CHILD AND FAMILY CENTRE
CENTRE DE L'ENFANT ET DE LA FAMILLE
NGODWEAANGIZWIN AASKAAGEWIN

TRADITIONAL ANISHNAABE ARTS AND TEACHINGS IN THE TREATMENT OF ANISHNAABE CHILDREN WITH MENTAL HEALTH PROBLEMS - A PILOT STUDY[1]

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ABSTRACT

The Noodjimo Enendaming / Healing Thoughts is a culturally appropriate clinical treatment program developed to meet the mental health needs of First Nations children. It introduces concepts that are meant to increase the participant's sense of belonging to family, extended family, community and Nation as Anishnaabe, beginning with an acceptance of self. The clinical intervention appears to have an impact on the participants' expression of behavioral patterns with differences according to gender, on the participants' general adaptive functioning and perceived self competence, and improvement in the sense of belonging to the family and community, two central factors to Anishnaabe people.

DIBAAJMOWIN

Maanda Noodjimo Enendaming / Healing Thoughts ezhi-bimaadizing nakeya gii-zhi-dibaamjigaade nnaandwechigewin wii-noodjimowad enendamoowad nakeya bimaadziwining giw Anishnaabe binoojiinhag. Kinoomaagaazo ow ebizhaad maampii waashme wii-mkawendang dibendaagozid ngodweaangizing, daanwendaaswin, enjibaad, miinwa Anishnaabewid, miinwa enji-maajtaad mno-daapinang eyaawid. Mno-naabminaagod go maanda nnaandwechigewin naadmaagemgag, naagozi go bkaan zhichiged ow ebizhad kwesenhs maage giwsenhs, ezhi-wiikjitood miinwa ezhi-gshkitood, miinwa waashme mkawendang dibendaagozid ngodweaangizing miinwa enjibaad nakeya, niizh memdage gchi-piitendaamowad Anishnaabek.

RÉSUMÉ

The *Noodjimo Enendaming / Healing Thoughts* est un programme d'intervention clinique adapté culturellement pour répondre aux besoins de santé mentale des enfants des Premières Nations. Des concepts sont introduits afin d'améliorer le sentiment d'appartenance à la famille, à la famille étendue, à la communauté et à la Nation par l'entremise de l'acceptation de soi. L'intervention clinique semble avoir eu un impact sur les patterns d'expression comportemental avec des différences liées au sexe, au fonctionnement adaptatif global et au sens de compétence personnel, ainsi qu'une amélioration au niveau du sens d'appartenance à la famille et à la communauté, deux facteurs centraux pour les personnes d'origine autochtone.

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Art therapy is a recognized therapeutic intervention in children and adult mental health. Although art therapy can be for beneficial to both genders and for any age group or race, it is especially helpful to people who are isolated, apathetic or withdrawn. Children are also particularly receptive to expressive art.

Expressive art consists of verbal and nonverbal ways of representing feelings (Gladding, 1992). If conducted properly, art therapy can be a safe and effective way of revealing unconscious feelings and desires (Synder, 1997). Burick and McKelvey (2004) assert that the clients of art therapy do not need to be artists since the creative process is the healing process, not the art piece itself. Burick and McKelvey state that the purpose of art therapy is "to help individuals with expression of feelings, self-esteem issues, emotional issues … and so forth".

According to Rogers (1992), expressive arts are a useful way of communicating across boundaries and cultures. This cross-cultural communication is a two way street, allowing the therapist to learn from the client while the client may also learn from the therapist.

Burick and McKelvey (2004) point out that the relationship between client and therapist must be a safe relationship, where the therapist creates a supportive and encouraging environment for the client to be able to let go and experience himself through his art. To achieve this end, the client need not be worried that someone will criticise his work.

When conducting art therapy with a person of a different culture, the therapist must keep in mind the ethno-cultural factors that affect each person. Campanelli (1991) explains that ethnotherapists are particularly aware of the client's ethnic differences and they incorporate some of the cultural factors in therapy. Similarly, cultural influences need to be considered in art therapy. Campanelli (1991) points out that different cultures have different symbolic images and different meanings that will influence the way in which art is interpreted.

