening to the second phone

call that night there was the vastest difference in the tone of his voice. He told the story and we could tell he was sincere about it. That was when the work started. His Mom was there and she cried and said it was just like giving birth again. She was so happy.

The client was trying to beat the rap for seven impaired charges and was not really aware that he needed to change for himself.

(The husband). That day I didn't realize that some of the staff was in touch with my counsellor back home and my counsellor said "get him the hell out of there, send him back home, he's not doing anything for himself" and I didn't know anything about that until after the next day. That particular day we were talking in small therapy group about making decisions whether to quit drinking or to keep going and my decision was to keep going (drinking) because I was there for other purposes to beat the rap so the judge would take it easy on me when we were in court. I had seven impaired charges and I was scared I was going to jail so I had to do something. We had to make this decision. One of my counsellors kept bugging me about making a decision so I did (to keep drinking).

The client is confronted by the counsellor on his decision to keep drinking. The importance of respectful confrontation in recovery is illustrated in the following:

She said "that's good you've made a decision, the next thing is to know whether it's a right or wrong decision." It was eating at me all night until I made the right decision. It felt like there was a big weight lifted off my shoulders and I didn't have to drink anymore. Realizing that, it didn't matter whether I went to jail or not.

It didn't effect me anymore, I just felt like dealing with a lot of my issues and getting through the programme. It was a good experience, it was a wonderful experience in 1984.

Following the husband's decision to quit drinking he discovers the importance of his family.

I got home and it didn't matter about my friends or anything. All I wanted to do was spend time with my family. I wanted my family together and to spend time with them. I think it was a good decision, intelligent.

The thing is when you go into treatment, you effect at least ten people around you. In my case I affected a lot of people because I had a lot of people around me. Some of those people I was out there with in 1984 are coming up here on Monday for a new program. That's a big catch, it will have a big effect in the community.

The Penticton Indian Band still faces lots of problems with alcohol and drugs and the husband and wife are able to bring clients to Nechako Centre.

(The wife) I think they pretty well all have been. When (blank) decided he should come through Nechako came, look at who came in behind him. How many of his family members? His sisters, his niece and just recently his son. It is just blossoming and right now we have a group of teenagers who are pretty wild. There's a lot of drugs, there's a lot of alcohol flowing and we don't know what they are doing for money to do all that. It seems to be all there, we are keeping our kids pretty active. I imagine there's going to be another big group that's going to have to come through Nechako again.

How treatment for alcoholism can improve a marital relationship is disclosed in the following paragraph.

When I came to relationship week in 1984 I found (blank) a little surer of himself. He still B.S'd a lot but it wasn't to get him out of jams anymore it was more a sense of humour passed down from his Dad. I certainly did notice a difference, a positive difference.

The husband describes how Nechako Centre affected their community.

(The husband) The other thing I think how Nechako Centre affected our community is that there were a lot of people who were cultural leaders. They had religion and everything else mixed up in it. They didn't want to use a Native treatment because of that so they chose Nechako where you deal with your own personal self. I find that a way to start, to deal with your own personal self. Some were in the church, some were using sweats, some were using fasts and certain cultural ceremonies and things like that. Some of the people were against that because of their religious beliefs. At this point I think people are coming around and realizing however people worship it is all to a higher power and people are lightening up on certain religious issues.

Nechako now has a certain cultural aspect. The big thing is that there is choice at Nechako. If you want to participate you can and if you don't want to participate in the cultural components you aren't pressured.

The wife talks about how important it is for treatment to have respect for the clients and that it is in contrast to the experience of residential schools.

(The wife) When I had a choice about fourteen years later, I decided to go to treatment to deal with issues that were hindering my growth. I looked at a lot of other brochures for different treatment centres in B.C. I didn't want to come to Nechako because of our affiliation with the Director, we see a lot of him. We've become personal friends with the staff and I felt that would hinder what I needed. But in looking over all these brochures it narrowed my choice down to Nechako Centre because the program is short, sweet and comes right to the point. I didn't want to go home feeling that I was stuck to the twelve-step programme because I had gone to that treatment centre or I didn't want to have them tell me that I couldn't chew gum or I couldn't do this or I couldn't do that. I had grown up with all that through the residential school system and I knew what Nechako was like and they didn't do that. It is the most relaxed of all the treatment centres. Nechako is very respectful, I know one of the other centres where we have taken one or two clients, they talk down to us, they don't treat us on an equal level and they are our own people which is the really sad part of it.

