Counselling & Traditional Indigenous Practices: Examining Practitioner Enabling Processes

by

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Abstract

For decades, Indigenous organizations in Canada have endeavored to make Indigenous knowledge, practices, and practitioners available for Indigenous peoples' health needs (Aboriginal Healing Foundation, 1999; Health Canada, 2015). But are these services readily available? Three Indigenous counselling practitioners were asked how they incorporated traditional healing or knowledge into their counselling service offerings. In semi-structured interviews counsellors discussed their life, education, and career experiences. These experiences were explored with narrative thematic analysis. Six primary themes of experience were identified: how a counsellor's background influenced their work; why Indigenous knowledge and practices are needed in counselling; what they did and how they did it; why they work the way they do; organizational experiences; and organizational change. Recommendations include increasing access to Indigenous specific counsellor training, providing anti-racism training for public agency staff, ensuring Indigenous staff are not overworked, and encouraging agencies to reach out to local land-based Indigenous nations for guidance.

Keywords: Indigenous; Aboriginal; qualitative; Indigenous knowledge; mental health; agency

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List of Acronyms

APA	American Psychological Association
AHF	Aboriginal Healing Foundation
EBP	Evidence based practice
FNHA	First Nations Health Authority
HT	Historical trauma
IK	Indigenous knowledge
TRC	Truth and Reconciliation Commission

Chapter 1.

Introduction

Who is this research for? While completing a bachelor's degree in psychology I had spoken with family members about how they dealt with mental health issues in the 'old days' when Indian agents[1] were stationed on/near reserves. I was told stories involving the duping of Western authorities and health practitioners in order to get people to an Indigenous healer for what was considered proper treatment.

Taking the stories I heard as a cue, questions about traditional Indigenous healing methods began to come to me. I wondered what research there was for Indigenous traditional healing methods in counselling, and what those findings were. As I had not seen Indigenous healing practices mentioned in the multicultural section of any psychology texts, I wondered if public health organizations offered traditional Indigenous healing practices, and where they were offered. Who this research is for then is multi-faceted. In part, it is for Indigenous counselling practitioners to understand what experiences others have had in incorporating traditional practices. Primarily though, it is for individuals in public health organizations to understand what is involved in offering Indigenous healing or traditional knowledge to Indigenous clients.

1.1. Self-Location

Reflexivity in qualitative research often involves making explicit to the reader an author's leanings, bias, and worldview filters. As this is something many readers find useful I will offer some personal details to help make my positionality in the analysis and meaning co-construction process clear (Burnette, Sanders, Butcher, & Rand, 2014). I have family of both Indigenous and settler ancestry and am registered with a Canadian First Nation. Among my Indigenous family I have members which attended the residential school system in Canada. Having grown up off-reserve and receiving the education where and when I did locates my tacit understanding to primarily Western in

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[1] Indian agents were a government position which had policing, magistrate, and even financial & goods procurement authority over Indigenous communities (Magistrate, 1882)

orientation. Using a social constructionism lens for a foundation to view societal artifacts, I recognize my elementary, post-secondary, and graduate education were steeped in Western epistemologies, methodologies, and methods. Contrasting this, I have experienced varied family and cultural activities growing up, and worked in a team alongside other Indigenous researchers on Indigenous focused projects. These details encouraged me to ask about my research interpretations from others with tacit assumptions informed by Indigenous epistemologies.

1.2. Indigenous Mental Health in Canada

In Canada, Indigenous people are twice as likely as non-Indigenous people to be hospitalized for a diagnosed mental or behavioral condition (Statistics Canada, 2018). Indigenous and non-Indigenous people present with the same top three diagnoses: substance-use, mood disorder, and schizophrenic/psychotic disorder, but the order and prevalence of diagnoses are vastly different. Indigenous people on reserve are seven times more likely to be diagnosed with a substance-use disorder; off reserve, Indigenous people are four times more likely than non-Indigenous people to receive the substance-use diagnosis. Indigenous people on reserve were 20% more likely to be diagnosed with a mood disorder compared to non-Indigenous people; off reserve Indigenous people were 60% more likely to be diagnosed compared to non-Indigenous people. Indigenous people are nearly twice as likely to be diagnosed as having schizophrenic/psychotic disorder compared to non-Indigenous people (Statistics Canada, 2018). Canadian Indigenous adults living off-reserve have a higher lifetime prevalence of suicidal thoughts with men being 5.9% more likely than non-Indigenous men, and women being 10.4% more likely than non-Indigenous women (Statistics Canada, 2016).

1.3. Indigenous Health and Healing in North America

In 2001 the Surgeon General of the United States issued a report which highlighted poverty as a major contributing factor in rates of mental distress and substance use for Indigenous people (U.S. Department of Health and Human Services, 2001). The report stated that treatments have overwhelming been Western therapies which had little research as to their benefits for American Indians or Alaskan natives.

Adding traditional Indigenous healing practices and testing their efficacy was considered potentially useful but a challenge to integrate within a scientific paradigm. The report specified that measurements of cultural evidence from an Indigenous knowledge perspective does not seem to match Western science's perspective of valid evidence. The Surgeon General's report closes with acknowledging Indigenous communities' resiliencies and psychosocial resources have not been examined with a mindset of enhancing existing strengths (U.S. Department of Health and Human Services, 2001).

Yet change happens slowly. In 2015, Health Canada issued a summary similar to the U.S. Surgeon General's recommendations. Included in the summary was culture as a foundational layer for healing, community development and ownership of healing, the need for measurement of services, the ability to collaborate between communities and federal/provincial parties, and more funding available for service delivery and development of services (Health Canada, 2015).

With a need for services, and a commitment seen on paper in both the U.S. and Canadian federal governmental bodies, I assumed there would be ample information both on how practitioners incorporated traditional knowledge and healing practices, and on agency or counsellor procedures for incorporating those practices alongside Western psychotherapies.

1.4. Research Strategy

I initially searched databases using a three-tiered keyword strategy. The first tier required one of: Indigenous, Aboriginal, American Indian, First Nations, métis, or Inuit. The second tier required traditional healing, and the third tier required one of psychotherapy or counselling. Initial search databases included PsychINFO, PsychArticles, and Medline, this resulted in seventeen found results. Of the seventeen, only one of the results contained information on how the practitioners or agencies incorporated traditional practices. Though database searches are prone to change as algorithms change and new research is available, this number is extremely small given the size of the population and increased prevalence of serious outcomes described in Section 1.2. There is to date, and has been, little information on how practitioners or agencies go about incorporating traditional Indigenous practices or knowledge or Indigenous counsellor experiences in these agencies.

To further examine this lack of existing research I looked at best practice history on which psychotherapies are being currently taught to practitioners and which are commonly used in agency settings. I also expanded the initial search area to include substance-use and paraprofessional positions while specifying agency work. And while my literature review accepted any setting for fear of lack of sources, my research interview focus was on the urban Indigenous experience as 62% of registered Indigenous people live off-reserve (Kelly-Scott & Smith, 2015).

The purpose of this study as alluded to in the introduction, is to develop a better understanding of how practitioners and agencies incorporate Indigenous traditional healing or knowledge into their counselling service offerings in order for other Indigenous healers and staff to understand what they may need to offer such services and what is at stake by making, or ignoring to make such services and knowledge available. This is represented by my two research questions: RQ1: What are the personal factors that enable the valuing of traditional Indigenous healing and knowledge as part of the counselling process? And RQ2: What are the systemic factors that enable Indigenous counsellors to integrate Indigenous knowledge or traditional Indigenous healing within counselling practices?

Chapter 2.

Literature Review

2.1. What Therapy for Whom?

Which psychological therapies get researched and used has a long history in psychology. After decades of meta-analyses attempting to discover what psychotherapy works for whom with which problem, the results show this is still a controversial question with no clear answer (Budd & Hughes, 2009). What therapies have been trained in academic settings, and practiced in clinical settings has been more straightforward - consisting primarily of Western-based interventions (Heatherington et al., 2012; Stevens, Dinoff, & Donnenworth, 1998). What of practitioners in the field using non-Western interventions, or from texts not commonly available to psychotherapy students? If psychotherapy researchers are serious about knowing what works for people, then there is a need to ask people not performing randomized control trials about what they do, how it is they manage to do it, and how they know it is working.

By interviewing Indigenous counsellors incorporating Indigenous practices or knowledge, I hoped to find personal and systemic factors that helped them add those practices or knowledge into their work or workplaces. I did not examine efficacy of Indigenous practices or knowledge for reasons which will become clear in Sections 2.4 and 2.6.

Given the difficulties the U.S. Surgeon General outlined in Section 1.3 regarding what constitutes evidence for Indigenous knowledge and healing, the question of who's epistemological perspective was being used in what-works-best conversations is one that needs examining.

2.2. American Psychological Association Research

How do psychological service providers know which psychological services are safe, efficacious for clients, and equal to or more effective than pharmacological treatments? In an attempt to answer these questions the American Psychological Association [APA] utilized a medical-model based movement called evidence based

practice [EBP] spearheaded initially by the APA's Division 12 - Clinical Psychology (APA Presidential Task Force, 2006). Research is critical for evidence-based practice. Qualitative research is listed as useful for describing the subjective experience of participants. Randomized control trials, meta-analysis, and experimental designs are listed as the standards to discover the effectiveness of psychological interventions; or as many of us heard in our psychology training "the gold standard", implying that quantitative measures are of greater importance than qualitative.

