

GROUP THERAPY OF ABORIGINAL¹ OFFENDERS IN A CANADIAN FORENSIC PSYCHIATRIC FACILITY

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Abstract: In recent years, the use of group therapy approaches with Aboriginal or Native Canadians/American Indians has become widely accepted. However, many advocates of this approach rarely consider the implications of group therapy for culturally heterogeneous groups, such as when non-Aboriginal peoples are involved or when there are Aboriginal peoples from different cultures and/or with different degrees of orientation to Euro-Canadian culture. This article documents the use of one form of group therapy for Aboriginal offenders in a forensic psychiatric facility, where this degree of cultural heterogeneity exists. The article concludes that, at least within a forensic psychiatric setting, group therapies that mirror the social, cultural, racial, and class structures of Euro-Canadian society are problematic in the treatment of traditional Aboriginal offenders but much less so for acculturated Aboriginal offenders.

Introduction

Group therapy is an important element in a variety of psychotherapeutic treatment programs in North America. There was a time when group therapy approaches were deemed to be too culturally biased to be useful in the treatment of Aboriginal peoples. In more recent years, group therapy has become more accepted in specific circumstances. The purpose of this article is to demonstrate one arena in which cultural misunderstandings and insensitivity and the differing social, class, and racial structures of group therapy affect the involvement of some Aboriginal peoples. The case in point in this article pertains to a forensic treatment program in which Aboriginal offenders are combined with non-Aboriginal offenders in a psychiatric facility.

Group Therapy and Aboriginal Peoples

Edwards and Edwards (1984, p. 7) have argued that, for treatment of alcohol abuse, group approaches have become "the treatment of

choice for a number of agencies with programs serving American Indians." Similarly, Neligh (1988, p. 145), in his discussion of group therapy for mental illness, has challenged the idea that Indian patients do not do well in structured group therapy settings. However, Neligh (1990, p. 156) also stated that "it was long taught that for whatever reason Indian people became so uncomfortable in groups that (group) psychotherapy should not be attempted." Although he has not discussed in detail the reasons for such an assertion, Neligh notes that his belief stems from the experiences of mental health professionals associated with the U.S. Indian Health Service. These mental health professionals were involved in the delivery of services through single-issue groups, such as one in Montana for American Indians suffering from panic disorders and agoraphobia. His views are supported by Wolman (1970), in her discussion of a Navajo group therapy exercise emphasizing "problem" drinking, and by McDonald (1975), concerning a multicultural all-female Aboriginal group in San Diego that handles problems unique to single, urban American Indian mothers (e.g., dealing with physical and sexual abuse). In both cases some cross-cultural problems were noted.

Similarly, Manson, Walker, and Kivlahan (1987, p. 170) described a "new movement" toward increasing use of group therapy for American Indians that "contrasts sharply with prior assertions that group psychotherapy is inapplicable" for these peoples. Alcohol treatment programs seem particularly well suited for such group approaches. Manson et al. (1987, p. 170) explain that such a negative view of the applicability of group psychotherapy was based on three assertions:

First, Indians have been stereotyped as being stoic and silent. Second, it was presumed that an unspoken solidarity among Indians would preclude the involvement of non-Indians as either fellow patients or group leaders. Third, it was believed that the Indians' social norms, which disapprove of setting oneself apart from others, would repress the therapeutic expression of fear, weaknesses, or problems.

The increasing use of group therapy approaches in alcohol and drug abuse programs is particularly noteworthy.

The observations of those in favor of group therapy differ from those of Archibald (1974, p. 43). He has suggested that because of the "unique communication characteristics" of American Indians, some alterations in the traditional group therapy process are needed to make group therapy useful for American Indians. These characteristics included a "comfort with protracted silence, an extreme sense of personal privacy coupled with a guardedness for fear that cultural secrets may be revealed and lost, and the acceptance of individual difference being a right." In his interviews with psychotherapists, Archibald determined that those who could claim to be making progress with Aboriginal clients were those who supported the Indians' desire to discuss the persecution of their people or

who encouraged discussion about the standards of the “dominant culture.” However, Archibald refers to both of these attitudes of psychotherapists as “traps,” noting in particular that the first is “a defense which has been found very hard to shift from once established” (1974, p. 44). The groups under discussion were heterogeneous, not only representing 32 tribes but also including non-Aboriginals in many cases. The heterogeneity of the groups led Archibald (1974, p. 44) to observe that “no one claimed to have a successful psychotherapy group with more than a 50% Indian composition.” Part of the problem, apparently, was the Indians’ use of silence as a defense and retreats into assertions that non-Indians would not understand them anyway. Furthermore, admissions by individuals of “greater strength or . . . weakness” violated Indian norms that disapproved of such boasting behavior.

The difficulty in understanding the group therapy experiences of Aboriginal peoples is the result of the lack of clarity in the sparse literature that addresses this topic. Significant variables, such as the objectives and cultural constitutions of groups, the political-legal context (e.g., whether patients are mandated to undergo treatment), the racial and cultural backgrounds of the therapists, and the values being communicated, are not afforded the attention they deserve. Implicit assumptions that the Aboriginal participants are culturally homogeneous or that cultural differences are not relevant are apparent though rarely detailed. Not only are possible cultural differences (e.g., Cree vs. Chipewyan) ignored or glossed over, but so, too, are the differing degrees to which Aboriginal people are oriented toward a Euro-North American (or African-American, Hispanic-American, etc.) culture versus an Aboriginal culture.