The client talks about the positive changes recovery made in his life and how he was able to contribute to his community.

(The husband) At the point when I left Nechako in 1984, I went home and I was on Band Council and in about four to six months, I resigned and went on my own. I think up-to-date that was the best two years of my life. I did some farming work, it was on my own and I think it was a real good experience for me. Then I went back into the community and thought I'd like to be on Council again.

I started doing counselling work where I started sending people to treatment. It was the first year on Council we realized we had a totally sober Chief and Council in our Community and that's how I feel these programs work in communities is that if they are supported by the leadership and the people in higher positions in the community are supporting this program either by participating or praising the people that are going through certain aspects of their life in terms of treatment or sobering up and recognizing that publicly.

The husband describes how important it is to give support to individuals in a Native community.

Giving those individuals support from the top down that's how programs would work in Native communities or in any community I would imagine in terms of growth and treatment and issues of drugs and alcohol. In my opinion that is how it would work and be successful in any community. In my community I am chief of police.

The wife talks about the importance of support groups in the recovery process.

(The wife) It is certainly nice to know that you can come back up any time. It is just a phone call away, we came up for relationship week this week and another couple came with us. There's such a bond between the people who have been to treatment as opposed to the people who are all sober and haven't been through treatment. I've always said, "it's really nice that you've been through treatment, if you need anyone to talk to our door is always open and the coffee is always on", that's what I have always said. A few have taken me up on it and have spent hours

talking, consequently we've started a support group of people who have been to a treatment centre because they have a hard time relating to people who have been to just A.A. It's a different mentality there these people often get very defensive if we want do something. So we have set up a support group for people who have been to just treatment centres. We say the serenity prayer, set up our rules and nobody's really the head of it, we're just there together.

The husband suggests that sobriety can be lost if personal issues are not dealt with.

(The husband) In Penticton right now we are not only dealing with people who have gone through treatment but also the issue of people that have just sobered up by themselves and still have issues so that they are having trouble hanging on to their sobriety. It is discouraging for people who have gone to treatment and are looking to that group for support. So we have taken steps to remedy that somehow offering our support in terms of treatment and helping with their follow-up. Alcoholics Anonymous is sometimes discouraging because people go there and they just do not do anything about themselves.

In the recovery process, the anonymity of AA and the celebratory nature of the First Nations culture present difficulties in the community.

One of our issues started in 1988 or 1989 because we were doing all these recognition dinners and honouring sobriety in our community and we were inviting a lot of people and had it on T.V. as a news item and A.A. was complaining that their program is supposed to be anonymous. We were breaking the rules by publicizing this stuff, mentioning last names and all that so there's a kind of division there.

Recovery itself can present further problems and the couple are doing problem solving to bring the community together.

We're taking steps to address it. I think these things like recognition and honouring will start up again because we realize through the support group that those things have to come from the leadership in the community, not the group itself - the honouring, the dinners the big celebrations the sobriety type celebrations. When things stopped I was doing all this myself being good natured I wanted to help them. We started doing things together, we did the first couple of celebrations and then we did a real big one. We invited chiefs and councils from all the neighbouring communities and we went from our little hall to the hall in town. Our little hall held one hundred and fifty and the hall in town would hold two hundred and fifty, so it was a growing thing. We packed it. We've lost something.

Discussion

From this interview, a number of issues can be identified, especially when we consider the position of this couple in their own community, that they are from a reserve and that they have maintained thirteen years of sobriety.

1. There is the actual awareness of the husband that he must make a choice between drinking and not drinking. He made his choice when his counsellor from home suggested he go home because he wasn't doing anything. Initially he had decided to keep drinking and it was on my suggestion that it was good that he had made a decision and the next step would be to decide whether the decision was right or wrong. He decided that to keep drinking was the wrong decision. He decided this on his own in 1984 (page 104) without coercion. This is the existential factor that

Yalom talks about: “learning that I must take ultimate responsibility of the way I live my life no matter how much guidance and support I get from others.”