The APA's Presidential Task Force asserts that understanding cultural contextual differences allows for EBP treatments to be better adapted to cultures in which the treatments were not originally designed for. The Task Force notes that different cultures may need different forms of treatment, acknowledging this as an empirical question to be answered. These two statements, of cultural understanding being important to adapt treatments to, and the possibility of different cultures needing different treatments, cover the spectrum on treatment possibilities and demonstrates the assumptions behind EBP. By adapting methods assumed to be universal to everyone and filtering new information through its own research paradigm, EBP is ensnared in the worldview of scientific positivism. In the APA's paper on EBP's, different treatments being needed for different cultures is given far less wordcount, a few sentences compared to the multiple sections devoted to adapting existing interventions, suggesting a larger focus on adaption over construction (APA Presidential Task Force, 2006). More specific than positivism, this focus is suggestive of a normative world view within Division 12 at the time EBP structure was initially being developed.

Division 27 of the APA - the Society for Community Research and Action, also believes in the possibility for adapting psychological interventions, but highlights the importance of development of theory and research with communities collaboratively, instead of for or on communities (APA, n.d.).

While taking a less normative view than Division 12, there is still potential for epistemic bias in Division 27. Practitioner and researcher training inadvertently elevates Western epistemologies over other ways of thinking leading to a potential of missed evidence. This is seen when examining psychotherapy training programs, where concepts, constructs, and components of therapy tend to be similar across APA approved therapies (Stevens et al., 1998). It has also been found that teaching

materials for psychotherapists tends to be very homogenous in both the U.S. and Canada with *Current Psychotherapies* by Corsini and Wedding, and *Interpersonal Process in Psychotherapy* by Teyber and McClure being used far more often than any other training texts (Stevens et al., 1998). At the time of their writing, these two texts only describe APA approved therapies in their pages.

2.3. Differences in Types of Evidence

Mainstream EBP's position of a normative, positivistic, expert role versus community psychologies for-community stance is important to think about because research exists in a socio-political context. This is seen plainly in Maori scholar Linda Tuhiwah Smith's (1999) *Decolonizing Methodologies* text where she opens with "From the vantage point of the colonized, a position from which I write, and choose to privilege, the term 'research' is inextricably linked to European imperialism and colonialism" (p. 1). Instead of being staunchly anti-research, Smith's stance is similar to Division 27's and expresses guidelines on how to avoid recolonizing in research and instead empower communities (Smith, 1999). Smith's declaration of location and her advice on methodology and method speak to a critical feminist constructivist standpoint where knowledge is culturally embedded, and issues of power inequity are addressed. *Decolonizing Methodologies* veers slightly away from a broad postmodern argument to a more contextualized political perspective as seen in its "Indigenous Research Agenda" (p.117), where Western and Indigenous ideas are on opposing sides. Smith explains this polarization is due to the need to reaffirm Indigenous culture from the deleterious effects of imperialism and colonialism (Smith, 1999). Smith's quote linking research to colonialism from *Decolonizing Methodologies* clearly describes a potential fear of continuing a cycle of colonized ideas and practices instead of Indigenous owned ones.

Recolonization in Indigenous communities is perhaps appropriately feared; as seen above, therapists are most often trained in approved APA methods. Western psychotherapeutic assumptions on identity, communication patterns, meanings of spirituality, healing, and distress historically have been prioritized over community understanding of those concepts (Fields, 2010; Gone, 2010; Hartmann & Gone, 2012; Kahn et al., 1988; Lucero, 2011; Thomas & Bellefeuille, 2006; Wendt & Gone, 2012; Wendt, Gone, & Nagata, 2015).

Even if Western psychotherapies are helpful when delivered in their standardized fashion to Indigenous clients, helpful after cultural adaptations are made, or used to help individuals who are acculturated in Western beliefs, there remains a desire for autonomy and a reclaiming of culture and Indigenous identity (BigFoot & Schmidt, 2010; Gone, 2011; Goodwill & McCormick, 2012; Marsh, Coholic, Cote-Meek, & Najavits, 2015).

Some Indigenous communities have an active dislike of research due to the poor ethical decisions of past researchers. In their article designed to offer guidance for research with Indigenous cultures Burnette, Sanders, Butcher, and Rand (2014) noted community members still have apprehension on participating in studies because of well known past studies unethical, and/or harmful behavior. Examples include an Inupiat study involving alcohol use in 1979 that was released without community understanding which garnered negative national media coverage (Foulks, 1989); Foulks, one of the initial studies' authors, mentioned conflicting stakeholder interests and understanding had been a problem in how findings were framed and published. In 2010 the Havasupai Indian band concluded a lawsuit against Arizona State University [ASU] for using blood samples from an earlier study in subsequent studies that were beyond initial informed consent scope (Harmon, 2010). The initial study had taken place in the late 1980's to early 1990's but it wasn't until 2003 when a Havasupai community member was in college and saw her community's data being used in a new doctoral students' dissertation, without consent, that the full extent of the university's actions was evident, leading to community distrust and anger towards ASU.

And It is not just community members who are tentative about research. In a study examining substance-abuse, clinical staff expressed knowing the poor treatment minorities have experienced through previous research, and thus were hesitant about reporting on their own adaptations of Western therapies lest it be misused by other researchers or policy makers (Larios, Wright, Jernstrom, Lebron, & Sorensen, 2011).

Even attempting evaluation of EBP's is complicated for researchers as some Indigenous communities have seen it as a strike against Indigenous sovereignty by elevating Western theory above traditional beliefs or community designed practices (Nebelkopf et al., 2011).

2.3.1. Indigenous Wholism

One alternative to reductionism is Indigenous wholism. There is an important caveat here, and that is the danger of assuming homogeneous beliefs across Canada between Indigenous groups. Even in this particular study which focuses on people living and working on the West coast of Canada, participants came from across the country and had different Indigenous familial backgrounds.

Kovach (2009) describes how several different nations across Canada construct knowledge with local epistemologies behind that knowledge. Wholistic understanding can mean between community and the individual, the spiritual, the sacred (ceremony, prayer), the land/living world, and the temporal (Kovach, 2009). One of the tensions between research evidence and Indigenous knowledge [IK] is the need for sacred Indigenous practices to be able to be referenced but not explicated; what can and can not be talked about may be different for different Indigenous communities (Kovach, 2009).

So, with a distaste for Western research evident in many Indigenous communities, and many Indigenous nations having differing worldviews, what is the current state of empirical research involving IK, methods, and mental health with Indigenous people?

2.3.2. Existing empirical research with Indigenous people

In a systematic review examining whether or not Indigenous populations had empirical psychotherapy research available, Pomerville, Burrage, and Gone (2016) found that even when going beyond North American Indigenous populations to include Australian and New Zealand Indigenous people, only forty-four studies were available (Pomerville et al., 2016). Of those, four were treatment evaluations with individual adults and half of those studies included controlled outcome trials. This illustrates that fifteen years after the Surgeon General's report there was still little psychological research with Indigenous populations. However, it was also found that research has become more frequent as of 2010. The authors came to the conclusion that if you want an empirically informed therapy choice there is no empirical evidence to support the assertion that existing EBP's are efficacious with Indigenous populations (Pomerville et al., 2016).

The sparse findings on treatment efficacy with Indigenous populations discovered by the authors above are in line with my own attempts at finding a *how-to* of including IK or traditional practices in public health agencies, an even more narrow focus.

2.4. Research Involving Healing and Indigenous People

A lack of outcome information is a problem for practitioners and agencies offering services to Indigenous clients for several reasons. The first reason is simple, money. Accredited agencies which offer services are often mandated to use EPB's in order to be eligible for funding; EPB's match the biomedical paradigm preferred by public health funders (Josewski, 2012; Nebelkopf et al., 2011). This financial pressure virtually ensures public health agencies utilize EBP's over Indigenous healing methodologies – something of an issue as it conflicts with calls to action from the Truth and Reconciliation Commission of Canada [TRC] listed below.

A second problem seen in Canada is that large-scale attempts to incorporate Indigenous traditional healing into therapy have involved socio-political events like the Royal Commission on Aboriginal Peoples report, which examined the effects of residential schools on Indigenous people (Aboriginal Healing Foundation, 1999). Following this report, a focus on reconciliation was set, and new federal policies were implemented which led to the creation of the Aboriginal Healing Foundation [AHF].

The AHF funded research, and healing programs to identify what would heal Canadian Indigenous communities from the legacy of the residential school system and the effects of historical trauma brought on by the history of colonialism. Funding for the AHF was federally distributed (Archibald, 2011).

In order for communities to qualify for funding, the AHF had requirements such as needing detailed descriptions of healing practices to be used and descriptions of what evidence of success will look like (Archibald, 2011). Given Indigenous understanding of the sacred as something to keep out of the public eye, as described in Section 2.3.1, the insistence of detailed descriptions is likely to have limited who applied for funding. A problem for researchers and practitioners outside these organizations is that neither the AHF in their final report, nor an in-depth review on a specific site involved in an AHF

funded program described by Gone (2009), detailed how it was the traditional methods were chosen, and how they were integrated with or replaced Western methods (Archibald, 2011; Gone, 2009).

In 2008 as part of the Indian Residential Schools Agreement, the TRC was started and its final report was issued in 2015 (Truth and Reconciliation Commission of Canada, 2015). The mandate of the TRC was to inform and educate Canadians on the residential school program; the great damages the program brought to individuals and communities as well as the resiliency and strengths Indigenous peoples demonstrated in surviving the program over the decades it ran. The TRC aimed to heal through inclusion and respect, hoping to bring Canadians together in reconciliation. In order to achieve this the TRC created a list of 94 calls to action. Calls to action relevant to this research are: (a) Call to Action 6, which involves the repealing of laws deemed to strip Indigenous identity from children; (b) Call 18, which insisted upon the recognition of Indigenous rights to health-care; (c) Call 19, which specifies measurement of health goals, including mental health as important; (d) Call 20, which calls for jurisdiction issues around health care be addressed as many Indigenous people do not live within reserves. But most importantly for this study, are Calls to Action 21-23. These call for sustainable funding for new and existing Indigenous healing centres, the inclusion of Indigenous healers and elders into such centres, and to increase the amount, and ensure retention of Indigenous professionals in health care (Truth and Reconciliation Commission of Canada, 2015).