Art and storytelling are particularly valued in the First Nations culture. Aboriginal people may use legend, personal stories about one's life history, contemporary stories or recent events to help one another overcome their personal circumstances (Rowan & al.) According to Dufrene (1990) and Dufrene et al. (1994), First Nations people's art, healing and religion go together, as one. First Nations people also value the family, extended family and community. Garrett & Garrett (1994) describe the First Nations as a community which consists of "cooperation, being, the group and extended family, non-interference, harmony with nature … living in the present". The extended family and the Nation are very important to them. Since family is so important, Elders are very respected by the First Nations people. Elders are looked up to because of the wisdom they have acquired over their lifetime (Garrett & Garrett, 1994). These differences with the dominant mainstream culture can be a source of conflict to the First Nations person, who debates whether he should act like the mainstream society or in accordance with their own culture and teachings.

Dufrene, 1990, considered art therapy as useful in bridging the gap between mainstream values and the native culture. Dufrene et al. (1994) goes on to explain that in this process, the therapists must respect the spiritual, symbolic and artistic dimensions of the

First Nations' culture. As an example, starting therapy sessions with a prayer or with a smudging ceremony shows respect for the client's heritage and religion. Knowing about the tribal affiliation of their client and being familiar with the values, beliefs and customs of that tribe shows interest and respect towards the First Nations client.

The development of the therapeutic intervention being researched has its theoretical underpinning in transcultural psychology and art therapy and was heavily influenced by the work of Natalie Rogers' person-centered perspective of art therapy. Rogers (1982, 1992, 1993) explains that expressive art therapy is used in a supportive setting to facilitate growth and healing. The clients discover themselves through the process of creating an art form from deep within. The way the art piece looks does not matter. What does matter is the ability of the client to let go of his feelings through the art, and to be able to heal through the process of creation. Rogers (1993) explains that the art work should not be interpreted. It should be left to the client to interpret his own art form. This gives the client empowerment and lets him discover his own unique potential.

Rogers (1993) describes the creative process, referred to as the creative connection, as a healing process. Personal growth and higher states of consciousness are achieved through self-awareness, self-understanding and insight. The feelings are the tunnel through which the client must pass to gain self-awareness, understanding and insight. The creative connection is a process that brings the client to an inner core or essence which will affect his writing or painting, while the writing or painting will affect how he feels and thinks. A connection exists between the life force, the inner core, and the essence of all beings. Therefore, as the client journeys inward to discover his essence or wholeness, he discovers his relatedness to the outer world. The inner and outer becomes one (Rogers, 1993).

The Noodjimo Enendaming / Healing Thoughts is a clinical program that was developed by a Clinician in the Anishnaabe team at the Child & Family Centre in 2002. The program was born out of the work done in individual therapy with clients using expressive arts as the medium. In unpublished pre-study trials, it was noted that it was particularly effective with females who struggled with conduct and trauma issues. In a second phase, the approach was extended to a 15 years old adolescent male who presented with depression and suicidal ideations. This youth received treatment until the age of 18 and his clinical progress through his art work was presented as a poster by Connie Caskanette and Don. F. Pearsall, at the 2003 Canadian Academy of Child & Adolescent Psychiatry Conference in Halifax, N.S. Canada following which, an abstract was published.

Based on their experience in individual therapy, the Clinician and the Psychiatrist contemplated the use of expressive arts as a therapeutic tool to work with Anishnaabe children within a group environment. The literature review confirmed that there were no evidence-based therapeutic group programs using expressive arts to specifically address the cultural needs of Anishnaabe clients in Canada and USA. Based on the lack of available programs, the Noodjimo Enendaming / Healing Thoughts was developed to meet the mental health needs of First Nations children. The program is culturally appropriate, informative and accessible to the urban Anishnaabe community living in the City of Greater Sudbury, Ontario. It introduces concepts that are meant to increase the participant's sense of belonging to family, extended family, community and Nation as Anishnaabe, beginning with an acceptance of self.