2. There are many references to the differences between Nechako Centre and other centres in the Province. One that is mentioned is that Nechako works on personal issues rather than cultural issues. It is also mentioned that Nechako now has more cultural components but that there is a choice as to whether to participate or not. It is also mentioned that there is not a lot of pressure about being told what to do and that it is the most relaxed of the treatment centres.

3. Another difference that the wife has found is that people are treated respectfully and on an equal level which was not always the case at other treatment centres. While it is not the purpose of this thesis to make comparisons with other centres in the province, it is interesting to note that respect and equality are two reasons why Nechako Centre has become popular with this couple and their community. It is also important to note that this couple also utilizes other centres in the province and speaks highly of them.

4. The numbers of people that have been affected by the attendance of this couple at Nechako Centre is astounding. The husband mentioned that there have been some two hundred people from Penticton Indian Band who have gone through the centre. He also mentioned that when you go into treatment you affect at least ten people around you. In his case there would be more than ten as he is counselling and he and his wife are still used as a resource for the people on the reserve who wish to go into treatment.

5. There is an indication of how treatment can affect people on the reserve when the husband says “I feel these programmes work in communities when the people are supported by the leadership and the people in higher positions.” So often people go back to the same conditions that they left and it is so hard for them to change without the support that appears to be enjoyed in the Penticton Indian Band.

6. In the end he stated “we’ve lost something.” Changing is not an easy path and it appears that toes can be stepped on if there is not a great sensitivity to the way of others. The honouring and the feasting and recognition are very much a part of First Nations culture and anonymity is part of the Alcoholics Anonymous tradition. So one of the next tasks appears to be a reconciliation of the two different traditions.

7. At the level of personal change when the man changed the wife could tell the change in his voice. We note that the mother cried and said “it was like giving birth again.” It appears that the mother was welcoming home the prodigal son and that the family could now begin its own healing journey. This is further substantiated when the man said upon returning home that “it didn’t matter about my friends or anything. All I wanted to do was spend time with my family. I wanted my family together and to spend time with them.”

8. I was the counsellor that asked him whether his decision to keep drinking was a right choice or a wrong choice. He remembered it at the time of the interview and he thinks I am a contributing factor in his recovery. It is important in treatment that the client be supported and that they should also be challenged by the counsellor.

9. There is another extremely important point that is brought out in this interview: that is that court sentencing is not always a successful route in the

treatment of alcoholism. The man in the beginning was in the Centre to “beat a rap” and it was not until he decided to change that we see “that it didn’t matter whether I went to jail or not. It didn’t effect me anymore, I just felt like dealing with a lot of my issues...” He could have gone through the programme, beat the rap and there would have not been a change. While fear of court sentencing is a factor in going to treatment it is not always a factor that promotes change. The clients themselves have to make the commitment to change.

10. What happens back in the community is important in the recovery process. When there is on-going support there is an enhanced chance of continued sobriety.

Epilogue

This remarkable couple continues on their journey of being a great resource to the Penticton Indian Band. They continue to drive people to the Nechako Centre and then return for the final ceremony and drive people back. I had the opportunity of attending a ceremony with them on January 29th, 1998 and they shared that there are now three generations of people from the Penticton Indian Band who continue to change their lives through treatment.

It was especially apparent to me as I continue to share in friendship with this couple that they are humble and grateful for the experience and change that they had through Nechako and that they are touched and grateful as they watch others they love change. A poem was read at the ceremony by one of the participants and I think the words speak for themselves. The First Nations author of the poem was happy to share it with us and so gave his permission to have it included in this thesis:-

Storm Riders

We came together
strangers
for a full frozen moon
a circle of men
strong in our weakness
building a foundation of trust
and a house of caring
a safe place
to ride out the storm
of alcohol abuse
drug addiction
and old hurts
to heal.
Let the wind of words
blow the bad away
and the rain of tears
wash the pain away
to emerge
Brothers united
cleaner, stronger
more whole of spirit
ready to
face the world
after the storm
(Howard Shields, Lillooet, B.C.)
(January 29th, 1998)

Chapter Eight

Conclusion

The aim of this thesis was to provide a picture of an alcohol treatment centre located in the northern portion of British Columbia. It seemed timely for two reasons:

1. The University of Northern British Columbia was established in 1994 in the same geographic location of the Province as the treatment centre. The general public of the area as well as the university have little knowledge of the centre and the profile of the people who attend. Neither is there knowledge of what actually goes on in this treatment centre for alcoholism. I felt it would provide a valuable background for the social sciences of the university as well as provide a base of knowledge for the people of this area.