The work of French (1981, 1989), Trimble and Fleming (1989), and Renfrey (1992) has brought these questions of cultural diversity more into focus. All explicitly recognize that cultural heterogeneity is a fact that must be addressed in assessing and treating Aboriginal peoples. French (1989) and Renfrey (1992) identify three basic groups of Aboriginal peoples: (a) traditional, (b) middle class, and (c) marginal. The “traditional” Indians are those whose “psychological perspective . . . comes closest to representing the Aboriginal tradition” (French, 1989, p. 159). These are the least acculturated of the American Indians. The “middle-class” Indians are those who have effectively acculturated to the non-Indian, American culture; that is, they “subscribe to the norms of the majority society and [are] openly rewarded for this loyalty” (French 1989, p. 160). Finally, “marginal” Indians “are those American Indians torn between their traditional cultural heritage and the dictates of the larger majority society.” The principle behind such designations — that there are different types of adaptation to colonialism — is sound. However, these authors mix concepts of culture and class and ignore the existence of “upper class” and “working class” Indians, culturally rooted middle-class Indians, or Indians who are functionally bicultural. French further states that “any viable transcultural

counseling model must have as its primary focus . . . the facilitation of a positive 'self-image' — one rooted in their cultural tradition" (French 1989, p. 161). According to French (1981, pp. 145–146), therapeutic interventions must critically assess the client's cultural and class biases before they can be effective:

Attempting to make an Indian learn white ways at the expense of his "Indianism" leads to increased turmoil which is often internalized and concealed through alcohol, tension and the like. . . . [F]or most Native Americans, the end result is massive self-aggression [alcoholism, mental and physical health problems and suicide] or other-aggression [assault and homicide]. There is little doubt that the most well-adjusted Native Americans are those who are proud of being Indians. . . . Clearly, any viable Native American therapeutic model must encourage Indian clients to become more responsible, with "responsibility" defined in culturally-relevant terms. Native American behavioral patterns, like those of most groups, seem to be dictated by certain cultural factors. In order to ascertain the nature of an Indian behavioral problem, the therapist must first understand the cultural circumstance surrounding the client's marginality.

Trimble and Fleming (1989) specifically discussed the issue of the extent of acculturation and treatment success. They note the existence of "successfully acculturated," "marginally acculturated" and "moderately traditional" American Indian clients. They argue:

Although no empirical evidence supports the contention, there is a strong likelihood that Indians raised in a very traditional, native-oriented manner, especially in reservation communities, pueblos, or villages, are not familiar with the conventional counseling process. Consequently, they are not likely to make "good" clients, largely because they are not accustomed to talking out their problems with strangers or, most certainly, non-Indian counselors. Furthermore, the traditional, native-oriented Indian is more likely to receive assistance from kin, friends, and traditional healers or shamans. In contrast, highly acculturated Indians, particularly those raised in urban settings, are more likely to respond to counseling. . . . [It] would appear that the acculturation of the client is a potent contributor to a client's receptivity to counseling in a conventional sense. (1989, pp. 195–196)

It is our contention that a hybrid of the ideas of French (1989) and Trimble and Fleming (1989) on the counseling of individual Aboriginal people can be extended to provide a framework for analyzing group therapy experiences for Aboriginal peoples and American Indians, a framework that incorporates cultural, racial, and class variables in the analyses. Based on the previous assumptions, there are a number of logical prerequisites for group therapy to work. First, the therapists must understand the cultural and life circumstances of the Aboriginal clients; this may well mean that some of the therapists should be Aboriginal peoples themselves. Second, there must be some degree of social and cultural homogeneity within the

group. Third, the values that underpin the group therapy exercise must be relevant to the clients.

But what of circumstances in which the treatment model is inherently based on Euro-Canadian/American norms, the group membership includes non-Aboriginal as well as Aboriginal peoples (including those with little or no knowledge of their heritage or culture), and the therapists have little practical knowledge of the life circumstances of the Aboriginal clients? These situations are frequently formed among treatment programs for Aboriginal peoples in a variety of settings. Can the therapist make the experience applicable to the various cultural and class backgrounds of such a diverse group? These questions are not answered when we examine the literature that supports group therapy among American Indians, primarily because it does not address these more complex group therapy situations.

The next section of this article will detail just such a complex, heterogeneous group therapy situation, in which the issues of history, culture, and class arise.

The Setting

Research was undertaken in 1991 and 1992 at the Regional Psychiatric Centre (RPC) in Saskatoon, Saskatchewan. The RPC is a federally operated, fully accredited forensic psychiatric hospital dedicated to the assessment and treatment of federal offenders (those serving sentences of 2 years or more). It is one of three such regional facilities in Canada. The RPC offers a variety of treatment programs for offenders suffering from psychiatric illnesses, substance abuse problems, personality disorders, and sexual deviancy. The treatment staff generally consists of social workers, addictions counselors, registered nurses and registered psychiatric nurses, occupational and recreational therapists, psychiatrists, and psychologists. Offenders are admitted to the RPC for treatment or assessment and are usually returned to the referring institution on completion of the intervention. Treatment programs vary in length depending upon the program in question and the seriousness of the presenting problems. The average length of stay is about 7 months, but in some instances offenders stay for treatment for a protracted period or they might return for subsequent treatment later in their sentences. Offenders are referred to as "patients" while they reside at the RPC.

The observations reported here were made over a 5-week period on the unit dedicated to the treatment of personality-disordered male offenders, based on the therapeutic community (TC) concept. Most of the participants of the TC had lengthy criminal records, often involving violent offenses such as armed robbery, assault, and homicide. They did not suffer from mental illnesses (e.g., a psychotic or affective illness). No psychotropic medication was used. Some were

servicing life sentences that required the offender to serve a minimum of 10 to 25 years before eligibility for parole. Others were serving shorter terms and could be released within a relatively short time. Indeed, for many offenders, treatment at the RPC is considered an essential step toward being granted parole.