To date, the program has received very favorable comments from Anishnaabe and mainstream professionals. During the agency's recent accreditation from Children's Mental Health Ontario, the management team was invited to consider disseminating the treatment program across the Province of Ontario.

The clinical experiences in the use of expressive arts with Anishnaabe clients in individual and group therapy led to the development of the following working hypotheses. At the completion of treatment improvement will be observed in each participant in at least one of the following areas:

Hypothesis 1: reduction in symptoms
Hypothesis 2: improvement in general adaptive functioning
Hypothesis 3: increase in sense of competence
Hypothesis 4: improved self concept
Hypothesis 5: increased sense of acceptance and belonging to community.

METHOD

Participants and Procedure

The research participants were clients referred to the Child and Family Centre, a children's community mental health agency serving the City of Greater Sudbury. Prior to admission to the treatment program, each participant completed a psychosocial assessment with the Clinician of the Anishnaabe team responsible for the program to ensure their suitability. The participants had to present difficulties in at least one of the following areas: behavioural disorders, delinquent behaviours, depression, suicidal ideation, low self-esteem, attachment disorder, post traumatic stress disorder. Those who met the eligibility criteria signed an informed consent to participate in the research. The selected participants also underwent a psychiatric assessment. Finally, the child and one of his caregivers completed the pre and post-outcome measurements.

Eight Anishnaabe children between the ages of 9 and 12 with mental health problems were invited to participate in the research project. Three declined: two moved out of the community and one had a conflict in his activity schedule. Five accepted the invitation and attended the first session. Two dropped out: the first one after the first session and the second client after the fifth session. Three completed the treatment program. Of the three participants who completed, two were referred to the Child & Family Centre by the grandmother (caregiver) and one by the Children's Aid Society and Mental Health Clinician. One of the three participants was living in a residential treatment program, receiving therapeutic milieu intervention while the other two were not receiving other mental health services. There were two girls, aged 10, who were diagnosed with an attachment disorder, and one boy, aged 9, who was diagnosed with trauma and attachment problems.

Measures

Psychiatric Diagnosis: A Psychiatrist completed a diagnostic assessment on each participant referenced by the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR).

Beck Youth Inventories for Emotional and Social Impairment *(Beck et al., 2001)* are five self report measures to assess a child's experiences with depression, anxiety, anger, disruptive behaviour and self-concept. The inventories are intended for use with children between the ages of 7 and 14. The norms were developed from an American clinical outpatient children population and children qualifying for special education. The raw scores obtained are converted into T scores. On four of the five inventories, the higher the T-score, the higher is the level of distress. T-70 is considered elevated and within the clinical range. The exception is the Self-Concept Inventory where a higher score indicates a more positive self concept. T-55 is considered above the average and within the nonclinical range.

Trauma Symptom Checklist for Children (Briere1996) is a self-report measure of posttraumatic distress and related psychological symptoms. It consists of six clinical scales: anxiety, depression, anger, posttraumatic stress, dissociation, sexual concerns. The instrument is intended for use with children between the ages of 8 and 16. The norms were developed from a non clinical sample of American children. The raw scores are converted into T scores, where T-70 is considered elevated and within the clinical range. A score between 65 and 70 is within the borderline range, and below 65 within the nonclinical range.

Youth Self Report Questionnaire/11-18 (Achenbach & al., 2001) is a self-report questionnaire completed by the youth. The norms were developed from sample of American children. The questionnaire results are reported along eight syndromes scales, grouped into two factors: internalizing and externalizing. The results are also reported along six DSM-Oriented Scales: affective, anxiety, somatic, attention/hyperactivity, oppositional defiant, and conduct problems. The raw scores are transformed into T scores. For all the scales, a T score above 63 is considered within the clinical range while T scores between 60 and 63 are considered borderline and a T score below 60 is within the non clinical range. Finally, the questionnaire provides a competence scale. A T score above 40 is considered within the normal range. A score below T-37 is within the clinical range, while a T score between 37 and 40 is within the borderline range.