2. In doing the research it became clearer to me that the proportion of First Nations people who attend is larger than the proportion of the general population who attend. From my general knowledge of people who have been curious over the years about where I work I realized that there is very little understanding of First Nations people and their problems with alcohol. The stereotype of the “drunken Indian” is one that prevails. I thought it necessary to place a history of First Nations people as it relates to their alcohol drinking patterns in this thesis to help broaden our understanding and deepen our respect for First Nations people. There are many other admirable qualities that First Nations people have and amongst them has been a great tolerance for white people’s lack of respect and understanding for their

grievous problems. Their problems were caused by lack of cultural understanding and respect due to the colonialization of their homelands.

I attempted to provide some data about the effectiveness of the Nechako programme by administering self-esteem questionnaires to a group of clients. This attempt falls far short of proving a link between increased self-esteem and an increase in the desire to stop the destructive habit of alcohol. There are so many other variables that can contribute to a desire to stop drinking not least amongst these are questions of spirituality, grieving, group dynamics and modeling by non-drinkers.

As Kirby and McKenna (1989, p. 43) point out “Research is like embarking on a voyage of discovery.” When I started the thesis it was to simply answer the question of what happens in this particular treatment centre. As it evolved I became aware that there was a deeper question that had to do with the predominant number of First Nations people that attended the centre. Although I had known this I had never collated the numbers. With this evidence in hand I realized that First Nations’ people and their drinking problems were very misunderstood by the general population. The aim of the thesis widened and I wanted others to understand more about First Nations people. Perhaps this had been my bias all along without knowing it. Payne (1991) makes the point that research tends to effect the climate of opinion and can lead to change.

I wanted to get across an idea of what happens for First Nations and others in a treatment centre. Hillman suggests “There is in fact a direct relation between the poverty of ideas in academic and therapeutic psychology and their insistence upon the practical.” (Hillman, 1989, p.55). The idea that I attempted to share was that we can

bring two cultures together and through the commonality of their shared problems and trust we can bring healing. There is no difference between the cultures when it comes to problem-solving the causes for alcoholism for as the man from the Queen Charlotte's said "We are all the same whether we are white or native."

Separate treatment centres for First Nations and others are being implemented so that First Nations can regain their own culture and spirituality. Yet this poses the question of segregation and so from the result of this thesis I suggest that perhaps we should also be looking at the possibility that combined treatment can increase understanding and respect between the cultures. If the cultures are balanced and others can learn from First Nations then both First Nations and other cultures will be enriched.

Furthermore, Smart and Ogborne (1996, p. 226) make the following recommendations: continued provision of low-cost, effective treatments for alcoholics and other problem drinkers, together with research on how to improve such treatments. For many areas an expansion of treatment facilities will be needed. Generally, the expansion of treatment services is followed by decreases in alcohol problems. Continued research is needed on problems among high-risk groups such as young people, native people and northerners. The problems are not small. As the wife from the interview (Chapter Seven) of this thesis suggests, perhaps it is best to have a choice between different models of treatment centres.

Limitations of the Study

This study does not prove that increased self-esteem leads to a better prognosis for recovery. Although we see increased self-esteem for those that attend, we have

no conclusive evidence to link increased self-esteem with continued recovery.

Nechako Centre used to host an afternoon for returning clients. It was held in October of each year on the Friday afternoon preceding the AA Round-Up in Prince George. People from as far away as Whitehorse, Terrace, Smithers, Prince Rupert, Quesnel, Williams Lake, Dawson Creek, Fort St John and other towns would attend the Round-Up and come back to Nechako Centre for that afternoon. I cannot give the numbers but several of the people had attained sobriety and felt better about themselves. I cannot give statistics here as none were kept and Nechako Centre no longer hosts returning clients.

