

**The Role of Social Support in the Well-being of First Nations and Inuit Youth
Following Treatment for Volatile Solvent Abuse**

By

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ABSTRACT

Using a risk and protection framework and primary socialization theory, this thesis examines the relationship between social support and the well-being of First Nations and Inuit youth following treatment for volatile solvent abuse (VSA). Semi-structured, qualitative interviews were conducted with fourteen service providers at a youth residential VSA treatment centre in Muncey, Ontario. There are two key findings. First, participants identified similar risk factors for VSA in the youths' lives both before and after treatment. Many paralleled the current literature while some new risks also emerged. Second, social support was identified as a form of protection from VSA for youth. Social support was developed/enhanced for youth during their time in treatment, and drawn upon when back in their communities in the form of resiliency. Primary socialization theory helps to explain and predict ways in which risk and protective factors operate and how they can be addressed. Based on these findings, this study concludes with a discussion of policy implications and future research areas.

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The Role of Social Support in the Well-being of First Nations and Inuit Youth Following Treatment for Volatile Solvent Abuse

CHAPTER ONE: INTRODUCTION

Our teachings tell us that the key to healing is about connection. That not anyone of us can live in isolation and so everything about Native people is about family and community. And if you don't have family and community some of the Elders will tell you that you don't have a life. Your identity depends on family and community so creating those social support networks is critical to [the youths'] health. Christine

Social support has been identified, through both theory and research, as a concept that shares a positive relationship with health and well-being. More specifically, it has been linked to the effects of stress; with most research focusing on the degree to which social support is able to offset the negative consequences of stress (Thoits, 1995; Wilcox & Vernberg, 1985). Of particular interest here, is the contribution this concept makes to the substance abuse field. It has been suggested that stress and/or stressful life events (e.g., poverty, family chaos) can increase the risk that one will engage in health compromising behaviors (e.g., alcohol consumption, drug involvement) (Ames & Roitzsch, 2000; Dobkin, DeCivita, Paraherakis, & Gill, 2002). My research interest lies in addressing the extent to which the presence of positive social support may act to counterbalance or act as protection against harmful behavior, such as substance abuse. More specifically, I am interested in how social support affects the well-being of First Nations and Inuit youth after a treatment episode for volatile solvent abuse (VSA).

Research has found social support to be beneficial in aiding in recovery and abstinence during post-treatment (Dobkin et al., 2002; Havassy, Hall, & Wasserman, 1991; Galanter & Brook, 2001), though this has mainly been demonstrated within

adult populations, and even more so, among adults who abuse alcohol (e.g., Beattie & Longabaugh, 1999; Dobkin et al., 2002). Also, the research that has focused on youth generally does not concern the specific sub-group of youth who have undergone treatment, but rather, involves investigating how social support strengthens resiliency and acts as a protective factor among general youth populations. Attention is focused mainly on adopting these findings to prevention strategies (e.g., Pollard, Hawkins, & Arthur, 1999; Hawkins, Catalano, & Miller, 1992). To address a gap in the literature, I have investigated the role of social support in the lives of First Nations and Inuit youth who have undergone treatment for VSA. This form of substance abuse has received relatively little attention from drug abuse researchers and as a result, there is a paucity of knowledge on it (Beauvais, 1997). Thus, by focusing on this sub-group of youth, I am able to contribute to a body of research that is, at present, under-investigated.

Both the research population and the form of substance abuse are as important as the concept under study in this project - social support. My research examines the role of social support in the well-being of First Nations and Inuit youth who have attended the *Nimkee NupiGawagan Healing Centre*, located in Muncey,¹ Ontario. There is limited access to the youth who have attended the centre, for example, they are not located in one central geographic area and many return to isolated, remote communities. Thus, I did not have direct contact with the youth. In place, the concept of social support and how it affects a youth's well-being post-treatment was discussed with the treatment providers and staff at the centre.

¹ Muncey is located in the Southern region of Ontario.

Having such a narrow focus created a further dimension to my research. I had to acknowledge that I was entering a cross-cultural environment. Because I was entering a field that was new to me and because I had little knowledge of First Nations and Inuit culture, I took direction from my supervisor as well as others (e.g., committee members and the centre's Executive Director), who have more experience with First Nations and Inuit groups. As well, I had to consider how the issue of VSA intersected with a wide range of other social problems and circumstances (e.g., family breakdown/dysfunction, family history of substance abuse, economic deprivation) (Howard & Jenson, 1999; Mosher, Rotolo, Krupski, & Stark, 2004; Dinwiddie: 1994), which are connected to the long history of cultural oppression, forced assimilation, and systematic racism and discrimination of Canada's First Nations and Inuit peoples (Kirmayer, Simpson, & Cargo, 2003). I addressed this in a comprehensive way by employing the risk and protective factors framework. The risk and protective factors framework allowed me to consider whether or not social support works to protect youth after treatment, and whether or not it strengthens youths' resiliency post-treatment, as well as to consider the interplay between social support and the risk factors that are present when the youth return to, what are oftentimes, unstable environments.

This thesis focuses on one main question - **to what extent does social support affect a youth's well-being after a treatment episode for volatile solvent abuse?** From my main question there are several sub-questions that arise. These include: What is social support for the youth? How important is social support to the youths' well-being post-treatment? How available is social support to the youth post-

treatment? Do youth relay experiences of support? How does one improve the availability of support? What is the relationship between the youths' resiliency and positive social support? What other conditions (risk factors) interfere with the youths' well-being? What changes occur in the youths' life domains (individual, family, school, peer, community) following treatment? Are there any structured social support resources available to youth upon re-entry into their communities? How does the *Nimkee NupiGawagan Healing Centre* assist with social support while the youth are in treatment?

There are several key concepts in this study. To begin, social support is a concept that is replete with definitional complexity. There is not one clear conception of social support in the substance abuse literature and the issue becomes even more blurred when the research is focused on substance abuse among youth. Although I have accounted for the academic literature during both the data collection and analysis phase of my study, I took a grounded theory approach.² I allowed the definition to emerge from the data, identifying what aspects of social support were meaningful to this specific situation. I inquired about what social support is offered while the youth are in treatment, what forms of social support the treatment providers believe best meet the needs of the youth after treatment, what the treatment providers perceive as social support, as well as how the youth relay their experiences once they re-enter their communities (e.g., what social support they are receiving and what they

² Grounded theory is an inductive approach to research that attempts to generate theory from data. In most instances, grounded theory indicates that the researcher has no preconceived notions about the topic or concept under investigation (Charmaz, 2002). I, however, have reviewed some general knowledge regarding social support. The general literature was the base from where I began my investigation, though my approach can still be considered grounded theory because I investigated what the concept meant in this specific situation and placed emphasis on the new and emerging ideas of the participants in this study.

are needing). Well-being refers to the reduction of harms associated with VSA. This term has been employed because it encompasses a range of success indicators, some of which include education, employment, mental functioning, drug/alcohol/solvent use, spiritual connectivity, social functioning, legal issues, living situations, physical functioning, and HIV risk behaviour (Youth Solvent Addiction Committee, 2001). This is also how the concept is defined by *The Nimkee NupiGawagan Healing Centre*.

This project reviews the current literature that is available on VSA and adolescence. Although the body of literature on youth VSA is not abundant, I have obtained what exists on the risk factors that have been linked to VSA as well as some general knowledge such as levels of use and health consequences. I have also carried out an in-depth review of primary socialization theory, which helps to explain why certain associations found in the risk and protection research exist. In short, the theory argues that there are three primary sources for learning social norms: the family, the school, and peer clusters (Oetting and Donnermeyer, 1998). The family and school are most often the source of pro-social norms, while deviant norms are usually generated within peer clusters (Oetting and Donnermeyer, 1998).

In order to address my research question I conducted in-depth, semi-structured interviews with treatment providers and staff at the *Nimkee NupiGawagan Healing Centre*.³ Initially I considered interviewing the youth themselves, though as I investigated this prospect further it became clear that it would not be feasible, as there

³ A treatment provider is anyone who deals directly with the youth, while a staff member is someone whose work is more indirect, for example, their job may involve administrative duties, scheduling outings, or preparing meals. Defining who is a treatment provider and who is a staff member is difficult, as many of the employees of the *Nimkee NupiGawagan Healing Centre* carry out both types of tasks (formally and informally).

are a number of barriers that would limit my access. For example, many of the youth return to isolated, remote communities, where in many instances there are no forms of outside communication (e.g., telephone). A further reason I chose to interview the treatment providers and staff of the centre is that some of the knowledge that I was interested in obtaining was information that the youth may not be able to provide (e.g., questions regarding how social support is accounted for in the treatment program). Choosing the treatment providers and staff of the *Nimkee NupiGawagan Healing Centre* as my sample population was an appropriate strategy that did not limit my research. The majority of management staff have been with the centre since it opened in 1996; as such these individuals have substantial experience, as well as considerable insight to share on the topic of VSA and the topic of this study. Due to the dearth of information regarding youth VSA and the role of social support following treatment, the interviews were exploratory in nature.

In this chapter I have outlined my research question and offered a general description of my project overall. The remainder of my thesis is comprised of five chapters. In the next chapter I report some basic knowledge on youth VSA and the history of Aboriginal peoples in Canada. I also introduce the risk and protection model and describe the factors that have been linked to VSA as well as to youth substance abuse in general. Following this, I discuss in greater detail the concepts of social support and well-being. In Chapter Three I focus on the theoretical framework that guides my analysis and interpretation. More specifically, I introduce primary socialization theory. I describe the underlying principles of the theory as well as identify both its value and limitations in relation to my project. In Chapter Four I

outline the methodological approach I chose to address my research question. Chapter Five includes my analysis and a discussion of my findings. In this chapter I discuss the risk factors that are present in many of the youths' lives and connect them to the history of oppression among Canada's Aboriginal peoples. I also review the participants' thoughts on the concept of social support as a form of protection. More specifically, I outline how the treatment providers and staff define social support in a youth VSA residential treatment setting, review the types of social support that are offered to the youth while they are attending the *Nimkee NupiGawagan Healing Centre*, discuss the relationship between social support and resiliency, and conclude by considering the importance and availability of social support in the lives of the youth post-treatment. Finally, in Chapter Six I offer some conclusions, address limitations of the study, discuss the policy implications that my research has, and identify future research questions.

CHAPTER TWO: LITERATURE REVIEW

I began answering my research question, *to what extent does social support affect a youth's well-being after a treatment episode for volatile solvent abuse (VSA)*, by conducting an in-depth search, retrieval, and review of current literature within the field. This chapter reviews the state of current knowledge on youth VSA, in particular among Aboriginal youth, and defines the key concepts I use in the study. In general, there is a dearth of information regarding youth volatile substance abuse and post-treatment well-being. There is even less research that is concerned specifically with Aboriginal youth. Therefore, in a number of places, I have turned to the addiction literature more generally for insight and guidance. In this section, I begin by providing a definition of VSA, as it is used in my research. This is followed by some current data and information that helps to explain the problem. I then provide a general description of the history of oppression among Canada's Aboriginal people. Describing the historical and structural impacts add context to understanding why certain risk factors are present in many Aboriginal peoples' lives. Following this, I describe the risk and protective factors model that I have used to frame my research. This includes an in-depth discussion of the factors that have been linked to VSA as well as youth substance abuse in general. Where research is available, I provide examples that have been linked specifically to Aboriginal youth populations.⁴ In the last part of this chapter, I define the terms social support and well-being and explain why and how I have chosen to employ these concepts in my research question.

⁴ This includes Canadian, American, and Australian Indigenous youth populations.

I. Introducing the Problem of Youth Volatile Solvent Abuse

Volatile solvent abuse (VSA) is defined as the deliberate inhalation of fumes or vapours given off from a substance for its intoxication and mind-altering effect (National Drug Abuse Information Centre, 1988). Unlike drugs which are identifiable by a pharmacological class (e.g., cocaine), volatile solvents are commonly defined by their route of administration—inhalation (Brouette & Anton, 2001; National Institute on Drug Abuse, 2006). As a result, VSA is frequently referred to as inhalant abuse (Carroll, Houghton, & Odgers, 1998). For the purpose of my research I have chosen not to use the term inhalant abuse. This is because the term inhalant can refer to a number of toxic substances that are not solvents, mainly atheistic gases⁵ and nitrates,⁶ which may have different neurological impacts and user populations (Beauvais, 1997). VSA is the term used here because solvents are the products most commonly abused by youth (Basu, Jhirwal, Singh, Kumar, & Mattoo, 2004; Dewey, 2002).

Canadian research indicates that the majority of solvent abusers are between the ages of ten and seventeen, with peak use occurring between the ages of twelve and fifteen (Youth Solvent Addiction Committee, 2004; The McCreary Centre Society, 2004; Alberta Alcohol and Drug Abuse Commission, 2003; Addiction Foundation Manitoba, 2001; Adlaf & Paglia, 2003; Perron & Loiselle, 2003; Van Til & Poulin, 2002; Poulin, 2002; Liu, Jones, Grobe, Balrom, & Poulin 2002; Yukon Women's Directorate, 2001). National data on youth VSA in Canada are scarce. Drug

⁵ Atheistic gases (e.g., nitrous oxide/laughing gas, ether) are common to medical and dental practices. They are also available in commercial products such as butane lighters and propane tanks. Nitrous oxide is the propellant in whipped topping products (Brouette & Anton, 2001).

⁶ Nitrates are typically found in room deodorizers and video head cleaner, and are referred to by such street terms as “Locker room”, “Poppers” and “Climax”. Nitrates are commonly available for purchase in stores that sell goods related to illegal drugs (i.e., head shops) and are typically used by males for sexual enhancement (Brouette & Anton, 2001).

and alcohol surveys conducted in the majority of Canada's provinces and territories provide some information, although it is difficult to make comparisons between the surveys because they differ in the years they were conducted, age groups surveyed, wording of questions, and the depth of information collected. Nonetheless, there is some consistency in the reporting of VSA across the country. For example, statistics for 2003 indicate that 4% of youth⁷ attending school in BC and 7% in Ontario used a solvent in the past year (Adlaf & Paglia, 2003; The McCreary Centre Society, 2004). Other provinces and territories surveyed over the past several years reveal comparable findings (e.g., Alberta Alcohol and Drug Abuse Commission, 2003; Patton, MacKay, & Broszeit, 2005; Perron & Loiselle, 2003; Van Til & Poulin, 2002; Poulin 2002; Liu et al., 2002; Yukon Women's Directorate, 2001; Poulin, Martin, & Murray, 2005). Similar rates of use have also been reported in the United States. For example, *The National Survey on Drug Use and Health* indicates that in 2003, 10.7% of youth 12 to 17 years of age reported using an inhalant in their lifetime and 4.5% in the past year (National Institute on Drug Abuse, site last visited 2006).

Research and practice have indicated higher rates of VSA among a number of marginalized, sub-groups of youth. This has been documented among some First Nations and Inuit youth living in select rural and remote areas of Canada. For example, a 2003 report from Pauingassi First Nation in Manitoba concluded that half of the children under 18 and living on reserve abused solvents (Manitoba Office of the Children's Advocate, 2003). A survey of all Bands and reserves in Canada, conducted in 1993, reported that more than half of all solvent abusing youth respondents began to abuse solvents at 11 years of age or younger (as cited in Dell &

⁷ In both provincial surveys youth is defined as adolescents enrolled in grades seven through twelve.

Garabedian, 2003). And, a 1997 study of First Nations youth living on reserve in Nova Scotia and Ontario found that more than half had tried drugs at least once, and these drugs were usually marijuana or inhalants (First Nations and Inuit Regional Health Survey, 1997). These findings however, require further qualification. High rates of VSA among some First Nations and Inuit youth have been linked to poverty, boredom, loss of self-respect, unemployment, family breakdown and poor social and economic structures (Kaweionnehta Human Resource Group, 1993). These issues are connected to the historic impact of residential schooling, systemic racism and discrimination, and multi-generational losses of land, language and culture (Dell & Beauchamp, 2006).

It is frequently noted within the literature that volatile solvents are often the first mood-altering substance used by children and youth because they are readily available, inexpensive and easily concealed (Wille & Lambert, 2004; Dewey, 2002; Basu et al, 2004). Among the most popular volatile solvents abused by young people are paint thinner, glue, gasoline, shoe polish, spray paint, correctional fluid, hairspray, and spray deodorants (Wu, Pilowsky, & Schlenger, 2004; Ballard, 1998; Brouette & Anton, 2001; Kurtzman, Otsuka, & Wahl, 2001). Most importantly, volatile solvents are not intended for human consumption. As a result they can have serious health consequences for the user. The physical health effects of VSA are highly unpredictable and can lead to death the first time (Dell, 2005; Beauvais, Wayman, Jumper-Thurman, Plested, & Helm, 2002). Some of the most dangerous, immediate

effects of VSA are sudden heart failure,⁸ suicide/risk taking behaviour, asphyxiation/suffocation,⁹ overdose, and/or frostbite and burns (Wille & Lambert, 2004; Garriot, 1997; Kurtzman et al., 2001; Albright, Lebovitz, Lipson, & Luft, 1999; Ho, To, Chan, & King, 1998).¹⁰ VSA is rarely addressed in mainstream discussions of youth substance abuse. As a result, there is not a strong perception of the harm related to it. This point demonstrates the need for research and attention to be brought to the problem.

II. The History of Oppression of Aboriginal Peoples in Canada

Before reviewing the risk and protection literature it is important to gain some insight on the historical circumstances that have contributed to the life situations of Aboriginal youth in Canada today. Describing the historical and structural impacts helps to provide a context to why certain risk factors are present in many Aboriginal communities. Aboriginal peoples is a collective term used to describe all of the original peoples of Canada and their decedents (Information Centre on Aboriginal Health, site last visited 2007).¹¹ Though there are commonalities among Aboriginal peoples, it is important to recognize that Aboriginal peoples of Canada are not a homogeneous group. There are approximately 633 bands exhibiting regional, tradition, and cultural variation, with over 50 Aboriginal languages that further

⁸ Commonly referred to as sudden sniffing death, it is among the most regularly cited cause of death by volatile solvents. It occurs when an adrenaline rush from extra exertion (e.g., running, fright) while intoxicated causes the heart to skip out of rhythm and stop beating (Wille et al., 2004).

⁹ This cause of death is commonly tied to the bagging method of inhalation. Asphyxiation most frequently occurs when the plastic bag used to concentrate and inhale volatile solvents prevents the passage of air to the user's nose and mouth (Kurtzman et al., 2001).

¹⁰ The freezing properties of many volatile solvents present the risk of frostbite. Burn accidents and fatalities also pose a serious danger, as many volatile solvents are flammable gases (Albright et al., 1999; Ho et al., 1998).

¹¹ The term Aboriginal people is defined in section 35(1) of the *Constitution Act* (1982) as the "Indian, Inuit, and Métis people of Canada" (Department of Justice Canada, site last visited 2007).

reinforce their differences (Fleras & Elliot, 2003). This discussion is confined to general terms, which ignores some of the historical and social specifics in different First Nations, Inuit, and Métis communities. The youth who attend the *Nimkee NupiGawagan Healing Centre* come from both First Nations and Inuit communities.¹² The majority of the youth are from First Nations communities thus, I focus mainly on the structural inequalities that have presented themselves within this group.¹³ To a lesser extent, I have included examples of the issues facing Inuit communities as well.

Many First Nations communities have suffered rapid and radical social change as a result of past as well as continued government policies that control their education, justice system, economies, and ways of life (York, 1999; Fleras & Elliot, 2003). Two prominent examples are the *Indian Act* and the residential school system, whereby Aboriginal peoples experienced systematic racism and discrimination, as well as a loss of language, culture, identity, and land (Nabigon, 2006; York, 1999). The *Indian Act* of 1876 marked the end of Aboriginal self-government. The *Indian Act* was enacted by the Parliament of Canada under section 91(24) of the *Constitution Act*, which provides Canada's Federal Government with legislative authority over "Indians and land reserved for Indians" (Department of Justice Canada, site last visited 2007). As a result of the *Indian Act*, self-government was replaced by federal control over cultural, social, economic and political activity (Graham, Swift, &

¹² Inuit-specific residential substance abuse programs in Canada are limited. Additionally, the Inuit-specific centres that do exist are focused on adult populations. As a result, Inuit youth are often referred to First Nations residential treatment centres (Dell and Lyons, 2007).

¹³ The term First Nations is not a synonym for Aboriginal peoples because it does not include Inuit or Métis. The term can apply to both Status (recognized under the *Indian Act*) and Non-Status (not recognized under the *Indian Act*) Indians (Information Centre on Aboriginal Health, site last visited 2007).

Delaney, 2003).¹⁴ As Fleras and Elliot (2003:182) explain, “The *Indian Act* was an essentially repressive instrument of containment and control, its role in usurping Aboriginal authority could not have been more forcefully articulated.”

Under the *Indian Act* and as part of Canada’s policy of assimilation, First Nations children were required to attend residential schools during the late nineteenth and mid-twentieth centuries (Graham et al., 2003). Similar schools were established in the North for Inuit youth during the mid 1950’s and early 1960’s (King, 2006). These schools were operated by missionaries who tried to suppress Native culture and identity (Nabigon, 2006; York, 1999; Miller, 2004; Miller, 2000). This repressive environment ultimately had a devastating and marginalizing effect on Canada’s Aboriginal people (Fleras & Elliot, 2003; Stout & Kipling, 2003; Miller, 2004; Miller, 2000).

The impact of these historical events is best understood through a rather lengthy quote taken from Herb Nabigon’s autobiography, *The Hollow Tree: Fighting Addiction with Traditional Healing*. He writes,

When I turned nine years old, like many other Native children, I was taken from my parents and sent to a Residential school in Spanish, Ontario. These schools were established by the federal government as part of a plan to assimilate Native peoples into the Western culture. In the 1850’s an act that made it mandatory that Native children be removed from their families was implemented. This act, called the *Indian Act*, was established to remove the traditional values and beliefs from our culture, forcing Western values upon our people. The policy of assimilation in the 1950’s forbid the spiritual teachings of fasting, pipe, and sweat lodge ceremonies. The policy of outlawing our spiritual beliefs and language had a devastating affect on our identities as Native people. Many Native people left the Christian churches (Roman Catholic, Anglican, United Church, etc.) as a result of this policy.

