CULTURAL HERITAGE AS A CORNERSTONE OF A REHABILITATION PROCESS: A SINGLE CASE STUDY

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ABSTRACT/RESUME

This is a case study of a Native adolescent sent from a rural reserve to an urban centre for psychiatric treatment. He was treated with some success by encouraging him to develop a particularly Ojibway identity.

C'est une étude sur un adolescent autochtone qui a été envoyé d'une Réserve rurale au centre urbain pour des soins psychiatriques. On l'a soigné avec quelque succès en l'encourageant à développer une identité particulièrement Ojibway.

In October 1984, a 15 year-old boy from an Ojibway community in Northwestern Ontario, who we shall refer to as E, was admitted to the Manitoba Adolescent Treatment Centre. The Centre was just opening at that date. It is a residential and day treatment program serving youths with a wide variety of psychiatric disturbances.

The Manitoba Adolescent Treatment Centre has a philosophy of community-based service. That is, an understanding that a child maintains mental health when well planted and supported in a home community of family, school and other important spiritual and social resources.

E was referred to the centre by the Winnipeg Children's Hospital Psychiatric Assessment Unit and by the Kenora (Ontario) Child Development Centre. On admission, he was presented as hostile and suspicious. His personal history included substance abuse (alcohol and gasoline), aggression towards family members, children in the community and himself. He had twice attempted suicide and appeared preoccupied with themes of God, the Devil and the Thunderbird, a figure in Native mythology. As well, E reported auditory and visual hallucinations related to these.

E's family history included alcoholism in both parents and chronic violence and neglect. He had a large number of siblings, one of whom had died of neglect at two years. E, although only a child himself at the time, felt ongoing responsibility for that death plus fear it would happen to him. His childhood afforded him no security, safety nor consistency. Perhaps as a result, he was always adversely affected by stress, even well into the last stages of treatment.

Compounding the mental and emotional trauma was a physical one. At 2-1/2 years, E lost the thumb and forefinger of his left hand in the wringer of a wringer washing machine. Subsequent surgery rebuilt a semi-functional thumb and two fingers, but made him a target for childhood teasing and he remained self-conscious and isolated from peers.

During E's 14th year, he was baptized into a fundamentalist Christian church and, time after time, E returned to examine this experience in treatment. It appeared the boy had accepted literally the injunction of this religious experience. He had heard that if he did not embrace the belief, then he was with the devil. As he did not understand and so could not embrace the belief, he became frightened and preoccupied with the devil. The baptism had been described as a rebirth of his soul, and being very concrete and literal in his thinking, he truly wondered where his spirit had gone. This was not an intellectual rumination for the boy, but a deeply frightening and disorienting event. His early childhood had not grounded him well in person, time, and place, and his weak orientation was undermined by substance abuse. E, an already fragile personality, was in a spiritual nightmare.

The one protecting factor in E's life was his paternal grandmother. The wife of a deceased medicine man, she was an important moral force

in his family, and the one person E felt loved him. We later came to understand how the force of her influence might be employed in our work with her troubled and confused grandson.

E's admission diagnosis was paranoid schizophrenia. His fears were pervasive and visible, breaking through in a manner overwhelming to the boy. When questioned about his goal for his time at the treatment centre, E stated that he wanted to be a "good boy", learn to control his temper and "have a good life". Impressed at the time with the manner in which E answered the question, we wondered silently whether the obvious regression in the boy, so severe and pervasive, was a permanent handicap to achieving his stated goal.

When E came into residence, the Manitoba Adolescent Treatment Centre had only been open two days. E was only our second admission. Naturally, he had been the topic of much discussion, mostly centering around the nature of his psychosis and his potential for violence to himself or others. Our initial plan was to focus on his illness, with his Native identity as a secondary issue. This reflected, we think, an inherent bias in the system which we were later to confront and overcome.

E arrived from Kenora Hospital heavily sedated and his movements and speech were sluggish. As medication was reduced and the sedation wore off, we became aware of him being very suspicious and guarded. He vacillated between provocative and attention-seeking behaviour of an immature nature, indiscriminately approaching and hugging female staff without warning or consent, and verbal aggression and threats to harm himself or others.