There are other treatment centres in the province which have a multi-cultural and First Nations cultural approach. I have not included other treatment centres in this thesis and this does not preclude them from being effective for the treatment of alcoholism.

The thesis, while endeavouring to honour First Nations peoples, falls short in giving a complete history of their pre and post-contact periods and the resultant anomie and loss of self-esteem. Eight brief pages written by a white person, no matter how well-intentioned can never tell the story of the loss of First Nations culture. So much of the tradition of the culture was through oral history. When the ceremonials were outlawed through the Indian Act much oral history was lost, values could not be passed down and the respected forms of government were interrupted. Laws were not written, they were orally transmitted.

Although two of the interviews are with women, the study does not deal with the implications of alcoholism for women. Neither does it look into the problems women face when going for treatment, such as child-care centres for the children.

Implications

This descriptive exploratory study that contains a description of residential group treatment and some personal histories could be followed up in these suggestions:-

1. Social work students or others could undertake follow-up studies on specific reserves to see how people are coping after treatment from any centre.
2. Longitudinal studies could be undertaken to track periods of sobriety amongst the general population of those that have attended treatment at the Nechako Centre.
3. A further study could be undertaken on what elements of the treatment programme lead to transformative changes through clients' self reports.
4. A follow-up study could be undertaken with the Penticton Indian Bands' permission to research the level of sobriety that has been reached and the impact that it had on the reserve. This could include a study of the level of sobriety of those who have gone through the Nechako Centre and those who have gone through AA programmes and culturally relevant treatment programs.
5. A larger sample of other groups who have gone through the Nechako Centre could be undertaken to see if the level of self-esteem for First Nations clients is dependent upon the proportion they represent within the client pool, and to discern if the three groups sampled in this thesis are representative of the client pool.

6. Advocacy for the efficacy of treatment centres could be undertaken by those who are interested in seeing that the stigma of alcoholism and treatment is eliminated or reduced.

7. Future groups going through Nechako Centre could be analyzed using Yalom's twelve therapeutic experiences to find out the experiences that are most helpful to the clients.

8. Further analysis of Yalom's twelve therapeutic experiences could be evaluated to determine which therapeutic experiences are most helpful to First Nations clients and the question could be asked "Is there a cross-cultural difference in group therapy treatment?"

9. Future groups going through Nechako Centre could be analyzed utilizing Hudson's Index of Self-Esteem.

I am aware of the level of observer bias that I bring to this project by virtue of my commitment to the group therapy offered at the Nechako Centre. However, through sharing my enthusiasm for residential group therapy I am hopeful that further dialogue will ensue. I envision advocacy for support of residential group therapy in the treatment of alcoholism. In the long term effective treatment will be cost-effective. Chapter One outlines the enormous costs of untreated alcoholism not to mention the deaths that ensue.

From a more general policy perspective I argue that residential group therapy is effective in the treatment of alcoholism. Alcoholism as a social problem persists and the provincial government does not have a clear commitment to providing more services for treatment. Nechako Centre is funded on a year-to-year basis and there is

underlying anxiety about how long the programme can last. The model demonstrated by Nechako Treatment Centre with its offering of residential group therapy and multi-cultural approach is effective as the improvement in self-esteem indicated. However we have also shown that even with improvements some clients level of self-esteem is still in a critical area after treatment.

Final Thoughts

It has not been the purpose of this thesis to provide an evaluation of the Nechako Centre Treatment Programme. It has been the purpose to provide a descriptive study of what goes on at the Centre so that the reader can understand the dynamics of group therapy and hear the life experience of two First Nations women clients and one First Nations couple. It has also been the purpose of the thesis to stimulate further questions regarding self-esteem and group therapy and to look at how self-esteem changed through treatment.

First Nations culture and other cultures can help each other in the healing process of recovery from alcoholism. There is a vulnerability when people come into treatment that allows them to look at each other as human beings and not as separate. It is important to add that First Nations spirituality is not to be overlooked in the treatment process. The quote below demonstrates how important native spiritual traditions are to return the self-esteem that has been lost since the time First Nations culture was devalued by the Canadian government and settler society.