This prescriptive and intrusive policy devastated parents and children alike. No longer would parents have any control over their children’s lives. Children as young

¹⁴ “The *Indian Act* does not apply to Inuit. However, in 1939, the Supreme Court of Canada interpreted the federal government’s power to make laws affecting ‘Indians, and Lands reserved for the Indians’ as extending to Inuit” (Information Centre on Aboriginal Health, site last visited 2007).

as six years old would be taken from their homes and placed in a school, often far from their homes, where their names would be replaced by numbers. They were completely stripped of their past identity and punished for speaking their Native tongue. This was the setting for the many triggers in my life that led me on a downward spiral of despair. (Nabigon, 2006:4)

Similarly, Geoffrey York's book, *The Dispossessed: Life and Death in Native Canada*, offers a number of stories that demonstrate how Canadian policies have led to the physical and cultural displacements that have negatively affected Native communities across Canada (York, 1999). Although from a journalistic perspective, he describes the impact of such events as leading many to feelings of powerlessness and alienation, which York believes has, in many instances, been transferred inward as an expression of self-hatred and self-destructiveness (York, 1999). Moreover, many of the risk factors that are present in Aboriginal communities are a direct result of colonialism and the structures it put in place. Some are more overt (e.g. First Nations and Inuit communities have been displaced in isolated regions of the country, which in turn has impacted their economic conditions), while others share a subtler relationship (e.g., the physical, sexual, emotional, and spiritual abuse that occurred in many of the residential school has contributed to low self-esteem and loss of a sense of identity, poor parenting skills, and inter-generational substance abuse). As Fleras and Elliot (2003:170) put it, our history demonstrates that government structures and policies in Canada have succeeded in ensuring "that the 'first' shall be the last".

III. Recognising Value in a Risk and Protection Framework

The profile of youth who inhale volatile solvents is broad. Volatile solvent abuse (VSA) can affect adolescents regardless of age, gender, race/ethnicity, geographic location, and/or economic status (Wu et al., 2004). VSA is not confined to a specific population. There is, however, a large body of literature that suggests there are

characteristics that put individuals at greater risk for becoming volatile solvent abusers. These characteristics are commonly described through the risk and protective factors model. The risk and protective factors framework identifies the problem, in this case VSA, as one that is based on multiple influences including, personality traits, family environments and interactions, peer relationships, school experiences and community contexts (Coie et al., 1993; George, Dyer, & Levin 2002; Halaevalu & Vakalahi, 2001; Pollard et al., 1999; Catalano & Hawkins, 1996). I have framed my research within this model in part because it is closely aligned with my own ontological assumptions. More specifically, it recognizes that the problem is not based solely on the individual, but rather it is the product of numerous social, historical, and cultural forces and environmental influences (Simpson, 1997; George et al., 2002). It looks beyond the abuse, in turn taking the blame and focus away from the individual, while still accounting for the individual's subjectivity. In addition, this model provides an opportunity to organize the findings of this research in a way that helps to understand the whole child - their mental, spiritual, physical and emotional well-being (George et al., 2002). This is particularly useful given the population under study, as the Aboriginal conception of individual is commonly described through mental, spiritual, physical, and emotional qualities.

Over the past two decades numerous studies have utilized the risk and protection model to determine what factors affect adolescent substance abuse (DeWit, Silverman, Goodstadt, & Stoduto, 1995). Risk factors documented for youth VSA are similar to those found in research that examines youth substance abuse in general, however, the general literature on risk and youth substance abuse is much more

extensive. Therefore, I have included a broad discussion of risk in relation to youth substance abuse in addition to identifying those risk factors that have been linked directly to VSA. This approach has assisted me not only in verifying others' observations within the VSA literature, but it has also provided me with the opportunity to potentially add to their findings, linking other key factors to the problem.¹⁵

IV. Identifying Risk Factors

Risk factors are those life events, relationships, characteristics, and experiences that increase the probability of substance use and/or influence an individual's level of use and involvement (George et al., 2002; Brook, Balka, Brook, Win, & Gursen, 1998; Pollard et al., 1999; Svensson, 2000). Within the literature, risk factors are commonly organized into five life domains: individual, family, school environment, peer group, and community (George et al., 2002; Borden, Donnermeyer, & Scheer, 2001; Catalano & Hawkins, 1996; DeWit et al., 1995; Pollard et al., 1999). It is important to note that the problem of substance abuse is complex; and so, these domains cannot be viewed as independent of one another (George et al., 2002). Rather, they interact with each other to form a web of influence, whereby some factors exert more influence than others (George et al., 2002).

For organizational purposes, the following five sections are structured according to the five life domains. I begin with a discussion of the individual domain. Within this section I identify the risk factors that have been linked to youth substance abuse in general as well as discuss those that share a relationship with volatile solvent

¹⁵ I have included a table (Appendix 1) at the end of the thesis, which is a comprehensive comparison of the similarities and differences between the general youth substance abuse literature and the more specific youth volatile solvent abuse literature.

abuse (VSA) more specifically. This format is followed for the remaining four life domains: family, school environment, peer group, and community. Before proceeding, it is important to mention that not all youth who possess these risk factors will necessarily abuse alcohol, drugs or volatile solvents (George et al., 2002; Wolin & Wolin, 1993; Wolin & Wolin, 1995; Hawkins et al., 1992; Catalano & Hawkins, 1996; DeWit et al., 1995). It is equally important to point out that the factors that I refer to have been linked to serious and/or persistent substance abuse, which differ from those factors that lead to occasional or experimental involvement with substances (Catalano & Hawkins, 1996).

a) *The Individual Domain*

There are a number of factors rooted in personality traits and characteristics that have been linked to adolescent substance abuse. Individual risk factors that have been identified within the literature include early onset of use, risk-taking and/or sensation seeking disposition, low perceived self-worth, brain trauma, exposure to toxins in utero or in early childhood, poor coping skills, antisocial behaviour, alienation and rebelliousness, and a low level of refusal skills or poor impulse control (George et al., 2002; Catalano & Hawkins, 1996; Oxford, Harachi, Catalano, & Abbott, 2000; Manger, Hawkins, Haggerty, & Catalano, 1992; Guo, Collins, Hill, & Hawkins, 2001; Pollard et al., 1999; Hawkins et al., 1992; Svensson, 2000). Similar results have been reported within the research that looks specifically at VSA among youth. For example, Oetting and Webb (as cited in Mosher et al., 2004) associate high levels of psychopathy, emotional distress, and personal adjustment problems with VSA. Other authors have linked low self-esteem and self-worth, increased thoughts of suicide,

high stress, aggression and delinquency (Coleman, Charles, & Collins, 2001; Bennett, Walters, Miller, & Woodall, 2000; Mackesy-Amiti & Fendrich, 2000; Howard, Walker, Walker, Cottler, & Compton, 1999; Kurtzman et al., 2001; Marelich, 1997). For instance, Howard et al. (1999) found in their study of 224 Native American youth that volatile solvent users had a significantly lower perceived self-worth and a greater propensity to express aggressive behaviour and delinquent conduct than non-users. Similarly, results from a study conducted with Aboriginal clients in Central Australia indicated that petrol sniffers exhibited feelings of worthlessness, being unwanted in their communities, poor self-esteem, and violent behaviour (White, 2004).

Although the literature does not confirm early onset of use of volatile solvents as a risk factor, it is frequently reported that they are among the first drug of choice by youth (Basu et al., 2004; World Youth Report, 2003). An additional risk factor that has been documented in youth VSA research is gender. Although recent studies report decreasing differences in rates of VSA among males and females, when differences do exist, higher rates are more frequent among males (Corbett, Akhtar, Currie, & Currie, 2004; White, 2004; Adalf & Paglia, 2003; Dell & Garabedian, 2003; Van Til & Poulin, 2002; Hibell et al., 2004). This has been supported in some of the research that looks exclusively at Aboriginal youth, where rates of use in Aboriginal communities are higher for males (Coleman et al., 2001). Studies also suggest that sustained and chronic use is more common among males (Wille & Lambert, 2004; National Institute on Drug Abuse, site last visited 2006).

b) *The Family Domain*

The family domain is recognized as one of the strongest sources of risk and protection for children and young adolescents (Halaevalu & Vakalahi, 2001). Some of the documented family risk factors for youth substance abuse include poor and inconsistent family management practices, poor parenting skills (e.g., lack of rules and discipline), lack of family cohesion, heightened family stress, parent and sibling substance use/abuse, family history of alcoholism or drug use, family history of crime, domestic violence, history of physical or sexual abuse, low family bonding, parent and sibling attitudes favourable towards alcohol and drugs, parent level of education, high levels of family conflict, economic deprivation (e.g., poor housing) and characteristics such as race and ethnicity (George et al., 2002; Catalano & Hawkins, 1996; Kilpatrick, Acierno, Saunders, Resnick, & Best, 2000; Oxford et al., 2000; Manger et al., 1992; Guo et al., 2001; Brook et al., 1998; Pollard et al., 1999; Hawkins et al., 1992; Svensson, 2000).¹⁶ A number of these risk factors have also shown to present significant risk for VSA among youth. For example, Coleman, Charles and Collins (2001) found that of the 78 Aboriginal Canadian youth who participated in their study, a large proportion of them came from backgrounds marked by family violence, poverty, and substance abuse. Likewise, Fendrich, Mackesy-Amiti, Wislar and Goldstein (1997) observed that heavy volatile solvent use was associated with disrupted parent-child relationships, in particular, physical and/or sexual abuse.

¹⁶ It is important to note that race or ethnicity may not be the risk factor itself but a precursor to risk for discrimination, racism and inequality, which have the potential to lead to stresses that can be linked to substance abuse among youth (Halaevalu & Vakalahi, 2001).

These are not the only studies that suggest that young people who come from dysfunctional and chaotic family backgrounds are at greater risk for VSA. Research indicates that family violence and aggression, neglect, family history of substance abuse, VSA by other family members (especially older siblings), and lack of cohesiveness and strength are all considerable risk factors for VSA (Wu et al., 2004; Simpson, 1997; Kikuchi & Wada, 2003; Mosher et al., 2004; Mackesy-Amiti & Fendrich, 2000; Wille & Lambert, 2004; Howard & Jenson, 1999; Kurtzman et al., 2001). Additionally, studies have demonstrated that economic deprivation and its consequences put individuals at greater risk for VSA (Wille & Lambert, 2004; Kurtzman et al., 2001; Dinwiddie, 1994; Marelich, 1997). For example, Howard and colleagues (1999) found that of the Native American youth who participated in their study, those who used volatile solvents were part of a significantly lower income family than those who did not. This suggests that youth of a lower socio-economic status are at higher risk of becoming involved with volatile solvents (Howard et al., 1999). An additional noteworthy point found within the literature is that several authors refer to ethnicity/race as a risk factor for VSA (Bellhouse, Johnston, & Fuller, 2000; Marelich, 1997; Mosher et al., 2004). For example, Mosher et al.'s (2004) findings suggest that ethnicity/race is a strong predictor of lifetime prevalence of volatile solvent use, with Native American youth being particularly likely to use volatile solvents. This point needs further clarification, in that there is nothing innate in any particular racial or ethnic population that would predetermine or influence their choice to abuse volatile solvents. However, cultural deprivation, social isolation,

inequality and discrimination associated with ethnicity/race can all contribute to an increased likelihood of VSA (Bellhouse et al., 2000).

c) *The Peer Domain*

Peer groups have also been shown to affect adolescent substance abuse. Peer risk factors that have been identified within the literature include association with other youth who engage in deviant or delinquent behaviours (e.g., drug and alcohol use), friends with attitudes and behaviours supportive of substance use, and peer rejection (George et al., 2002; Catalano & Hawkins, 1996; Manger et al., 1992; Guo et al., 2001; Pollard et al., 1999; Hawkins et al., 1992; Svensson, 2000). Similarly, studies that look specifically at VSA report that a youth's proximity to volatile solvent abusers and deviant peer networks can contribute to their likelihood of abusing volatile solvents (Beauvais et al., 2002; Kikuchi & Wada, 2003). In addition, multiple studies have indicated that peer influence and peer pressure increase the risk for VSA (Coleman et al., 2001; Kikuchi et al., 2003; McGarvey & Clavet, 1999; Zabedah, Razak, Zakiah, & Zuraidah, 2001). For example, Kikuchi and Wada (2003) found that within a sample of junior high school students in their study, peer pressure and relations with volatile solvent users were both correlates of VSA. Furthermore, White (2004) found within his sample of Aboriginal clients in Australia those who were petrol sniffers also had a greater tendency to follow others.

d) *The School Domain*

Predictors of adolescent substance abuse have also been identified within the school domain. In the school setting, low levels of commitment to school, academic failure, truancy, lenient school policies, and social norms favourable toward substance use

have all shown to increase the risk of adolescent substance abuse (George et al., 2002; Guo et al., 2001; Pollard et al., 1999). Findings are similar within the literature that looks specifically at VSA among youth. The use of volatile solvents has been associated with poor academic performance, high rates of absenteeism, suspension/expulsion, school dropout, learning difficulties, and declining interests in school activities (Bennett et al., 2000; Mosher et al., 2004; Basu et al., 2004; Ballard, 1998; Maruff, Burns, Tyler, Currie, & Currie, 1998; Carroll et al., 1998; Shu & Tsai, 2003). For example, Oetting and Webb (as cited in Mosher et al., 2004) point out that the problem of VSA is associated with troubles in school such as truancy, suspension, and academic failure. Additionally, Simpson (1997) found in his study that low levels of education were a predictor of heavier volatile solvent use.

e) The Community Domain

Community variables also influence the level of risk for youth substance abuse. In general, community factors that put youth at greater risk for substance abuse include disorganization, transition, laws and norms that are favourable towards substance use, easy availability and accessibility of substances, and extreme poverty or economic deprivation (George et al., 2002; Catalano & Hawkins, 1996; Manger et al., 1992; Guo et al., 2001; Pollard et al., 1999). Socio-economic status was touched on in the above discussion of the family life domain; however, it is also important to include it among the community risk factors. There are a number of factors that can affect the economic status of a community. The labour market, for example, may present community members with greater challenges (e.g., where job demand outweighs job opportunity). Economically disadvantaged groups were also found to be at greater

risk for VSA (Coleman et al., 2001; Wu et al., 2004; Wille & Lambert, 2004; Ho et al., 1998; Howard et al., 1999; Kurtzman et al., 2001; Taggart 2003). For example, Tapia-Conyer, Cravioto, De La Rosa, and Velez (1995) found that among the youth who participated in their study, lower socio-economic level and labour status were two of the principal risk factors associated with VSA.

Geography is a further community risk factor that is highlighted within the VSA literature. In particular, geographic isolation has been identified as a variable that may contribute to the likelihood of a youth abusing volatile solvents (Coleman et al., 2001; Wu et al., 2004; Spiller; 2004; Cairney, Maruff, Burns, & Currie, 2002; Howard et al., 1999; Taggart; 2003). For example, Spiller (2004) found that rural populations, when compared to urban areas, were more susceptible to VSA.

Similarly, Coleman et al. (2001) report that volatile solvent use is higher in many First Nations and Inuit communities, due in part to their remote and isolated locations. In addition to geographic isolation, social isolation has been presented as a risk factor for youth VSA (Cairney et al., 2002). Cairney, Maruff, Burns and Currie (2002) point out that communities comprised of ethnic minorities may suffer from social isolation. For example, many First Nations and Inuit communities in Canada are isolated geographically, but they are also socially isolated in that they must struggle to maintain their own traditional culture and identity among the mainstream culture of North America (Cairney et al., 2002; Kirmayer et al., 2003).

V. Identifying Protective Factors

The life domains discussed above are able to generate both risk and protective variables (Halaevalu & Vakalahi, 2001). Protective factors are those life events,

relationships, characteristics, and experiences that mitigate or moderate the effects of risk exposure, helping to prevent negative outcomes (e.g., substance abuse) and contribute to positive development (George et al., 2002; SAMHSA, 2002; Brook et al., 1998; Pollard et al., 1999; Hawkins et al., 1992). Protective factors, like risk factors, should be viewed as a web of interrelated variables, with some having greater influence than others (George et al., 2002). The literature surrounding protection is not as abundant as that investigating risk. As a result, protective factors are not identified as clearly as risk factors, though they generally fall within two main categories: 1) those that are inherent or individual and 2) those that are made available through relationships and social bonding with others and their environment. Some examples of individual characteristics that may act as protection against substance abuse during adolescent development include positive temperament or disposition, high level of refusal skills, secure identity, and/or strong coping skills (Guo et al., 2001; Brook et al., 1998; Hawkins et al., 1992). External factors such as adult monitoring and supervision, appropriate discipline, positive relationships, strong bonding to family and/or other pro-social models, strong familial and external value systems, and positive social support also serve as a form of protection against youth substance abuse (Halaevalu & Vakalahi, 2001; Guo et al., 2001; Coie et al., 1993; Hawkins et al., 1992).

It is important to point out that risk and protection are not simply opposing ends of one spectrum. They are distinct concepts belonging to a larger construct of adolescent vulnerability (DeWit et al., 1995; Catalano & Hawkins, 1996). As Dewitt, Silverman, Goodstadt, and Stoduto (1995) maintain, the absence of risk is not

necessarily the same as protection. Also, having protection does not inevitably eliminate risk. However, protective contributions may serve to reduce the impact or influence of risk variables (Manger et al., 1992; Coie et al., 1993; Brook et al., 1998; Pollard et al., 1999; Hawkins et al., 1992). For example, a youth who has positive relationships and bonds within their school environment (e.g., play on a school sport team, an honour role student) may be less influenced by peer pressure and deviant peer activities, because the protection the school environment offers increases the youth's perception of the personal cost associated with substance abuse (e.g., kicked off sport team, lower grade achievement) (Pollard et al., 1999). To summarize, protective factors in environments where risks are present, interact with the risk factors to weaken their effects (Manger et al., 1992; Coie et al., 1993; Brook et al., 1998; Pollard et al., 1999). Stated another way, protective factors reduce the vulnerability of the youth, and in turn enhance their resiliency (Wolin & Wolin, 1995; Hawkins et al., 1992).

Resiliency is another concept that is in need of discussion in this thesis.

Resiliency, defined by Henderson and Milstein,

Is the capacity to spring back, rebound, successfully adapt in the face of adversity, and develop social, academic, and vocational competence despite exposure to severe stress or simply to the stress inherent in today's world. (in Lewis, 1999: 201)

The key feature of resiliency is having the ability to cope, which can develop both through individual characteristics and external supports (George et al., 2002; Wolin & Wolin, 1993; Dell, Hopkins, & Dell, 2005).¹⁷ Youth who are resilient are capable of managing troublesome situations and environments because they carry a strong sense

¹⁷ The definition and features of resiliency that are presented here are compatible with the holistic conception of resiliency that the *Nimkee NupiGawagan Healing Centre* promotes (Dell et al., 2005).

of self-efficacy (George, et al., 2002; Hawkins et al., 1992). And, it is the protective variables in the lives of youth that enhance their ability to form resilient responses (Hawkins et al., 1992).

Research in the area of resilience provides evidence to one of the key points made previously, namely that not all youth who live in high-risk environments will inevitably succumb to substance abuse or problem behaviour (George et al., 2002; Wolin & Wolin, 1993; Wolin & Wolin, 1995; Hawkins et al., 1992; Catalano & Hawkins, 1996; DeWit et al., 1995; Dell et al., 2005). Studies surrounding resilience and protection provide more promise than earlier studies that looked solely at risk. Risk focused studies identify the deficits in the lives of youth while research that takes protection into consideration goes one step further, demonstrating that there is more than one avenue to avoiding problem behaviour. More specifically, by examining variables that make positive contributions to youths' lives, research has been able to present protection/resiliency enhancement as an alternative or in addition to simply reducing risk.

This shift in research has also led to a large debate within the literature over appropriate intervention and prevention strategies. In particular, there is discussion over whether strategies should take a protection approach (enhance protection) or a risk approach (reduce risk). Some authors have suggested that strategies that aim exclusively to increase protection and resilience will lead to more positive outcomes than those that focus only on trying to reduce risk (Pollard et al., 1999). In the past, researchers have provided valid rationale for taking this approach. For instance, Coie and colleagues (1993) proposed that this type of approach is ideal for situations where

risk factors are difficult to identify ahead of time (e.g., family violence) or to remove altogether (e.g., extreme economic deprivation). As a further example, Wolin and Wolin (1995) argue against a risk approach, suggesting that using an 'at risk' label, like other negative labels, may lead to feelings of powerlessness and defeat, making the label itself a risk factor. On the other hand, some have argued that a protection approach is too narrow and individualistic, in turn ignoring some important social and contextual factors (Pollard et al., 1999).

Current studies demonstrate that there is a need for both (Svensson, 2000; Pollard et al., 1999; Hawkins et al., 1992). For example, Pollard, Hawkins and Arthur (1999) found in their study that among youth exposed to high levels of risk, focusing attention only on strengthening assets without considering risk was an incomplete approach for reducing problem behaviour. Their data suggest that a strategy that is successful in both increasing protection and decreasing risk is more valuable than one that only considers building assets or protection (Pollard et al., 1999). It is for this reason that I have chosen not to eliminate the discussion of risk in my own research.

VI. Defining Social Support and Well-being

My goal is to investigate social support as a form of protection as well as to look at the risks that are present in the lives of youth who abuse volatile substances.

Protection as a general concept is too broad to cover in one study; therefore, I have narrowed the scope of the present study, looking exclusively at social support as a protective factor. Part of my rationale for focusing on social support is that it is a fluid concept, in that it can be made available in any or all of the life domains. Choosing to examine social support is not, however, without its difficulties. Social support is a

concept that is replete with definitional complexity. There is not one clear conception of social support in the literature and the issue becomes even more blurred when the research is focused on youth. Broadly speaking, social support is the resources provided and functions performed for an individual by others (Havassy et al., 1991; Thoits, 1995; Wilcox & Vernberg, 1985; Thoits, 1985). Social support however, is considered to be a multidimensional concept (Wilcox & Vernberg, 1985; Thoits, 1985). Thus, although this definition seems fairly straight forward, it requires further explanation. To begin, several authors have made a distinction between the structural and functional components of social support. Structural support refers to the extent to which social support resources are available (e.g., the number of ties or relationships a person has with others), while functional support is defined as the actual or perceived social support that an individual is able to receive (e.g., having a confidant or someone to turn to in times of need) (Dobkin et al., 2002; Thoits, 1995; Cohen, Mermelstein, Kamarck, & Hoberman, 1985).