The most common diagnosis among this group of offenders is antisocial personality disorder (APD), according to the criteria of the *Diagnostic and Statistical Manual, Third Edition-Revised*, of the American Psychiatric Association (1987). The disorder, applied only to those over 18 years old, is characterized by a pattern of irresponsible and antisocial behavior since the age of 15. There must also be persistent evidence of conduct disorder before the age of 15 (for example, running away from home or fighting). Many of those diagnosed as APD present management problems while incarcerated, typically display antiauthority attitudes, and often present problems in aggression and emotional instability.

The TC concept was developed by Jones (1963, 1982) who stressed that one approach to rehabilitate inmates is to provide them with an environment in which they can learn to take responsibility for their behaviors. To this end, positive peer group influences are mobilized, in addition to therapeutic inputs from staff, to bring about behavioral changes (see also Vorrath & Brentro, 1985). The central method of intervention in the TC program is the daily group meeting, which is mandatory for all patients and includes most available staff. This "large group," which usually lasts for about 2 hours, functions as a major forum for therapy. Personal and other day-to-day living problems that the offender has been experiencing are encouraged to be brought up for discussion. The rationale behind this approach is that the offenders will likely experience similar problems in the community. It is believed that open and honest communication and interactions in the group will foster a level of trust among patients and between patients and staff. Ways to resolve problems are actively solicited from the patient's peers rather than being imposed on the patient unilaterally by staff. Subsequent groups are used to monitor the willingness of the offender to incorporate problem-solving techniques into his behavioral repertoire and his progress toward problem resolution. Open and constructive confrontations among members of the group are strongly encouraged. Peer group influences are actively utilized to obtain compliance from offenders, because some offenders are much more receptive to suggestions and constructive confrontations from fellow offenders than from staff. Democratic decision making is strongly encouraged to engage offenders in practicing conflict resolution skills. The offender's disruptive behaviors are openly confronted by both staff and patients. Staff take on the role of facilitators in the group and serve as models of prosocial behaviors.

A contract is drawn up at the beginning of treatment through the collaborative effort of the staff and each patient. It consists of a set of

objectives that the patient intends to address during treatment. For example, one objective in a treatment contract may read, "I will not threaten others in order to get what I want." Once weekly, in the presence of the whole group, a "ward rounds" is undertaken, in which the staff review the progress of two or three patients based on their treatment contracts.

Noncompliant and unmotivated patients may then be challenged during the large group and during ward rounds. Over time, a group culture develops that serves as a positive socializing influence on inmates.

The program also offers other "small" groups that are optional and focus on specific problems, for example, stress management, substance abuse, and assertiveness training. Offenders are also provided with brief, goal-directed, individual counseling to deal with issues that cannot be handled within the large group. Alcohol and substance abuse programs, such as AA, are available. Some Aboriginal offenders also have recourse to an elder and more traditional treatment approaches, including the use of sweat lodges (see Waldram, 1993). The overall treatment goals emphasize the need for the patient to (a) behave responsibly toward himself and others, (b) increase his level of prosocial interactions with staff and other group members, and (c) behave assertively rather than aggressively or passively (see Ogloff, Wong, & Greenwood, 1990, for a more comprehensive discussion of the program).

The research reported here was part of a larger project to assess the effects of culture on treatment for Aboriginal offenders. One author, Waldram, a medical anthropologist with extensive Aboriginal research and community experience, was afforded the opportunity to interview patients and observe group therapy sessions as part of the research. The other author, Wong, is the psychologist for the 24-bed TC unit and therefore is actively involved in the treatment of Aboriginal and non-Aboriginal patients alike. The observer's presence in the group was explained to the patients, who consented to his presence. At no time did the observer offer comments during the group sessions, although he was offered a seat within the circle (a tacit indication by patients that he was welcome to speak).

Over the period of the research, of the 24 patients in this unit, the number of Aboriginal patients fluctuated between 7 and 9. None of the treatment staff were of Aboriginal ancestry, and most were female. On any given day, four or five staff members would attend the large group, including primarily the psychiatric nurses and social workers (and occasionally a psychiatrist and/or psychologist).

In addition to directly observing the large group, the observer interviewed Aboriginal patients extensively about their group therapy experiences. These interviews were conducted in multiple parts, and most were tape recorded. Ranging from 1 to 3 hours, the first interview with a patient followed a semistructured format and usually dealt with his cultural and family background and prison experiences. The patient's

general views of the group therapy process as it operated were also sought. Subsequently, as each individual was active in the group, follow-up interviews were conducted to obtain the patient's views of these specific events. As a result, observations on the specific group therapy behavior of various patients could be made and compared with their general comments made in the interviews regarding group therapy. This exposure to the group therapy setting, combined with the interviews, provided an orientation to the cultural nature of the treatment approach utilized and the reactions of the Aboriginal patients to it.

In this article, reference is made to the individual's cultural orientation. The specific details of the three broad orientations employed, "traditional," "bicultural" and "acculturated," are discussed at relevant points in the text. These designations were developed as part of the broader research project, utilizing data from the semistructured interviews as a guide.

Patient Experiences

In each session observed, the individual "taking group" loosely followed a theme that was determined in consultation with unit staff. The individual taking group was expected to talk at length but would occasionally be interrupted for questions or comments from staff or other patients. At a certain point in the sessions, the patient would be expected to respond to questions or "feedback" from the others. Hence, the ability to articulate well in English is crucial to a successful large group experience. Furthermore, individuals demonstrating "shy" personalities, that is, those who find it difficult talking about themselves or offering feedback, are at a disadvantage. The quiet, introverted person may be viewed, alternatively, as being unwilling to "open up" as others have done or as hiding behind their shyness to avoid participating. Assertiveness training is an important component of the treatment program.