A potential problem is that the AHF and TRC were time-limited events which have had their beginnings and ending now passed, and while many recommendations were made there is no guarantee they will be fulfilled in a sustainable manner, or even, at all.

Smaller scale attempts at incorporation of traditional healing into therapy have also occurred, but like the large-scale attempts, do not necessarily have details easily available for practitioners and researchers. In Manitoba, Hollow Water's process, which predates the AHF's research call, started with community members adapting other Indigenous communities methods; notably, work done at Alkali Lake (Bushie, 1999; Lajeunesse, 1993). Hollow Water's own healing processes ended up not using a standardized external method, as none were considered a good enough fit for their community unmodified. Hollow Water's processes ended up being shaped organically

over the course of years through trial and error. To function as a system of healing, Hollow Water employed both professionals - psychologists, and paraprofessionals. Paraprofessionals included family violence and assessment workers who were trained by facilitators from Alkali Lake in their *New Directions* program (Bushie, 1999; Lajeunesse, 1993).

Lajeuness's (1993) report on Hollow Water contains brief descriptions on steps in the Hollow Water healing process, but not detailed descriptions. Healing at Hollow Water involved a restorative justice perspective not considered mainstream and required permission from the province. Hollow Water also did not adhere to an existing standardized organizational structure, instead they created their own in which paraprofessionals did the majority of work with only a few professionals available, though this was mostly due to lack of funding (Lajeunesse, 1993).

More recently in Canada, the Thunderbird Partnership Foundation [TPF] created the *Native Wellness Assessment* using a framework of Indigenous culture as treatment (Fiedeldey-Van Dijk et al., 2017; Hall et al., 2015). Their culture as treatment perspective values Indigenous epistemologically based concepts of evidence as well as the scientific positivism perspective. TPF's assessment tool is free for students to see in relation to a case example (Thunderbird Partnership Foundation, 2019c). The assessment and courses are not free for agencies and practitioners (Thunderbird Partnership Foundation, 2019a). Courses by the TPF include topics such as education on protocols, cultural competency, training for administrative staff, and community development. TPF content seems to be a close match to what I am looking for as stated in the introduction in terms of a *how-to* for communities and agencies. Unfortunately, and characteristically of research in this area, little research currently exists on TPF's assessment and methods. The TPF healing framework is limited as to where its taught and is not included in the APA's EBP list (APA, 2016). It also should be noted that TPF's work originated from the field of substance abuse, potentially limiting its generalizability for broader psychotherapy usage (Thunderbird Partnership Foundation, 2019b).

2.5. Intersections of History, Theory, and Healing

2.5.1. Historical Trauma

Mental health issues in Indigenous communities are often discussed as related to historical trauma. Historical trauma [HT] is defined as psychological and emotional wounds across generations and lifespan resultant from repeated, or overwhelming group trauma (Brave Heart, Chase, Elkins, & Altschul, 2011).

Brave Heart's theoretical framework of HT describes contemporary trauma response for Indigenous people as a result from unresolved grief (Brave Heart, 1998). Colonization is often listed as a primary cause of HT for Indigenous people in North America not as a one-time event, but a series of reinforcing events (Brave Heart, 2003). There is a long history of policies which enabled HT events in both the U.S. and Canada. Examples from past U.S. legislation include Indigenous people being "controlled and managed at its [Committee on Indian Affairs] discretion" and "[Indians] have no alternative but to choose between this policy of the government and extermination", the later resulted in American Indians being forced to live on reservations without recognition of previous tribal bonds or language (Senate, 1868).

In Canada, an Indian Act revision from Deputy Minister of Indian Affairs, Duncan Campbell Scott is infamously known today for "I want to get rid of the Indian problem" (p.126), and "our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic" (Scott, 1920, as cited by Treaties Historical Research Centre, 1978). D.C. Scott was referring to the process of enfranchisement in which Indigenous people in Canada would become uplifted from their barbarism and become civilized beings, this resulted in a bill from which the Canadian residential school system was born.

Brave Heart's (1998) conceptualization outlines how the ban on traditional practices, the history of destructive events towards Indigenous people, and how grief beyond today's nuclear family constellation to entire communities are related. According to Brave Heart, with communal grieving having been banned or difficult to access, this impaired ability to grieve combined with a feeling of loyalty towards one's ancestors has resulted in a collective victimized identity which in turn results in depression and

substance abuse. A limitation to Brave Heart's original theory is that it centred specifically on the Lakota experience (Brave Heart, 1998). This potential limitation however is challenged in later writing as the similarities of the losses suffered by Indigenous communities are explicated. HT is said to be relevant to Indigenous communities in North America broadly because most communities: share a focus of the collective versus individual; have wholism as a core belief; and have a focus on spiritual non-human agents, such as ancestor or animal spirits (Brave Heart et al., 2011). So while the construct of unresolved grief being a transmitter of suffering is still within Brave Heart's theory, the Lakota specific focus has broadened as tribes have a shared experience of racism, genocide, colonization and oppression. Brave Heart along with other authors are now challenging HT's previous past-origin orientation, instead, they say systemic forces in Canada and the U. S. are still in effect and are part of ongoing colonial oppression (Brave Heart et al., 2011). A systemic example in Canada is seen in the difficulty the country has had in adapting elements from the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). UNDRIP had been adopted by 144 countries in 2007; Australia, Canada, New Zealand, and the United States chose not to adopt the rights (APTN National News, 2016). In 2016 UNDRIP was described by Canada's Justice Minister as being unworkable in regards to its incompatibility with the Canadian constitution, and insufficient as an aid to Indigenous communities (APTN National News, 2016). And although UNDRIP was adopted in 2021 (Department of Justice Canada, 2021) the method of adoption has been criticized by Indigenous activists, including a TRC spokesperson, for allowing Canada to ignore the U.N.'s recommendations in their entirety, and instead being adopted only in part and as a type of federal virtue signaling (Fiegehen, 2021).

Epigenetics and ongoing sources of suffering

Epigenetic transmission of trauma reaction was examined in a survey of the current state of literature around post-traumatic stress disorder (PTSD): twins were found to have a 46% likelihood of heritability for PTSD, though no specific genes were identified (Sartor et al., 2012). However, previous research has identified specific genes that negatively effect stress responses from survivors of childhood abuse (McGowan et al., 2009).

HT as a causal factor for poor mental health is not absolute. While epigenetic research posits hypothetical links to how trauma gets embedded in genes, generally, over time, in communities which experienced single event traumas, the succeeding generations do better than previous generations in regard to traumatic symptoms; this is not the case for Indigenous communities (Kirmayer, Gone, & Moses, 2014). Several in-progress systemic issues facing Indigenous peoples in Canada include: reserves having inadequate infrastructure for their communities; poor urban Indigenous people being treated more harshly than poor white people by law enforcement; ongoing racism; disproportionate childhood adoptions; government sanctioned resource extraction and land use of Indigenous lands, and experiences of racism in healthcare settings (Caldwell & Sinha, 2020; Czyzewski, 2011; Health Canada, 2014; Razack, 2014; Scobie & Rodgers, 2019; Turpel, 2020).

Who controls the ethics of counselling

Perhaps a less obvious area to some is the epistemic discordance between mainstream organizations' ethical paradigms and Indigenous wholism. Counselling organizations in Canada hold their members to ethical standards and principles. The most common principles used in British Columbia originate from the individual-focused biomedical model. Core values from the biomedical model include: autonomy, non-maleficence, beneficence, and justice (Beauchamp, 2001). The Canadian Professional Counsellors Association map their standards directly onto the these principles by name and definition (Canadian Professional Counsellors Association, 2021). The Canadian Psychological Association and British Columbia Association of Clinical Counsellors include the first three guiding principles (BCACC, 2019; Canadian Psychological Association, 2017). These two organizations go beyond the biomedical interpretation of justice, acknowledging other ways of being and seeing, listing 'broader society' as a fourth principle (BCACC, 2019; Canadian Psychological Association, 2017). The discordance is the underlying construction of the biomedical model originating from a conception of the individual self that is wholly separate from all else (Beauchamp, 2001). This conception of self is not shared by many Indigenous groups which instead view the self as tied to spirit, family, community, and the land (Ellerby, McKenzie, McKay, Gariepy, & Kaufert, 2000).

2.6. Decolonization

Community decolonization is seen in the work of researchers who espouse the belief that Indigenous populations would experience better mental health once health services are turned from government to Indigenous control (Czyzewski, 2011; de Leeuw, Greenwood, & Cameron, 2010). This perspective fits the U.S. Surgeon General's recommendation to utilize Indigenous people's resiliencies and psychosocial resources (U.S. Department of Health and Human Services, 2001). It is also in alignment with calls to action 21 through 23 from the Canadian TRC final report which included: new Indigenous healing facilities, and funding, Indigenous healers and elders being part of the healing process, and plans to ensure retention of Indigenous professionals (Truth and Reconciliation Commission of Canada, 2015).

One recommended action towards decolonization of mental health services is for researchers to look at clinics, schools, governing bodies, and agencies to identify lack of opportunity, poverty, and discrimination in their midst (Gone, Hartmann, & Sprague, 2017). This allows for systemic sources of suffering to be challenged and repaired. However, these decolonization actions are contingent on political and public support.

Smaller in scope than broad systemic changes but no less important, it has also been suggested that Indigenous therapeutic alternatives be created or adapted in consultation with communities while eschewing standard treatments in order to have Indigenous community acceptance (Pomerville et al., 2016). To this point, when therapy has involved a decolonizing approach it was said "it would be difficult to overestimate the sacred and sociopolitical significance of turning to and relying on indigenous traditional principles and practices as a primary source of therapeutic recovery" (Gone & Calf Looking, 2015, p. 87). Clients, community members, and staff all described feeling more empowered and hopeful for the future than before after using the community led approach (Gone & Calf Looking, 2015).