The definition of social support is further complicated by the fact that it is a broad, umbrella construct, which has several forms or categories of support that fall underneath it. Most commonly, social support is divided into three types: emotional, instrumental, and informational (Bazemore & Erbe, 2003; Beattie & Longabaugh, 1999; Thoits, 1995; Wilcox & Vernberg, 1985; Thoits, 1985; Rook, 1985). Emotional support generally involves assertions of love, empathy, care, sympathy, and understanding, which help to reinforce an individual's sense of self (Beattie & Longabaugh, 1999; Thoits, 1995; Wilcox & Vernberg, 1985; Thoits, 1985; Rook, 1985). Instrumental support is monies, goods, and services that are aimed at helping

individuals to fulfill their everyday responsibilities (Beattie & Longabaugh, 1999; Wilcox & Vernberg, 1985; Thoits, 1985; Rook, 1985). Some examples of instrumental aid include services that assist individuals in finding employment, providing childcare, and/or household financing (Thoits, 1985). Informational support refers to personal feedback, advice, opinion, and guidance (Wilcox & Vernberg, 1985; Thoits, 1985; Rook, 185). The exchange of information and opportunities that are available such as job openings, academic courses, or medical assistance are all examples of informational aid (Thoits, 1985). Though each form of social support is unique, there is a common thread that ties them together. That is, all forms of social support provide the individual with the opportunity to be part of a network of communication and mutual obligation (Maholtra, Dhawan, & Prakash, 2002; Beattie & Longabaugh, 1999; Wilcox & Vernberg, 1985). This gives individuals a sense that they are valued and important, which in turn, enhances their self-esteem and feelings of group belonging (Maholtra et al., 2002; Beattie & Longabaugh, 1999; Wilcox & Vernberg, 1985).

The task of defining social support becomes even more difficult because a number of studies have found that not all sources of social support are equally effective for a given problem (Wilcox & Vernberg, 1985). Also, definitions of social support can vary based on the context in which they are being described. For instance, if there is an explicit problem in a person's life (e.g., substance abuse) social support may be described in problem-specific terms (e.g., Alcoholics Anonymous). Additionally, my research is concerned with a very specific population, First Nations and Inuit youth who have attended treatment for volatile solvent abuse (VSA), which

could potentially influence the way social support is perceived. Thus, although I have accounted for the academic literature here, I have taken a grounded theory approach with my data collection and analysis. I allowed the definition to emerge from the data, identifying what aspects of social support were meaningful in the specific situation. I inquired about what social support was offered while the youth were in treatment, what forms of social support the treatment providers believe would best meet the needs of the youth after treatment, what the treatment providers perceived as social support, as well as how the youth relayed their experiences once they re-entered their communities (e.g., what social support they were receiving and what they needed).

Outside of the risk and protection literature there are a number of studies that investigate the benefits of social support in the lives of individuals who have undergone treatment for substance abuse. Although not youth specific, the findings of these studies suggest that positive social support may help former substance abusers maintain their treatment success and sobriety (Dobkin et al., 2002; Havassy et al., 1991; Lemeux, 2002; Galanter & Brook, 2001). Some authors go one step further, suggesting that social support works to protect the individual from negative influences and stresses (Lemeux, 2002; Wilcox & Vernberg, 1985; Thoits 1985). Although the terminology differs from that used in the risk and protection research, it is clear that they share similar findings and perspectives.

One last concept that is in need of clarification is success. Many of the studies that examine social support post-treatment use sobriety or abstinence as a measure of success (e.g., Dobkin et al., 2002; Galanter & Brook, 2001). I however, have chosen to look at 'success' in broader terms. The concept that I have used is well-being. This

term has been employed because it encompasses a range of success indicators, including education, employment, mental functioning, drug/alcohol/solvent use, spiritual connectivity, social functioning, legal issues, living situations, physical functioning, and HIV risk behaviour (Youth Solvent Addiction Committee, 2001).¹⁸ It is important to recognize all achievements, large or small, particularly in instances when youth come from high-risk environments. Using a broad definition allows youth to be proud of their progress, which makes change not such a daunting task. Change is often a process that occurs over time. Looking at it from this perspective allows the youth to see the success in each step that they take.

To review, the problem of VSA cannot be simplified to the problem of the user; it is just as important to consider the social context and environment of the youth who abuse volatile solvents (Broome, Simpson, & Joe, 2002; Simpson, 1997; Vuchinich & Tucker, 1988). Risk and protection research has helped to explain VSA by identifying factors that both increase and decrease the likelihood of youth abusing such substances. Although research examining youth VSA and post-treatment well-being is not abundant, I have been able to turn to other, more general bodies of research for information and direction. In this chapter I have pointed out the association between risk, protection, and substance abuse. In the following chapter I describe primary socialization theory, which aims to address why this association exists.

¹⁸ In addition, this how the *Nimkee NupiGawagan Healing Centre* defines well-being.

CHAPTER THREE: THEORIZING ADOLESCENT SUBSTANCE ABUSE

Numerous theories have been put forward over the past few decades that aim to better understand the issue of adolescent substance abuse. Many of these theories attempt to identify the relationship between risk, protection, substance abuse, and adolescence. For example, family systems theory advocates that the interactions between family members are among the most powerful influences in an adolescent's life and have the ability to strengthen or weaken the negative influences from other systems, such as peers, school, and community (Halaevalu & Vakalahi, 2001). Alternatively, social development theory hypothesizes that children and adolescents learn and follow patterns of behaviour from the family, school, community, and peers. Within this model, there is an emphasis on the role of pro-social influences within the socializing units, which act as protection against the development of delinquent behaviours (Catalano & Hawkins, 1996; Guo, et al., 2001; Hawkins et al., 1992).

Though various theories attempt to explain youth substance abuse primary socialization theory is best suited to my research question because it presents a model that attempts to explain the impact of various environmental characteristics that link volatile solvent abuse (VSA) with First Nations and Inuit youth. Primary socialization theory proposes that there are three primary sources for learning social norms: the family, the school, and peer clusters (Oetting & Donnermeyer, 1998). It proposes that both pro-social and deviant behaviours can be learned within these socialization sources; healthy families and school environments are identified as more likely to transmit pro-social norms, while deviant norms are usually generated within peer clusters (Oetting & Donnermeyer, 1998). Using this encompassing model will be

useful in the analysis of this project given that there is a dearth of previous research to draw upon regarding risk, protection, VSA, and adolescence.

The risk and protective factors framework is fairly contemporary; as such, so are the theoretical models that guide it. Grounded in more traditional theories, primary socialization theory offers a foundation to work from and build on when attempting to understand the relationship between risk, protection, substance abuse, and adolescence. Formulated by Eugene Oetting and colleagues, primary socialization theory describes a threefold socialization process involving the family, school, and peer networks. It attempts to explain the influence that these socialization sources have on adolescence (Oetting & Donnermeyer, 1998). In particular, the theory specifies how some personal, social, cultural, and community characteristics (identified as risk and protective factors) operate to increase or decrease the amount of deviant behaviour among adolescents (Oetting & Donnermeyer, 1998). Broadly speaking, the theory postulates that bonds between youth and the primary socialization sources (family, school, peers) serve as the basis for communication of either pro-social or deviant norms (Oetting & Donnermeyer, 1998). Because primary socialization theory is a large-scale theory, which attempts to link diverse research and traditional models into one source, there are several components that need to be addressed (Oetting, 1999; Whitback, 1999).

In this chapter I elaborate on primary socialization theory's guiding principles. I first consider the general assumptions of the theory. This includes further discussion of the primary socialization sources as well as examples that can be linked to the risk and protective factor research. Following this, I provide my reason for using primary

socialization theory in guiding my own research. I then consider secondary socialization sources and the influence that they have on the primary socialization process. In addition, I discuss culture and its role within the theoretical model. Finally, I discuss the practical implications that the theory holds. Throughout the chapter, I address the limitations of primary socialization theory, in a broad sense as well as within the specific context of my own research. Examples to help clarify the theory are also provided throughout.

I. Exploring Primary Socialization Theory

As mentioned above, Oetting and colleagues maintain that there are three primary socialization sources during adolescence¹⁹ within western culture: the family, the school, and peer clusters (Oetting & Donnermeyer, 1998). These sources influence social attitudes, beliefs, values, and behaviours (Oetting & Donnermeyer, 1998). More specifically, it is through these sources that social behaviours, both pro-social and deviant, are learned (Oetting & Donnermeyer, 1998). Primary socialization theory is a broad theory that encompasses many diverse assumptions, though it is based upon five propositions. They are as follows: 1) the strength of the bonds between the youth and the primary socialization sources are key to how well norms are transmitted, 2) any socialization source can transmit deviant norms, though healthy school and family environments are more likely to transmit pro-social norms, 3) peers are able to transmit both pro-social and deviant norms, but are more often the source of deviant norms, 4) weak bonds with family and school environments

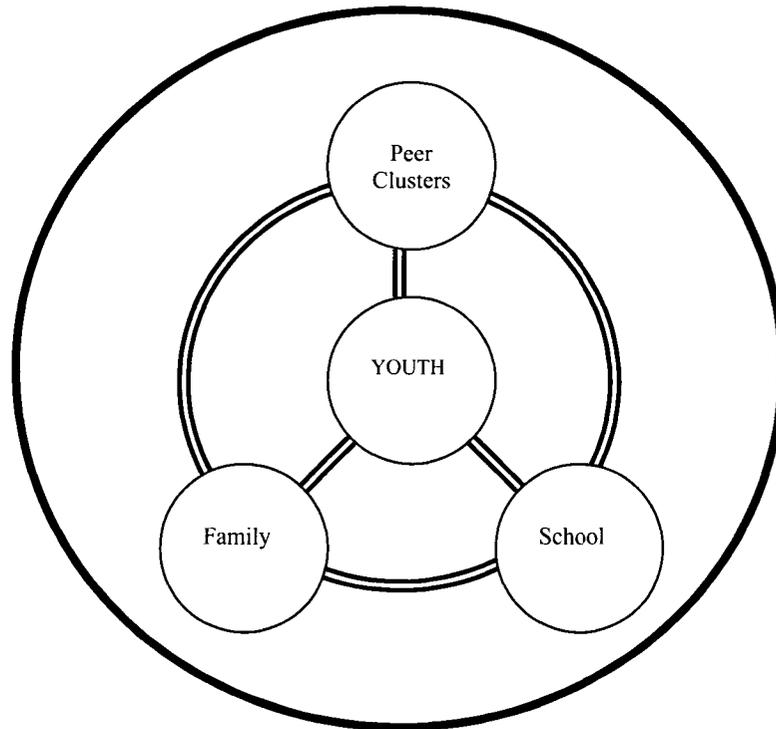
¹⁹ The model refers only to the period of development referred to as adolescence. Primary socialization theory is an active, dynamic process that continuously changes over a lifetime (Oetting, 1999).

increase the chance a youth will bond with deviant peers, and 5) weak peer bonds can also lead to bonding with negative peers (Oetting & Donnermeyer, 1998: 995).

As these propositions point out, primary socialization theory coincides with the results found in much of the risk and protection literature. For example, numerous authors have found that positive relationships, strong bonding to family and other pro-social models, and positive social support all serve as a form of protection against youth substance abuse (Halaevalu & Vakahali, 2001; Guo et al., 2001; Coie et al., 1993; Hawkins et al., 1992). Furthermore, it has been suggested that peers do in fact have an influence on adolescent substance abuse, with factors such as association with other youth who engage in delinquent behaviours, friends with attitudes and behaviours supportive of substance abuse, and peer rejection all identified as risk factors (George et al., 2002; Catalano & Hawkins, 1996; Manger et al., 1992; Guo et al., 2001; Pollard et al., 1999; Hawkins et al., 1992; Svensson, 2000). More importantly, primary socialization theory offers a way in which to explain and predict these as well as other research findings (they are the result of the bonds that are formed between youth and primary socialization sources). Oetting and colleagues use a diagram to illustrate the influence of primary socialization sources during adolescence:

Diagram 1.0

PRIMARY SOCIALIZATION DURING ADOLESCENCE



Source: Oetting, E.R. & Donnermeyer, J.F. (1998). Primary socialization theory: The etiology of drug use and deviance (I). *Substance Use and Misuse* 33(4): 995-1026.

A key feature of their model is that it demonstrates how the socialization sources influence youth both independently and interactively (Oetting & Donnermeyer, 1998). It shows direct relationships from the primary socialization sources to the youth, as well as relationships amongst the sources themselves. For example, if a youth's peer group has a negative attitude towards spending time with their families, it will be difficult for the youth him/herself to maintain a positive outlook on family get-togethers and experiences.

Primary socialization theory is used in this research for two reasons. First, the model focuses on what is one of the strongest influences during adolescent development - peers (Oetting & Donnermeyer, 1998). More specifically, the theory argues that the most influential risk factors are those that prevent bonding with positive influences and the communication of pro-social norms, and that these risk factors are most commonly linked to peers during adolescence (Oetting, 1999). The idea that peers or associational groups play a significant role in the development of social behaviours is supported in earlier research and literature (e.g., Sutherland's differential association theory), yet Oetting and colleagues offer an innovative and insightful twist with their theory of primary socialization (Oxford et al., 2000; Schmallegger & Volk, 2005; Oetting & Donnermeyer, 1998).

The second reason that I applied primary socialization theory to this study is because although the theory focuses on society and socialization, it does not ignore the role or influence that personal characteristics and/or personality have on the choices youth make. The theory does not view the youth as passive subjects or recipients of ideas, values, attitudes, and norms, but rather as active participants in the bonding and transmission of social behaviours (Oetting, Deffenbacher, & Donnermeyer, 1998a). Their approach to understanding how individual characteristics influence behaviour is unique. According to Oetting et al., personal traits have an interactive relationship with the primary socialization process (Oetting & Donnermeyer, 1998). In particular, socialization can alter the expression of personal traits and qualities and personal characteristics can alter the outcome of socialization (Oetting et al., 1998a). They also maintain that individual characteristics

do not directly lead to drug use (Oetting & Donnermeyer, 1998). A person is not seen to have an internal mechanism that craves drugs; instead personal characteristics (physical, emotional, and social) lead an individual to interact with others who share similar characteristics (Oetting & Donnermeyer, 1998; Oetting et al., 1998a). Thus, the personality trait is itself a risk factor for substance abuse in that it increases the likelihood that a youth will be involved with other youth who encourage certain types of behaviour (Oetting et al., 1998a). It is important to note however, that such characteristics do not inevitably lead to substance abuse. As was discussed above, socialization influences the expression of personality traits (Oetting et al., 1998a). For instance, youth who identify themselves as risk seekers or adventurous, may choose to participate in extreme sports, such as off road mountain biking or rock climbing. Though the possibility is also there that they will chose friends who use substances and will in turn use substances themselves as their form of risk-taking behaviour. Again, it is dependent on the socialization influences and their sources (Oetting et al., 1998a).²⁰

Similar to individual characteristics, aspects of the broader environment, such as the community, influence youths' choices indirectly, through their effect on the primary socialization process (Oetting, Donnermeyer, & Deffenbacher, 1998b). As such, Oetting and colleagues refer to the community as a secondary socialization source (Oetting et al., 1998b). Community characteristics can influence the primary socialization process in three ways: 1) they can increase or decrease the opportunity

²⁰ This argument is aligned with the critical theory perspective, which recognizes agency. Individuals are constituted through the dominant ideologies that are supported by social, political, cultural, economic, ethnic, class and gender structures, though subjects are not powerless. Individuals can in part determine their own existence (Kinchloe & MacLaren, 1998 p.262).

for primary socialization to occur, 2) they can strengthen or weaken the bonding between the individual and the primary socialization sources, and/or 3) they can influence the norms that are transmitted through the primary socialization sources (Oetting et al., 1998b: 1632). The economic and social characteristics of a community frame the social attitudes and behaviours that are expressed by community members (Oetting et al., 1998b). For example, communities that provide opportunity for employment, recreation, and transportation will encourage positive social attitudes and behaviours, whereas communities that are isolated and have little or no job opportunity and/or recreational activity may endorse feelings of boredom and defeat. Similarly, the physical environment of a community is able to send messages about community norms (Oetting et al., 1998b). For instance, a neighbourhood that has clean, well-lit streets and parks sends messages of conformance, in turn increasing the bonds with pro-social primary socialization sources. Conversely, a neighbourhood with vacant homes and ill maintained yards sends messages that encourage unstructured activity, which results in increased bonds with antisocial primary socialization sources (Oetting et al., 1998b). This is evidenced in the risk and protection literature, which suggests that poor economic and social conditions within a community are risk factors for deviant behaviours such as substance abuse (Wille & Lambert, 2004; Kurtzman et al., 2001; Dinwiddie, 1994). To summarize, primary socialization theory views community characteristics as either risk or protective factors depending on how they affect bonding with the primary socialization sources and the communication of either pro-social or deviant norms (Oetting et al., 1998b).

II. Critiquing Primary Socialization Theory

Adding to this discussion, it is important, especially to my research, to address the role of ethnicity within the community context. Youth who attend the *Nimkee NupiGawagan Healing Centre* come mainly from communities comprised of First Nations and Inuit peoples, and it is therefore, important to discuss any implications this may have on the primary socialization process. Oetting and colleagues maintain that communities that are comprised mainly of an ethnic minority group can be beneficial or detrimental to its members (Oetting et al., 1998b). They propose that the effect of having an ethnic community can be positive if the members retain a strong ethnic identity and maintain a social environment that encourages and supports ethnic identification and the communication of cultural norms (Oetting et al., 1998b). On the other hand, if there are high levels of prejudice and discrimination against the group from surrounding populations there may be feelings of separation and isolation, which can have a negative effect (Oetting et al., 1998b). To summarize, ethnic identity does have an effect on the primary socialization process, though it is dependent on whether the characteristics of the community promote or discourage bonding with pro-social primary socialization sources (Oetting et al. 1998b). Most important to mention, is that environments comprised of an ethnic minority group are not necessarily negative. As Oetting et al. put it, they are,

Instead, a rich and complex mixture of family dysfunction and family support, of the breakdown of values and of strong traditions, of both antisocial and pro-social attitudes and beliefs...it is how the pro-social and deviant socialization sources converge that determines the development of deviance in any given youngster. (Oetting et al., 1998b: 1635)

On this note, it is necessary to point out what I understand as a potential flaw with primary socialization theory. The assumptions of the theory focus on the

'average' North American youth. This is problematic, as the theory does not consider some of the more devastating circumstances that disadvantaged youth must endure (Anderson-Garcia, 1999). For instance, many First Nations and Inuit youth in Canada are affected by racism, poverty, loss of culture and tradition, and isolation. In many cases, these social conditions and environments may deny youth access to bonding with pro-social primary socialization sources (Anderson-Garcia, 1999). Moreover, the theory argues that youth can succeed even in circumstances where forces are acting against them *if* they maintain a bond with a pro-social primary socialization source (Oetting et al., 1998b). However, Oetting et al. do not elaborate on what the potential outcome is for youth if they do not have pro-social primary socialization sources available to them (Anderson-Garcia, 1999). Take for example, a child raised in foster care, or a youth who attends a school where there is little or no expectation for their success (Anderson-Garcia, 1999). Oetting et al. do not adequately address whether youth who do not have access to pro-social primary socialization sources can still succeed. I suggest that there are other potential ways of creating and learning positive norms if the primary socialization sources are not available to youth, though this is a point that needs further investigation and clarification within the theory. My expectation that youth can succeed stems from the literature on resiliency, which clearly acknowledges that not all youth who come from high-risk environments will inevitably succumb to a life of deviance (George et al., 2002; Wolin & Wolin, 1993; Wolin & Wolin, 1995; Hawkins et al., 1992; Catalano & Hawkins, 1996; DeWit et al., 1995). This is explained through my own findings, and raised again as a concern in my concluding chapter.

A further socialization source that Oetting and colleagues deem secondary is extended family (Oetting et al., 1998b). This may be true for most westernized families, however it is not necessarily the case for First Nations and Inuit peoples, where extended family holds a different function. In First Nations and Inuit communities, older aunts and uncles are often expected to act as primary role models and messengers of cultural norms (Nabigon, 2006). As noted above, the primary socialization model provided by Oetting et al. is based on youth who live in western culture. This needs to be kept in mind and addressed as a limitation in my own analysis. Further to Oetting et al.'s discussion of family, they argue that siblings can act both as family and peer influence (Oetting et al., 1998b). Evidence in support of this lies in the fact that sibling substance use is considered a risk factor for youth substance abuse (Kilpatrick et al., 2000; Svensson, 2000). For example, older siblings who experiment with substances may encourage their younger siblings to do the same, creating an environment similar to peer groups, where pressure to use is combined with feelings of belonging and acceptance.

Government institutions are another secondary socialization source described within the model. Government institutions, such as the judicial system, health services, and unemployment services can have both positive and negative effects on individuals who use them (Oetting, 1999). More important to discuss is the potential that they have to cause damage to those who are most disadvantaged in our society (Oetting, 1999). Oetting provides an example of how a service such as welfare has the possibility of supporting or damaging the primary socialization process. He describes welfare as a service that is able to provide transitional support and aid, though there is

also the possibility of it embarrassing, humiliating, and reducing family pride and independence, which could potentially influence family bonding and the transmission of pro-social norms (Oetting, 1999:965-966). Other government institutions and policies, such as the *Indian Act*, have also had a devastating impact on Aboriginal peoples in Canada.

These examples demonstrate how secondary socialization sources are influential through their effect on the primary socialization process. They also outline the interconnectedness between socialization sources, both primary and secondary. To further explain, the need for unemployment services is most often tied to the lack of job opportunity in the community. Both the government service (welfare) and the community characteristic (lack of job opportunity) have been identified as risk factors. The interactive relationship between the socialization sources can have a detrimental and cumulative affect on those who are faced with struggles. There are a number of negative factors present in many First Nations and Inuit communities, some of which include poverty, racism and discrimination, loss of language and culture, lack of community resources, and isolation. The culmination of these factors can be extensively damaging to these individuals and their communities.