It is evident that most patients, Aboriginal and other, find the initial large group experience to be difficult. Most inmates in prison are influenced by the "con code," part of the inmate subculture that breeds suspicion and a passively unco-operative attitude toward prison authorities. There is a strong sense of individualism, and inmates often talk of doing "my own time," which by inference means keeping to oneself and not being concerned with other inmates. But with group therapy, one is expected to expose one's past, and those who appear to be "sloughing off" are routinely chastised by other patients. Although patients are taught that personal details that are exposed in group are not to be communicated beyond that setting, patients are acutely aware that they will likely encounter other patients after transfer back to their parent institutions and that there are no guarantees that details of their offenses and personal lives will not be spread. Furthermore, these details may well form part of

their official case management record, which travels with them from institution to institution and is used in various progress reports (including parole assessment). Over time, many adjust to the ritual of large group, learning what types of comments solicit positive feedback, how to avoid negative feedback, and how to offer feedback to other patients that is or appears to be insightful to the treatment staff. Patients are aware that they are always being scrutinized by staff, and their own performance is occasionally raised for discussion in the large group.

Many of the personality characteristics normally associated with traditional Aboriginal peoples are in conflict with the assertiveness that is central to the large group experience.² In many Aboriginal cultures it is inappropriate to talk directly about oneself or to criticize others. It is also a sign of disrespect to make sustained eye contact during formal discourse. And many Aboriginal peoples come from small communities where ties of kinship interconnect most residents and where there are few strangers. Hence, those patients who are traditional are triply disadvantaged in the large group experience: they may have a relatively poor grasp of the English language, they may be forced to challenge not just their past behavior but also the cultural basis of that behavior, and they may be less experienced at communicating with large groups of non-kin or strangers, many of whom are "white." Although all Aboriginal patients admitted to the program have learned to some extent the dominant Euro-Canadian cultural context of the correctional system (itself a unique subculture), some of them still find the treatment approach radically different from anything they have known before.

One traditional northern Cree patient discussed the language problems he encountered:

I don't know, I just sometimes get frustrated. Like I can't really express myself. I would rather talk Cree to these people, but they can't understand. I can't explain, I can't express myself in English like I do in Cree, and sometimes in large groups when they ask me questions, I don't really know what to say in English.

Another traditional patient, an Inuk, was barely able to communicate in English. Indeed, during the two interviews held with this person, it was difficult to communicate even basic questions and answers. Although he represents the extreme in linguistic difficulties likely to be encountered in the program, his situation deserves further elaboration. Despite staff efforts at providing English tutors and translators, this individual remained largely unclear as to what the treatment process was about. It was unlikely that he would improve as a result of treatment:

No, I get frustrated when I don't understand it so I just sit there, dream, dream that I was out there [out of prison]. . . . I don't nothing. I don't know what they are saying. But I am getting a little bit to know more. No, mostly in group I spit out a few words but I wish I could talk more. But I

can't do it. Like I go I might say wrong words and I feel that I don't want to get them confused as to what I am saying or get in their way.

It was his decision not to demand translation services, since to do so would, in his eyes, be a bother to the center staff.

The need to discuss one's life and to offer feedback to other participants in the group engenders rather stressful reactions in all participants in the group, in particular Aboriginal offenders who are unfamiliar with the behaviors that underlie the process of group therapy. One traditional northern Cree patient stated:

First few feedbacks I took they asked me, they asked me what I could think, and one time I just wanted to give feedback on my own without anybody saying, asking me what I think or feel. And after I gave that feedback, then my heart was going fast, it was beating fast, I was nervous, my face went red and I got real nervous. I was nervous for about five minutes and after that it was alright. The second time I gave feedback I was still kind of, I still feel the nervousness. I could feel it, but I wasn't that nervous anymore, and it felt good to be able to talk.

Stated a traditional northern Ojibwa:

I'm scared [in group]. I don't know, like I know I speak kind of low [normally] but when I go into a large group, everything slows down. I get scared I might say something wrong, that I will offend them. I'm scared.

For some traditional patients, simply talking to large groups of people was difficult:

So eighteen years, I think I lived half of that in the bush. So there was nobody there, and I got used to that. Now I'm going the other way. I'm trying to get used to people. I used to go to Brotherhood, too, Native Awareness. But I couldn't go to those places because I couldn't get used to being around people, lots of people. So I didn't really mind about three or four guys, eh, but more than that, that was kind of hard for me [northern Cree].

Even in the Pen [penitentiary] I had a hard time with all the interaction, from the different kind of people, that I sometimes have a hard time with. Well here [at RPC] I had a hard time with that, interacting with so many people [northern Cree].

It really hurts for me. I've never been in a group, you know, many guys to talk to. . . . I get nervous, sweat, I can hardly speak [northern Cree].

Finally, it should be noted that some traditional offenders strongly believed that neither the non-Aboriginal staff nor other patients understood or cared to understand the rural/remote/reserve context that shaped their lives:

Like I said that one time that I sensed that I'm not too comfortable talking about my childhood because I can sense that a lot of people don't understand how it is living on a reserve, and that's what I said in the group one time. Like the way I was brought up, what I seen, the changes in the reserve and all those things that I've seen when I was a kid. A lot of these guys grew up in cities and they don't understand [northern Cree].

That there were cultural differences between Aboriginal patients raised in the reserve context (likely more traditional) and those raised in the city (likely more acculturated) did not escape some patients. Offered one traditional northern Cree patient:

I know that they are part of the Native, they are Natives. But I see that they missed something in life. When I know people that grew up in cities or down south, down here, they miss a lot of that, that they weren't taught these things [life in the bush culture] and I sort of feel sorry that they are Natives but they are nothing else. . . .