The task of rebuilding Indian nationhood has helped restore community to those who felt its lack, and pride to those who have been robbed of their self-esteem. Even more important, treatments for alcoholism created by Indians often revolve around a return to native spiritual traditions.

(Ballantine & Ballantine, 1993, p. 450.)

Nechako Centre celebrates Native spirituality with smudges, the Medicine Wheel, visiting First Nations spiritual leaders and speakers. Also in its closing ceremony First Nations people are spiritual contributors as we can observe from the poem “Storm Rider’s”. Although the programme does not revolve around native spiritual traditions, it does acknowledge and celebrate them.

My lengthy association with Nechako Centre has helped me to know, understand and appreciate First Nations people. As Grand Chief Jocelyne Gros Louis of the Huron-Wendat Nation told The Royal Commission on Aboriginal Peoples :

What we want Canada to do is to give us the support we need in order to regain our own strength so that we can once again walk the right path under our own steam. This means sharing with us the renewal of our self-respect and our pride in our heritage. This means paying attention to the use of language, symbols and cultural opinions so that our peoples are not offended. This also means letting us take care of ourselves through equal access to the revenues generated on our traditional lands and working with us as partners on these vast expanses of land (translation). (Report of the Royal Commission on Aboriginal Peoples, 1996 Volume 1, Principles of a Renewed Relationship).

First Nations and non-Natives enhanced appreciation of one another adds to our present and future in our common country.

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Appendix A

Approval From Nechako Centre



NECHAKO TREATMENT CENTRE

28 April 1999

Dear Phyllis:

This letter is to confirm what I had told you verbally, sometime ago. You can have access to the Nechako Treatment Centre data requested - and use it as you have specified - for research purposes.

Yours truly,

A handwritten signature in black ink, appearing to read 'P. Hanki'. The signature is fluid and cursive, with a large 'P' and a long, sweeping underline.

Paul Hanki, RSW
Director
Chemical Dependency Programs

PH/cd

Appendix B

Hudson's Index Of Self-Esteem

INDEX OF SELF-ESTEEM (ISE)

AUTHOR: Walter W. Hudson

PURPOSE: To measure problems with self-esteem.

DESCRIPTION: The ISE is a 25-item scale designed to measure the degree, severity, or magnitude of a problem the client has with self-esteem. Self-esteem is considered as the evaluative component of self-concept. The ISE is written in very simple language, is easily administered, and easily scored. Because problems with self-esteem are often central to social and psychological difficulties, this instrument has a wide range of utility for a number of clinical problems. The ISE has a cutting score of 30 (± 5), with scores above 30 indicating the respondent has a clinically significant problem and scores below 30 indicating the individual has no such problem. Another advantage of the ISE is that it is one of nine scales of the Clinical Measurement Package (Hudson, 1982) reproduced here, all of which are administered and scored the same way.

NORMS: This scale was derived from tests of 1745 respondents, including single and married individuals, clinical and nonclinical populations, college students and nonstudents. Respondents included Caucasians, Japanese and Chinese American and a smaller number of members of other ethnic groups. The ISE is not recommended for use with children under the age of 12.

SCORING: The ISE is scored by first reverse-scoring the items listed at the bottom of the scale (3, 4, 7, 14, 15, 18, 21, 22, 23, 25), totaling these and the other items scores, and subtracting 25. This gives a range of 0 to 100 with higher scores giving more evidence of the presence of problems with self-esteem. For scoring questionnaires with missing items, see Hudson (1982) or instructions for scoring the Index of Family Relations in this book.

RELIABILITY: The ISE has a mean alpha of .93, indicating excellent internal consistency, and an excellent low S.E.M. of 3.70. The ISE also has excellent stability with a two-hour test re-test correlation of .92.

VALIDITY: The ISE has good known-groups validity, significantly distinguishing between clients judged by clinicians to have problems in the area of self-esteem and those known not to. Further, the ISE has very good construct validity, correlating poorly with measures with which it should not and correlating well with a range of other measures with which it should correlate highly, e.g. depression, happiness, sense of identity, and scores on the Generalized Contentment Scale (depression).