As treatment progressed, a debate ensued over how much of this behaviour was based upon a psychotic illness and how much was an undersocialized, immature and psychologically damaged individual's way of attempting to control his environment. It became clear E related differently to different people and that the difference seemed dependent upon the individual's perception of him. By defining his inappropriate physical contact as serving to meet nurturance and affection needs, and the aggression as a means to maintain distance and boundaries, we were able to design alternate methods of fulfilling both needs. With these plans in place, it became clear a major portion of E's dilemma stemmed from an absence of identity. The new focus became aiding him in consolidating a sense of who he was and where he belonged. But how does a Native youth from a Northern Ontario reserve pick up a valid identity while residing in an urban psychiatric centre staffed predominantly by middle class whites, serving a predominantly non-Native clientele?

E's lack of a sense of self stemmed from several sources. His chaotic upbringing deprived him of a strong bond to his mother or father, so he did not identify positively with his immediate family. His physical handicap ostracized him from his peers, and by his early teens his community, which had already isolated his family due to his father's violence, began to see

E's inappropriate physical contact as increasingly "strange".

Exploring these issues in treatment, we became aware E had a small "oasis" of stability in the general confusion of his life. His paternal grandparents appeared like an anchor for him and his family. Through the disintegration of his immediate family, E's grandparents remained solid and acted as head of the entire extended family. They orchestrated their other children to care for E when his father could not, and bullied and berated the family into at least supporting him long after the community stopped. More important, their constant acceptance, despite his behaviour and appearance, provided in E's mind his only source of affection and support on the reserve.

E's grandfather died before E's deterioration began, his death perhaps a precipitative factor in that deterioration. Grandmother remained involved with E and while he was in care forced the family to remain open to his return. As we discussed family issues, it soon became obvious how important grandmother and grandfather were to him. We began to use them as a model for E's identity. He was very fearful he would be violent and alcoholic like his father, so the positive image grandparents presented was a welcome alternative. We now could say, "Not all Natives are violent or alcoholic, nor do they all reject you".

Having picked the grandparents as a base upon which to build an identity, we began to focus heavily on what their best qualities were. It emerged that neither were full Christians as E had been baptized. Both followed many Native religious traditions and appeared to have merged Christian values and traditional spiritualism in a manner E could not. Then E informed us his grandfather was more than a mere believer. He had been a medicine man, a shaman, and as such a well respected and powerful member of the Ojibway spiritual community.

This disclosure appeared to free E from much of the confusion he had over which path, Christian or traditional, to follow. However, we knew virtually nothing about Ojibway tradition and E was looking to his therapists for direction in a spiritual journey. We were faced with a treatment dilemma. E's realization that he did not have to reject his Native identity because of his Christian baptism had given us a powerful therapeutic tool, but we didn't know how it worked.

It was obvious we had to understand the boy's condition not only from the medical and social constructs of our trade, but also through an appreciation of the perception of E by his family and community. By consulting with the Native Medical Service at Winnipeg's Health Science Centre and the University of Manitoba, we learned about child raising practices and perception of illness in the Ojibway community. Discussion with members of Winnipeg's Native community, including talks with people who themselves had experienced major distress and dislocation of a spiritual, psychological, and social nature, helped us form our treatment plan.

There had been a suggestion made in the referral information that perhaps E was the subject of "bad medicine", a retribution in a feud that might involve other family members. We had been assured, though, that as outsiders to E's community we could not expect information about such an event.

In the end, we let E teach us. In anger he would attack us with "you're White, you don't know anything. All Whites are stupid". Trying to build strength for himself as an Indian, he was building a hollow structure. E had not yet come to value his cultural identity and so still lacked a sense of self other than the negative images of his immediate family. E had to build his Aboriginal identity based upon its own worth, not upon comparisons with others. Taking a one-down position, we replied, "You're right about this, we know nothing, teach us".

With this bit of therapeutic jiu-jitsu (to borrow a phrase from Bergman, 1985), we side-stepped E's aggression and empowered him to take control in a positive and growth-inducing manner. In order to teach us, E had to learn himself, and with this knowledge came confidence. He began to consolidate an image of himself as Native. E talked more of his grandfather and related how grandfather had given him his spiritual name. Later he confided the name with some pride, telling us both how it was significant and particular to him. He no longer felt he had to grow up an alcoholic, as had been predicted by himself and his family.