Bicultural Aboriginal offenders are able to function fairly well in both Aboriginal and Euro-Canadian cultures. Typically, they have been raised in Aboriginal communities and speak an Aboriginal language, but they have extensive experience in non-Aboriginal environments, perhaps because of residential schooling experiences or growing up in proximity to non-Aboriginal communities. These individuals also experienced many problems similar to those of the traditional Aboriginal men, including language problems and difficulty speaking in large groups, although in general these were less significant. In contrast to traditional Aboriginal men, bicultural offenders tended to be more critical of the group therapy process, often perceiving racism and discrimination directed toward the Aboriginal offenders by both the staff and other patients. One such patient stated:

From my experience, you know they [staff] focus more on the white people in my unit anyways. They aren't so hard on them in disclosure groups and stuff like that. . . . They don't ask them [Aboriginal patients] the same questions as they ask white people and stuff, you know. And after the disclosure groups they give them a hug³ and a pat on the back and everything you know. And that never happened to me [Chipewyan].

And another bicultural patient commented:

Well, when I first come up here. . . . maybe this is where I am racist. . . . there is this one guy, Caucasian, who was taking group, and nobody said anything to him. And then this Indian guy took group and everybody was on him. Everybody was on him and I got choked at that, eh. All I seen was all these white people on this Indian guy and that got me choked. And I talked to this other Indian guy after and I told him how I saw things and he told me that I have to overcome that, eh. But that's what I saw. . . . and that kind of turned me off. Now when white guys talk, I

won't say anything. I won't give them any feedback or anything. But if a Native guy is talking, I will help them out [Saulteaux].

Observations of this patient indicated that he did, indeed, participate only when an Aboriginal patient was taking group.

It is quite likely that these perceptions of racism are linked strongly to both previous prison experiences and life "on the street," as one bicultural offender explained:

Some of these guys here [taking group] and myself, eh, get uncomfortable here because they're [staff] white. They're white and it is not that I am a racist guy, eh, it is nothing like that. But when I was growing up, I came to believe that I could never trust a white man [northern Cree].

Similar to many traditional offenders, the bicultural offenders sometimes felt that their Aboriginal experiences, including living on the reserve, were misunderstood or even ridiculed by staff and other patients. One Chipewyan patient, arguing that the staff did not understand "where I am coming from," noted that "they haven't experienced the lifestyle that I have experienced, and to me sometimes I think they don't understand a thing about the violence that is associated with a lot of reserves in our country." While it is true that the staff have not experienced the lifestyle of any incarcerated offender they treat, this individual is clearly making reference to the Indian reserve lifestyle. Another commented on the problems that some Aboriginal patients experience when discussing such issues as gas sniffing, a major health issue on some reserves. Abusers are often held up to ridicule by non-Aboriginal patients with more glamorous substance abuse problems, such as cocaine addiction. As one patient stated,

Some reserves are, you know, pretty well known for sniffing or drinking [L]ysol and some reserves are very bad for assaults. And a lot of these staff members don't realize that, eh, and in a lot of these [groups] they don't understand it either. And at first there was one Native guy, he was taking groups and he was talking about his offenses, and assault, eh, and these guys, they were kind of putting him down, in a sense. "Why would you do something like that." eh? And after the group the guy was all freaked out, eh.

After this incident, the subject in question opened his next group with a discussion of the reserve and put his criminal activity into focus. As a result, according to the patient's memory, the staff and other patients were much more understanding. It is not that the patient was trying to minimize his own criminal behavior by blaming it on the violence in his community. Most offenders, Aboriginal offenders included, have come from disruptive and often violent environments. Some Aboriginal patients perceived that the staff and other patients were simply unable to understand the extent of social pathology and prevalence of crimes in some Aboriginal communities. It becomes relatively easy for some patients to

feel that they are not understood and never will be understood by non-Aboriginal offenders or staff. This in turn affects the performance of Aboriginal offenders in group therapy.

Acculturated Aboriginal offenders are those whose cultural orientations are most similar to the Euro-Canadian, non-Aboriginal patients. Many of these individuals were raised in Euro-Canadian foster or adoptive homes, usually in urban areas. Typically, they lack knowledge of their heritage, language, and culture (although some begin to learn about their culture while in prison). We would not suggest that their cultural orientations are identical to those of Euro-Canadians, however, since issues of race and Aboriginality are nevertheless part of such a cultural formulation. However, in general, there was a significant lack of culture-specific problems associated with the large group experience for these individuals. It is quite likely that these individuals share essentially the same group experiences as non-Aboriginal offenders. There is one exception to this, however. Since most of these offenders identify themselves as Native or Aboriginal in one way or another, they share with their bicultural counterparts some perceptions of racism within Canadian society as a whole as well as within the forensic treatment program.

Observations of Group Therapy Sessions

In an effort to substantiate some of the observations made by respondents, as well as to learn more about the programming they were experiencing, one of the authors, Waldram, attended most of the daily large group therapy sessions for 5 weeks in 1991. The other author, Wong, routinely attends these sessions as part of the therapeutic team.

Patients voluntarily offer to take group, although in practice there appears to be a variety of pressures that are brought to bear on certain individuals, both by staff and by other patients, to take group when it is felt that there is a need for them to do so. Similarly, the topic for discussion is usually decided by the patient, though often in consultation with the staff. The first group that any patient takes after arrival to the unit normally involves a description and an analysis of his criminal activities and, in particular, his current offense.