In discussing the limits of primary socialization theory it is also important to consider where the concept of well-being fits. The theory argues that pro-social bonds, resulting from the protective characteristics (e.g., social support) of a youth's social environment, increase the opportunity for positive outcomes (behaviours, attitudes, values, and norms) in youth. What is meant by positive outcome however is not elaborated on by Oetting and his colleagues. Given the vagueness of this concept,

I will not argue that the term positive outcome is synonymous with well-being, though I suggest that the positive outcomes that result from pro-social bonding can increase a youth's well-being. This relationship is considered further in my own analysis and discussion.

III. Culture and the Primary Socialization Process

Aside from the socialization sources, there is a need to discuss the role of culture in the primary socialization process. According to Oetting and his contemporaries, there is an interactive relationship between the primary socialization sources and culture (Oetting, Donnermeyer, Trimble, & Beauvais, 1998c). That is, each has the ability to influence the other (Oetting et al., 1998c). The communication and transmission of culture occurs through the primary socialization process, but the primary socialization process is embedded in the culture, so culture determines the norms that are being conveyed through primary socialization, as well as whether attitudes or behaviours are deemed pro-social or deviant within that culture (Oetting et al., 1998c). Further to this point, culture determines who communicates social norms. Stated another way, culture determines the primary socialization sources (Oetting et al., 1998c).

Moreover, culture plays an important role in the primary socialization process and in the outcome of individual attitudes and behaviours.

Primary socialization theory fits well within a critical theory paradigm.

Critical theory describes social reality as being produced through the discourses and power relations that are shaped by social, cultural, and historical contexts (Kinchloe & MacLaren, 1998). These discourses and power relations can be observed in numerous institutions and structures, including but not limited to social, political,

cultural, and economic realms, as well as ethnicity, class, and gender (Kinchloe & MacLaren, 1998; Guba & Lincoln, 1998). The relationship between critical theory and the primary socialization process is illustrated here with an example. Consider the western school system within First Nations and Inuit communities. Traditional First Nations and Inuit culture did not involve the school as a primary socialization source (Oetting et al., 1998c). However, through historical change, in particular the encroachment of the dominant western culture on Aboriginal peoples' traditional culture, their primary socialization sources were altered (Oetting et al., 1998c). Oetting et al. recognize that dominant culture and ideology are able to affect the primary socialization process for those outside of that culture, however, I think that the theory should more closely consider what the outcome or effect of this may be on those who are subject to change. Returning to a previous example, the residential school system that was implemented through federal government policy marginalized Canada's Aboriginal peoples and contributed to racism and discrimination, as well as the loss of languages, cultures, identities, and lands.

Further to this discussion is the role of cultural identification, which according to Oetting and colleagues plays an important role as a protective factor (Oetting et al., 1998c). Cultural identification refers to the degree to which a person feels involved and invested in a particular culture (Oetting et al., 1998c). The strength of a person's cultural identification is primarily learned and determined through the primary socialization process (Oetting et al., 1998c). Cultural identification is viewed as a protective factor mainly because it offers individuals feelings of success and belonging (Oetting et al., 1998c). Conversely, those who are not strongly connected

to their culture do not have the influence and reward that culture may provide, which may lead to them turning elsewhere to meet their needs (e.g., negative peer groups) (Oetting et al., 1998c). This however is not to say that those with high cultural identification are safe from substance abuse, or vice versa, that those who use substances will not have high cultural identification (Oetting et al., 1998c). In fact, individuals can be influenced by more than one primary socialization source at any given time (Oetting et al., 1998c). This point is similar to that described in the risk and protection literature, which describes the risk and protective factors as belonging to a web of influence (George et al., 2002). Oetting et al. refer to this as a dual influence effect (Oetting et al., 1998c). For instance, a family may provide a strong cultural connection for a youth, while a youth's peer group may promote substance use.

IV. Some Final Thoughts

Aside from simply describing the theory, it is important to consider the practical implications that it holds. This theory calls for treatment to move beyond the individual, considering the bonds between the individual and the developmentally appropriate primary socialization sources and the influence they have on the youth (Luekefield et al., 1999; Oetting, 1999). To be successful, treatment must also include changes in the primary socialization process (Oetting, 1999). The *Nimkee Nupigawagan Healing Centre* incorporates numerous program components that aim to influence the socialization sources. For instance, the centre's family therapy component assists in assessing the youths' primary socialization sources. In particular, the family therapy component involves bringing the client's family

members to the centre for group therapy and discussion. Other methods applied at the *Nimkee Nupigawagan Healing Centre* include improving school adjustment and success, offering work placements, altering the influence of deviant peer groups, and involving the youth in community and cultural activities (<http://www.nimkee.ca/>, 2006). Recognizing that youth need to re-establish their primary socialization sources after treatment is key to primary socialization theory's guiding principles. As Oetting states,

Unless treatment also alters the patterns of primary socialization, the client is likely to return to the socialization patterns that originally elicited and reinforced the deviant behaviour, and high rates of recidivism can be expected. (Oetting, 1999: 978)

To conclude, primary socialization theory offers a useful approach to explaining and understanding the issue of adolescent substance abuse and in the context of my research, youth volatile solvent abuse (VSA). To summarize, the theory argues that youth are embedded in a threefold socialization process that consists of the family, school, and peer groups, and that it is within these socialization sources that norms, beliefs, attitudes, and values are learned (Whitback, 1999; Oetting & Donnermeyer, 1998). In addition, personality traits and secondary socialization sources (e.g., neighbourhood characteristics, government institutions, extended family) may influence youth but only through their effect on the primary socialization process (Oetting & Donnermeyer, 1998; Oetting, 1999). As aforementioned, there are several theories that describe and explain deviant behaviour, though primary socialization theory is unique in that it attempts to link personal, social, environmental, and cultural influences (Oetting, 1999). Nevertheless, there are some limitations to this theory in the context of this research. Namely: 1) the assumptions

of the theory focus on the 'average' North American youth living in the dominant western culture and 2) the theory does not consider some of the more devastating circumstances that disadvantaged youth must endure (e.g., racism, isolation, poverty). Keeping in mind that there are some limitations, the theory holds valuable insight for interpreting and analyzing the findings of this research. Because primary socialization theory is a relatively new theory, it presents me with the opportunity to apply it to an Aboriginal context and to add my own voice. I identify areas for further investigation and theorizing in both my analysis and conclusion.

CHAPTER FOUR: METHODOLOGY

In order to address my research question I utilized qualitative interview techniques. More specifically, I conducted in-depth, semi-structured interviews with the treatment providers and staff of the *Nimkee NupiGawagan Healing Centre*. The majority of management staff have been with the centre since it opened in 1996; as such these individuals have substantial experience, as well as considerable insight to share on the topic of volatile solvent abuse (VSA) as related to my research focus. Due to the dearth of information regarding youth VSA and the role of social support following treatment, the interviews were exploratory in nature. In this chapter, I elaborate on the methods that I used in this project, my rationale for choosing them, as well as some of the challenges that I had to overcome during the research process.

I. Rationale For Employing Qualitative Techniques

Drawing on the work of several authors, it was decided that qualitative interview techniques would be the most appropriate for my research. My rationale for choosing to take a qualitative methodological approach stemmed mainly from Morrow's work, *Critical Theory and Methodology: Deconstructing the Conventional Discourse of Methodology*. In his book Morrow explains that by utilizing a qualitative approach, one does not risk misplacing social relationships, which he claims is a potential danger with quantitative methodologies (Morrow, 1994). This danger exists because people are brought together as aggregates; they are no longer individuals and the social is no longer constituted in the methodology that wishes to describe it (Morrow, 1994). I agree with Morrow, and I feel it is an insightful comment that should be kept in mind when undergoing any research regardless of the methodology being

employed. Flyvbjerg also offers an intuitive explanation of why qualitative methods prove to be valuable. Flyvbjerg contends that only by looking at the particular are we able to get a sense of what is really going on - how the social is actually functioning (Flyvbjerg, 2001). Taking Morrow and Flyvbjerg's perspectives as advice, it became necessary for me to uncover the particulars of the *Nimkee NupiGawagan Healing Centre*, to hear the voices of those who are immersed in the problem of youth VSA treatment in an Aboriginal context.

II. Preparing an Interview Guide and Fulfilling Ethical Obligations

One of the first steps I took was to develop an interview guide. The knowledge I gained while reviewing the literature regarding risk and protection was able to give me some direction, though writing the interview guide was not without its challenges. This is mainly because there is a lack of in-depth information and research to turn to for insight on youth volatile solvent abuse (VSA) and post-treatment well-being. Thus, important parts of this process included conducting a number of pre-tests and consulting with others working within the field. I conducted mock interviews with the Coordinator of the *Youth Solvent Addiction Committee (YSAC)*, a First Nations community member, and four of my peers (two from within and two from outside academia). I also met with the Executive Director of the *Nimkee NupiGawagan Healing Centre* and several other *YSAC* members prior to reaching a final draft of the interview guide.²¹ These individuals all offered invaluable suggestions and advice. Since I was the sole researcher of this study, self-reflexivity played an important role in every stage of this project. As Alvesson and Sköldbberg point out, the process of developing, conducting, and analyzing interviews is full of making judgment calls;

²¹ A final copy of the interview guide can be found in the Appendix (Appendix 2)

this has the potential to be problematic if reflexivity techniques are not used (2000). Thus, it was important that I asked others who were not invested in the project for suggestions and insight. Taking a self-reflexive approach during the developmental stage has allowed me to produce, in a collective effort, a useful tool for investigating my research question.

As a researcher, I also needed to consider the ethical obligations I had to the study population, the academic community, and society as a whole. The methodology that I proposed was carried out only after receiving approval from the *Nimkee NupiGawagan Healing Centre* as well as Carleton University's research ethics committee.²²

III. Sample Strategy and Potential Limitations

I drew a sample of fifteen individuals. I chose this sample size assuming that data saturation would begin to occur somewhere inside the range of ten to fifteen interviews. The interviews were face-to-face and took place between May 15, 2006 and May 19, 2006. The interviews were conducted on site, in a private room, at the *Nimkee NupiGawagan Healing Centre* in Muncey, Ontario. I chose to conduct the interviews during mid-May, as this was the beginning of an intake period and represents a time when the staff are more accessible. Each interview was approximately one hour in length. There was no formal remuneration for participation; however, I provided food and drinks during the interviews as well as send each participant a letter of thanks with a Tim Hortons gift certificate. The research question and proposed method was undertaken using a non-probability,

²² Copies of the letter of information and consent form that were distributed to the participants can be found in the Appendix (Appendix 3 and Appendix 4)

theoretical sampling strategy, as this technique does not call for whole representation of a population (e.g., all staff and treatment providers of youth who abuse volatile solvents) (Charmaz, 2002). In this instance, the sample was drawn from one treatment facility, the *Nimkee NupiGawagan Healing Centre*. In order to ensure that I interviewed individuals occupying different positions within the centre I used purposive sampling methods.

The sample included individuals from the management team, the full-time treatment team, and the casual child and youth worker staff. More specifically, I interviewed four members of the management team, seven members of the full-time treatment team, and three casual child and youth worker staff. Within the management team I spoke with the Teacher, the Executive Director, the Treatment Coordinator, and the Nutritionist. My rationale for choosing to interview these four members was that they have more interaction with the daily activities of the youth, and thus more insight to offer surrounding issues of social support. Within the full-time treatment team I interviewed four child and youth workers, two child and youth worker team leaders, and the Senior Treatment Councilor. I used random sampling techniques in order to select the participants from the treatment team. For example, there are six child and youth workers (excluding those who are also team leaders). The names of these individuals were put into a lottery and I choose four. By using a random sampling strategy each child and youth worker had an equal chance of being selected (Dooley, 2001). This method was repeated with the three child and youth worker team leaders (this process was not necessary for the Senior Treatment Counselor, as there is only one). I also used random sampling techniques to select

four participants from the fifteen casual child and youth worker staff. Although all fifteen individuals agreed to participate, when it came time to conduct the interviews two participants were unable to participate (not present at the centre). A colleague replaced one of the child and youth worker participants and the fifteenth spot belonging to a casual child and youth worker was not filled, leaving only fourteen interviews to be completed. With the exception of one interview, the interviews were recorded with audio equipment and transcribed at a later date.²³

Theoretical sampling techniques are often used to help researchers sharpen their understandings of concepts, deepen their analysis, and develop theory; a strategy that lends itself well to a study that is exploratory in nature (Charmaz, 2002). One of the limitations with using such a method is that the staff and treatment providers of the *Nimkee NupiGawagan Healing Centre* may hold different perspectives from providers at another centre (Berg, 2001). For example, they may have access to more/less resources, and/or the strengths and developments of the communities that the youth return to could vary. Such differences as these may contribute to an experience based perspective, and thus a lack of wide generalizability from the research (Berg, 2001). On the other hand, taking such a focused approach is necessary when there is a paucity of research in any given field. This research may act as a useful indicator of the direction that future research could take.

²³ One respondent was not comfortable with the interview being recorded. As an alternative approach, we spent a longer time conducting the interview, which allowed me to take extensive, detailed notes.

IV. Achieving Triangulation

A further point of discussion when applying qualitative methods to a research question is triangulation. More specifically, it is important to convey how triangulation will be achieved. Triangulation is best described as,

An alternative to validation [which is achieved through] the combination of multiple methods, empirical materials, perspectives and observers in a single study...a strategy that adds rigor, breadth, and depth to any investigation. (Denzin and Lincoln, 1998: 4)

Approaches to reaching triangulation vary, though the goal is constant; that is, to strengthen findings and enrich understandings of the phenomenon in question (Berg, 2001). In this instance triangulation was achieved through a within-method approach (Berg, 2001). Based on their role within the centre (e.g., nutritionist, child and youth worker, treatment coordinator), each of the treatment providers and staff have different relationships with the youth, as well as different perspectives on the youths' needs. By combining these different experience-based viewpoints, I was able to obtain a clearer picture and deeper understanding of the topic under investigation. A further provision I employed was inter-researcher reliability. More specifically, I had another researcher code and interpret a sample of the data to help ensure that my interpretations were not intertwined with my own epistemological and ontological assumptions and/or beliefs. Approximately 95% of the time our codes matched one another.

V. Grounded Theory Approaches and Reflexivity

Considering the above, inductive, grounded theory methods fit my research question and interviewing approach very well. As was mentioned, I did not impose a definition of social support on the interview participants. This is key when applying grounded

theory methods; that is, the interviewer must allow the participants to define key terms and avoid impressing pre-conceived concepts on the data (Charmaz, 2002). This is especially useful in a situation such as the one proposed, where previous information on the topic to be investigated is limited. By taking such a flexible approach I was able to explore more openly the issues and ideas of the research participants. This allowed me to obtain additional focused data, which in turn, enhanced my understanding and refined my analysis and interpretation (Charmaz, 2002).

Another key component to grounded theory is reflexivity (Glaser & Strauss, 1967; Charmaz, 2002). Since I am the sole researcher of this study, self-reflexivity played an important role in the development of each part of the research process. As was pointed out above, the research process is full of making judgment calls, which could be problematic if reflexivity techniques are not employed (Alvesson & Skoldberg, 2000). Whether it is deciding how much to write down, or the importance of gestures and non-verbal cues, decisions like these all play an essential role in developing meaning and knowledge.

In an attempt to overcome some of these issues I wrote a journal as I moved through the research process. This journal allowed me to revisit my thoughts and add additional information as my perspective changed. Having a journal made a significant impact on this research. For instance, the journal gave me an opportunity to comment on my own performance as an interviewer. I would write notes such as “let silence be an opportunity for the respondents to think about how they want to answer the question or if they want to add to their responses”, which made for

stronger interviews as the research progressed. My notes were also useful during the analysis phase of this project. In reading them, I was able to bring to mind the setting and context of the interviews, which in turn helped to strengthen my interpretations and analysis.

The phrase ‘conceptual baggage’ is a term used by Kirby and McKenna. It describes this journaling process particularly well; it is, “a process by which you can state your personal assumptions about the topic and the research process...[which] add[s] another dimension to the data, one that is always present, but rarely acknowledged” (Kirby & McKenna, 1989: 32). Similarly, Doucet and Mauthner maintain that research is a learning process, which is continuously evolving, and by recognizing the value of hindsight, I was able to strengthen my final interpretation and identify my limitations (Doucet & Mauthner, 2003).

In addition to taking these precautions it was also important for me to consider my own subjectivity in relation to the respondents. I needed to ask myself questions such as: will my subject positioning (e.g., age, gender, ethnicity) affect the data that I will be able to retrieve? And, how will I be able to build trust with the respondents? Although I had not had any prior contact with the expected participants, a previous research project conducted by Colleen Anne Dell and Greg Graves, “Designing a Tool to Measure the Impact of Client Length of Stay on Treatment Outcome”, was completed at the centre in 2005. Consequently, some trust between the research community and the centre had already been established. In addition, I attended a meeting with the *Youth Solvent Addiction Committee (YSAC)* coordinators in December 2005 where I was able to present to the Executive Director of the *Nimkee*

NupiGawagan Healing Centre, Carol Hopkins, a preliminary outline of my proposed research and obtain her feedback.

VI. Acknowledging my Obligations to the Community

This project has a strong community focus. As such, it was important that I ask for feedback from the community members during the research process. For example, when I sent the letter inviting those selected to participate in my project I also attached a copy of the proposed interview guide, which gave the participants an opportunity to provide their own input and suggestions. Feedback about the interview guide was positive. None of the participants made any suggested changes, though a number of them said that they were glad to have an opportunity to review it prior to the actual interview (e.g., it gave them a more thorough understanding about the project and time to think about how they would respond to certain questions). In addition it will also be important for me to relay my findings back to the community. Once my research is complete, I will present my key findings, as well as provide a plain language summary to all of those who participated in the study. I also offered each participant the opportunity to receive a copy of my final written thesis.

I will now turn to the research findings.

CHAPTER FIVE: ANALYSIS AND FINDINGS

In this chapter I present the findings of my research as they relate to the question, *to what extent does social support affect a youth's well-being after a treatment episode for volatile solvent abuse?* This chapter is organized in two parts. In the first part, I offer a brief description of the participants, the intake process, and the program components at the *Nimkee NupiGawagan Healing Centre*. This is followed by an in-depth discussion of the risk factors that are present in the youths' lives, both before and after treatment. In the second part, I investigate social support as a form of protection in the lives of youth who abuse volatile solvents. More specifically, I: 1) outline how the treatment providers and staff define social support in a youth volatile solvent abuse (VSA) residential treatment setting, 2) review the types of social support that are offered to the youth while they are attending the *Nimkee NupiGawagan Healing Centre*, 3) discuss the relationship between social support and resiliency, and 4) consider the role of social support in the lives of the youth post-treatment.

PART ONE

I. Description of the Participants and the Program

Before turning to the detailed findings of my study, I offer a brief description of the participants, as well as review the intake process and key program components at the *Nimkee NupiGawagan Healing Centre*.

All of the treatment providers and staff who participated in this study had at least one year of experience working with youth at the *Nimkee NupiGawagan Healing Centre*. The average length of time worked at the centre among all the

participants was 4.7 years (with a range of 1 to 10 years). Four of the participants had worked at the centre since it opened in 1996. The average age of the respondents was 43 years (with a range of 23 to 55). Over half of the sample was female (71.4%), though I anticipated a greater proportion of the respondents to be female as there are more female treatment providers and staff at the centre overall. Two (14%) of the staff identified themselves as Caucasian or white. The remaining twelve (86%) indicated they were of Aboriginal descent. Some of those who identified as First Nations provided more detailed information, such as specifying the band they belonged to. Participants were able to draw on both their experience working at the centre (e.g., daily interactions with the youth, courses completed through the *Youth Solvent Addiction Committee*, and the literature and research they have read) as well as their own personal experiences (e.g., many are from communities that are experiencing similar issues as the communities that the youth come from) when responding to interview questions. All of the participants were given pseudonyms to ensure their anonymity.

Participants were asked to describe the intake process and key program components at the *Nimkee NupiGawagan Healing Centre*. They indicated that their intakes are male or female specific, with approximately nine youth per intake. They accept youth between the ages of twelve and seventeen, with the average age of approximately fifteen. The majority of the youth who attend the *Nimkee NupiGawagan Healing Centre* are First Nations, though some of the youth are Inuit.²⁴ The intake periods run on a four-month cycle, allowing three intakes to take place

²⁴ Eighty-nine percent of the youth are from First Nations communities in Northern Ontario. The remaining 11% are from Inuit communities in Quebec and Labrador (*Nimkee NupiGawagan Healing Centre*, 2006).

every year. Over the course of the four months the youth advance through four different stages/levels of the program. During the four month program, families and referral workers participate in a variety of ways, first through monthly teleconference calls to establish and review the youths' treatment plan of care and then through a family treatment program. The families (a minimum of two significant caregivers whom may be biological or extended family members, or foster family) will attend the program and live in the residence for an average of five days. Referral workers may accompany the family and participate in the week long program as well.

The program maintains a strong philosophy of traditional Native teachings and healing practices. Participants identified a number of program components that reflected this (e.g., they offer fasting ceremonies, sweat lodge ceremonies, full moon ceremonies). Other treatment philosophies, for example, emotional intelligence theory and resiliency theory, are also used to compliment the cultural philosophy (foundation) of the program. Taken together, these philosophies ensure that the programming with the youth is strength based.²⁵

The participants' also described some of the group programs at the treatment centre. These include mood management, addictions, life skills, violence prevention, health and nutrition, social skills, feelings, sexuality, and leadership skills. Throughout the program, individual and group counselling are key components. The centre also has an in-house school where the youth are offered academic courses and skills in a classroom setting. Another part of the program involves getting the youth involved in both western and traditional recreational activities in neighbouring

²⁵ Most 'helping' interventions work from a deficit model where assessments determine what needs to be addressed and rarely focus on strengths.

communities. For instance, during the spring intake of 2002 the youth went camping, went to the Museum of Archaeology, and attended Aboriginal Day at Canada's Wonderland (Nimkee NupiGawagan Healing Centre, site last visited January 2007). They also offer outpatient counselling and day treatment programs for youth and community based prevention, intervention, and training programs.