Child Behavior Checklist/6-18 (Achenbach & al., 2001) is a revision of the CBCL/4-18. It is a self-report questionnaire completed by the parents or caregiver. The norms were developed from sample of American parents. The questionnaire results are reported along eight syndromes scales, grouped into three factors: internalizing and externalizing. The results are also reported along six DSM-Oriented Scales: affective, anxiety, somatic, attention/hyperactivity, oppositional defiant, and conduct problems. The raw scores are transformed into T scores. For all the scales, a score above T-63 is considered within the clinical range while T scores between 60 and 63 are considered borderline. Finally, the questionnaire provides a competence scale. A score above T-40 is considered within the normal range. A score below T-37 is within the clinical range, while a T score between 37 and 40 is within the borderline range.

Child and Adolescent Functional Assessment Scale was designed to rate impairment of children and adolescents who have or may have emotional, behavioral, substance use, psychiatric, or psychological problems. The scale provides for rating the youth across eight domains of functioning: school/work, home, community, behaviours toward others, mood/emotions, self harm, substance use. Each domain is rated along a

continuum of impairment: minimal (0), mild (10), moderate (20), or severe (30). The scores on each scale are added to provide a global level of impairment.

***Self-portrait**:* During the first and last group sessions, the participants were asked to draw a self-portrait. They were then invited to comment on their self-portrait through a semi structured interview process, led by the therapist. The qualitative analysis of the responses allowed the therapist to determine a movement in the sense of acceptance as an Anishnaabe person and the sense of belonging to the community.

***Treatment Intervention**:* The Noodjimo Enendaming / Healing Thoughts Program is a seven week, fourteen session group treatment program (complete outline in Appendix) facilitated by a Clinician in the Anishnaabe team at the Child & Family Centre. The overall objective of the treatment program is for the participants to develop and enhance their level of awareness of the First Nations cultural values, to promote their cultural identity and to increase their self-esteem and assertive behaviours. Native art is the medium used to achieve these goals. The participants are taught the fundamentals of Anishnaabe art. As they incorporate and express their new learning through completion of Native art, they are invited to explore their traditions as a medium to self-awareness.

The first phase of the treatment program is to promote an environment that will stimulate the level of creativity and personal comfort. The focus is on the process. The environment allows the clients to express themselves in a positive and non-threatening way, to enhance the talent, passion or interest that they already possess, to build their self-esteem and confidence and to relate to others. Within this relational process the clients develop a sense of belonging to the community. The program hopes to promote a connection between one's self as Anishnaabe, eliciting a sense of pride, and the sense of belonging to the Anishnaabe community. The focus on identity and encouraging an appreciation of his/her self through traditional teachings presents a message to the individual that they are sacred and do belong to a community and a Nation. The co-facilitation of Elders and traditional resource people affords an additional connection for the youth to their community as well as a connection to and knowledge of their heritage and traditions. This presents the youth with perhaps new information of who he/she is and challenges stereotypes and possible negative messages that the youth may have received about Anishnaabe from peers, adults, media and at times their own family and community.

RESULTS

The first hypothesis, namely an expected reduction in symptoms following treatment, was not supported. A reduction in symptoms is considered when the T score for a given scale moves from its initial category to a lower one (i.e.: clinical to borderline, borderline to nonclinical). The YSR and the CBCL respectively present the participants' and the caregivers' perceptions over the participants' improvements. Discrepancies between the participants' and caregivers' perceptions are observed. The response patterns from the participants (Table 1) are inconclusive with only 5.6 % of the symptoms improved, while 66.6 % did not change and 27.8 % became worse. The caregivers' response patterns (Table 2) tend to be more favorable. They reported 22.2 % symptom improvement, 38.9 % remained the same, and 38.9 % deteriorated. Considering the global patterns of responses by participants, the caregiver of case #2 reported most improvement.