The atmosphere within the group is at times very controlled and supportive and at other times confrontational and somewhat volatile. Both the other patients and the staff participate in questioning the patient and offering him feedback. Whereas the feedback offered by the staff is usually couched in professional language, the other patients tend to be more direct in their use of language. Self-disclosure in group entails talking about one's feelings, thoughts, weaknesses, and vulnerabilities, among other things. There is no doubt that self-disclosure is quite threatening to most people, and in particular to many offenders who have had very little experience with this type of exercise. It is not surprising, then, that many

patients are apprehensive of the idea of taking group; it is a time of great tension for most. Many recounted how they spent numerous prior nights awake, worrying about it. During the course of this research, one non-Aboriginal patient attempted suicide minutes before he was to take group, but such a reaction is extremely rare.

In a typical group session, the patient taking group is effectively in charge. He begins when he is ready, concludes when he finishes what he has to say, then opens up for questions and feedback. Although there is normally a 1 1/2-hour time limit, in some cases this may be exceeded, or the patient may call the session to an early close. Throughout the session, the patient taking group is the subject of intense attention and commentary. The others listen, question, offer support, or criticize. Very clearly, the ability to articulate and verbally defend oneself is essential to achieving an acceptable outcome as defined by the patients.

The large group experience, like other aspects of forensic programming, is laden with Euro-Canadian cultural meaning. In many ways, the groups demonstrate a certain tension between the professional "helping" culture of the staff, complete with its own concepts of deviancy and therapy, and the culture of the patients, including the con code and other subcultural behaviors that develop within the prison system. The patients' discourse tends to be earthy, with the occasional use of profanity, and seems to fall in line with the adage "You can't con a con." But overall, for both staff and patients, the rules of group therapy are based on the conceptualization of criminal behavior with Euro-Canadian cultural rules as the background. The problems experienced by some Aboriginal offenders in this setting are due, in part, to their differing cultural backgrounds. A few examples will illustrate.

The first is a traditional Aboriginal offender. This Ojibwa man from a relatively remote area indicated that his topic was "communicating." He spoke very softly, so softly in fact that he was barely audible. While he seemed to want to discuss his inability to communicate with people and to be assertive in interpersonal contexts, the staff tended to concentrate mostly on his soft-spokenness (admittedly a component of "communication"). On numerous occasions he was asked to speak up, and some staff even chastised him for this. He was told that he had important things to say but that he could not be heard.

At one point, he was asked if he could communicate better in his own language. Although he responded in the affirmative, there was no subsequent mention by staff of his Aboriginal status and linguistic duality. There was no exploration of the possibility that his quietness was a product of his Ojibwa culture and upbringing. The staff once again challenged him to speak up. Subsequent discussion with him indicated that these challenges were extremely disconcerting, as he did not see his quietness per se to be a problem. He felt that he was not permitted to talk about his communication problems as he understood them.

During this session, there was fairly active participation by some of the other Aboriginal patients in the group, offering mostly supportive comments. This was in sharp contrast to their relative quietness when a Euro-Canadian patient was taking group.

While others, including Aboriginal patients, also spoke very quietly from time to time, this was the only case witnessed in which the auditory level was made an issue by the staff. Ironically, from the researcher's vantage point in the group circle, there was one staff member whose voice was every bit as quiet and inaudible as that of the patient. No mention was made of this by anyone. Only a few days later, a Euro-Canadian taking group also spoke softly but was asked to speak up only a couple of times. Unlike the Aboriginal patient referred to previously, this Euro-Canadian patient's quiet demeanor was not made the central focus of the session, despite the fact that his voice was equally inaudible.

A second traditional patient, a Slavey from the far north, was discussed during ward rounds. He was challenged by the staff for doing little to fulfill the terms of his treatment contract. He replied rather bluntly that he did not trust the staff. He related that he had once confessed to a priest who turned over the confession to a local newspaper. As a result, he had problems trusting the "white" staff and believing that "opening up" would not bring him harm.

This patient was then challenged for frequently wearing a baseball cap during the group, although on this particular day he was not. The rules for group prohibit the wearing of hats, although the rule is not uniformly enforced. When asked why he always wore the hat, the patient replied simply that he just liked to wear it. He was then confronted by one staff member who suggested that he wore the hat because he was "hiding behind it." Although not explained further, the implication was that the hat was a tool that he used to assist in his nonparticipation and uncooperative behavior regarding his treatment program. He replied once again that he wore it only because he liked to. For the rest of the observed time period, this patient never wore his cap again in group, although he was always observed wearing it in other situations. Throughout this exchange regarding the cap, the patient spoke in a quiet voice and rarely looked up from the floor.

In a subsequent interview with the patient, the cap incident was raised. The patient stated that, in his remote northern Indian community, virtually every adult male wore a cap and that he had worn one his entire adult life. He stated that he did not like to make eye contact with people but that the hat was not an eye shield; indeed, he continued to stare at the floor when he spoke without the hat. For him, the hat was an integral part of his apparel, and he felt more comfortable with it on.

These two cases illustrate a number of points. The quiet, shy demeanor that is often characteristic of traditional Aboriginal people in unfamiliar situations is the product of both their cultural upbringing and

their relative lack of experience in a Euro-Canadian cultural milieu. The lack of eye contact in many Aboriginal cultures is considered a sign of respect. Speaking in a passive or a nonassertive, quiet voice is also typical, and loud, assertive behavior is considered rude. The wearing of baseball caps has become a common trait in northern communities.⁴ Although there is considerable intracultural variability, all of these examples represent cultural behaviors that are very typical. These behaviors were, however, interpreted by the staff as signs of evasiveness or uncooperativeness or simply regarded as problematic. In challenging these behaviors, the staff were inadvertently challenging the Ojibwa and Slavey cultures. Unlike the Euro-Canadian patients, these Aboriginal patients were being challenged to surmount not only their own personality traits but also those traits imbued in them as cultural beings.