In addition to describing the program components, it is also necessary to make the case that the program itself is 'successful'. The *Nimkee NupiGawagan Healing Centre* uses various instruments to measure their 'success'. It is based on holistically defined treatment results, which include spiritual, mental, physical, and emotional health. They use a number of measures to determine their outcomes. For example, emotional health is measured through a resiliency traits scale and the average rate of improvement is 30% (Nimkee NupiGawagan Healing Centre, 2006). The 'success' of the program is also measured post-treatment at three, six, and twelve months with the following indicators of success: return to school (20% higher post-treatment), change in use of solvents (84% average not 'sniffing'), change in other substance use (67% average not using), increased positive social activities (64% engage in regular positive social activity), and continued use of culture (56% continue use of cultural activities) (Nimkee NupiGawagan Healing Centre, 2006). In addition to this, the completion rate can be used as an indicator of 'success'. In 2006, the completion rate at the *Nimkee NupiGawagan Healing Centre* is 100%, compared to a national average of 40% (Nimkee NupiGawagan Healing Centre, 2006). The centre is also accredited by the *Canadian Council for Health Services Accreditation*, which means that their performance is assessed and evaluated against standards of excellence every three

years. They have been accredited for eight years and have always met the national standards of excellence and have exceeded the national averages in all four quality dimensions of the standards (quality of work life, client and community focused, system competency, and responsiveness) (Nimkee NupiGawagan Healing Centre, 2006).

This is not meant to be an exhaustive list of the programming components at the *Nimkee NupiGawagan Healing Centre*. Rather, it is meant to give the reader a general sense of how the treatment centre operates, which will add context to the responses and findings that follow.

II. Risk Factors

Though the goal of my research is to understand the relationship between social support and well-being post-treatment, it is important to first consider the risk factors that are present in the youths' lives and how these factors may interfere with the formation of protective/resilient responses. In this section, I focus on the responses to the questions in which I inquired about risk. During the interview process I asked participants about what might put youth at risk for volatile solvent abuse (VSA) prior to coming to treatment (e.g., are there certain factors that the youth face within their communities/ families/school environment/peer networks that put them at risk for volatile solvent abuse?) as well as whether or not risk factors were still present post-treatment (e.g., what conditions/risk factors, if any, interfere with the youths' well-being when they return to their communities?).

In the following six sub-sections I report my findings. The first five parts review pre-treatment risk and are organized using the five life domains: individual,

family, school environment, peer group, and community. The results of this study are compared with what other authors have reported within the VSA literature. Though many of the risks match the current research, some new risks have also emerged within the life domains. These new findings are also discussed. In addition, primary socialization theory is used to help expand and further reflect on the findings. Also, in a number of places, I demonstrate the relationship between Canadian Aboriginal people's history and current situations. The sixth sub-section reviews participants' thoughts on post-treatment risk. In particular, I consider the relationship between pre- and post-treatment risks. Additionally, I report participants' perceptions on how risk factors might affect youth after treatment.

a) *Pre-treatment Risk: The Individual Domain*

Previous research has identified numerous factors rooted in personality traits and characteristics that have been linked to adolescent VSA. Similarly, the participants in this project indicated a number of potential risk factors linked to VSA within the individual domain. Most frequently reported were aggression or violent behaviour (57%), lack of identity (57%), and low self-esteem or self-worth (50%). Noted less frequently were no sense of the future (21%), poly-substance use (21%), history of suicide ideation or attempt (21%), and history of involvement with the criminal justice system (7%).

Aggressive behaviour was described as a risk factor for VSA by eight (57%) of the treatment providers in this study. Interestingly, over half of those individuals suggested gender differences in the way in which the violent behaviour is acted out. As Christine pointed out,

With the female youth there is more of an inclination for them to be involved in self-harming behaviours um, and with the boys there is more of an inclination for them to be involved in externalized aggression.

This finding is an extension of what has been found in previous research. Current literature recognizes aggression as a risk factor for VSA (e.g., Howard et al., 1999; White, 2004; Coleman et al., 2001), though it has not identified gender differences in the way in which that aggression is acted out.²⁶

Lacking identity was also described as a risk factor for VSA by eight of the participants (57%) in this study. In particular, the respondents felt that the youth were lacking “*cultural identity.*” For instance, Ellie said, “[*the youth*] *come in [to the centre] with little identity of who they are as First Nations youth...and when they don't have that it is like they are at risk.*” Oetting et al. also maintain that culture plays an important role in the outcome of individuals’ attitudes and behaviours. Those that are not strongly connected to their culture do not have the influence and reward that culture may provide, which may lead to them turning elsewhere to meet their needs (Oetting et al., 1998c). This finding is specific to the population under study and thus it is not widely discussed within the general VSA literature. The lack of cultural identity that the participants described can be tied to the shame that is a result of the oppressive policies that have for many decades negatively impacted Canadian Aboriginal peoples’ cultures, languages, and traditions.

Following this, low self-esteem and low sense of self-worth were reported by half (50%) of the participants in the study as risk factors for VSA. As Mike said, “[*The youth*] *have very little self-worth, so they would be like promiscuous or ...they*

²⁶ Participants were asked probing questions regarding gender in sections three, four, and five of the interview guide, though this was the only significant finding relating to it.

will abuse different substances um, they have no sense of the value of themselves.”

Jill expressed a similar view when she commented, “...and to me, it doesn't seem like they feel important in their community, they don't feel the sense that they are needed or that they have a lot to contribute to their community.” She connected to this point at a later time during the interview when she noted that “[the youth] don't really want to respect their body and they don't realize that it is precious.” This finding is comparable to current VSA literature, which has also identified low self-esteem and self-worth as risk factors for abuse (e.g., Kurtzman et al., 2001; White, 2004; Bennett et al., 2000).

Though reported less frequently, three (21%) of the participants felt that many of the youth lacked a sense of the future. For instance, Mike argued that the youth who are not “looking towards the future” or “focused on any long-term goals” are more susceptible to VSA. Although the participants identified ‘no sense of future’ as a risk unto itself, this finding may be better expressed as an extension of the former (lacking a sense of self-worth or low self-esteem). Having no sense of the future may be the result of feeling that one is not able to contribute in the present.

Poly-substance use and history of suicide ideation or attempt were both identified as precursors to VSA by three (21%) participants in this study. The VSA literature recognizes that many volatile solvent abusers engage in the use of other drugs (e.g., alcohol, tobacco), though it does not report poly-substance use as a direct influence to VSA (Alberta Alcohol and Drug Abuse Commission, site last visited January, 2007). Increased thoughts of suicide however, have been identified as a risk

factor for VSA within the broader literature (e.g., Coleman et al., 2001; Bennett et al., 2000).

And last, one respondent (7%) identified a history of involvement with the criminal justice system as a risk for VSA. Individual criminal activity has not been reported as a precursor to VSA in other research, though a family history of crime has been described as a risk factor within the general substance abuse literature. Further, Aboriginal peoples are disproportionately represented in Canada's criminal justice system (Bonta et al., 1997).

These findings demonstrate that youth are not simply passive subjects that fall victim to risk. Individual characteristics can influence behaviour (Oetting et al., 1998a). In particular, personal characteristics may lead an individual to interact with others who share similar characteristics (Oetting and Donnermeyer, 1998). Jesse's comments support this assertion. He said that "*many of the youth have similar problems*" and they hang out together because "*they can relate to one another.*" Moreover, personality traits are risk factors for VSA because they increase the likelihood that the youth will be involved with other youth who engage in certain types of behaviours (Oetting et al., 1998a).

b) *Pre-treatment Risk: The Family Domain*

Participants revealed numerous risk factors for VSA within the family domain. Most frequently mentioned were family history of drug and alcohol abuse (86%), history of family violence (physical, sexual, emotional, and spiritual abuse) (79%), lack of family cohesion and strength (71%), poor and inconsistent family management practices (50%), and economic deprivation (43%). Others less frequently reported

include neglect (29%), guardianship (29%), poor parenting skills (29%), sibling VSA (21%), other mental health issues within the family (7%), and parent's education level (7%).

Family history of drug and alcohol use was the most frequent reported risk factor for VSA within the family domain. Jill's comment is quite typical of the sample; she said, "*a lot of the times [the youths'] families abuse drugs and alcohol or solvents, so it is normalized in their families.*" Similarly, Paul, Debby, and Lisa explained that the abuse is often times "*generational.*" This finding is equally prevalent in the VSA literature, where numerous authors report similar findings (e.g., Coleman et al., 2001; Wu et al., 2004; Mosher et al., 2004). Seventy-nine percent of the participants indicated that a history of family violence was also a significant risk factor for VSA. This risk factor is also widely reported in the VSA literature (e.g., Fendrich et al., 1997; Simpson, 1997; Kikuchi & Wada, 2003). Paul, Emily, and others said that prior to coming to treatment many of the youth are being abused "*physically, sexually, emotionally, and spiritually.*" Mike's response demonstrates how both a family history of substance abuse and a history of family violence can be significant risk factors for the youth. He said,

There is a lot of different types of unhealthy situations, like whether it be incest or sexual abuse by others um, different types of addictions like whether it be alcohol, solvent abuse, drug abuse, so that effects them, that is one of the risk factors that the youth are exposed to...unhealthy family situations.

A lack of family cohesion and strength was reported by ten (71%) of the participants in this study. This risk factor was expressed in a number of ways. For example, Sarah described it as the marital state of the parents. She said, "*some of*

[the youth] come from broken homes, you know single parents.” Karli expressed a similar view, though she also indicated that a major part of it was communication, *“I guess the majority of them come from some type of, I would say dysfunctional family. Like broken homes or separated families, or where there are communication barriers within the family.”* Mike also felt that there was *“little communication”* that went on between family members. In sum, the participants felt that marital status and lack of communication were major barriers to enabling family strength. The strength of the bonds between the youth and the family are key to how well norms are transmitted (Oetting and Donnermeyer, 1998). These findings demonstrate that weak family bonds can increase the chance that youth will engage in deviant activity, such as VSA (Oetting and Donnermeyer, 1998).

Poor and inconsistent family management practices were identified as a risk factor for VSA by half (50%) of the participants in this study. This finding has not been reported in the volatile solvent specific literature, but is common within the general substance abuse literature regarding youth and risk (e.g., George et al., 2002; Guo et al., 2001; Hawkins et al., 1992). Participants highlighted a lack of routine and scheduling as a major source for risk. For example, Adele argued that a major part of the problem is that many of the youth have *“no structure or routine in their lives.”* Similarly Mike pointed out that in many cases,

The youth just feel like they can do anything without any ramifications cause their parents don't tell them that that is wrong to do...like just talking to some of them or talking to some of their parents, no one is really diligent in ensuring that they are attending school or you know...

Six participants (43%) noted economic deprivation as a potential risk for VSA. This finding is consistent with the literature, which recognizes economic

deprivation as a risk for VSA (e.g., Wille & Lambert, 2004; Kurtzman et al., 2001; Dinwiddie, 1994; Marelich, 1997; Howard et al., 1999). As part of economic deprivation, respondents cited limited housing and overcrowding as a concern. Jesse summed up the situation when he said,

With a lot of the youth that I have talked to it's uh, very limited housing. They have got their aunts and uncles and like twelve people living in their house...The housing becomes a problem for overcrowding and the youth, well every teenager wants to be by themselves, listen to their own music but they got like two, three or four siblings in their room...up there [in the north] it's like um, a family gets a house and its got like one, two, or three other families within that house who are you know trying to get their own home but can't [because of funding constraints]...so yah, the poor living conditions can really effect [the youth]...there are only so many allocation dollars...even if you have a perfect credit record no bank is going to touch you in the north...so that's where the economics are, they are not viable on the First Nations because there are certain boundaries and there are certain economic restraints where uh, people are not going to, people on the outside are not going to take a chance with you.

This point is also strongly connected to the history of Aboriginal peoples in Canada.

As Jesse made clear, government funding controls housing and in turn economic viability. In this instance, the economic restraints are causing damage to those who are subject to them. To further explain, the government grants and funding that Jesse described aim to support and aid families, but they can also endorse a feeling of defeat, which may reduce family pride and independence. Moreover, the economic characteristics of a family frame the social attitudes and behaviours that are expressed by family members. As this example demonstrates, dependence on government institutions may influence family bonding and the transmission of pro-social norms (Oetting, 1999).

Parental neglect was reported as a risk factor for VSA by 29% of the respondents in this study. This risk factor is also reported in the VSA literature (e.g.,

Wu et al., 2004; Simpson, 1997; Mackesy-Amiti & Fendrich, 2000). A further 29% listed guardianship as a risk factor for VSA. Mike commented that many of the youth are under different guardianship, both “*formal*” (e.g., children’s aid or crown ward) and “*informal*” (e.g., living with an extended family member), which he viewed as a potential risk factor. Guardianship is not a risk factor that is widely reported in the VSA literature, though it can be linked to other family risk factors like neglect, which was previously noted. These conditions deny youth access to bonding with pro-social sources. Not having an opportunity to bond with the family is a risk because it may increase the likelihood that a youth will turn elsewhere to meet their needs (e.g., negative peer groups) (Oetting and Donnermeyer, 1998).

Poor parenting skills were also reported by four (29%) of the respondents in this study. As Lisa pointed out, “*the parents are caught up in a vicious circle of not knowing what to do...they don’t really have the parenting skills.*” This risk factor provides further evidence to the connection between the history of oppression and current situations. For example, Constance attributes this risk factor to the residential schooling that many of the youths’ parents and grandparents endured. As she said,

I think it is because um, residential school. The parents haven’t uh, had a good upbringing in some cases. They have lost touch with their language and their culture and they may be ashamed. So some of the parents and grandparents have been treated badly in residential schools...there was a lot of sexual abuse and abuse in general from that residential setting...and it is something that is passed down through the generations because they haven’t had proper parenting so then our youth come from families where there is not really a strong parental role or the parents don’t really know their role in the family.

Sibling solvent abuse was reported as a risk factor for VSA by three (21%) of the respondents. This finding has been observed in other research focused on youth VSA (e.g., Wu et al., 2004; Wille & Lambert, 2004; Mosher et al., 2004). Sibling

influence is similar to peer influence (see next section). Older siblings who experiment with volatile solvents may create an environment similar to peer groups in that pressure to use is combined with feelings of belonging and acceptance (Oetting et al., 1998b).

Further, one participant (7%) felt that a parent's education level was a potential risk factor for youth VSA. This risk has been documented in the general substance abuse literature but it is not a finding that has been reported in other VSA research (George et al., 2002). Lastly, one participant (7%) brought up other mental health issues within the family as a risk factor for VSA. In particular, Ellie commented, "*with the parents there is a high risk of depression...[and other] mental health issues. A lot of them being diagnosed with bi-polar, schizophrenia um, different mental health issues.*" This finding is new to this research and has not been reported elsewhere.

c) *Pre-treatment Risk: The Peer Domain*

Peers are often the most significant influence during adolescence. As a result, they have been shown to affect adolescent substance abuse and in particular, VSA (e.g., George et al. 2002; Guo et al., 2001, Svensson, 2000). Within the peer domain the most often reported risk factor for VSA was a sense of belonging (71%), which was followed by peer influence/peer pressure (64%), bullying (50%), and curiosity/proximity to solvent users (14%).

Seventy-one percent of the respondents felt that wanting to gain membership, respect, or a sense of belonging within a peer group was associated with youth VSA. For example, Karli felt that

...Maybe [the youth] are lacking in support from the family so they turn to their peers to get that support and I guess [they want] a connection with something. So, instead of turning to family, they turn to those friends and those friends aren't necessarily really positive role models or anything so...

Karli's comment provides evidence to an assertion that was made in the previous section. That is, low family bonding can increase a youth's opportunity or willingness to belong to negative peer groups. Her observation also demonstrates the interconnectedness between the life domains. More specifically, socialization sources (e.g., family, peer, school) have the ability to influence youth both independently and interactively (Oetting and Donnermeyer, 1998).

Peer pressure was identified as a risk for VSA by nine (64%) of the participants in this study. Comments from a few participants illustrate this finding,

Paul: You know, I don't think anybody just decides they are going to stick their head over a can of gasoline, it's got to be, you know, influential.

Jesse: There is a lot of peer pressure...they you know, feel ostracized if they are not joining in...yah, the peer environments are really negative.

Emily: It's never been that a youth will specifically go out and say today I'm going to go out and sniff. It's that somebody has lured them or pulled them into solvents.

Peer pressure has also been widely recognized in the literature as a risk factor for VSA (e.g., Kikuchi & Wada, 2003; White 2004; Coleman et al., 2001; Zabedah et al., 2001). Peer pressure, like all risks within the peer domain, is an influential risk factor that has the potential to prevent bonding with positive influences and the communication of pro-social norms (Oetting et al., 1999).

Bullying was reported by half (50%) of the respondents as a precursor to VSA. Respondents felt that in some instances, "*youth have to be a part of the group to feel safe.*" Lisa points to the danger in this,

[The youth] say that the youth wander around the neighbourhood and are constantly asking people, you know the other kids to come out and they get bullied. They will even bully like the family and really it sounds like a game, come on out and sniff with us, or whatever. And they get beat up and targeted if they don't do that so yah it's a big risk factor.

A further 14% of respondents considered proximity to solvent users a risk. For example, Paul said “*[the youth] talk about how difficult it is for them to avoid the negative peer groups because it is such a small population base in these communities so you know, that's uh, sometimes difficult.*”

d) Pre-treatment Risk: The School Domain

Predictors of adolescent VSA have also been identified within the school domain. In the school setting, school drop out (64%), low levels of education (50%), lack of connection to the school curriculum (50%), absenteeism and truancy (36%), inadequate schools (36%), poor academic performance (29%), little or no expectation for success (21%), and community beliefs and attitudes regarding education (14%) were perceived as risk factors for VSA by the participants in this study.

School drop out was identified as a risk factor for VSA by nine (64%) of the participants in this study. A number of the respondents noted that many of the youth are not attending school when they arrive at the *Nimkee NupiGawagan Healing Centre*. This has also been found to be a risk factor in other research focusing on VSA among youth (e.g., Bennett et al., 2000; Shu & Tsai, 2003). Low levels of education were also reported as a risk factor for VSA by half (50%) of the participants in this study. This finding has been observed in other research that focuses on youth VSA (e.g., Simpson, 1997).

An interesting finding, which is specific to the population under study, is that half (50%) of the participants felt that the education the youth were receiving was not relevant to them and as a result, a risk factor for VSA. As Jill put it,

It is really foreign to them. I'm sure when any First Nations [youth] goes to school for the first time it is a completely different atmosphere, a different language, and most of it, like the history component about Canada is mostly all not true as far as they are concerned or at least confusing because they are like, well what about our people, they are not in the history books...it doesn't show us as an important part of Canada or anything like that. And a lot of the times it will talk about First Nations people as extinct almost, like we are not really living in the present time...it doesn't really talk about us in the present tense...it could make a person feel like, do we really exist? Are we part of society? Or they might be really confused about their identity so, it might not really be relevant to them what they are learning in school.

Lisa made a similar point when she said,

School is taught using our system, which is um, the white system...so that kind of loses them. A lot of the youth don't know English until they go to school, so they are lost to begin with...so they begin to feel inadequate, naturally if you give kids stuff and they can't do it they don't feel like they are worth anything and that goes back to my point about low self-esteem [being a risk factor].

Traditional First Nations and Inuit cultures did not involve the school as a primary socialization source. Jill and Lisa's observations demonstrate how dominant western culture and ideologies can increase risk and negative outcomes for those who are outside of that culture.

High rates of absenteeism and truancy were identified as a risk factor for VSA by 36% of the respondents. This finding has also been reported in the VSA literature (e.g., Mosher et al., 2004; Basu et al., 2004). Thirty-six percent of the respondents also reported that inadequate schools were a risk factor for the youth. Emily felt that "the youth don't have high schools that meet their needs." She said, "One teacher might teach three or four different subjects, so you know all of those things to me play

a big factor in what happens to our kids.” Paul pointed out how inadequate schools could act as a risk factor when he said, *“I don’t know how good the schools are, a lot of the kids are not happy with their schools and that forces them back into relationships with [negative] peers.”* Paul’s comment also offers insight into how a weak school bond can lead youth to engaging with negative peer groups and participating in negative peer activities. Another part of inadequate schooling that was a concern was the quality of teachers. Constance commented,

I think because they are remote communities, teachers, like the really good quality teachers don’t have the incentive to be in those really remote communities. They don’t get paid like a whole lot more and um, the cost of living is really high so therefore they get teachers that maybe are not as qualified.

Following this was poor academic performance, which was reported as a risk factor by 29% of the respondents in this study. With this point it is important to mention the debate that surrounds whether some of these factors existed prior to the use of substances or whether they are outcomes of the abuse itself. Research is yet to provide us with a clear answer, though it is an issue that should be kept in mind when reviewing the information presented here. Paul’s comment demonstrates the unclear nature of this debate,

Um, well some of the youth that are really uh, who have sniffed for long periods of time you know it shows. Our learning centre facilitator tests them when uh, well we have had returning youth that have dropped three or four grade levels because of increased substance abuse, you know, gasoline predominantly.

So while some may attribute the ‘sniffing’ in part to the poor grade achievement, others would argue that the poor grade achievement is a result of the ‘sniffing.’

In addition, 21% of the participants felt that there is little or no expectation for the youth to succeed. They viewed this as a risk factor for VSA. As Jill said,

A lot of the time the teachers that are hired in the isolated communities don't really want to be there. They are usually just going for the money or going because they can't get a job in the south. That's not all teachers but some of them and so they don't really care that much about teaching and they don't really care that much about their students, so they are not really trying to get the best work out of them. They are just kind of like well if they do the work they do the work, so they are not really expected to accomplish much in school.

This social condition may deny youth access to forming positive bonds within the school environment.

Fourteen percent of the respondents in this study felt that community beliefs and attitudes surrounding education were a risk factor for VSA. Jill noted, *"It is not emphasized in their community as important to go to school."* Mike made a similar point, he said, *"like if they don't go to school it's not a big deal cause like [they have the attitude that] school is not going to do anything for them...there is no guidance or no respect for education or the education system."* This risk factor may also be connected to the fact that the school is not part of the traditional socialization sources in First Nations and Inuit cultures. This finding demonstrates that culture plays a strong role in the outcomes of individuals' attitudes and behaviours.