In the school program at the Manitoba Adolescent Treatment Centre, a dedicated and sensitive teacher responded to an influx of Indian and Métis clients by creating a Native Studies program. Through her class, Native students were encouraged to explore their own heritage through art, literature or any other medium they chose.

E was very reluctant at first, refusing even to attend. As his comfort in his identity grew, he became eager to share with people, both Native and non-Native, his knowledge and understanding of his own culture. He wrote articles for the school newspaper and eventually put together a book, bound and covered by himself, of Ojibway myths and stories. With it he seemed to say, "This is what I know, this is who I am."

E was getting better and we began to talk of discharge, leading to another dilemma. E was in an intense, supportive environment at the Treatment Centre, but could he return to his home and remain intact? We feared his community would not see the progress and change we had seen and on his return he would experience once more the rejection and isolation which had helped to precipitate his crisis. With virtually no psychiatric support on the reserve, we feared he would deteriorate.

In response to this possibility, we tried to create options which did not include living on the reserve. We introduced the idea of being an urban Indian. We were fortunate at that time to have three Native women on staff. All three had been born and spent their childhoods on reserves, yet now lived in the city. One belonged to an Evangelical Christian church similar

to the one in which E had been baptized, and the other two followed a more traditional path. This was a coincidence, but one of which we could take advantage. All three worked with E, preaching nothing, but explaining much.

Through these three women, E saw first-hand how he could live in "the White man's world", yet remain Native. They took E to pow-wows in the city and introduced him to both traditional and Christian Native communities. He talked about being Indian while believing in the "White man's" (in his eyes) church. He was able to see that an Indian could believe without being overwhelmed. In the end E, like many of his generation, felt he could best understand what it meant to be Native by returning almost totally to his people's pre-Christianity beliefs. Despite choosing the traditional path, E remained very close to the "Christian" Native woman. As therapists, we rejoiced that he was able to reject the idea while still accepting the friendship of the individual.

Soon E began attending pow wows himself and we felt encouraged enough to initiate contact with Native social services agencies, with the plan being to integrate E into a traditionally-based Native foster family. This plan, however, did not materialize. As we were heading in one direction, E took the lead himself and decided he would rather face the known hazards of his reserve community than the uncertain promise of the city. He wanted to go home. Our access to and knowledge of his reserve was severely limited due to culture and distance.

Accordingly we felt we needed to meet E's family and discuss his future directly with them, with the Band administration, and with the school.

E's community appeared to be relatively well off. A fair number of houses sported satellite dishes and a housing boom made it seem as if suburban Winnipeg had been dropped into the wilderness. At that time, E was in his aunt's custody and had been home for a visit with her. When we arrived on the reserve, we found him on the road waiting for us. With some pride he gave us a tour, showing off the new houses, the modern school, the co-op and the video arcade. Lastly he took us around to his father's house. It did not look like suburban Winnipeg. Instead it was shabby and old, heated by a wood stove and with no furniture other than many beds, a kitchen table and chair and a T.V. We could only explain the discrepancy between E's father's house and the majority of the houses on the reserve by what we had heard from E's social worker. E's father had been so violent he had ostracized himself and his whole family. The reality of that meant he would be very low on the list of those eligible for the new houses.

Later we went to meet with the Band Administrator to discuss the support E would need when he returned to the reserve. He talked about government grants and special needs money and how to work with the Department of Indian Affairs to get that support. We talked about E's progress and potential, and the stability he showed in residence.

The administrator initially sounded so positive about E that we

wondered why E had had difficulties in the community at all. Then he told us several stories about other Band members who had "been strange" in their youth, and, although they went away and came back seeming better, had not been accepted even after 20 years. It was clear E's re-integration would not be a foregone conclusion even with the financial backing of the Band Council.

Finally we met with E's grandmother and aunt. Grandmother spoke no English and E translated for us. Through him, she related the family's story. Later, through E, we heard that many in the community, including family members, and E himself, believed "bad medicine" had been practised on his family, and E was the most visible manifestation of that practice.