Bicultural patients tended to be considerably more assertive in group, maintaining strong eye contact and articulating well in English. Unlike the traditional patients, these patients expressed an acute understanding of the plight of Aboriginal peoples and often placed their own predicament within a historic context of what had happened to their "people."

One bicultural Plains Cree patient took group on the topic of self-esteem. For him, the question of self-esteem revolved around his experiences as an Indian and the problems he encountered when he began to attend a predominantly "white" high school in a nearby city. Seeing the occasional drunken Indian on the streets of the city made him feel ashamed of his culture. He explained that he lost pride in his people, and the racism he experienced in the city as he attended school resulted in numerous acts of violence and left him feeling bitter about "white" society.

This patient articulated well and spoke at an adequate volume. He was able to maintain eye contact easily throughout.

The patient received very little feedback at first. Eventually, another bicultural patient, a Saulteaux, raised the question of racism and the role of government in oppressing the Aboriginal peoples. In general, the Euro-Canadian patients remained fairly quiet until a staff member directed the conversation to the subject of drug abuse and the nature of the criminal activity involved.

Interestingly, both a Euro-Canadian patient and a Euro-Canadian staff member tried to equate the patient's experiences with racism to their own. The Euro-Canadian patient, of Eastern European descent, suggested that he, too, had experienced racism at the hands of other "white" kids in his neighborhood, including racial taunts and namecalling, and indicated that the Aboriginal patient seemed to want to blame all his problems on the "white man," which was denied. The staff member suggested that the patient's problems in the city high school were really no different from those she and other rural peoples experienced in Saskatchewan when transported to urban schools. Although the patient responded by

emphasizing that his situation was different because he was a member of a minority, this issue was not pursued by staff.

At a later ward round when this patient was addressed, he suggested that he had not received much feedback from the time he took group and also noted that he was still a little uncomfortable speaking in group. A Euro-Canadian patient confronted him, stating that it was "bullshit" when some patients said they were uncomfortable when talking in group, and that he was just hiding behind this excuse to avoid participating. No one challenged this interpretation.

At another ward round, a different bicultural patient was discussed. Mention was made that this Saulteaux man appeared to be dozing in group and that he tended to talk quietly into his hand. He replied, "I don't listen with my eyes. I listen with my ears," which evoked some laughter. He was informed by staff that it was impolite to listen with his eyes closed, and he agreed to try to keep them open.

This individual's overall participation in group was relatively minimal. He spoke quietly and often looked downward as he did. He tended to speak more when another Aboriginal patient was the subject. The interview with him and other observations indicated he was not really a shy individual, and thus his behavior in group seemed to be somewhat unique and situation-specific. He had a deep mistrust and resentment of Euro-Canadian peoples.

These two bicultural patients, on various occasions, expressed the viewpoint that historical processes and contemporary problems such as racism were important factors in understanding their own criminality. This attitude seemed somewhat contrary to one objective of the staff, which was to make the patients take personal responsibility for their actions. Indeed, the staff obviously have no control over the sociohistoric factors that have led to Aboriginal oppression in Canada. However, in our view, these are not incompatible. The demonstration of an understanding by staff of the historic issues pertinent to Aboriginal peoples would likely facilitate a positive working alliance between staff and patients; ignoring these issues may have the opposite effect. Indeed, these patients were expressing their own identity and difficulties in cultural and historic terms, but they received little feedback as such and generally found the staff uninterested in pursuing these avenues of inquiry. This only further worked to convince some patients that staff did not care about their backgrounds. The lack of empathy expressed on the question of racism was particularly noteworthy. At some point in the treatment process, but not necessarily in the large group, these issues needed to be addressed.

While these bicultural patients have had considerably more exposure to Anglo-Canadian culture, there was still more evidence of discomfort regarding speaking in large group.

The acculturated patients who took group during the period of research were largely indistinguishable from the Euro-Canadians. Issues

regarding their Aboriginal heritages were not raised, and they appeared to be able to handle the pressures of group therapy fairly well, at least as well as the Euro-Canadian patients. As noted earlier, these Aboriginal offenders appear as distinctly different from the others; they may have problems in the large group, but these are not differentiated from those of the non-Aboriginal offenders for the most part. However, the acculturated offenders did express some problems in self-identity related to their Aboriginal heritage but lack of knowledge of Aboriginal language and culture. They also suggested that experiences with racism were important in shaping their lives both on the street and in prison. But these topics were not generally raised in group therapy. We would suggest that, of all the Aboriginal offenders, they were the most able to adopt the rules of behavior expected of the patients in the group.

Conclusion

Group therapy is an unnerving experience for most Aboriginal offenders, as it is for their Euro-Canadian counterparts. However, many Aboriginal offenders do appear to be at a greater disadvantage. Topics of relevance to them, such as racism and the reserve context, appear to be minimized in treatment. Indeed, it may be difficult for non-Aboriginal staff and patients to truly understand the legacy of colonialism as it has affected and continues to affect Aboriginal peoples. Traditional and bicultural offenders may have difficulties expressing themselves in English, and traditional offenders in particular may exhibit culture-specific behaviors that are counterproductive to performance in the large group setting.

Success, as defined by the patients⁵ in the large group is determined in part by the degree to which they accept the norms of the group, at least superficially. These norms are inherently based on Euro-Canadian, middle-class culture. Patients are expected to speak directly, openly, and honestly, to offer feedback to others, and to present themselves as interested, active participants. Maintaining eye contact and an audible voice level are inherent elements of this. In effect, for all patients, success is predicated on their ability and/or desire to comply with the objectives of the group. While the traditional patients seem to have great difficulty doing this for cultural reasons (and they do appear to try), the bicultural patients may be more resentful of the Euro-Canadian domination of the group and seem to select not to cooperate any more than is necessary. These individuals encounter much more hostility from other, non-Aboriginal patients and staff and are not afraid to return the sentiment.