A number of the risk factors presented above were attributed to a lack of understanding between the youth and their teachers. As Christine pointed out, many of the teachers who go into communities to work lack knowledge about the history and culture of First Nations and Inuit peoples in Canada. She said,

In the school system we still have teachers that believe in the three R's, reading, writing, and arithmetic and don't believe um, you know that culture has a role. [They believe] that it takes away time from important things...you still have people in the communities who don't have the education on the history of oppression um, specifically with education and religion and the whole residential schooling system and its impact on communities. We have teachers coming into communities without that kind of knowledge and education. They come in with an attitude where they want

to be fair, because we are all the same, let's just get along, well we are all human beings but our culture and our identity is what distinguishes us from each other and those differences don't have to be a struggle, a barrier, or something that is looked on as competition or right or wrong. The difference just needs to be respected and um, I mean school where, or teachers in classrooms that overtly perpetuate the idea that you know, I am here to save you poor little Indians, if you just get an education then you won't be on welfare in fact confirms shame that is already present in communities and does nothing to build self-esteem or a connection to the school.

Conversely, many respondents felt that the youth and community lacked respect and support for their teachers. As Mike put it, *"it's like the youth have no respect for the teachers and also if a youth wants to get up and abuse a teacher whether it be verbally or whatever, it's just like there is no community support for that teacher."* This finding, though not identified as a risk in and of itself, helps set the context as to why the youth may not be invested in their education.

e) Pre-treatment Risk: The Community Domain

Community variables also influence the level of risk for youth VSA. Participants in this study indicated a number of community factors that put youth at greater risk for VSA. They include geographic isolation (93%), lack of community resources (71%), religious infiltration (50%), media and technology (50%), lack of opportunity (50%), economic conditions (36%), lack of consistency in programming (29%), lack of trust within the communities (29%), prejudice and discrimination (21%), stigmatization within their communities (7%), and high rates of tragedy and crisis within their communities (7%).

Geographic isolation (tied to boredom) was reported by thirteen (93%) of the respondents in this project. Jill pointed out that the youth *"come from isolated communities from all over Canada. And that means that there is usually not much*

economic activity and opportunity, so isolation is a big risk factor". This type of comment was recurring throughout the interviews. For example, Jesse said,

Boredom is a big factor. A lot of the youth say they are really, well they feel lonely like because they are in fly in communities boredom gets to them. And um, they are secluded communities like when they travel they are talking plane ride...and the youth activities in those communities are really few and far between.

And, Emily felt that *"the biggest thing is isolation. Everything comes back to the fact that they are isolated."* Geographic isolation is a risk factor that is also described in other VSA literature (e.g., Spiller 2004; Coleman et al., 2001).

This finding was followed by a lack of resources, which was reported by nearly three-quarters (71%) of the respondents. Karli spoke to this concern when she said, *"they don't have recreation, they don't have support systems and it's just um, I guess that's what they turn to [solvent abuse] instead of like having opportunities that other youth have within well established communities."* Often times, lacking recreation and structured activities encourages youth to participate in unstructured forms of entertainment. More specifically, it increases the youths' opportunity to bond with antisocial sources and participate in deviant behaviours.

Half (50%) of the respondents felt that religious infiltration was a risk factor because it prevented the youth from connecting with their tradition and culture.

Christine explained,

Another risk factor is that many First Nations communities um, while their traditional values are still ever present and strong they have discarded native culture and spirituality as meaningless; either because of a replacement by another religion, or with a religion I should say because I don't think culture is religion um, that has dominated their thinking and caused them to believe that native spirituality is um, satanic or, so it has caused a lot of shame.

This risk factor is yet another strong example of how the oppression of Aboriginal peoples has had a negative impact on their communities. The media and technology was also identified as a risk factor by 50% of the participants. Emily described how the media acts as risk factor when she said,

I think one of the biggest things is the fact that they have, when I lived in the north we didn't have satellite and we didn't have access to TV and to see all of what the rest of the world has at large and computers. Since those things it's like we have this really old culture trying to play catch up with this modern technology and the two of them are colliding together.

Both religious infiltration and the media can be linked to social isolation, which is commonly described as a risk factor for VSA in the wider literature. Social isolation was not mentioned directly by the participants, though the prominent role of the church and the media has meant that many communities are struggling to maintain their own traditions, cultures, and identities with respect to the mainstream culture of North America. It has been suggested elsewhere that ethnic minorities that struggle to maintain ethnic identification and the communication of cultural norms are at a social disadvantage (Oetting et al., 1998b). The findings presented above provide support to this statement.

Half (50%) also felt lack of opportunity (including job opportunities) should be considered a risk. In more general terms, economic conditions were thought to be a potential risk by five participants (36%). Both labour status and socio-economic level have also been identified as risks in the VSA literature (e.g. Coleman et al., 2001; Wu et al., 2004; Wille & Lambert, 2004; Ho et al., 1998; Taggart et al., 2003). The economic and social characteristics of a community frame the social attitudes, beliefs, norms, and behaviours that are expressed within the community. These findings show

that unstable economic environments may create feelings of defeat and in turn, negative social attitudes and behaviours.

No consistency in programming was reported by four (29%) of the respondents in this study. For instance, Christine commented,

So while communities have community centres, community centres are not always open or uh, have the resources to run programs. And um, because of um, I guess the history of oppression within First Nations communities the capacity within the community doesn't always lend itself to be proactive. Communities tend to be more reactive to situations, so um, long-term kinds of solutions are difficult to sustain...they run into barriers such as not having resources or not having support.

Sarah echoed this point, saying, “[there is] a high staff turnover. Once a program gets going and is consistent somebody leaves...there are some people who like go into these communities and they get a contract for a year and then their contract is done and then that person is gone.” This finding has not been previously reported in the VSA literature, though it could be tied to the lack of funding and community resources.

Lack of trust was also considered a risk factor by 29% of the participants.

Sarah used an example to illustrate this point,

If there is a counsellor who is um, who is working with the youth sometimes it's a family member so they don't, or they can't uh, talk to them because they are afraid of a lack of confidentiality...Gossip goes on in the community and the confidentiality is not there.

Less commonly reported, though equally important, was prejudice and discrimination from outside the community. Twenty-one percent of the respondents indicated prejudice and discrimination were risk factors for VSA. Discrimination and inequality have also been identified as risk factors for VSA in the broader literature (e.g., Mosher et al., 2004; Bellhouse et al., 2000). Oetting et al. (1998b) maintain that high

levels of prejudice and discrimination against a group from surrounding populations can contribute to feelings of separation, isolation, and shame, which can have a negative effect on the group members. These findings show how high levels of prejudice and discrimination can contribute to negative outcomes such as VSA.

Furthermore, stigmatization within their own communities was also identified as a risk for VSA. One participant (7%) felt that the stigma that is located in some of the communities could be contributing to negative outcomes in the youth.

Stigmatization is an important and new finding that has not been reported within the VSA literature. Emily used an example to demonstrate how stigma can act as risk,

“[One youth expressed to her that his] family are known in the community as drunks, [his] family are known in the community as welfare recipients.” She continued to comment,

They already know even at his young age how they will be moulded, [by creating the label] the community is telling him where he is going to be when he grows up, which is wrong, but that label is on him already and he is finding that stigmatism not only in the outside world but right in his own community.

One participant (7%) also reported that the high rates of tragedy and crisis within many of the youths’ communities were a potential risk for VSA. She explained,

“the background of many of the kids when they are coming here um, they have lost a lot of people, relatives and friends, through suicides or accidental deaths or killing each other.” So, many of the youth are *“turning to substances to deal with these tragedies.”* This finding is also new to the VSA literature that is concerned with risk and thus it should be explored in future research.

f) *Post-Treatment Risk: A General Overview*

Participants were asked to relay what risk factors were present in the lives of youth both before and after treatment. In the following section I review the participants' feelings about post-treatment risk, as well as how they compare to pre-treatment risk. In addition, I describe how attempts to reduce risks have been made. Due to a methodological shortcoming, the section is significantly shorter than the previous five that reviewed pre-treatment risk (questions that inquired about post-treatment risk were asked after those that inquired about pre-treatment risk). This flaw is discussed further in Chapter Six, where I review the limitations of this study.

When the participants responded to questions about risk and post-treatment, ten (71%) agreed that the risks that were identified during pre-treatment were, in most cases, still present when the youth returned to their communities after treatment. Though most agreed that the risks remained, their responses varied when they discussed how the risk factors affected the youth post-treatment. Some of the respondents believed that the youth were better prepared to face the risks. For example, Paul commented, "*of course they are going to be there but hopefully we give them the tools [and social support] to deal with those better than they have in the past.*" Mike also felt that the "*external things when they return home will be the same. Like they still may have those friends smoking up or those types of things or still nothing for them to do in their communities*" but that the youth would be "*better prepared to take on those challenges [after leaving the Nimkee NupiGawagan Healing Centre].*" Others felt that the youth were more prepared but that the risk factors may be harder to overcome. For instance Anton said,

Yah [the risk factors] are still present and I think sometimes there are more because um, the clients are learning all these skills...but there is more peer pressure on them...more specifically when a kid is saying no or you know I don't want to do that, the other ones are going to pressure them more...it is almost like they are targeted at times [because they have been to treatment].

Lisa echoed this sentiment when she said, “Yes they are [still there], maybe even more so for them because they are trying to fit back in and because they may over do it trying to fit back in and be accepted again. It's hard to live a life alone. Especially when you are a kid.”

A number of the respondents felt that while it was uncommon for risks to be eliminated or reduced in the youths' wider environment (e.g., community), attempts at risk reduction were, in some instances, being made within their immediate family environment. Four (29%) of the respondents in this study pointed out that sometimes families seek out change and make efforts to heal. For instance, Jesse explained that some,

...move on to the next stage, they go to a place down the road here called KiKi [Kii-kee-wan-nii-kaan Healing Lodge] that takes them as a family and it helps them to work with each other as a family, rather than having that you know um, negative family to deal with. They start to learn to deal with one another, like a mother to a child, a father to a child, rather than you know just building up that anger and creating brick walls between one another.

The *Kii-kee-wan-nii-kaan Healing Lodge* is one example of a place where First Nations and Inuit families can start their healing journey together. The *Kii-kee-wan-nii-kaan Healing Lodge* helps them to look at the issues that have impacted their family of origin and how those things have caused violence and addiction within their family (Aboriginal Healing and Wellness Strategy, 2004). What was once a source of risk is worked through and turned into a source of protection.

I now turn to the second part of this chapter, in which I examine how social support makes a positive contribution in youths' lives. More specifically, I review the results of the participants' responses that focused on protection, resiliency, social support, and well-being and discuss how these concepts work together to help youth overcome risk.

PART TWO

III. Social Support as Protection

In addition to looking at the risks for youth volatile solvent abuse (VSA), the main goal of my research is to investigate social support as a form of protection in the lives of youth. Protective factors are those life events, relationships, characteristics, and experiences that mitigate or moderate the effects of risk exposure, helping to prevent negative outcomes (e.g., volatile solvent abuse) and contribute to positive development (George et al. 2002; SAMHSA, 2002; Brook et al., 1998, Pollard et al., 1999; Hawkins et al., 1992). In this part of the chapter I review participants' thoughts on the concept of social support as a form of protection. The following is divided into four sub-sections. In the first sub-section I outline how treatment providers and staff define social support in a youth VSA residential treatment setting. In the second sub-section I review the types of social support that are offered to the youth while they are attending the *Nimkee NupiGawagan Healing Centre*. This is followed by a discussion of the relationship between social support and resiliency. In the last sub-section, I consider the role of social support in the lives of youth post-treatment.

a) Defining Social Support

Social support is a concept that is replete with definitional complexity. As described earlier, I chose to take a grounded theory approach when it came to defining this concept.²⁷ The goal of this research was not to develop a clear and concise understanding of what is meant by the term social support; rather, it was to find out what aspects of social support were meaningful in this specific situation. In this section I review what the treatment providers and staff perceive as social support in the specific context of youth VSA residential treatment.²⁸ Here it becomes clear that the participants' definitions of social support are aligned with the wider literature on social support.

As one participant relayed, “[social support is] something that helps to build a person’s positive well-being.” The treatment providers and staff that participated in this project identified a number of things that social support could involve. Generally speaking, it involves contact and interaction with friends, family, and the community. All fourteen participants in the study reported a connection to others as the main characteristic of social support. Christine related this to the traditional teachings of First Nations and Inuit cultures, explaining,

Our teachings tell us that the key to healing is about connection. That not any one of us can live in isolation and so everything about Native people is about family and community. And if you don’t have family and community some of the Elders will tell you that you don’t have a life. Your identity depends on family and community, so creating those social support networks is critical to their health.

²⁷ It is important to mention that I did not go into this research unguided. I reviewed the literature regarding social support and thus had some preconceived notions of what the concept meant in broad, general terms.

²⁸ Participants were asked, “If you as a treatment provider were going to give me a definition of social support what types of things would that involve?”.

Social support and a positive connection with others were further expressed by the participants as strong lines of communication (86%), feelings of love and acceptance (79%), receiving guidance (57%), receiving encouragement (43%), and having trusting relationships (21%).

Twelve of the respondents in this study felt that having strong lines of communication was an important aspect of social support. As Lisa commented, “[social support is] having someone to listen to you or having someone to talk to.” Similarly, Mike felt that social support involved “having someone to share the good and bad news with.” And, Ellie believed that social support involved having an “empathic and understanding listener.” Another component that was identified by eleven (79%) of the respondents was feelings of love and acceptance. That is, in interacting with others it is important that “people show you that they genuinely care about you.” As Adele said, “it’s about showing the youth that they are loved, cared for, and safe.”

The respondents also thought that guidance was an important part of social support. Fifty-seven percent felt that the youth needed “people in their lives who would help give them direction.” More specifically, the respondents thought that youth needed a connection to people who would help them identify their life goals, feel confident about themselves, and direct them to the resources and institutions that would help them obtain the necessary skills to reach their goals. Ellie believed that offering this type of guidance “empowers the youth to be able to stand on their own.” Further to this point, participants maintained that cultural guidance played a significant role in supporting the youth. This point is connected to the healing

traditions and teachings of First Nations and Inuit peoples, which are centered around spiritual guidance, ceremonies, and practices that help to build self-esteem and enhance well-being (Nabigon, 2006; Dell et al, 2005).

Encouragement was identified by six (43%) of the respondents in this study as an important part of social support. As Mike explained “*[support involves] people who validate your accomplishments and show that they are proud of what you have done.*” Respondents (21%) also felt that trust and safety were part of what it means to be socially supported. Sarah’s comment highlights this finding, she said, “*I think social support means the safety of the kids, how safe they feel with a person and uh, in order for them to share and become open and for that relationship to grow and develop there has to be some trust...in order for the trust to come there has to be safety.*”

Aside from the connection to positive role models, participants also pointed out that instrumental aid and structural services could act as a form of social support to the youth. As Mike said, “*social support can come through formal services too.*” The examples that participants identified covered a wide range of types of services. Some included community recreational centres, social assistance, community councilors, and addiction and mental health programs. For instance, Emily commented,

Supports to me are people in the community like recreation directors that operate the school gymnasium or the library that has computers and different things like that so that the kids can go places other than somebody’s house to sniff gasoline or maybe the bush where they meet...or wherever.

These types of support are particularly important when the youth are coming from high-risk environments where pro-social primary socialization sources may not be

available. In those circumstances, secondary socialization sources such as government institutions and community resources may take the place of the primary sources (Anderson-Garcia, 1999).

b) Social Support During Treatment

Participants were asked various questions relating to the social support that youth receive while they are attending treatment at the *Nimkee NupiGawagan Healing Centre*. This sub-section of the paper reviews the responses to two key questions: 1) how important is social support to the well-being of the youth while they are in treatment? and 2) what does the *Nimkee NupiGawagan Healing Centre* do to increase social support for the youth?

Almost all of the participants (93%) agreed that social support is key to the well-being of the youth while they attend treatment at the *Nimkee NupiGawagan Healing Centre*. Comments from a few participants illustrate this finding,

Paul: It is uh, a big factor you know that we have that. As I said, when they come in they feel isolated, they are scared, they don't know why you know. So to make them feel comfortable here is probably the first step to allowing them to benefit from any of the groups or programs.

Karli: I think it is really important. Its helps them grow, it helps them to trust and to open up...they can feel safe while they are here.

Constance: It is the most important thing, the emotional support and anything that makes them aware of their feelings and connect to their emotions. A lot of our youth cut that off when they come from a hard background or when they start abusing drugs, they cut themselves off.

Jill: It is very important, um, it's their whole programming. We make sure we are there for them and that they have the support they need through community involvement and workshops we provide and the relationships that they build.

The participants of this study identified both formal and informal sources of social support that are offered to the youth while they are attending treatment at the *Nimkee NupiGawagan Healing Centre*. When discussing formal procedures it was most often noted that the program offers the youth an opportunity to connect with their tradition and cultural identity. Emily explains why this is such a significant part of the program, she said,

If you were to come to graduation and listen to their stories about what they have learned in treatment and how treatment has helped them you would be truly amazed at what they can say about themselves. And almost 100% of them will say it is the cultural part of the program that has had the biggest impact on them because it gives them that sense of identity, it gives them back all of those things that they have lost, that all of us have lost.

Constance also commented on the importance of offering culture awareness to the youth, she said, *“it starts with building up their self-esteem, making them feel important, making them aware of their culture and their background. I would say that a big thing is the spirituality that they gain while they are here, you know that they have a spirit and they are a good person.”* The goal of social support is to enhance self-esteem and resilient responses in youth. This finding demonstrates that cultural awareness and teaching as a form of social support can have a positive influence on the youth. It is aligned with traditional First Nations and Inuit healing practices, which highlights the alliance between spirituality and strength; “the spirit is not a material form, so it is indestructible” (Dell et al., 2005:5). The connection to cultural identity that is offered at the *Nimkee NupiGawagan Healing Centre* is based on a basic belief that is consistent across cultural variations (e.g., First Nations and Inuit communities) and comes from commonalities across teachings from each culture,

which are essentially their creation story and the medicine wheel. As Christine explained,

The Creator made 4 colours of people and gave to each of them their own orientation (gifts, world view, traits / characteristics) and land by which to live in the world. Inuit and First Nations are all one colour or one Nation- 'The Red People' and have fundamental similarities, such as belief in all of creation as an essential relative, helpers to our daily living. The cultural differences come about in the practice of beliefs. For example, there are different ways we live on the land and different ways of knowing our relationship to the land because of the land differences. So in treatment we can't possibly get to all of the differences. We focus on the foundational similarities while respecting that there are differences. One of the critical areas that attention to cultural identity addresses is the shame that has displaced a positive connection to cultural identity; the shame instilled through historical oppression and current day racism, both of which impacts upon the addiction and misuse of substances.

Additionally, primary socialization theory maintains that cultural identification plays a significant role as a protective factor (Oetting et al., 1998c). This finding is discussed further in the section that reviews the relationship between resiliency and social support.

The respondents also identified other aspects of the program that provide social support to the youth. For example, the groups and workshops carried out at the centre act as a source of social support. As Adele said, "*all of the groups we do at the centre encourage [the youth] and help them to deal with the issues that are coming up in their lives.*" Jill provided an example to this when she said, "*[one part of the groups] is teaching them how to walk away from peer pressure.*" Another method that they use to increase social support is building 'buddy systems' among the youth. Sarah and Jesse explain,

Sarah: We take um, two from a community. We try to take two from a community so that when they go back they can support each other.

Jesse: You can't just bring one kid in from one community and then send him back. We try to bring in a few from each community then that way they can network with each other when they are having troubled times. And yah, when they return to their communities they interact with each other and some of what they come up with is what they learned at Nimkee.

In addition to this, they bring in Elders and community members from neighbouring communities to participate in ceremonies and offer added support, they identify other positive role models and support services that the youth have available to them in their own communities (e.g., other members of the community who have been to treatment, Elders in their community who are “*clean, straight and sober,*” or counselors and youth workers), they expose the youth to different environments that get them involved in pro-social recreational activities, and they act as continuing support for the youth once they leave treatment through their toll free phone line.

The forms of social support described above are all formal approaches or part of the *Nimkee NupiGawagan Healing Centre's* objectives and initiatives that ensure the youth receive social support. I will turn now to a brief discussion of some of the informal personal responses that the participants identified. These were consistent with their definitions of social support. That is, the participants believed that they offered the youth social support by connecting to them through communication, love and acceptance, guidance, encouragement, and trust.

The communication they offered was twofold. It involved listening and being empathetic to what the youth were going through, as well as teaching them how to be in touch with and identify their own feelings. The participants also created a sense of belonging and acceptance for the youth. They felt it was important to “*make them feel connected to somebody/something,*” to “*nurture them*” and to “*fulfill their needs.*”

They also offer the youth advice and guidance as a form of social support. As Emily said,

All of us here are or almost all of the population here of staff are First Nations so we all have a lot of background knowledge, information, uh, personal experiences that we have gone through in our lifetime that I think is a wealth of information and knowledge that we can share with the youth and in many different forms right?

Sarah also felt that their advice and opinions were important forms of social support, she said, *“it is really important to hear what others have to say...and through their own experiences how they have gotten out of whatever issues that they have had or situations. To know that there is hope, I mean that’s the thing, it’s always giving them hope.”* Respondents also believed that as part of the guidance, they help the youth find their identity. For example, Sarah said that part of the social support is *“developing or helping them find their identity and helping them build on their strengths.”* A further part to this is offering the youth spiritual guidance and helping them with their *“life journey.”*

Encouragement was also identified as a way in which the treatment providers and staff offer the youth social support. Encouraging the youth involved instilling confidence in the youth and building their self-esteem, asking them their opinions and showing them they have a voice, offering reassurance, getting them involved in decision making, and simply believing in them. For instance, Sarah said, *“[we] encourage and empower the youth, show them their strengths, give them a voice, and [teach them] negotiation skills that empower them and [get them] to realize that they have choices and they have the freedom to make them.”* Trust was crucial to the social support that the treatment providers and staff offer to the youth. More specifically, this involves creating a safe environment where the youth are able to

open up, feel comfortable, and share their emotions and feelings. Emily explained, “*we don’t have those big barriers, those big walls [we have] a very informal environment and to me that makes it much more approachable for the youth...I think that is a big factor in getting them to trust.*”

To summarize, social support plays an integral role in the well-being of the youth while they are attending treatment. As Lisa said, “*the program is basically set up to support.*” I turn now to a discussion on the relationship between social support, resiliency, and the post-treatment well-being of the youth.