2.6.1. Research with Indigenous People

Researchers identified that many Indigenous therapy clients and research participants feel disconnected from non-Indigenous counsellors and methods (Britten & Borgen, 2010; Wendt & Gone, 2012). A related problem frequently espoused is that

Western-based methods are not appropriate for Indigenous people and incongruous with Indigenous worldview (Hartmann & Gone, 2012; Mullany et al., 2012; Waldram, 2014; Wendt & Gone, 2016, 2012). One longitudinal study described an Indigenous community using Western psychotherapeutic consultants only as a last resort for "when all else fails" (Kahn et al., 1988, p. 4). This last study is further noteworthy for its decolonization efforts by relying on community paraprofessionals/community-trained lay health workers which were well received and evaluated as highly capable by both the community members and researchers.

A common problem with mental health interventions, poor therapeutic retention, has had mixed findings. Therapy drop-out is more prevalent with Indigenous populations than other populations though it is not clear why (Dickerson et al., 2010; Goodkind, LaNoue, Lee, Freeland, & Freund, 2012a; Quinn, 2007; U.S. Department of Health and Human Services, 2001). Goodkind (2012a) has suggested, that it is not always that treatment types are too incongruent for Indigenous clients to take part in, but instead it is a problem of poverty and access which leads to drop-out. This too matches the U.S. Surgeon General's (2001) description of poverty being a primary factor of distress as mentioned in introduction Section 1.3, it also signals that in the eleven intervening years between their recommendations and Goodkind's research, the stresses poverty brings are still an important factor for health professionals and researchers to take into consideration.

2.6.2. Traditional Indigenous Healing Research

Beyond the findings of the EBP movement there is the question of what research is available for Indigenous healing practices. The short answer as alluded to in the empirical research section around EBP's is: There is only scant research available.

In a 2010 study, Joseph Gone found that there were only five peer-reviewed journal articles which included citations of traditional healing; of those only one gave results from traditional healing practices (Gone, 2010). Furthermore, the traditional healing in the last study was not Canadian First Nations, Metis, Inuit, or American Indian healing practices; it was a description of an exorcism from Zanzibar (Tantam, 1993). When looking for North American traditional healing, not a single instance was available (Gone, 2010). The studies Gone examined tended not to describe what enables

traditional healing to be offered. Clients in two of the studies were seeing traditional healers in addition to mainstream therapy and happened to be willing to share what the different experiences with those healers was like compared to a psychotherapist or medical doctor (Moodley, 1999; Tantam, 1993). Vontress (1991) on the other hand sought out traditional healers from remote villages in Africa, far away from urban health facilities (Vontress, 1991).

One of the papers by Vontress however did have details on how traditional methods and beliefs were used in a Western clinical setting. The study described the ethnopsychiatry movement in France where non-Indigenous counsellors and psychiatrists elicited, then enacted their clients' healing practices in session (Vontress & Epp, 2000). One therapist interviewed in the study described having performed an animal sacrifice for a client's well being, another provided their client with therapist-procured culturally specific protective fetishes. The interventions were said to be efficient, cost effective and therapeutically effective (Vontress & Epp, 2000). It is perhaps worth noting here that ethnopsychiatry has changed over the years since Vontress and Epp's (2000) paper, with ethnopsychiatry practitioners now being more likely to involve cultural mediators and interpreters rather than therapist-led interventions (Grandsard, 2018).

In examining health disparities between Indigenous and non-Indigenous youth, Whitbeck (2011) found that Indigenous cultural interventions were rated by participants as equal to, or better than institutional interventions for dealing with substance use.

While it is almost certainly the case that the therapist in the Vontress and Epp (2000) study wanted to help in the most effective way for their client, it is exactly contrary to underlying theory I am working from. I am advocating as Smith does in *Decolonizing Methodologies,* from a feminist constructivist perspective for Indigenous-run traditional activities, and against cultural appropriation (Smith, 1999). From this position I believe non-Indigenous people's most beneficial stance is to help enable policy and process to aid Indigenous practitioners use of traditional methods. This perspective was espoused by clients at a substance abuse treatment facility where clients expressed their beliefs that practitioners using Indigenous healing methods need to be properly trained in the practices even if it takes years, as to do otherwise is both exploitative and potentially harmful (Larios et al., 2011). This last point suggests that agencies who currently do not

utilize traditional practices but are interested in doing so would be advised to seek out already working practitioners and local community resources, a belief shared by Indigenous researchers as well as clients (Oulanova & Moodley, 2010). The problem with this, is that how an agency or practitioner goes about doing that is something that is not written about in the literature.

Because the previous sections have talked about larger conceptual or systemic problems like competing epistemologies, decolonization, and research, I would like to briefly illustrate what exactly those concepts are referring to in the context of Indigenous healing. In this next section are examples of traditional healing or cultural interventions being used as therapy for Canadian and U.S. Indigenous people as well as some tensions around their use.

Culture as healing

Powwows, sweat lodge ceremony, fasting, smudging, and “other blessing[s]” (p.192) are among the cultural activities used at a healing centre with a focus on HT and substance use (Gone, 2011). A Blackfoot cultural immersion camp for substance abuse used pipe ceremony, sweat lodge, talking circles, harvesting plants, visiting a sacred site, crafting teepees, moccasins, pipes, drum creation and drumming, and collecting fossilized shellfish (Gone & Calf Looking, 2015). Whitbeck (2011) listed sweat lodges, healing circles, spiritual healer interventions, talking with elders, offerings of tobacco, and pipe ceremony as being used for substance disorders with Indigenous youth. Smudging, eagle feathers, drumming, medicine wheel teachings, and bridging clients to traditional healers and elders outside of the therapy office are examples from a Canadian study (Oulanova & Moodley, 2010).

These examples are given for two reasons, first, they are for us to understand what kind of interventions are being used and reported in existing literature. Second, in keeping awareness of the tensions behind including rich descriptions of the sacred as discussed in Section 2.3.1, I believe it is important to note that researchers in those studies considered the descriptions to be evidence, and did not need to have atomized descriptions of each cultural practice or knowledge used.

It is also important to note that Western based psychotherapy need not be ignored completely, many of the centres and individual practitioners that offered the aforementioned cultural activities also utilized Western counselling interventions.

2.6.3. Integrating Traditional Healing and Knowledge

An early example of integration comes from Brave Heart's work where she purposefully invoked positive cultural identity, group bonds, and traditional Lakota spirituality in an attempt to heal while still utilizing a Western psychoeducational format (Brave Heart, 1998).

The act of integrating traditional healing and Western healing practices can be a tricky process. At a centre whose staff understood their clients lived with both mainstream Canadian and First Nations cultural beliefs, staff attempted to integrate interventions based on construct similarities, e.g. using and adapting Alcoholics Anonymous because of its overt spirituality with, and alongside Indigenous spiritual rites (Gone, 2011). While the centre was considered successful in its adaptions of interventions, the Western-trained Indigenous counsellors still held tacit Western assumptions on what constituted and facilitated psychological healing processes, something previously unaccounted for by staff (Gone, 2011). While this oversight of the epistemological background of the centre's programs may make it hard to judge treatment efficacy from a reductionist perspective, it also highlights those multiple worldviews are often engaged for Indigenous people. This will be even more prevalent in urban settings where normative culture influences will be embedded in agencies' procedures and practitioner thought.

Integrative practice purposefully using the differing advantages of Western and Indigenous methods and epistemologies is sometimes called two-eyed seeing (Hall et al., 2015; Marsh et al., 2015). This perspective has the potential to be valuable as often Indigenous cultural methods are employed in a community decolonization fashion at the expense of the Western individual-centred perspective even when the Western perspective may hold healing value for Indigenous clients (Marsh et al., 2015). This is not to say the political desire for an Indigenous run system and tailored therapy is bad, indeed I believe that Indigenous ownership and healing can occur alongside Western elements. I am referring to the often implicit argument of individualist versus collectivist,

where historically, collectivist cultures like Indigenous people of North America are said to need different healing delivery, like group healing over individual counselling (Pomerville et al., 2016).

Individualism vs collectivism

One note from the area of organizational research on individualism versus collectivism worth considering is that voluntary engagement in group process is correlated with higher trust and an individual's acceptance of the group whereas involuntary participation is correlated with distrust and negative affect (Branzei, Camp, & Vertinsky, 2013). An important moderator to the involuntary participation is an individual's sense of benefit in participating. When participants felt they would benefit from being a part of group process, this offset any negative effect from distrust (Branzei et al., 2013).

I mention this here because when an organization is integrating services to a group as diverse as Canadian Indigenous people there will be those that have lived outside of traditional cultural beliefs, especially in urban settings, and may feel resistance to these beliefs for any number of reasons, e.g. internalized racism, religious incompatibility, or belief in Western healing elevated above Indigenous healing.

While some have proposed that underlying similarities between people should be explicated to help mitigate a sense of disconnection, or expressing a broad 'all peoples are capable of this' argument, analysing the truth of those statements is not my focus (Hilert & Tirado, 2018). As we've seen in this section broadly, the desire for cultural rebirth is important to communities, and an element practitioners and service providers must consider the benefit of versus the possibility of losing a resistant client. As a solution to this researchers have discussed having a blended solution is one such way to still offer aid, hopefully curtailing early client drop-out due to epistemological differences (Marsh et al., 2015). This is in alignment with what Brave Heart found where by offering an integrated solution of Western with Indigenous methods even Christian Lakota participants found value in her interventions (Brave Heart, 1998).