To understand the utility of group therapy, it is essential to separate the process of the group from the content or lessons to be communicated. For the traditional Aboriginal offenders, and many of the bicultural offenders as well, the confrontational nature of the large group is culturally inappropriate, and renders them at a distinct disadvantage. Though

we cannot provide many details here (see Waldram, 1993), it is interesting to note that all-Aboriginal groups such as the Native Brotherhood meetings, sweat lodge, and sweetgrass ceremonies often involve confession and taking responsibility for one's actions but without direct confrontation of any kind. In terms of content, then, some elements, such as taking responsibility, seem appropriate for all offenders, but others, such as assertiveness training, are not appropriate for the traditional people. It is essential at the outset of the treatment program to identify the cultural orientation and the degree of acculturation of the patient. The staff should also determine whether, upon completion of the sentence, the patient intends to return to a small Aboriginal community, a large urban center, or other types of community living. It makes little sense to adopt a therapeutic approach that, if successful (i.e., the patient adopts a new attitude and changes his behavior to be more law-abiding), actually renders the patient a cultural misfit in his home community. Such a problem is particularly acute for the traditional patients.

The type of group therapy described in this paper adds a new dimension to our understanding of this mode of treatment. The participation of Aboriginal offenders is conditioned by their own cultural orientations, the cultural makeup of the group, the cultural underpinnings of the group therapy model, and the unique setting of the institution. These data support the assertions of French (1981, 1989), Trimble and Fleming (1989), and Renfrey (1992) that culture does matter and must be taken into account when offering group therapy to Aboriginal offenders. Furthermore, the dynamics of Aboriginal history and resistance to colonialism also explain their participation and working relationship with the staff. Although commentators such as Manson et al. (1987) and Neligh (1988) are able to support group therapy as a successful treatment modality, attention must be paid to the contexts in which it is useful. From the perspective of many Aboriginal offenders, the group therapy approach described in this article is little more than a re-creation of the larger Canadian society and history, wherein non-Aboriginal or "white" people have complete control over the Aboriginal peoples and the "white" people overtly state that they know what is best for the Aboriginal peoples and make the rules and assess behavior.⁶ The Aboriginal peoples are numerically in the minority among the other offenders, and perceptions of racism condition interaction between "white" and Aboriginal peoples. The fact that the group therapy occurs among an offender population in a prison setting suggests that the offender subculture and prison environment also are important.

This article argues that multicultural settings in which non-Aboriginals are combined with Aboriginal peoples who have differing degrees of orientation to or familiarity with Euro-Canadian culture, and in which the treatment approach and the therapists are Euro-Canadian may be too

complex to allow the Aboriginal participants to experience an outcome as successful as that of non-Aboriginal participants.

To be effective in providing services to Aboriginal offenders, it is imperative to assess the degree of acculturation of the client. Unfortunately, there is no valid and reliable instrument available to assess acculturation. However, a thorough assessment of the client's proficiency in the relevant Aboriginal and English languages, the duration of urban versus reserve residency, the educational and occupational experiences, and the client's comfort level with the intervention would be very useful. The process and the content of intervention, be it group or individual counseling, should be explained clearly to the client, preferably by someone sensitive to their cultural needs.

The personal agenda of the client, especially his future release plan, should direct the intervention. The client who wishes to go back to the reserve and live among other Aboriginal people would have little use for predominantly Euro-Canadian interpersonal skills, for example. On the other hand, if he wishes to leave the reserve and start a new life in the mainstream society, mainstream interpersonal skills would be quite essential to his work and living. Service providers should further explore such personal plans and wishes prior to the intervention. As such, Euro-Canadian based interventions may or may not be appropriate, depending on the Aboriginal person's personal agenda.

Training should be provided to sensitize staff to Aboriginal history and issues. Knowledge and awareness of the prevailing culture and other forces in and around the client's area of residency, which could shape the client's future behaviors, antisocial or otherwise, would also be very useful in preventing future relapses.

Finally, having a forum, separate from the ongoing interventions, for the discussion of racism and Aboriginal history between clients and staff may be useful in bridging the gap of mistrust.

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Notes

1. The term “Aboriginal” is used in this article to collectively identify all peoples recognized in the Canadian constitution as “aboriginal”; this includes the “Indian, Inuit and Metis” peoples. The uppercase is used for Aboriginal in keeping with current Canadian usage.
2. It is important to emphasize to readers who lack detailed knowledge of the Canadian scene that there are still many isolated Aboriginal communities. Some of these lack permanent road access, and many people still speak their Aboriginal languages as their first language (and the elderly may be unilingual). For many, life in the bush or on the tundra defines their cultural and social existence.

3. The patient's comment here should be interpreted figuratively, since staff never actually hug patients.
4. The wearing of baseball-style caps is extensive among northern Aboriginal peoples. It is more a "cultural behavior" than an individual habit because it is so widespread and is considered the norm for adult males. It is rare to see such men in public without their hats.
5. "Success" includes various elements, including receiving positive feedback from the staff and support from the other patients. It also includes a subjective assessment of the degree to which the patient was criticized or made to feel anxious or uncomfortable during the session.
6. It is true that many non-Aboriginal offenders also react negatively to the idea that the treatment staff know what is best for them and have significant control over their lives while at the psychiatric center. However, these feelings are not conditioned by more than 130 years of oppressive, paternalistic policies directed specifically at them through the use of legislative action and military force, as is the case for Aboriginal peoples. This, we would argue, makes the Aboriginal case unique.