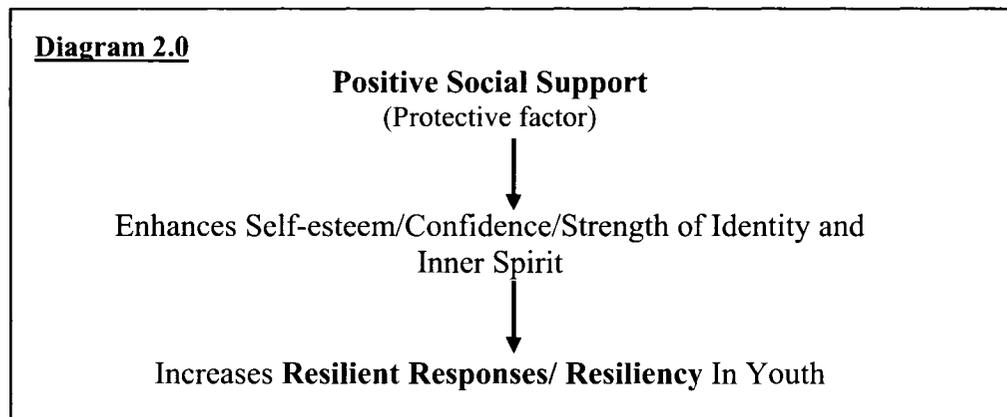
c) The Relationship between Resiliency and Social Support

This section has two goals: 1) to clearly define and explain the relationship between social support and resiliency and 2) to review responses to questions that link social support to resiliency and the post-treatment well-being of the youth.

Resiliency is defined as the ability to recover from adversity and cope with continuing stress and risk in an effective and positive way (Wolin & Wolin, 1995). The *Nimkee NupiGawagan Healing Centre* employs a holistic perspective of resiliency, which maintains that resilient responses are formed through a balance between the inherent ‘inner spirit’ of the individual and community supports (Dell et al., 2005).²⁹ This is similar to the protection literature, which groups protective contributions into two categories: 1) those that are innate or individual and 2) those that are made available through external supports. The findings presented here look exclusively at the latter category, as this is where the concept of social support fits. Broadly speaking, these findings suggest that social support helps to build the youths’

²⁹ The holistic approach also acknowledges the influence of risk and protective dynamics (Dell et al., 2005)

confidence, strength, and “inner spirit” which in turn enhances resilient responses within the youth. This relationship is best described in the following diagram:



When participants of this study were asked, “do you feel that the social support that you offer to the youth while they are in treatment influences the way the youth seek out social support following treatment?,” the majority agreed that it did. They felt that the social support that they offer the youth helps to build their self-esteem, so they are better able to recognize and express their needs. As Mike said,

From talking to some of the youth that have left it is because they are able to uh, they have the confidence and their communication skills are better so they can like let people know what their needs are. Whereas before ...they would have this attitude that no one cared about them so like, why ask anyone.

Ellie echoed this sentiment when she said,

Nimkee gives them the courage to go into their community and say like hey, look I did this. Or, go to their aunties and uncles or grandmas and say, I need this. So I think [the social support we offer here] does help them because like I said, a lot of them find their voice here and once they get that self-confidence they are able to use that voice.

The participants were also asked to identify some of the positive changes that the youth make in their lives once they leave treatment. The most frequently reported changes were staying connected to their culture and going back to school. Emily

commented, “a lot of them when they leave here they will go to ceremonies, some of them will go to Sundance ceremonies in Manitoba...so they participate in ceremonies and things like that.” Constance said, “They discover that they have a spirit and a spirit name and culture ...they take a lot more time to themselves...I guess you would say they are more in touch with themselves.” Christine provided an example of how connecting to their culture could help the youth overcome risk and cope with stress, she said,

There was a young girl um, who called after she left treatment and she was telling us how she had all this pressure from her peers and her brother as well about uh, getting into substance use again. And she was talking about what a struggle it was to say no and so whenever she felt lonely or she felt she was having a really hard time she would take her tobacco, which is a sacred medicine, and she would go and sit by the water and she would pray. She said it brought her a lot of peace and comfort and strength.

Dell, Dell, and Hopkins (2005:5) explain, “in the First Nations perspective the attachment to the creator and ways of accessing the creator through spiritual ceremonies and practices are important factors in building resilience.” Similarly, primary socialization theory maintains that cultural identification plays a significant role as a protective factor (Oetting et al., 1998c). At the *Nimkee NupiGawagan Healing Centre*, traditional healing and cultural values are placed in the forefront. The importance of history, tradition, and culture to the youths’ well-being is evident. In particular, these findings suggest that connecting to culture as a form of social support may transcend treatment, enhancing a youth’s ability to cope and overcome risk when they return home.

Participants also reported that many of the youth return to school once they complete treatment. More specifically, they believed that when the youth leave treatment, many of them are going home and “*setting clearly marked goals for*

themselves” and trying “to better themselves through education.” For instance, Emily said,

One of the big things that I see is a lot of them make a sincere effort to go back to school and we've had a lot, not 100%, but a good percentage of them who stay in school...that is a really big plus to me because school is going to provide a way out for those who do want to leave their community and want to seek uh whatever. Education to me is key.

Jill explained how the social support and assistance that is offered through the academic component of the treatment program contributes to the youth making positive choices post-treatment. She said, “*they start going back to school because they are caught up after they come to Nimkee so they might feel more confident doing their work.*” Returning to school will provide the youth with greater opportunity to bond with pro-social primary socialization sources (Oetting and Donnermeyer, 1998). This is an interesting finding, given that the participants identified ‘lack of relevant school curriculum’ as a risk factor for VSA.

Other changes that were mentioned include changing their peer groups, changing their living arrangements, employing harm reduction strategies, and starting support groups in their own communities. Regarding peer groups, Mike commented, “*they recognize that they have to change their peer group. They need to sometimes make significant changes in their peer group in order to get away from that behaviour. They have to leave that environment.*” Paul also felt that “*some youth...I think they make a conscious effort to hang out with you know, the good kids and not the bad kids. They try to change groups and become more focused on other activities rather than just getting high.*” This is key to primary socialization theory’s guiding principles. That is, the youth must recognize the need to re-establish their primary socialization sources (in particular, negative peers) after treatment (Oetting, 1999).

Another positive adjustment that some of the youth make in their lives is changing their living arrangements. Jill said, *"I spoke to some youth and a lot of the times they move. They will move when they get back. They will move with a family member in another town or in another part of the country and start a new school so...this is probably a good change."* Karli explains why moving can be a positive change for the youth, she said,

Some of them come from unstable homes and what they identify here is that that is not good for them and when they return they don't want to go to their homes. They will ask to go to their Grandma or Grandpa's and stuff, so they try and make that choice for themselves...they make a lot of choices on their own because they start learning what they need and what they want while they are at [Nimkee].

Harm reduction is yet another approach that the youth take that contributes to their improved well-being. More specifically, some youth do not stop using substances altogether but after being at the *Nimkee NupiGawagan Healing Centre* they are more aware of the danger volatile solvents can cause, so they turn to other, less hazardous substances such as marijuana. In keeping with the *Nimkee NupiGawagan Healing Centre's* definition of success/well-being, harm reduction approaches are supported. As Anton pointed out, *"it is success when we hear of kids who have stopped using solvents but are using something else um...they are switching drugs [employing harm reduction strategies]."* Similarly Christine said,

I don't know when it was 98' or 99' maybe. The kids went home at Christmas time...and when they came back from there visit, I remember these boys they were all from the same community, and when they came back they were so excited and full of pride that they didn't sniff they just smoked marijuana. It was our first experience with that, with the idea of harm reduction...but at least they weren't at risk for death in those moments that they were using.

Some of the youth also start support groups in their own communities.

Responses from some of the participants describe a few of the approaches to continuing support that the youth have used.

Emily: [One youth] has a group of young people that come to her house now and [she uses] some of the lessons that she would have in group here. She has her own little groups with teenagers in her community...she is trying to help young people in her community.

Christine: We had this young girl, she came into the program in probably 98'...what she did was, well she noticed that there were both youth and adults who were leaving the community um, to go to treatment for addictions. So she started to go visit them when they would get back...and she would ask them about their treatment experience and she started asking if they could consolidate all of their treatment materials. So all of the papers, all of the workbooks, all of the materials that they had brought home with them. Then she started a group.

Karli: We have a lot of youth who um, email each other and connect through the Internet and keep in contact, either by writing letters, emails, different things like that.

These findings demonstrate how the youth have learned through their experience at the *Nimkee NupiGawagan Healing Centre* to better cope with the stresses and risks that are present in their lives. Social support, as a protective factor, reduces the vulnerability of the youth, and in turn enhances their resiliency, which helps them to maintain their treatment success and well-being. As part of the social support that the youth receive, they are challenged to look inwards to identify their strengths. Sarah's comment summarizes this point, she said,

It's all the developing that the kids do when they are here. I mean the identity building, being proud that they are Native, learning that they have a spirit name, knowing that that spirit name means something. It grounds them to know that they can be alone with themselves, they learn that through fasting...when we experience that quietness, when we are out there we realize, hey I can deal without that stuff I need to really pay attention to what is going on inside of me...because I mean ourselves is who we live with and we have to learn to live in our body and be proud of who we are.

Moreover, the social support that is offered to the youth while they are attending treatment instills confidence and responsibility in the youth, which in turn enhances their ability to make positive and resilient choices. These findings also demonstrate that youth who come from high-risk environments will not inevitably succumb to a life of deviance. Though further research exploring the relationship between the changes the youth make in their lives post-treatment and the social support that they are offered in treatment is necessary, the findings of this study suggest that many of these changes are the product of enhanced self-esteem and confidence, resulting from the social support that is offered through the *Nimkee NupiGawagan Healing Centre*.

d) Social Support in the Well-being of Youth Post-treatment

To answer the question, “to what extent does social support affect a youth’s well-being after a treatment episode for VSA?”, it was necessary to consider both its importance and availability. In general, the treatment providers and staff that participated in this study felt that social support was very important to the youths’ well-being post-treatment but that it was not always available to them. As was mentioned in the section that reviewed post-treatment risk, many of the youth are oftentimes returning to high-risk environments. As a result, the social support is not always available to them. Karli commented,

They learn the skills while they are here, like how to talk to people, how to communicate, what is important but when they go home that is not necessarily there for them. They are coming to treatment and working on themselves for four months but then at home everything is still the same.

Similarly Mike felt that in many instances the youths’ accomplishments go unnoticed.

He said,

No one validates the great things that they have done right. Like you know...they are benefiting themselves for the future and that is huge and you

know there is no validation of that when they return home...it is a low percentage that do return home and someone does acknowledge their accomplishment.

Paul noted “*a lot of the youth express frustration that they...they are scared when they get here and they are scared when they leave because they have to go back to the same old crap you know.*” Karli continued to express her concerns, claiming that parents need to be more accountable and responsible for their actions. She said,

Sometimes I feel like um, these guys are coming here and these kids are awesome for coming here and they are courageous. They are staying here for four months and the parents have that break and that opportunity where they are not with their kids...but what are they doing in the meantime like to help them? They could be creating a more supportive environment, or getting parenting skills, or anything you know but there is a lack of that there.

This particular finding overlaps with what has been discussed in the section that reviewed post-treatment risk. I would like again to point out that these comments do not refer to all families; some are taking action. For example, Christine, like Jesse said,

We have a lot of families who go to treatment themselves as a result of their youth participating in the program. There is a family treatment centre down the road [Kii-kee-wan-nii-kaan Healing Lodge] and so some of the kids and their families have gone to the family treatment program, or referral workers have insisted that parents go to treatment while their kids are here and um, so we have a lot of families who are in their own healing process.

Some participants were also concerned about the lack of community resources and supports. For instance, Mike believed that it was “*crucial that the community is active in the youths’ lives*” but that this is sometimes difficult to achieve. For instance, “*there may be one worker that covers like six communities...there is really no capacity in those First Nations to really support the youth when they go back.*”

Similarly, Constance said, *“there are just not enough resources in their community to provide the [social support] that the youth need.”*

Although it may not always be readily available, the participants believed that it was essential that youth continue to receive social support once they left the treatment centre. In fact, social support was identified by the participants' as one of the youths' immediate needs following treatment. In particular, the respondents noted that *“the youth need to have a supportive family and a healthy connection to one another so that they can continue to develop their relationship”* and they need *“to be accepted back into their community and get support for that transition back home.”* Sarah also stressed, *“it is really important for the community to have some programming in place for them when they go home. Something for them to do that is healthy...something that will enhance their skills and help them to cope better.”* This includes having community resources available to them such as cultural ceremonies, strong community leaders and Elders, and drug free environments.

A further concern that was brought up by the majority of participants in the study was that there is not enough aftercare and follow-up for the youth. They argued that social support and continued care are essential to the youths' well-being post-treatment, but that *“the funding and resources are just not there.”* For instance, Christine said,

We don't have the budget to go [visit the youth in their communities] and the communities don't have a budget to bring us so that is a big barrier um, to the aftercare. Families and communities want that. They want us to come to the community, they want us to visit regularly, and they want us to do programming. We just can't afford it.

As a result of financial constraints, they cited strain on the treatment providers and staff as a further limitation to offering the follow-up and aftercare that the youth need.

For example, Sarah commented,

I would just really like to see more um aftercare done from the treatment centers. I mean we try to do follow-up work here...but then that follow-up [and the training involved with doing follow-up] is then added to our job, so our job just becomes bigger. We need a person to do all that stuff here because it is just too much...It is really time consuming so it would be nice if we had a person focusing just on follow-up and working on the 1 800 number to talk to the kids.

Further to this discussion, many participants felt it was necessary that follow-up and aftercare programs be developed, implemented and carried out by the communities themselves. This was also evidenced in the findings that outlined the importance of community, culture, and traditional healing. As Emily noted,

I think it has to start in the community...My personal belief is that we can pump all kinds of dollars and all kinds of support people in there but I think we need to go in and actually...you know, it has to come from the community. Going back and teaching and giving them the culture and giving them the skills that they have lost along the way.

For the population under study, community support plays a strong role in the youths' well-being. This points out a potential flaw with utilizing primary socialization theory as my theoretical framework. Primary socialization theory views community as a secondary socialization source, however, the assumptions of primary socialization theory focus on the socialization sources of adolescents within dominant western culture (Oetting and Donnermeyer, 1998). This finding demonstrates the need to reconsider, or at least acknowledge, that primary socialization sources may differ within this population.

I will turn now to the conclusion, where I summarize my key findings, report policy implications, identify the limitations with this study, and outline avenues for future research.

CHAPTER SIX: DISCUSSION/CONCLUSION

This project focused on the contribution that the concept social support makes to the substance abuse field. In particular, this research addressed the extent to which the presence of positive social support affects the well-being of First Nations and Inuit youth after a treatment episode for volatile solvent abuse (VSA). In this chapter, I begin with a summary of the key findings that were uncovered in this study. I explain how the findings support the primary socialization model presented in Chapter Two and I provide some suggestions for expanding and improving upon the theory. I then discuss the limits of the study. Following this, I explore the policy implications resulting from the project. And last, I consider future directions research in the area could take.

I. Discussion of Key Findings

In order to answer the research questions posed in Chapter One, it was necessary to first consider how the issue of VSA intersected with the wide range of other social and environmental problems (risk factors) that are present in the youths' lives and how these dynamics potentially interfered with the formation of protective/resilient responses. The participants of this study identified a number of risk factors that are present in the youths' lives both before and after treatment.³⁰ Many of the risks they discussed were parallel to those found in other VSA research and the general substance abuse literature (e.g., poor academic performance, low perceived self-worth, family history of violence). However, some new risks also emerged. These include gender differences in aggressive behaviour, lack of cultural identity, no sense

³⁰ A table outing the risks that were identified can be found in the Appendix (Appendix 5)

of the future, poly-use, guardianship, other mental health issues within the family, bullying, lack of connection to school curriculum, inadequate schools with little or no expectation for success, religious infiltration, media and technology, lack of trust within their communities, stigmatization within their communities, and high rates of tragedy and crisis within their communities. In addition to identifying risks, this study investigated how social support works as a form of protection for the youth. To summarize, it was concluded that social support helps to build confidence, strength, and “inner spirit” in youth, and this in turn, enhances resilient responses within them.

In review of the findings, it became clear that the results of this study support, in many ways, the assertions made by Oetting and colleagues in their theory of primary socialization. The results highlight six main features: 1) weak bonds with family and school environments can increase the chance a youth will bond with deviant peers, 2) secondary socialization sources, such as community characteristics, can be a source of risk, 3) individual characteristics can influence behaviour, 4) peers are often the source of deviant norms, 5) culture plays a significant role in the outcome of an individual’s attitudes, beliefs, values, norms, and behaviours, and 6) healthy environments that provide positive social support contribute to positive outcomes (attitudes, beliefs, values, norms, and behaviours) and increased well-being.

To begin, the findings of this study demonstrate that weak family and school bonds, resulting from high-risk environments, can increase the chance that youth will engage in deviant activity, such as VSA (Oetting and Donnermeyer, 1998). For example, participants felt that marital status and lack of communication were major barriers to establishing a strong family unit. In addition, the respondents’ argued that

weak school bonds, resulting from risk factors such as little or no expectation for success, could lead to youth engaging in negative peer groups and participating in negative peer activities (Oetting and Donnermeyer, 1998).

This project also provides evidence to the claim that secondary socialization sources can act as a source of risk through their influence on the primary socialization process. Secondary socialization sources influence the norms that are transmitted through primary socialization and can either strengthen or weaken the bonds between the individual and their primary socialization sources (Oetting et al., 1998b). One example provided in the interviews was government funding controls on Aboriginal housing. Government funding grants, which aim to support and aid families, can also cause feelings of defeat and dependence. These feelings are then transmitted into the social attitudes and behaviours that are expressed by families (Oetting, 1999). Similarly, economic conditions (such as lack of job opportunity) were identified as risk factors for VSA. The findings of this research show that unstable economic environments may create feelings of hopelessness and, in turn, negative social outlooks that affect bonding with pro-social primary socialization sources (Oetting et al., 1998b). Further, the participants of this study identified community characteristics that could contribute to a youth's opportunity to strengthen bonds with antisocial sources and participate in deviant behaviours (Oetting et al., 1998b). For instance, lack of recreation and structured activities within communities are risks for VSA because community characteristics such as these encourage youth to participate in unstructured and unsupervised forms of entertainment.

The results of this study are also in agreement with the proposition that individual characteristics can influence behaviour (Oetting et al., 1998a). To elaborate, youth are not simply passive subjects that fall victim to risk. Personality traits are risk factors for deviant behaviour because they increase the likelihood that youth will be involved with other youth who engage in certain types of behaviour (Oetting et al., 1998a). To illustrate, Jesse said, “*you know, birds of a feather will flock together.*” Further to this point, participants agreed that peers are influential during adolescence and can quite often be the source of deviant norms (Oetting et al., 1998a). For example, respondents identified peer pressure, bullying, and proximity to other solvent users all as risk factors for VSA. Respondents also recognized the need to eliminate negative peers from the youths’ immediate environment after treatment. This is congruent with primary socialization theory’s position that youth must re-establish their primary socialization sources (in particular, negative peers) following treatment (Oetting, 1999).

This research also recognized that culture plays a significant role in the outcome of individuals’ attitudes, beliefs, values, norms, and behaviours. For instance, lack of cultural identity is identified as a risk factor for VSA because youth who do not have a strong connection to their culture do not have access to the positive influences and rewards that culture can provide (Oetting et al., 1998c). It was also observed that dominant western culture and ideologies can increase risk and negative outcomes for those who are outside of that culture. An example provided was the school system. Participants argued that the material being taught was not relevant to the youths’ everyday lives and experiences and thus, a risk factor for VSA. Another

example of how dominant culture can negatively impact those who are subject to it is social isolation. Many communities are struggling to maintain their own tradition, culture, and identity among the mainstream culture of North America. Identifying social isolation as a risk supports the idea that ethnic minorities that struggle to maintain ethnic identification and cultural norms are at a disadvantage (Oetting et al., 1998b).

Also revealed was the relationship between social support, resiliency, and culture. In particular, it was observed that connecting to culture and traditional healing practices as a form of social support may transcend treatment. This contributed to a youth's ability to cope and overcome risk when they return home. Moreover, many of the respondents in this study argue that culture (expressed as a form of social support) plays a significant role as a type of protection in the youths' well-being. This statement is in agreement with primary socialization theory's assumption that culture and cultural identification are forms of protection (Oetting et al., 1998c). And, it is also aligned with the healing traditions and teachings of First Nations and Inuit peoples, which are centred on spiritual guidance, ceremonies, and practices that help to build self-esteem and enhance well-being (Nabigon, 2006; Dell et al., 2005).

Taken all together, the results of this study indicate that healthy environments that provide positive social support contribute to positive outcomes (attitudes, beliefs, values, norms, and behaviours) and increased well-being in youth. For instance, participants observed that after treatment, many youth make changes in their lives that contribute to their positive well-being. Some of these include maintaining a

cultural connection, returning to school, changing their peer groups, changing their living arrangements, employing harm reduction strategies, and starting support groups in their own communities. These efforts to create and maintain healthy environments aid in enhancing the youths' well-being. What's more, the findings of this study support the notion that youth who come from high-risk environments can 'bounce back,' overcome adversity, and make positive choices and changes in their lives (Dell et al., 2005; Wolin and Wolin, 1993).

These findings identify three areas for further investigation and theorizing within the primary socialization model. As was discussed in Chapter Two, Oetting et al. do not adequately address whether or not youth can succeed in environments where forces are acting against them. The results of this research suggest that they can. The *Nimkee NupiGawagan Healing Centre* uses philosophies that encourage youth to build on their strengths. This approach helps to reduce the vulnerability of the youth, and in turn enhances their resiliency, which helps them to maintain their treatment success and well-being even when they return to high-risk environments. Additionally, it would prove useful if Oetting et al. included some discussion on the of concept well-being. Earlier, I argued that positive outcomes that result from pro-social bonding can increase the youths' well-being. The results of this study are in agreement with that statement. In other words, pro-social bonds, resulting from positive social support, increase the opportunity for positive outcomes, which in turn enhance the youths' well-being. Furthermore, the theory should expand by considering gender differences that may be present during adolescence. Although findings relating to gender in this study were minimal (e.g., differences in the way in

which aggressive behaviour is acted out) future research would benefit from more discussion regarding gender and how it affects risk, protection, and primary socialization.