Another note from the individualist versus collectivist research is that autonomy is not inexorably linked to individualism and against collectivism. Instead, individuals need to believe themselves as capable in order to participate and connect with others

(Chirkov, Ryan, Kim, & Kaplan, 2003). This last point bears consideration as there is not agreement between researchers on whether focusing on creating greater autonomy, or focusing on interconnectedness with Indigenous psychotherapy clients is the correct approach (Kirmayer, Fletcher, & Watt, 2009; McCormick, 1995). It is likely that what is needed is contextual, something practitioners will have to gauge based on their individual clients. It is foreseeable that even when offering group counselling there may be a client that needs individual services which focus on their autonomy whereas the rest of the group would be fine with concentrating on the group interconnectedness experience.

Autonomy and interconnectedness are important areas for practitioner consideration on where to put their efforts, but there is also a related issue around Indigenous identity and discrimination that needs to be discussed if traditional healing or integrated healing is being offered.

Discrimination and identity

Brave Heart found development of positive Indigenous identity is not guaranteed, and for Indigenous people, feelings of shame and self-consciousness in normative culture is common (Brave Heart, 1998). Goodwill and McCormick (2012) identified fifteen categories which helped or hindered identity development in adult Canadian Indigenous participants. Of the fifteen categories, twelve aided positive identity formation. The top three categories most indicative of positive development were participating in cultural events, being in a group of other Indigenous people, and connecting with family. The bottom three hindering categories were living in separation from culture and Indigenous people, experiencing prejudice, and noticing negative portrayals of Indigenous people. Indigenous people were more likely to be hindered in identity formation by negative portrayals than aided by positive portrayals (Goodwill & McCormick, 2012).

Among American Indigenous youth living on or near reservations with shared tribal cultural backgrounds, perceived discrimination was strongly associated with internalized anger and negative externalizing behaviours like delinquency (Whitbeck, Hoyt, McMorris, Chen, & Stubben, 2001). Increased negative externalized behaviours were predictive of early substance use. Authors theorized that externalizing behaviours

and internalized racism created a negative developmental trajectory for Indigenous youth (Whitbeck et al., 2001).

In a related study in the same geographic area, authors also examined effects of perceived discrimination with adults (Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002). When examining adults, engagement with traditional activities and perceived social support were found to be strongly related to decreased depressive symptoms. One of the specific findings was an interaction between depression and traditional activities. When a participant had reported high levels of perceived discrimination there were greater depressive symptoms unless their level of traditional activities was also higher. Greater amount of traditional activity participation was protective moderator against high levels of perceived discrimination, therefore depression. The authors concluded this was not due to the specific activities themselves but a greater sense of self and community value. Whether or not the activities were responsible for greater mental wellbeing was not something specifically studied and was an assumption based on some of the activities being individual and not necessarily including others from the community. A notable limitation in the study described by the authors was having no measure for moderators involving HT, something believed to be highly related to depressive symptoms in Indigenous communities. Another limitation was the homogeneity of the participants, all were from the same tribal cultural background thereby potentially limiting generalizability across different nations (Whitbeck et al., 2002). This last point is one worth considering as even though North American Indigenous people share a history of colonization and ongoing systemic violence there are many different tribal affiliations which have varied beliefs and local history across North America.

In a study surveying Indigenous youth in Canada, greater positive adjustment and resiliency was found in bicultural or traditional students who associated positively with their Indigenous cultural heritage (Gfellner & Armstrong, 2013). Positive adjustment included behaviours such as helping and enjoying the company of others and being engaged with school. Negative adjustment was measured in terms of behaviours such as delinquency and substance use. An important limitation to the study was a focus on non-integrated First Nations schools for data (Gfellner & Armstrong, 2013).

Of the studies above, one was qualitative. From that study the authors noted that sanctions on verbal expression prohibited some discussion on culturally sacred elements of their experience (Goodwill & McCormick, 2012). This is an indicator that member checks are crucial for Indigenous research to ensure proper information is given without overstepping bounds and what is acceptable to report on. I considered this important to my interview process as I am of Indigenous identity as my participants are, and like my participants have been trained in counselling techniques which could have potentially led a participant to feeling more at ease with me, thus potentially more likely to share prohibited knowledge. How this was handled is discussed in chapter 3, methods.

2.6.4. Access

Service access for both Western and Indigenous healing is often a barrier for Indigenous people. Among the Gros Ventres there had been no consensus of recognized Indigenous medicine people leading to few trusted sources of healing (Gone, 2010). In the U.S., EBPs have been so well accepted that health care organizations only fund or reimburse practices that meet the EBP research standard, a process which many Indigenous healing practices have not undergone (Gone, 2015). Given that Indigenous communities often have varying access to traditional practices contrasted against the reality of many different studies being required to meet EBP standards, the prospect of widespread funding is in doubt as funding is finite (Gone & Calf Looking, 2015; Mullany et al., 2012; Nebelkopf et al., 2011). Some communities find it less risky to adapt an EBP than attempt validation of their own practices as funding may simply not be there for an untested therapy (Lucero, 2011). But even attempting to offer a blended approach can be difficult as it costs money to revitalize language and local culture whereas standardized EBPs can be brought in quite easily (Marsh et al., 2015). In Canada, cognitive behavioural therapy [CBT] is often still seen as the most cost effective option and is championed for more use thereof by researchers (Myhr & Payne, 2006). And though there have been research funded projects for mental health, the issue of them being research funded means they are time limited and not sustainable or guaranteed to be examined again even with positive results unless a funder is found (Hutt-MacLeod et al., 2019).

The problem with unified accepted systems like EBPs is that they are steeped in Western epistemologies which has resulted in a power differential where Indigenous people are inadvertently being taught Western assumptions on healing (Gone, 2010, 2011). This is something Indigenous mental health scholar-practitioners themselves have acknowledged occurring within psychology training in Canada (Ansloos et al., 2019).

Life circumstance can make attending therapy difficult for Indigenous people who experience more stressors than majority culture. Poverty, financial instability, substance abuse, caretaking responsibilities, and lack of transportation have all been identified by clients as limiters to access (Goodkind, LaNoue, Lee, Freeland, & Freund, 2012b; Whitbeck et al., 2004). Clients however, have expressed that even when circumstances forced them to quit, they hoped they would still be eligible for culturally-informed mental health interventions in the future (Goodkind et al., 2012b). One attempt to help solve this with Indigenous teens involved delivering an adapted service to the homes of teens (Mullany et al., 2012). After a year in a follow-up study found this program had a retention rate of 90%, considered remarkable as financial situations and family life complications did not lead to dropout; in short, participants going through life difficulty still took the time to engage with the program (Tingey et al., 2015).

Fit of counsellor to client is important and further limits whom an Indigenous client may see. Urban Indigenous people have noted feeling disconnected from their culture, identity, and other Indigenous people (Goodwill & McCormick, 2012). For some clients a difference in understanding of time versus a counsellor's have left them feeling like they could never express their stories to be fully heard with Western therapists (Gone, 2011). In part this is a causality of pragmatics with counsellors needing to fit in other clients at set times in many counselling settings.

Given the diversity in Indigenous cultures, clients in urban centres can be sceptical over the trustworthiness or applicability of a traditional healer to their own tribal affiliation as there is unlikely to be a shared history (Hartmann & Gone, 2012). Even on reserves, language and practices have faced a struggle to maintain their existence potentially limiting future healers and practices (Koster, Baccar, & Lemelin, 2012).

2.7. Specific Findings on Enabling Processes

In a qualitative study with seven Indigenous and two non-Indigenous practitioners, the most common enabling factors for traditional healing or knowledge to be available was the presence of traditional healers among their ancestors, growing up accustomed to ceremony, and having protocols handed down in communities (Oulanova & Moodley, 2010). Indigenous practitioners mentioned that being an informal healer in their community tended to precede their counselling education. In offering traditional healing, initially practitioners were mixed with some doing an intuitive cultural assessment of their client and others asking outright. Most practitioners would follow the client’s lead to request a traditional healing method. Often visual reminders of traditional healing were found in a practitioner’s office, items such as a drum or eagle feather easily visible to clients (Oulanova & Moodley, 2010). This likely demonstrated the practitioners ease with alternate healing methods and engaged client curiosity The most common agency workplace enabling factors were practitioner autonomy, and the ability to take healing outside of the office as necessary. This spoke in part to practical considerations like smudging and smoke alarms, but also to healing being facilitated by nature. Knowing whom to refer clients to was listed as important since practitioners could not always offer traditional healing; both non-Indigenous practitioners referred in all instances of clients accessing traditional healing (Oulanova & Moodley, 2010).

Practitioners also spoke of limiting factors similar to ones in previous sections. Financial barriers were described as existing but not explicated upon (Oulanova & Moodley, 2010). Similar to Ansloos et al. (2019) in the preceding subsection, Oulanova & Moodley (2010) found training was difficult to attain as IK was completely overshadowed by Western theory. Practitioners mentioned they were never stopped or dissuaded from delivering traditional methods by their workplaces, but they often feared negative responses from their regulatory bodies. This fear was further accentuated by their consultations with elders potentially violating agency non-disclosure even though it was in alignment with Indigenous healing. The non-Indigenous practitioners described having long relationships and involvement with Indigenous communities, a quality that is not portable. The authors close by saying the amount of dynamic factors make it quite difficult to offer Indigenous healing (Oulanova & Moodley, 2010).

A limiting factor to the Oulanova & Moodley (2010) study was the small number (9) of participants. The limited amount of people working in the field who knew Indigenous protocols was said to be a critical problem as it led to practitioners feeling isolated. The article further demonstrated the necessity for accepting non-professionals as competent. Both referrals and practitioners' own healing was facilitated and enacted by either local healers or elders (Oulanova & Moodley, 2010). A further limitation was no explication on when the practitioners came across a situation in which their autonomy and leeway to offer traditional healing was compromised, leading me to wonder if it was resolved (and how) or if they moved on to a new work environment.