TABLE 1: YSR CHANGES IN RATING SCALES BY CASE AND TOTAL

	Improved	Same	Deteriorated
Case #1	1	4	1
Case #2	0	5	1
Case #3	0	3	3
Total	**1**	**12**	**5**

TABLE 2: CBCL CHANGES IN RATING SCALES BY CASE AND TOTAL

	Improved	Same	Deteriorated
Case #1	0	4	2
Case #2	3	2	1
Case #3	1	1	4
Total	**4**	**7**	**7**

The participants and caregivers however report a change in behavioural expression. The female participants reported an increase in the externalizing patterns while the internalizing patterns decreased or remained the same (Table 3). It is the contrary for the male participant. There is an increase on the internalizing factor while the externalizing factor remains within the nonclinical range. There are discrepancies between participants' and caregivers' responses. The caregivers of the female participants reported an increase in the internalizing patterns while the externalizing patterns remained the same (Table 4). As for the caregiver of the male participant, there is a decrease in both factors.

TABLE 3: PRE/POST MEASURES ON EXTERNALIZING AND INTERNALIZING FACTORS BY PARTICIPANTS AND CAREGIVERS

CASE	#1		#2		#3	
	Pre	Post	Pre	Post	Pre	Post
Externalizing	57	60	46	55	61	66
Internalizing	65	62	58	66	63	63

TABLE 4: PRE/POST MEASURES ON EXTERNALIZING AND INTERNALIZING FACTORS BY CAREGIVERS

CASE	#1		#2		#3	
	Pre	Post	Pre	Post	Pre	Post
Externalizing	71	74	62	50	57	59
Internalizing	58	69	61	52	54	64

Improvement in general adaptive functioning is reported, which supports hypothesis 2. The improvement is present with all cases as reported in Table 5. While the improvement is significant with case #2, the changes are modest with cases #1 and #3.

TABLE 5: PRE/POST MEASURES ON GENERAL LEVEL OF IMPAIRMENT – CAFAS SCALE BY PARTICIPANTS

CASE	#1		#2		#3	
	Pre	Post	Pre	Post	Pre	Post
CAFAS Total	60	50	100	40	50	40

Hypothesis 3 is supported. The sense of competence for the youths tends to improve. As reported inTable 6, one of the three participants reported an improvement in competence (case #1), from the clinical range to within the normal range. The other two participants scored themselves within the normal range on both repeated measures. Two of the caregivers reported an improvement; from the clinical range to the borderline range (case #1) and to the normal range (case #3). The caregiver of case #2 reported a deterioration, which goes in the opposite direction from his ratings on reported changes in symptoms.

TABLE 6: PRE/POST MEASURES ON COMPETENCE SCALE FOR EACH PARTICIPANTS BY PARTICIPANTS AND CAREGIVERS

CASE	#1		#2		#3	
	Pre	Post	Pre	Post	Pre	Post
YSR	29	55	42	56	55	54
CBCL	25	39	49	36	30	50

Hypothesis 4 was not supported. As reported in Table 7, the pre/post measures of self-concept remained much lower than average for case #1, lower than average for case #3, and within average for case #2.

TABLE 7: PRE POST MEASURES ON SELF CONCEPT FOR EACH PARTICIPANTS

CASE	#1		#2		#3	
	Pre	Post	Pre	Post	Pre	Post
Self concept	27	27	48	46	42	40

As demonstrated by the subjects' self portrait drawings, Hypothesis 5 was supported. The indications of accepting of one's self and the sense of belonging to family and community are evident in their discussions. All three subjects appeared to share similar views that, at some level, there is a sense they are part of a family, community, and peer group. Elders and traditional resource people also play a role in becoming a positive adult connection for the youth. Elders are often referred to as Nookomis or Mishomis (Grandmother/Grandfather), while traditional resource people who do tend to be younger, are referred as aunties and uncles. They hold traditional

responsibility as teachers to the youth, focusing on that youth's responsibility to self, family, community and Nation. A desirable long term goal of traditional teachings and ceremony is to prepare youth to reconnect with their Clan, which becomes their extended family. This process is especially important for those children who have been in care for extended periods of time. Also, youth are guided towards receiving their spirit name, essential in understanding one's purpose in this world.