PRIMARY REFERENCE: Hudson, W. W. (1982). *The Clinical Measurement Package: A Field Manual*, Chicago: Dorsey. Instrument reproduced with permission of Walter W. Hudson and Dorsey Press.

AVAILABILITY: The Dorsey Press, 224 South Michigan Avenue, Suite 440, Chicago, IL 60604.

ISE

This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follows:

- 1 = Rarely or none of the time
- 2 = A little of the time
- 3 = Some of the time
- 4 = A good part of the time
- 5 = Most or all of the time

- _____ 1. I feel that people would not like me if they really knew me well.
- _____ 2. I feel that others get along much better than I do.
- _____ 3. I feel that I am a beautiful person.
- _____ 4. When I am with other people I feel they are glad I am with them.
- _____ 5. I feel that people really like to talk with me.
- _____ 6. I feel that I am a very competent person.
- _____ 7. I think I make a good impression on others
- _____ 8. I feel that I need more self-confidence.
- _____ 9. When I am with strangers I am very nervous.
- _____ 10. I think that I am a dull person.
- _____ 11. I feel ugly.
- _____ 12. I feel that others have more fun than I do.
- _____ 13. I feel that I bore people.
- _____ 14. I think my friends find me interesting.
- _____ 15. I think I have a good sense of humor.
- _____ 16. I feel very self-conscious when I am with strangers.
- _____ 17. I feel that if I could be more like other people I would have it made.
- _____ 18. I feel that people have a good time when they are with me.
- _____ 19. I feel like a wall flower when I go out.
- _____ 20. I feel I get pushed around more than others.
- _____ 21. I think I am a rather nice person.
- _____ 22. I feel that people really like me very much.
- _____ 23. I feel that I am a likeable person.
- _____ 24. I am afraid I will appear foolish to others.
- _____ 25. My friends think very highly of me.

Appendix C

Consent To Release Information

October 10th, 1995

I, _____, do willingly agree to participate in a research project with Phyllis Parker at Nechako Centre over the course of my stay here in treatment. The research results will include: _____ Questionnaire One - at the beginning of the program

_____ Questionnaire One - at the end of program

No names will be used and the results of the research will be shared with the participants before leaving treatment.

(Signed)

(Date)

(In their own handwriting) "I am willing to participate in an in-depth interview"

Appendix D

Consent to disclose geographical location

October 10, 1995

I, _____ of _____

Telephone _____ - hereby consent to Phyllis R.

Parker of 100 Douglas Street, Prince George, B.C., V2M 2L8 that she may keep in touch with me for the next two years. I understand that I am to be part of a research thesis for the University of Northern British Columbia. I further understand that my name will not be used and that I will remain anonymous. I further understand that my geographical location will not be disclosed unless I consent to this.

Geographical location _____, _____ Please write "yes" or "no"
Yes No

The purpose of the research is to further understanding of chemical addiction in order to be able to help others.

Signed this _____ day of November, 1995.

Signature

Appendix E

Mission Statement

Vision Portrait

Program Philosophy

Mission Statement

“Nechako Centre is a community where personal transformation can begin.

Our mission is to create a safe, intimate environment for the healing of people whose lives are affected by chemical dependency” (undated brochure, Nechako Centre).

Vision Portrait

- At Nechako Treatment Centre we dream about a time in the future in which transformational work begun here is continued within peoples’ families and communities. Our hope is that ongoing recovery will bring the freedom to create a life that has purpose and meaning.
- We envision a strengthening of our connection with people with whom we work, their families, referral agents and communities. We are deeply committed to acknowledging every person’s uniqueness and worth.
- As a staff we struggle to work in an equal and interdependent way. We are also aware that our lives continue to be transformed by all the people with whom we come in contact” (undated brochure, Nechako Centre).