The literature review shows the complicated history and what the potential benefits are for more study of Indigenous healing practices. Politics are inevitable, as are conversations and potentially disagreement on what constitutes evidence. But neither of these things should stop counsellors, researchers, or agency staff from knowing how to go about integrating Indigenous practices. The TRC has requested greater Indigenous presence in healing (Truth and Reconciliation Commission of Canada, 2015). It seems that agency and practitioner enabling processes need to continue to be explicated in order to have a framework to start from.

Chapter 3.

Method

3.1. Theoretical Orientation

The overarching theory informing my interview questions and analysis will be social constructionism. Social constructionism refers to the external world as containing constructed systems which interact with individuals (Burr, 2003).

Social constructionism encourages us to be critical of the taken-for-granted assumption that how we see the world is objective and unbiased (Burr, 2003). Unlike strict positivistic stances, this allows for a lack of objective evidence in retrospective accounts. It also allows for understanding people as perceiving and understanding knowledge differently from others and the self over time. This is important to my analysis as the counsellors' and I co-constructed evidence/story through my questions, which had varying prompts and tangents. The counsellors' chosen recollections were potentially influenced by any number of contextual events in their lives and the social climate at the time of the interviews.

My focus on theory which privilege different perceptions of experience has applicability as the counsellors I interviewed have used, or encourage the use of interventions and evidence based on Indigenous epistemologies alongside or instead of Western epistemologies. With social constructionism in mind, it needs to be noted that the current social climate is one in which several calls-to-action around Indigenous needs have occurred. Furthermore, additional discoveries of the fate of Indigenous children from the Canadian residential school system came to light over the course of the interviews; these situations may have influenced the counsellors retrospective accounts and they were certainly on my mind and likely influenced what parts of a participant's story I attended to.

Burr describes the use of social constructionism research to examine both micro and macro levels as being theoretically compatible (Burr, 2003). This suits my work as the people I interviewed may have experienced working in a health care system and organization which in the past did not have traditional Indigenous methods and

knowledge visibly embedded within, but has since changed; at the same time, it allows for examining the meanings those changes have had for individuals.

I will take a moment to describe why I have chosen to stay with social constructionism over flexible forms of empiricism, specifically new materialism. New materialism is a theory that allows for humans and non-human agents. It allows for a series of interactions between material constructs to interact with thought, social structures and debate (Coole et al., 2010). While seemingly compatible, I am avoiding using new materialist constructs because of the references to non-human agents by the counsellors in their stories. The non-human agents I refer to include any reference to spiritual practices, spirit, the land, or even their stories. Specifically, while new materialism may be compatible with Indigenous perspectives, it is new enough that there is the potential for reinforcing colonial preconceptions when viewing non-human agency through a materialist lens, something I with to avoid (Rosiek, Snyder, & Pratt, 2020).

Before I applied for institutional ethics approval, I had concerns on interviewing Indigenous people working for public organizations. Even though I planned on anonymity for participants, I had some concern about how their testimony could be taken should their perspectives or described actions come in conflict with their accreditation board, agency stakeholders, or administrative staff. However, given that Indigenous participants in Oulanova & Moodley's (2010) Canadian-based study never experienced negative reactions with their regulatory bodies or workplaces I believed this to be a fairly low risk. I gave participants the option to be acknowledged if they wished though no participant chose that option. One of the counsellors interviewed noted they wanted to ensure all quotes would be confidential; unlike my concern on testimony, their uncertainty was due to not knowing their current organization's stance on staff participating in research in general, regardless of whether or not their current workplace was mentioned.

One of the models I used to guide my analysis and interview questions is appreciative inquiry [AI].The main tenant and goal of AI is to examine problem areas and focus on what worked to make things better (Cooperrider & Barrett, 2002). This concentration on what works should help show how organizations can pivot to do better, while also showing areas of strength that can be kept up or enhanced. Another positive aspect AI has is its association with the language of spirituality. Given that ceremony is

sacred and enlivening this seems particularly well suited. Questions and in the moment prompts in this model can be structured to highlight partial success and allow the interviewees to experience possibility for future success (Cooperrider & Barrett, 2002). While AI looks aligned in terms of honouring interviewees, the underlying theoretical constructs should also be explicated to confirm its compatibility with social constructionism.

AI model assumptions include: reality is something being constantly recreated, questioning changes people and groups, people tend to move forward more confidently when utilizing past experience, and differences are valued (Reed, 2007). All these assumptions fit within social constructionism.

While not originating from the field of counselling, the following assumptions and the valuing of participant actions have been used to success in an AI informed study in Northern Ontario between researchers, and participants from the Red Rock Indian Band (Koster et al., 2012). In this case, AI questioning methods helped researchers first to see the need to change their approach, then move smoothly from doing research on the participants, to doing research with and for the participants. AI allowed for participants knowledge to guide the research direction as they were considered to be the experts in their situation (Koster et al., 2012). This piece highlights the importance of having a loosely structured interview style with only a few questions and prompts to allow for participants to shape the knowledge more fully than a structured survey interview style would allow. It also shows the importance on member checks of participant quotes compared to identified themes.

3.2. Participants

3.2.1. Recruitment & Interviewing

Interviewees were found through publicly available information and community-networks (e.g. counselling association websites, public organization websites, professional networks). Invitations to participate were sent via email in a letter of invitation (Appendix). Upon receiving the letter of invitation, or at the conclusion of an interview, knowledge holders were encouraged to share the letter with others who fit within the scope of the project. I did not gather contact information directly from existing

participants about potential participants. To honour their time for participating participants received a $20 gift card, and a culturally appropriate gift (approx. $5).

Institutional approval to recruit was obtained in August of 2020, interviews commenced from March to June 2021. All participants received interview questions before the interview took place. Interviews were loosely structured and conversational in nature. Two participants did interviews over telephone with one of those also sending a typed response to each question. The third participant did an interview over Zoom, a video conferencing software. More information on the data recording is contained in the procedure Section 3.3 below. Interviews were scheduled to take 25-60 minutes although all went longer by participant request after a check-in on time was made.

Though I am Indigenous and have worked as a counsellor in a public agency, none of the counsellors and I had met previously, or to my knowledge, worked at the same locations; neither did we share any home-nation links.

3.2.2. Participants

All three participants were Indigenous counsellors working in B.C. but may have been born or worked outside the province previously. The three counsellors are briefly described below and have been given the pseudonyms of Ada, Christine, and Lisa. In both this participants' section and the proceeding findings' section, quotes from participants which include the word 'Indian' refer to Canadian or American Indigenous people and not people from the continent of India. Participant descriptions are kept brief to ensure anonymity as the pool of potential participants was extremely small.

Ada. Ada "grew up on reserve but not my reserve". This allowed for experience of ceremony and Indigenous traditional ways of healing from a young age, "I learned from [nation's] culture as well as [another nation's] teachings and practices so, I had a lot of access to that". Ada experienced racism during her adolescent and teenage years and "pushed that [Indigenous identity] aside for a long time". Ada reconnected with her Indigenous identity in university and felt a lot of healing came from doing such. Ada's formal counsellor education was in a Western theory focused program. Ada has worked for several years in both clinical and K-12 settings as a counsellor.

Christine. Christine grew up off reservation and learned of her Indigenous heritage later in life. Christine recalled negative messaging around Indigenous people heard as a child, “the comments I heard were, ‘they are just Indians’. So it seemed they didn’t matter to people in society”. Christine recollected having a wholistic understanding of the world as a child, “I connected with nature, with the animals, with the stars in the sky, with the moon and the sun”. Christine finished formal counselling education as an adult in a largely Western theory focused program. Christine has since had decades of experience and worked in public health organizations, private-practice, and in outreach to Indigenous communities.

Lisa. Lisa grew up off reservation in a family where their Indigenous heritage wasn’t always acknowledged. Lisa experienced racism at an early age, “my father was very visible as an Indian man so he wasn’t allowed in restaurants”. Lisa internalized a sense of spirit in nature and land from a young age, “and [I] related that the spirit was in the trees, and I just knew that”. Once in university Lisa found the native centre and connections to ceremony gratifying. Lisa’s formal counselling education was Indigenous-focused and included a decolonization lens for use with Western psychotherapies. Lisa has worked for decades in public health organizations, private-practice, and post-secondary institutions.

3.3. Procedures

3.3.1. Recording, Data Management & Verification

Initial recording of phone interviews was done on a smartphone with an encrypted call recording application that stored data only on the device. Once the phone calls were complete the data was moved into an encrypted folder on a password protected desktop computer. The single Zoom [video conferencing] interview was recorded with audio-only straight to the aforementioned desktop computer. Raw data was secured on encrypted password protected devices and transcribed by me alone. Alongside participant data was my own interviewer notes which included my reactions and thoughts on the interviews. After raw participant data was transcribed, it was destroyed. Participants were sent back the transcriptions to their preferred email addresses. The participants were given the opportunity to make any clarifications or changes to their transcription though at this stage none did, one participant followed up

mentioning they were happy their clarifications were asked for. Transcribed data was then entered in the qualitative analysis software, Nvivo. The Nvivo file was stored, and password protected on SFU's secured Vault platform and an encrypted directory on a password protected desktop computer to which only I had access to.

After participant bios and quotes were selected, participants were sent back their respective sections and asked for feedback or changes. At this stage one participant wanted a follow-up conversation to discuss quotes. This was facilitated with an unrecorded Zoom call, then brief phone call after a power disruption occurred. Changes were made directly to the manuscript and some tweaking to themes components occurred as result of this follow-up. After this the draft of the findings and discussion sections were sent to participants with no additional changes desired from participants.