II. Limits of this Study

It is important to reiterate that my research sample was not intended to be generalized beyond the studied population. I used a non-probability theoretical sampling strategy, which did not call for whole representation of the population. The sample was drawn from one treatment facility, and so some may argue this results in a homogeneous sample (e.g., their perspectives could be experiential and based on such things as their resources/funding, their community strengths, and/or their geographic location). It is possible that different findings could have emerged if the respondents were from different treatment centres or different stakeholder groups. Moreover, this problem could have been eliminated if a more rigorous approach of triangulation was employed. Ideally, I would have liked to interview treatment providers, community members, and the youth themselves, though this was not possible due to both time and funding constraints.

A second limitation with the methodology I used is that the sequence in which the questions were asked about pre- and post-treatment risks limited the responses that were given regarding post-treatment risk. Participants spent a considerable amount of time during the first half of the interview describing in-depth the risk factors that are present in the youths' lives pre-treatment. When I asked questions about post-treatment risk most simply stated that they were the same as those that

they described for pre-treatment without elaborating further, even though I probed. This resulted in a smaller section of findings in Chapter Five for post-treatment risk.

A further limitation to this study is that not all the youth who attend the *Nimkee NupiGawagan Healing Centre* are habitual volatile solvent abusers.³¹ Some abuse other substances such as alcohol, cocaine, or methamphetamines.³² As a result, it was difficult to isolate the risk factors that contribute solely to VSA. Although participants were asked to identify the risk factors associated with VSA, it is possible that some of the respondents were identifying risk dynamics for the youth who attend their treatment program in general. Additionally, the findings of this study suggest that there is significant overlap between the risks reported for VSA and for substance abuse in general. This is not a substantial setback, though it is necessary that I acknowledge it as a potential limitation with the findings.

It is also important to point out the flaws of utilizing primary socialization theory in this study. The primary socialization model provided by Oetting et al. is based on 'average' youth living in the dominant western culture (Oetting and Donnermeyer, 1998). Culture, however, is key to the primary socialization process. In fact, culture determines the socialization sources that communicate the norms, values, attitudes, and beliefs of individuals belonging to a culture (Oetting et al., 1998c). The findings of this study may have been interpreted differently if the primary socialization model was realigned to consider the unique population under study.

³¹ Approximately 25% of the youth are not currently abusing solvents but have at some point experimented with them.

³² This was made known during the interview process, whereby several participants indicated that not all of the youth who attend their centre are volatile solvent abusers. For example, Jill said, "they are not all solvent abusers, I didn't know if anyone had told you that...but that's not to say that the client has never used solvents [it just might not be their main drug of choice]."

Determining the primary socialization sources for First Nations and Inuit peoples is something that needs to be investigated further. I suggest that the repressive and marginalizing historical circumstances that Canadian Aboriginal peoples have endured could contribute to confusion, disagreement, and difficulty in identifying their primary socialization sources. Identifying such sources may only be possible through full redemption of Aboriginal cultures, traditions, languages, identities and lands. A similar problem with the theory is that it fails to consider some of the more devastating circumstances that disadvantaged youth may endure. Many of the youth who attend treatment at the *Nimkee NupiGawagan Healing Centre* come from communities that are marked by systemic racism, extreme poverty, loss of culture and tradition, and isolation. More insight on marginalized youth would have proved useful in this study.

III. Policy Implications

The results of this study show that approaches to treatment that focus on both building assets and/or protection within youth and reducing risks in their social environment are most valuable to their treatment success and well-being. Through positive social support, the *Nimkee NupiGawagan Healing Centre* is able to enhance protection in the lives of youth. The participants in this study believed that their social support is also vital to the youths' well-being post-treatment, but that funding restrictions limit their efforts. As such, improved funding and long-term support are necessary. More funding provided to youth VSA residential treatment programs would allow them to expand their staff and offer continued social support and follow-up care.

The participants of this study also recognized the importance of risk reduction. For example, the participants felt that in order for the youth to achieve treatment success and well-being they had to make changes to their social environment once they returned home (thereby reducing risks). The treatment success and well-being of the youth could be improved upon if there were policies that ensured families also sought help. A healthy family environment would serve to eliminate a significant amount of risk. It would also prove useful to conduct policy research related to the school environment. Creating a school environment that considers the cultures, traditions, and languages of First Nations and Inuit youth may help to better serve their needs, thereby eliminating risk.

IV. Directions for Future Research

There are other directions that future research on this topic could take. For instance, it would prove valuable to consider more closely the relationship between the social support that youth receive while in treatment and the resilient responses of the youth post-treatment. This could be explored through an in-depth examination of the positive changes that the youth make in their lives post-treatment. In particular, it would be useful to understand the youths' perceptions about why they make those changes and how those changes contribute to their well-being. Studies such as this would extend our understanding of resiliency and in turn allow us to contribute further to Oetting and colleague's theory of primary socialization.

In addition, our current understanding of what puts youth at risk might be furthered by carrying out an investigation of the risk factors that have been identified in this study but not reported elsewhere (e.g., gender differences in aggressive

behavior, lacking cultural-identity, involvement with the criminal justice system, guardianship, other mental health issues within the family, lack of connection to school curriculum, religious infiltration, lack of trust within communities, stigmatization, etc.). Of particular interest to me, is the relationship between substance abuse and stigma. It would be interesting to follow-up on this by undertaking an analysis that focuses solely on the relationship between these two variables. Another area where more focused research should be conducted is the school system. Research on risk, in particular among Aboriginal youth, would benefit from an investigation that focused solely on the role of the school environment, as the findings of this study reveal contradiction on this subject. For example, participants argued that the current school system was detrimental because it does not meet the needs of First Nations and Inuit youth but also that it was important to their future and well-being that they receive an education. An analysis such as the one suggested may serve to improve the role of the school system and in turn add to the protective contributions in the lives of First Nations and Inuit youth.

Furthermore, our knowledge of social support and post-treatment well-being of First Nations and Inuit youth who abuse volatile solvents could expand greatly if a diverse assortment of stakeholders (e.g., treatment providers, community leaders and Elders, families, etc.) were asked how they feel about it. For example, I only spoke with the treatment providers and staff at the *Nimkee NupiGawagan Healing Centre* and I am curious to know what community members, families, and the youth themselves think about social support and post-treatment well-being. Research in this area may also benefit from an investigation that looks exclusively at culture. The

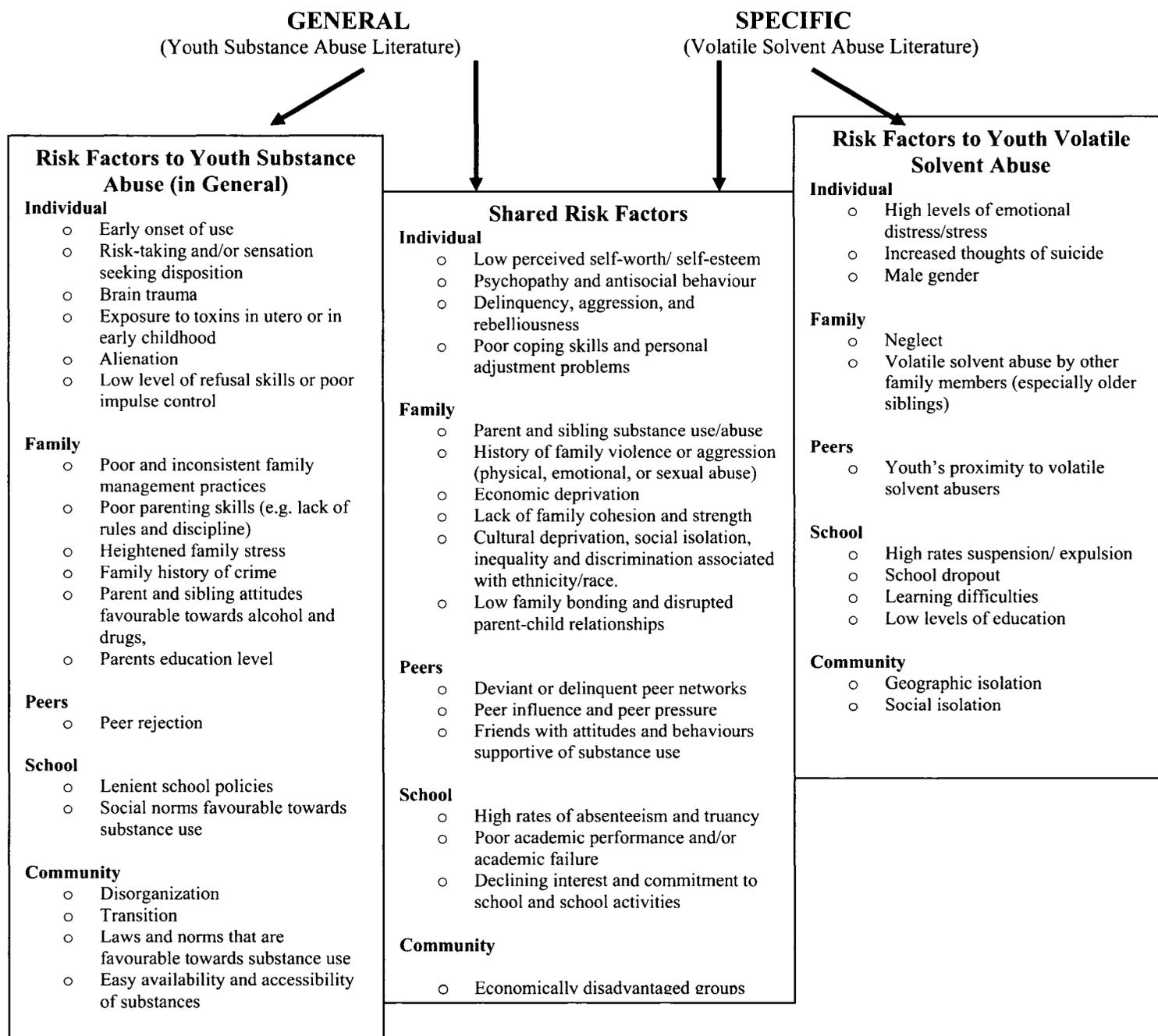
findings of this study suggest that culture plays a significant role in the well-being of First Nations and Inuit youth who have attended treatment for VSA. Thus, it may be important to consider how treatment accounts for cultural variation (e.g., First Nations and Inuit) and/or whether or not cultural needs need to be distinguished. Lastly, as was mentioned previously, there is a dearth of information regarding youth VSA in general. Thus, a large-scale Canadian survey on youth VSA may also help to further expand our knowledge on this topic.

To conclude, I provide a quote taken from a recent Canadian news article. The article demonstrates the practical applications of this research and shows how it is relevant to current situations in Canadian society. Shawn's story closely resembles the struggles that many of the youth who come from high-risk environments endure. More specifically, his story highlights the influence and affect of ones social environment and addresses the importance of social support and culture in overcoming risk and enhancing well-being.

Shawn Bernard has been caught up in substance abuse his whole life...When he was four, his mom died of an overdose. Bernard and his sister went to live with their grandmother in the inner city, where they watched relatives drink and get high...By six, Bernard was sniffing glue and paint with other troubled kids...After he turned 18, Bernard was on the streets "hustling flaps on the drag" (dealing coke on 96th Street)...He committed B&Es daily to pay for his habit and was charged dozens of times...Bernard's sister, Chrissy, was addicted too, working as a prostitute to support her habit. Last spring, she died of an overdose while Bernard was in jail after being charged with aggravated assault. "I wasn't there (for her) that time," he says...When Chrissy died, so did the old Shawn Bernard...Bernard realized he couldn't be a dad to his two sons if he was in prison or dead. He turned to aboriginal spirituality to help him get his life together. "I prayed and fasted and made promises to the Creator that if He gave me one more chance, I'd prove to everyone that I was serious," he says. Now, Bernard sees an Elder and depends on a support network of friends and family to help him through the rough patches. He hasn't touched drugs or alcohol for more than a year. "Sometimes I have my what ifs, but that's when I call my support, and smudge," he says. The 33-year-old still faces some criminal charges, but he is optimistic about the future. Bernard is currently upgrading at Norquest College so he can get into social work and help

youth get out of high-risk lifestyles. (Withey, June 03, 2006: *The Edmonton Journal*)

APPENDIX 1



Note: It is important to mention the debate about whether some of these factors existed prior to the use of substances or are outcomes of the abuse itself. Research is yet to provide us with a definitive answer, though it is an issue that should be kept in mind when reviewing information such as that presented above.

Sources: George et al., 2002; Catalano & Hawkins, 1996; Oxford et al., 2000; Manger et al., 1992; Guo et al., 2001; Pollard et al., 1999; Hawkins et al., 1992; Svensson, 2000; Mosher et al., 2004; Coleman et al., 2001; Bennett et al., 2000; Mackesy-Amity & Fendrich, 2000; Howard et al., 1999; Kurtzman et al., 2001; Marelich, 1997; Basu et al., 2004; World Youth Report, 2003; Corbett et al., 2004; White et al., 2004; Adalf et al., 2003; Dell et al., 2003; Van Til & Poulin, 2002; Hibell et al., 2004; Wille & Lambert, 2004; National Institute on Drug Abuse, site last visited 2006; Kilpatrick et al., 2000; Brook et al., 1998; Fendrich et al., 1997; Wu et al., 2004; Simpson, 1997; Kikuchi & Wada, 2003; Dinwiddie, 1994; Bellhouse et al., 2000; Beauvais et al., 2002; McGarvey & Clavet, 1999; Zabedah et al., 2001; Ballard, 1998; Maruff et al., 1998; Carroll et al., 1998; Shu & Tsai, 2003; Ho et al., 1998; Taggart 2003; Tapia-Conyer et al., 1995; Spiller, 2004; Cairney et al., 2002

**APPENDIX 2
INTERVIEW GUIDE**

Section 1: General Background Information

- 1) Male ____ Female ____
- 2) Race/Ethnicity: _____
- 3) What year were you born?
- 4) How long have you been employed at the *Nimkee NupiGawagan Healing Centre*?
 - a. How long have you been in your current position?
 - b. What other positions have you previously occupied at the centre?
- 5) Have you participated in any formal education programs or accredited workshops in the area of addictions?
 - a. Have you participated in any specific to volatile solvent abuse?
- 6) What is your current job position?

Executive Director ____
Treatment Coordinator ____
Nutritionist ____
Child and youth worker ____
Child and youth worker (team leader) ____
Night staff ____
Senior Treatment Councilor ____
Casual child and youth worker staff ____
Other _____

Section 2: Program Components

- 7) Can you tell be about a typical intake cycle?

Section 3: Pre-treatment Risk Factors

- 8) Can you tell me about the background of the youth who come to your centre?
- 9) Are there certain factors that the youth face within their communities that put them at risk for volatile solvent abuse?

- 10) Are there certain factors that the youth face within their families that put them at risk for volatile solvent abuse?
- 11) Are there certain factors that the youth face within their school environment that put them at risk for volatile solvent abuse?
- 12) Are there certain factors that the youth face within their peer networks that put them at risk for volatile solvent abuse?

Section 4: Social Support Within the Treatment Program

- 13) How would you describe social support here at the *Nimkee NupiGawagan Healing Centre*?
- 14) What do you do here at the centre to increase social support? (This could range from formal programs to informal, personal responses)
- 15) In your view, how important is social support to the youths' well-being while they are in treatment?
- 16) Do you believe that the social support that is offered while the youth are in treatment may influence the way the youth seek out social support after treatment? How so (or not)?

Section 5: Social Support Following Treatment

- 17) How important do you feel social support is to the youths' well-being after treatment?
- 18) Based on your experiences with the youth, how do they describe/define social support following treatment?
- 19) How do you define social support following treatment?
- 20) Do the youth relay experiences of social support once they leave the centre?
 - a. If yes, how do they describe the support they are receiving?
 - b. If no, how do they describe the support they want?
- 21) What forms of social support do you feel will best meet the needs of the youth after treatment?
- 22) What types, if any, of structured social support resources are available to the youth upon re-entry into their communities?

- 23) What types of changes occur in the youths' life domains (individual, family, school, peer, community) following treatment? And, how are these related to the types of social support identified?
- 24) What conditions (risk factors), if any, interfere with the youths' well-being when they return to their communities?
- 25) How do the youth overcome their former abuse?

Section 6: Closing Questions

- 26) Is there anything that you feel has been left out that you would like to comment on at this time?
- 27) Is there anything that you would like to ask me?

APPENDIX 3
LETTER OF INFORMATION

[Date]

Dear [Name],

My name is Tara Beauchamp and I am a graduate student at Carleton University in the Department of Sociology and Anthropology. I would like to invite you to take part in the research project that I am undertaking as part of my M.A. thesis requirement. My research interest lies in addressing how social support affects the well-being of First Nations and Inuit youth after a treatment episode for volatile solvent abuse. As a treatment provider/ staff member of the *Nimkee NupiGawagan Healing Centre* your insight and knowledge will be essential to this project.

This research will be explored through in-depth, semi-structured interviews. The interviews will focus on questions regarding what risk factors are present within the community, what social support is offered while youth are in treatment, what forms of social support you believe best meets the needs of youth after treatment, what you perceive as social support, as well as how youth relay their experiences once they re-enter their communities (e.g., what social support they are receiving and what they are needing). I have attached a copy of the proposed interview guide and I am welcoming your feedback.

Should you agree to take part your participation will not be anonymous. I cannot offer anonymity due to the small sample size (approximately 15 participants) and the fact that the interviews will be carried out at your place of employment (*Nimkee NupiGawagan Healing Centre*). Although I will not be able to guarantee anonymity while I am conducting the research, I will not use any names, job positions or other any other identifiers in my final thesis. Due to the nature of the anonymity that is being offered it is difficult to guarantee confidentiality. No quotes or responses will be attributed to individuals by name, job position or any other identifier in my thesis. Although I will not use any identifiers in my thesis, the risk of being identified still remains. That is, there may be assumptions among participants/co-workers about who said what. Moreover, those who choose to take part in the study should be aware that there is the risk that their views will be identified (or assumingly identified).

Should you agree to participate a one-to-one interview will be set up at a time that is convenient for you. I intend on tape recording the interviews, though you can decline the use of audio equipment if you wish. In addition, you will not be obligated to answer any of the questions being asked and you may withdrawal your agreement to participate at any time during the study. The interview will be approximately one hour in length and will take place at the *Nimkee NupiGawagan Healing Centre*. The data retrieved will be stored separately from the informed consent forms and will be destroyed upon completion of the project; that is, the files will be erased from the primary researchers (Tara Beauchamp) home computer approximately eight months from the time of the interview (December 2006).

APPENDIX 4 CONSENT TO PARTICIPATE IN RESEARCH

I _____ have agreed to participate in a research study conducted by Tara Beauchamp, which is being undertaken as part of her M.A. thesis requirement. This research study is being supervised by Dr. Colleen Anne Dell and is entitled: The Role of Social Support in the Well-being of First Nations and Inuit Youth Following Treatment for Volatile Solvent Abuse.

The purpose of this study is to examine the extent to which social support affects youth's well-being after a treatment episode for volatile solvent abuse. This interview will take place at the *Nimkee NupiGawagan Healing Centre* and will be approximately one hour in length. I will be one of fifteen individuals interviewed from my organization. ____ I give my permission for the information I provide to be recorded with audio equipment. ____ I do not give my permission for the information I provide to be recorded with audio equipment. The information I provide will be kept on file at the researcher's home and only she will have access to the data. The consent forms will be kept separate from the data collected. Once the project is complete the data will be destroyed (December 2006).

I understand that the researcher will not be able to guarantee me complete anonymity or confidentiality. I understand that anonymity cannot be offered because the sample size for this research is small and the interview will be carried out at my place of employment. Although it is difficult for the researcher to offer anonymity and confidentiality she will not identify any of my quotes or responses by name, job position or any other identifier in her final thesis. I understand that the risk of being identified (or assumingly identified) still remains. By partaking in this study I will be adding to a body of research that is, at present, under-investigated. My participation in this study could lead to an increased awareness of current issues and may act as a useful indicator of the direction that future research and initiatives should take.

The information I provide will be used in a final written thesis. I understand that this is a public document. The researcher will also present using power point her key findings, as well as provide a written summary document to myself and the other participants.

As a participant in this project I have several definite rights:

My participation in this interview is entirely voluntary.

I am free to refuse to answer any questions at any time.

I am free to withdraw from the interview at any time.

If I choose to withdraw from the interview, I may decide at that time if the researcher may use any of the information already provided.

I understand that I have the right to ask that any information I disclose be off the record at any time, which means it will not be repeated, discussed, or reported at any time.

I understand that I will receive no compensation for my participation in this interview.

I understand I may request a copy of the thesis prepared by Tara Beauchamp.

APPENDIX 5
RISK DYNAMICS IDENTIFIED IN THIS STUDY

DESCRIPTION OF RISKS:	PERCENT REPORTED:
<i>The Individual Domain</i>	
Aggression/ violent behaviour	57%
Lack of cultural identity	57%
Low self-esteem/ self-worth	50%
No sense of the future	21%
Poly-use	21%
History of suicide ideation or attempt	21%
History of involvement with the criminal justice system	7%
<i>The Family Domain</i>	
Family history of drug and alcohol abuse	86%
History of family violence (physical, sexual, emotional, and spiritual abuse)	79%
Lack of family cohesion and strength	71%
Poor and inconsistent family management practices	50%
Economic deprivation	43%
Neglect	29%
Guardianship	29%
Poor parenting skills	29%
Sibling volatile solvent abuse	21%
Other mental health issues within the family	7%
Parent's education level	7%
<i>The Peer Domain</i>	
Wanting to gain membership or a sense of belonging	71%
Peer pressure	64%
Bullying	50%
Proximity to volatile solvent users	14%

<i>The School Domain</i>	
School drop out	64%
Low levels of education	50%
Lacking connection to school curriculum	50%
Absenteeism and truancy	36%
Inadequate schools	36%
Poor academic performance	29%
Little or no expectation for success	21%
Community attitudes and beliefs regarding education	14%
<i>The Community Domain</i>	
Geographic isolation	93%
Lack of community resources	71%
Religious infiltration	50%
Media and technology	50%
Lack of opportunity	50%
Economic conditions	36%
Lack of consistency in programming	29%
Lack of trust within communities	29%
Prejudice and discrimination	21%
Stigmatization within their communities	7%
High rates of tragedy and crisis within their communities	7%

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