Programme Philosophy

- The people we work with are those who identify themselves as having a problem with alcohol and/or drugs. They come to our Treatment Centre to develop a different relationship with alcohol and/or drugs. We work collaboratively in a group setting with each participant viewed as expert of his or her own life. We explore what barriers get in the way of initiating and implementing this new relationship as well as what personal strengths each person already possesses that will promote this change. Together we identify the social context of their lived experience, its relative impact on them, the way they perceive the world and how this now fits with examined beliefs of who they are.
- Because social context is a key element, we have found that gender specific programs are particularly effective--as men and women are socialized in different ways. We believe it is important to offer different program options for men and women so they can work in a therapeutic setting that is most beneficial to them.
- We operate within a Bio\Psycho\Social\Spiritual philosophical framework in order to help people take charge of their lives by making changes that enhance their strengths, their freedom and their choices. (Prince George Regional Hospital, Nechako Treatment Centre Policy and Procedure Manual, 1981).

Substance abuse treatment is dominated by a few approaches, included amongst these are the following theories: moral, spiritual, disease, symptomatic, social, chemical dependency and learning. The disease theory is more widely known than the other theories and has been extensively applied by Alcoholic Anonymous (AA) in North America. However, Nechako Centre does not use these approaches. The following table extracts some of Nechako Centre’s model.

Appendix F

Comparison of Different Treatment Models

DOMINANT MODELS	NECHAKO CENTRE	AUTHOR'S APPROACH
MORAL THEORY	MORAL THEORY	MORAL THEORY
The moral theory denotes substance misuse as a vice or a sin. The theory implies that some individuals, through their own free will, make a conscious choice to become substance misusers	Multivariate approach does not consider addiction as vice or sin.	Cause is related to early trauma or later life dissatisfaction. Not considered a vice or sin.
SPIRITUAL THEORY	SPIRITUAL THEORY	SPIRITUAL THEORY
Attributes substance misuse to the absence of a metaphysical focus within the affected individual.	Acknowledge spirituality as one of the multivariate approaches to addiction.	Acknowledges spirituality as an important component in addiction and recovery.
DISEASE THEORY (AA)	DISEASE THEORY (AA)	DISEASE THEORY (AA)
Substance misuse is a progressive illness with an identifiable natural history as well as a permanent condition or lifetime illness. Believes in abstinence.	Not an illness. Recovery may or may not require abstinence depending upon degree of severity and/or type of syndrome.	Not an illness. Belief in abstinence, "why play with fire?"
SYMPTOMATIC THEORY	SYMPTOMATIC THEORY	SYMPTOMATIC THEORY
Substance misuse is a symptom of another primary mental disorder, e.g. anxiety, depression, neurosis, personality disorder.	Although substance misuse and psychiatric illnesses co-exist and interact, these conditions are distinct.	Belief that some psychiatric illnesses can co-exist, i.e. anxiety, but belief in a root cause such as sexual abuse, childhood violence and neglect.
SOCIAL THEORY	SOCIAL THEORY	SOCIAL THEORY
Substance misuse develops and endures as a result of disruptive social forces such as unemployment, poverty, violence, family dysfunction, as well as gender and age inequities. Substance misuse is an adaptation to the resultant misery and unhappiness.	Little evidence to support a direct causal relationship between social problems alone and the development of substance misuse.	Belief that unhappiness as a result of social problems can be one of the factors leading to addiction but believe there is a psychological root cause as well. (i.e sexual abuse)
CHEMICAL DEPENDENCY	CHEMICAL DEPENDENCY	CHEMICAL DEPENDENCY
Substance misuse is a syndrome characterized by a clustering of both biological and psychological phenomena. It permits measurement of severity of dependency through the application of standardized assessment or testing.	The concept of chemical dependency has important clinical applications and helps to guide research into the biological determinants of addiction. The biopsychosocial theory incorporates the concept of chemical dependency.	Belief in altered behavioural states, lack of control over consumption and physical symptoms relieved temporarily by further use. Disagree with definition that a heavy user may not necessarily be dependent.
LEARNING THEORY	LEARNING THEORY	LEARNING THEORY
Substance misuse is learned through the complex processes of behavioural acquisition and reinforcement	Tends to ignore the biological processes that are triggered and accelerated by excessive substance misuse. Incorporates certain principles of learning theory, i.e. reduction or cessation of substance misuse.	Addiction is learned behaviour and anything that is learned can be unlearned and new behaviour relearned.