3.3.2. Interview questions

Interview questions were created with the goal of exploring experiences that occurred over a lifespan and the current perceptions on those experiences. Questions thus and were positioned to look at how organizations, social norms, and policy affected the ability to incorporate Indigenous perspectives. Questions were never answered in strict order and jumping back and forth between questions regularly occurred as one may expect from a conversational recollective account. As an example of how co-construction of knowledge occurred during the interview, before asking the questions I always introduced myself including my family background which includes both settler and Indigenous ancestry, and although this was not a formal interview question this was mirrored by interviewees and often included story that answered or expanded on questions 1-3 below. Additionally, when a participant discussed a particular question my own experience in an area would sometimes be queried by the participant, and my disclosure would in turn lead them into further story inspired by the topic. The formal questions asked, and that were provided before the interview were:

1. Where did you first learn or experience traditional practices?

2. What do traditional practices mean to you, in the counselling context?

3. What helped you incorporate traditional healing or knowledge?

4. Were there ever any barriers?

5. What advice would you give someone looking to incorporate traditional practices or knowledge into counselling?

3.4. Analysis Method

The method of analysis I chose was a qualitative narrative method, narrative thematic analysis.

Narratives allow for participants to make sense of their past experiences, this is in alignment with social constructionism (Riessman, 2008). ‘Narrative’ in narrative thematic analysis is different than narratives in Indigenous storytelling; the former being a technology for examining pattern, and the later for describing experiences and teaching (Kovach, 2009; Riessman, 2008). I will begin by discussing why I chose this method by describing thematic analysis in relation to social constructionism.

Narrative thematic analysis has a sequential and structural focus (Riessman, 2008). This is something I desired as all interviews were audio-recorded, with one interviewee also supplying a document with the question answered. There were also notes I took during the interviews; these processes created a representative sequence of story. In examining the transcribed texts and personal notes I looked for patterns/structures in recollections primarily in relationship to the literature while acknowledging there are values attached to my own interpretations which potentially changed from the time of the interview to the analysis. Conceptually atheoretical, thematic analysis can be used as a constructionist method to examine events, meaning, and experiences (Braun & Clarke, 2006). I value narrative thematic analysis’s atheoretical alignment between postmodern and realist states in order to use is as a realist reflector of reality to simply state situations/contexts which were occurring at the time in a story. Because recollections have the potential to have shifted give the changes in political climate, themes involved interpretation on my part which is in alignment with a constructionist latent thematic analysis stance (Braun & Clarke, 2006).

Transcription of interviews was done on a personal computer; these transcriptions were then brought into the qualitative analysis software Nvivo. Each interview, and my interviewer notes were coded individually for themes before examining

across participant interviews. The workflow went thus, broad stroke coding was first done for each question, then codes from each question were created. A total of 62 initial codes were created. Codes were then grouped into similar concept categories, e.g., wholism gained non-human agents and land as sub-codes in the same group. Then I looked across all three interviews and created larger themes based on concepts I had seen in the literature review through Nvivo analysis of all relevant studies found. Some themes were dropped as being common at this point and others like wholism, remained. Once I had created these themes, I consulted another Indigenous researcher on the applicability and appropriateness of the themes. From this consultation I discovered that some themes, like my wholism theme, could be used to describe several areas of the literature, this acknowledgement helped shaped how I would write about them. I wanted to present themes in a manner informed by appreciative inquiry that showed a variety of participant experience that someone could read, and take up as a way to Indigenize their workplace whether they were Indigenous or not. Following my consultation themes became transformed along these lines, e.g., wholism and its sub-codes became part of themes around counsellor background and why IK is needed. After hearing back from participants some tweaking of themes and quotes in the findings was done based on their input.

The theoretical stances and use of qualitative methods used for interviews and analysis begs a question, are they compatible with Indigenous epistemologies?

3.5. Qualitative Research and Indigenous Epistemology Compatibility

Self-reflective narrative process coupled with acknowledging multiple truths is compatible with Cree understanding (Kovach, 2009). Likewise, and more broadly, narrative inquiry is compatible with general Indigenous understanding of making meaning from story. Kovach (2009) describes the pattern examining aspect of narrative in this sense as encompassing Indigenous epistemologies in general as it puts primacy on what an individual learns from interactions. The relational worldview of social constructionism is also compatible with the interconnected perspective of Indigenous wholism (Kovach, 2009).

Kovach mentions a common problem for researchers is not speaking a tribal language (Kovach, 2009). This was a potential limiting factor for me since I do not speak a tribal language yet am aware that language itself is one of the co-creators of meaning (Burr, 2003). I will note here that my participants were all from different tribal nation backgrounds than myself, and that no participant requested to speak in their nation's language. In the context of counselling in a public agency I believe this to be a less limiting factor than if the counsellors were strictly community based where local language would take on a far greater importance.

Chapter 4.

Findings

Across the interviews six main themes were generated, these themes consisted of categories from the interviews, some of which I'll mention here briefly. Themes listed here are their abbreviated versions, of which the longer section titles are derived from. There is a diamond to pyramid shaped organizational flow between individual and larger context themes with Sections 4.1, 4.3, and 4.4 having a focus on the individual level and 4.2, 4.5 and 4.6 at progressively larger macro levels.

Theme one, 'background in IK' [Indigenous knowledge] is covered in Section 4.1 below. This individual focused theme referenced how a counsellor's background influenced their desire or interest to offer IK or practices within their counselling practice. Categories include racism, spirituality, formal training, and initial experiences of Indigenous culture. Theme two covered in Section 4.2, is a larger context theme of 'why IK and practice is needed'. Categories include participant perspectives on wholism, Western-psychotherapy, and gaps in service offerings for Indigenous clients. Theme three in Section 4.3, 'what & how' focuses on what an individual counsellor did to include IK, and in what manner they included it. Categories involve healing, goals for clients, respect, two-eyed seeing, and multiple-nations. This theme has overlap with the later macro level theme 4.5 'organization'. Theme 4.4, 'why they worked that way' is similar to Section 4.2 but zoomed into the individual level. This theme was quite nuanced including categories around outsider-insider tensions, appropriate-healing, appropriation, resource deficiencies, and how others can respect or include IK. Given the level of nuance a related category was included here as Section 4.4.1 and includes the counsellors' suggestions for others working with Indigenous clients. Section 4.5, 'organization', is a macro theme contrasted against individual experience. Categories here included broader organization response, respect/lack-of-respect in the workplace, translation of healing modalities, two-eyed seeing, and colonial structures. Both the pluses and minuses were covered in regard to organizational experiences. The final theme in 4.6, 'organizational change' is the theme with the largest overall view. This theme lists what was seen as influencing changes seen in organizations the counsellors had worked in, as well as participant suggestions for organization change. The

categories were straight forward with systemic change, TRC, and trauma & suffering being the most talked about by participants.

4.1. How a counsellor's background influenced their work

For Ada the idea of ceremony to connect and heal was a normative life understanding, "I went to pow-wows and there were certain ceremonies that I participated in like [ceremony], I had been to lots of those, and so those kinds of things I knew and had witnessed". Both Lisa and Christine discussed land and a sense of spirit from it being a source of calm and strength growing up.

All three counsellors described experiences where being Indigenous was not celebrated, nor felt safe to acknowledge. The impact of this was felt as shame or fear towards others' perceptions of them should they be known to be Indigenous; Christine described a felt-sense of fear of having an Indigenous identify: "being called 'Indian' when I was a child. I saw that was not a good thing to be called, and was afraid to find out if I did in fact have Aboriginal heritage"; Lisa recollected family reticence, "so we knew the history, in a sense, but a lot of the identification we didn't know because it was just so much denial in the family", and Ada was able to succinctly describe an advantage of looking like the normative culture:

> "I pushed a lot of that aside through high-school because I definitely experienced a lot of racism when I let people know about that side of me, and because I was able to sometimes be white-passing or at least be racially ambiguous enough so that I didn't always have to identify".

Positive experience of culture through ceremony and/or conversation with elders was a turning point for all the counsellors who attributed these experiences with helping them push back against both internalized, and external racism. "At the [university] Native centre we did a lot of traditional groups, helped facilitate groups and all that", "then I was doing some [groups], I went to sweat lodges and was trained in the sweat lodge.", later, when working in the field she noted that "[Indigenous nation] was fully practicing healing traditions. It was awesome." Christine remembered being positively impacted at their university where they "incorporated a traditional ceremony [ceremony description], for loved ones and anyone whom we wanted to say a prayer for."

> Ada: “I experienced a miscarriage just shortly after my Masters program and during this time I reconnected with elders to figure out how to grieve that. And so when I did that I realized that what it was I had been missing the, the cultural therapy piece. The cultural healing that I needed”.

Training between the three counsellors was highly variable. Two of the counsellors experienced Indigenous specific experience which was highly valued:

> Lisa: “They [university] went out of their way to hire professors from across the country who are Indigenous […] So it was great, it was a really great program […] [Indigenous instructor] taught us all of them [Western therapies] and how to view them using an Indigenous lens.”

Christine: “I found this [ceremony] very touching and it was my first fore into cultural practise within counseling because we were a counseling graduating class”.

While both Christine and Lisa had the opportunity to experience some Indigenous perspectives as part of their counselling education, Ada found their more traditional Western based training sometimes did not match with her ideas of healing:

> “I had one supervisor at one point who found out I had gone a different direction that I felt was better suited for the situation, and she had said to me ‘was my help not helpful? Did you need something else?’ And I didn’t really know how to respond because… No, it wasn’t helpful, but I can’t really tell my supervisor that.”

4.2. Why Indigenous knowledge and practices are needed in counselling

As discussed in chapters 2.5 and 2.6 there is a desire and theoretical backing to Indigenous ownership of healing for Indigenous people. This was noted as important, but a challenge by the counsellors interviewed, as not all Indigenous people live on reserve, yet many want their traditional practices. As pointed out by both Lisa, “I don’t mind to [do] practices in [university] but its… its not really the space people relate to. […] In an institution it’s pretty cold to begin with”, and Christine “people are wanting to engage with culture and traditions within their own territories and in urban areas”.