It was this to which the Band Administrator had referred. He could get grants and work to get counsellors for E, but if E was seen as cursed, he would never be accepted back into the community. To us this was a re-working of a common problem. The mentally ill are stigmatized everywhere and we are constantly educating the families, friends and co-workers of the recovered not to treat them as abnormal. This education is a part of normal procedure in psychiatry. However, our attempt to do this with E's home community had led us back to the issue we had faced since the beginning of treatment, that is our ignorance of the culture and tradition which E and, as we now saw, his community, still followed. Seeking to put it in a Native context, we again empowered E to take control.

"If there is bad medicine put on you, what do you do?"
"I go to a medicine man to get rid of the bad medicine."

On his next visit home E did just that.

After a year in residential care we began talking with E about getting a discharge date. By this time, he appeared solidly rooted in his Native identity, was off medication, and had abandoned, except for times of severe stress, his immature and inappropriate behaviour. However, the thought of discharge frightened him. His aunt, in whose custody he had been, was in severe difficulty with alcohol and it was no longer an option for E to live with her. His father had been sober for nearly a year, but E had been in care all that time so still knew him only as drunk and abusive. And then his grandmother died.

After his grandmother's death, and as discharge loomed, E began to feel more and more afraid. He no longer knew of anyone he could count on at home. He had thought his grandmother the only one who loved him, and with her gone, he felt he had no one. E began to decompensate. He stopped eating and in the space of a week, he became withdrawn and incoherent. He appeared unable to handle the simplest task and could not follow the easiest directions. He would stand and stare at staff, mumble something incomprehensible, and when asked what he meant, walk away.

We did two things. First we held a meeting with E, the agency from Kenora, his reserve's mental health worker, and the Manitoba Adolescent Treatment Centre treatment team. In this meeting, we said E was doing very well, almost well enough for discharge, but we, and he, were worried the people of his Band were not ready to accept him back yet because no one there had witnessed the change in E we had seen.

He had become "sick" again, we said, in order to show he was not ready to go home. Saying the community wasn't ready to accept him because they weren't aware of how much he had changed, we let E be healthy yet still stay at Manitoba Adolescent Treatment Centre. E responded quickly. We met on Friday. By Monday, the crisis had passed and he returned to the level of functioning he had been at a month before.

The second thing we did was start talking about where his grandparents were and what they were doing. E had spoken of joining his grandmother after she had died. Suicidal ideation had been present in the past and we feared its re-appearance. We helped E reframe the idea of joining his grandmother from joining her physically in death (by suicide) into a metaphysical union. He said his grandparents' presence could still be with him if he let them into his spirit. Once there, they would continue to guide and care for him. He talked of speaking to his grandfather, which once would have earned a "delusional" entry in his chart, and an increase in medication. When E said in panic "I saw the devil in my window last night", we replied, "Dreams sure can be realistic. Good thing you have the spirits of grandma and grandpa to guide you". Together with E we wove his fear and anxiety at the loss of his grandmother into a protective cloak he carried inside of him.

One day E said to us, "How can I tell what it will be like to live at home unless I'm there for a long time? My dad's stopped drinking, next time I go for a visit, I should stay at least three weeks."

Again, he was leading us. By Christmas 1985, fourteen months after admission, and only three months after the decompensation precipitated by his grandmother's death, he was spending three weeks out of eight in his father's house on the reserve. Had the bad medicine been taken care of? Had the full onslaught of schizophrenia been avoided or postponed? As therapists we saw an individual rooted in his own identity, sure of where he wanted to be, strong enough to try, and a community again willing to receive him.

In summation, our approach had been multi-levelled and based upon an understanding of the social and cultural context from which E stemmed. We recognized that his needs for basic nurturance, so lacking in his early chaotic years, had to meet the cultural expectations of his home environment. The need for a valid identity at the level of his immediate family, his community, his spiritual and cultural heritage, were identified. This identity was built on the foundation of the model of his grandparents and his exploration of his cultural and spiritual birthright. The resources of

the Manitoba Adolescent Treatment Centre treatment team, the academic education, social education and individual therapeutic work, were repeatedly focused and refocused to accommodate the client's needs for an identity and a future firmly planted in his home soil.

REFERENCE

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