DISCUSSION

The strength of this pilot project lies in the fact that it is a first attempt to measure the effectiveness of a First Nations clinical program. A mainstream research model was used, which may in itself prove to not be the most appropriate approach to meet this objective. If this is the case, it will hopefully provide new insight and research directions.

The results reported have to be interpreted with caution. The first and most obvious factor to this caution lies in the limited number of cases. It would be fair to say that this study remains primarily anecdotal. The number of cases are obviously too low to do any statistical analysis. Even trend analysis cannot be achieved. Nevertheless, the authors attempted to draw commonality and convergence amongst subjects. A second limitation is the use of the Youth Self-Report with participants younger than the intended age group for whom the scale was developed. The authors were expecting a larger number of older children in their pilot study. They were also relying on the Beck inventories and the TSCC scales to measure the symptoms of the younger group.

The converging data suggests that the clinical intervention had an impact on the participants' expression of behavioural patterns, with observed differences according to gender. The intervention resulted in increased externalizing behaviours for the girls and internalizing behaviours for the boy. In future analysis, it will be interesting to determine if these gender specific patterns will be maintained. There was no convergence noted in relation to specific symptoms scales and self-concept.

It also appears that the clinical intervention had a favorable impact on the participant's general adaptive functioning and perceived self-competence. The improvement is modest, but present. With a sufficient number of subjects, a statistical procedure would determine if the change is significant. Finally, the qualitative analysis of the participants' artwork and their comments to the pre/post structured interviews suggest an improvement in the sense of belonging to the family and community, two central factors to Anishnaabe people.

The findings in this pilot study are too preliminary to permit any prediction of future outcomes with any confidence. The authors are however encouraged to pursue their study by developing a data bank that will eventually allow reliable statistical analysis.

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APPENDIX

PROGRAM OUTLINE

WEEK ONE – INTRODUCTION

Monday - Traditional Teachings
- Introduction to the Medicine Wheel Teachings.
- Learn the symbols of the Wheel
- Learn the concept of balance
- Learn about spirituality and it's relationship to Native art.

Wednesday – Self Portrait
- Use of paints that client chooses. Portrait to be actual size of client.
- Client to write a short story about creation using 7 words described in activity section.
- Story telling about creation

WEEK TWO – START DRAWING

Monday
- Use of oil pastels, any colours used
- On display, Anishnaabe artist creations. Variation of water colour, acrylic and oil paintings for clients to observe.
- Teachings of "Balance" – the mind, body and spirit. Connection of spirituality with expressive arts.
- Story telling about creation

Wednesday
- Use of oil pastels, only Medicine Wheel colours
- Second activity of cut and paste. Free expression using Medicine Wheel colours only.
- Story telling about creation

WEEK THREE – PAINTING

Monday & Wednesday
- Use of paints, free expression of thoughts and feelings.
- Story telling about creation.

WEEK FOUR – DREAM CATCHERS

Monday & Wednesday
- Traditional Teachings of the Dream Catcher
- To make a dream catcher of the client's choice.
- Sharing circle about personal dreams, aspirations, goal setting

WEEK FIVE – FREE EXPRESSION

Monday & Wednesday
- Free drawing, anything client chooses, use of any medium.
- Story telling about creation

WEEK SIX

Monday
- Self Portrait
- Use of oil pastels or paints, client's choice
- Story telling about creation
- (evaluation tool to compare with first drawing of self-portrait).

Wednesday
- Client's expressive arts description with Clinician
- Post B.C.F.P.I to be completed and a post C.A.F.A.S
- Evaluation form to be completed by client
- Presentation of Certificates

WEEK SEVEN – WRAP UP.

Monday
- Clients have free expression, to create anything they want out of any materials supplied.
- Story telling about creation.

Wednesday
- Traditional Teachings with Elder about Medicine Wheel.
- Sharing Circle
- FEAST (closure)