All three counsellors discussed a disconnect between agency settings they worked in during their careers and how it did not meet the needs of Indigenous clients. B.C.’s family services conceptions of family in particular seemed inflexible with regards to Indigenous families as Christine points out, “the system has utilized a colonialist

approach in defining family functioning and not taken into account the cultural differences". For Ada the separation of community, food, and celebration from health was nonsensical:

> "I think that was so important to get the teachings of nourishing our body, mind, and our spirit. And you know all these different aspects of ourselves that we would be nourishing at one time because we are a whole person as opposed to separated"

Lisa talked about how existing policies and work-culture embedded in public instuitions need to be re-examined as "the existing ones are toxic! It's not that they aren't going anywhere, they are completely toxic. They are not good for anybody. Not good for Indigenous people for sure, but not good for anybody". Lisa pointed out this will not be easy because even traditional principles such as Indigenous understanding of consensus has changed "because there have been residential schools for a hundred years, and there has been colonization and of course so [Western] principles have all been adopted." Hopefully, the recent movement in B.C. to a more diverse and culturally respective stance from provincial guidance through training, evaluation, and fund shifting will begin to address some of this mismatch of service offerings (Multicultural Advisory Council, 2021). Even with changes regarding who decides what healing looks like happening, it still requires effort and support as IK or healers may simply not be available as Lisa points out "like [community] had no practices because they went underground."

And while paraprofessionals have been used in funded health endeavours in the past as seen in Section 2.4, there is still "a lack of qualified people" to aid in mental health discourse for some communities. Even when there is a financial or skill-building sponsor available like a non-profit organization or university, communities sometimes do not have the staff, time, or understanding of the system to engage in setting up training or events as Lisa describes, "we are trying our best but the communities have not been inviting us".

4.3. What they did and how they did it

All of the counsellors discussed using both Western and Indigenous practices and knowledge bases. There was considered to be advantages of both practice systems and thus Western practices would not be neglected in their work. Christine

noted that for assessment “we incorporated a humanistic approach with focus on the client at the centre. From my perspective, the family system’s approach to understanding the problem was effective”. Lisa talked about how CBT would be used with trauma survivors when it was applied through an Indigenous lens, “the cognitive part is the affirmation of their relationship to the land, to themselves, to their spiritual, that’s the part you affirm.” And Ada referenced her own experience with CBT, “that was what I worked with, and there were definitely some benefits to it, there were tools”.

All three counsellors warned against assuming Indigenous clients would want traditional knowledge or practices as not all Indigenous clients will identify with being Indigenous or may still feel reticence towards the practices. Both Lisa and Ada noted that they see a diverse range of clients so knowing multiple therapeutic tools is crucial for both non-Indigenous clients as well as Indigenous clients not in their home territories. Ada provided the most succinct example of this perspective: “[I’m not] always working with Indigenous people, so I knew I couldn’t fully bring in Indigenous practices because they weren’t for everybody, even Indigenous people aren’t [necessarily] deeply connected to that”.

Showing respect for the Indigenous community and clients is critical, respecting their knowledge is part of that. Christine who has worked with a variety of Indigenous communities in B.C. stresses the importance of being humble, “do not go into a community or counseling situation thinking you are going to be the expert on what is needed for them”. Christine recalled when doing trauma counselling as a community outsider, if a community had capacity and “we were unable to be specific to a particular First Nations group [we] would regularly invite Elders to lead a healing circle and provide some traditional teachings and practises to our clinical team.” Lisa stated they would not utilize practices from a nation they were not a part of as it would be disrespectful, instead they made efforts to ensure their office and surrounding space reflected their land-based Indigenous clients, “Some people give me different cultural items so people can see those items they relate to. [...] Some connection to feeling safe.” Lisa expanded on this noting she requested, and was granted, the aid of a local Indigenous practitioner who could properly harvest local flora to ensure the land-based Indigenous nation had cleansed spaces.

It is important to remember when working in public agencies with walk-in clients that nation affiliation cannot be assumed, “there are many traditional practices, but each nation has their own traditional practises specific to their group”. Even when the fit between Indigenous counsellor background and client matches, the need to be respectful of a client’s needs was highlighted, “I have never just started to use traditional or cultural practises, but have learned [the client’s level of readiness] and then gradually introduced some traditions respectfully”. All three counsellors believed that traditional practices should only be attempted by Indigenous counsellors. Non-Indigenous counsellors can still work with Indigenous clients with the caveat, “do not attempt to do major traditional practises without the aid of another person such as a spiritual Elder who may work with you and conduct some ceremony for the client.” This ensures the sacred is respected with the appropriate knowledge holders doing their part and preventing cultural appropriation of practices as seen in the ethnopsychiatry examples from Section 2.6.2.

Indigenous identity and resurgence are part of what has been called the Red Road to wellness (Gone, 2011). All of the counsellors espoused the idea of a positive Indigenous identity as being important to them. Christine stated several times during the interview that she had noticed “anxiety is relieved” by utilizing traditional practices. If an Indigenous client seemed curious or interested in traditional knowledge she would ease them into practice, “I am strong in my spirituality and so gradually I would ask if the person would like us to do a prayer”. Many of Lisa’s clients came from communities where ceremonies were known but due to circumstance, including living away from home, sometimes would fall out of practice, and so she would encourage reflection on them:

> “They already know the ceremonies because they are raised here but they get away from it, and they neglect it. So I can remind them, ‘so when was the last time you did a [ceremony]?’ And reference to nature, so these kind of things keep reminding people of those resources that are there for them that they’ve put aside.”

Two-eyed seeing approaches were valued as well. Ada expressed needing a two-eyed seeing approach to ensure they could fully serve their Indigenous clients within the confines of their workplace, “there are aspects I pull from it [CBT], but I really wanted this blended version of what traditional knowledge I had”.

Christine described their two-eyed seeing implementation as the blending of humanistic psychotherapy practices with Indigenous perspectives. They preferred family systems "as it was different than the medical model that looked at the problem as being within the client." Lisa noted that her aforementioned trained Indigenous lens on CBT was also related to narrative therapy which had the most relevance to their Indigenous clients. Ada described Indigenous storytelling as valuable both for communities, "I had been raised where everyone told their stories, everyone's stories were valuable, and everyone's stories could contribute to someone else's life", and individuals in agency settings "I believe that the storytelling can be healing in and of itself".

Goals for clients were not directly asked about but counsellors did offer some of their hopes for clients. For Ada's K-12 clientele, goal achievement emerged from a client's experience with storytelling, with no predetermined outcome in mind. Christine's stories focused on anxiety reduction and on "help[ing] people deal with deep seated issues as a result of generational impact of Indian Residential Schools". Lisa wanted to help clients process their problems then empower them to find ways forward, "if maybe disconnected [from their territory/community], how can they connect to their medicines or how can they find them […] it's about helping them find that."

4.4. Why they work the way they do

When steeped in Western epistemologies from a counselling program with no Indigenous content Ada found that engaging with Indigenous practice helped her with her own struggles, in turn this helped shape their counselling practice, "when I was in University, I reconnected with that side of me [Indigenous identity] again, and started working a lot with Elders. There was a lot of healing that came out of working with Elders."

All three counsellors discussed issues around mainstream psychological interventions with Indigenous clients when applied without considering the history of Indigenous people in Canada or the structure of families and communities. Christine described using a more narrative method for assessing family trauma history and "not using a mental status exam developed with the mainstream medical model in mind". Similarly, when discussing treatment both Lisa, "[CBT] can be useful for sure, it's a good skill, but when you're talking about trauma those people don't need to be questioned on

how they think", and Ada described a desire for something they saw as a better fit for their Indigenous clientele:

> "I just knew right away that CBT wasn't going to fit for my practice, […] the push for genograms, that's also a tough one because I'm like, well… I don't know if you've ever been to a rez but people are like cousins, and second cousins and no one really knows. You call them like sister but their actually your cousin and maybe your actually related but maybe you're not"

For Christine giving Indigenous clients access to IK and practices was critical as Western methods do not always match the community needs, "[I experienced] the ineffectiveness of mainstream talk therapy and found the traditional Aboriginal ways more helpful as they included spiritual, cultural, emotional, and physical into their approach".

4.4.1. Counsellors' suggestions for others

Indigenous counsellors in Canada who are just starting to embark on exploring their own family histories or are beginning their own counselling training need to ensure they have support: "I do a lot with people who are traumatized by the very courses that they take [First Nations studies], and Truth and Reconciliation. Basically, what happens is that people have discovered their history and traumatized by the discovery of their history."

All three counsellors cautioned on making assumptions before use of IK or practices with Indigenous clients, "I can't just share my traditional healing practices because it's about respecting that person and how they heal", "don't just assume they're traditional". While it is perhaps to be expected in an institutional setting to see a range of Indigenous clients who may not be of the same nation, being a counsellor with Indigenous identity was still seen as positive, "an advantage for me was my heritage, as well as my ease working with people [of other nations]". When discussing recommendations for counsellors both Christine and Lisa recommended that for a non-Indigenous person, or an Indigenous person that does not have a background in the community traditions, an outside counsellor should seek out an Elder or other knowledge holder that can share the sacred practices with the client. And as Christine succinctly stated, in opposition to cultural appropriate, "do not start doing traditional practicing that

do not belong to you". Allies however, were still considered to be of important to the resurgence and empowerment of IK.

One of the concepts only discussed by Ada was how racialized counsellors and collectives, and consulting agencies were seen as having a strong role in decolonizing therapy at an organizational level as they too are endeavoring to change the system. Ada pointed out a unique source of inspiration for how she practiced that went beyond her traditional knowledge:

> "I learn a lot from elders and community members, but I follow a lot of young activists on Instagram, or different social media, on Twitter, and I just follow them and try to listen to what they have to say. Just hearing out where their struggles are, and I always get these tidbits or perspectives that I never thought about".

The counsellors also shared common practice suggestions both Indigenous and non-Indigenous counsellors could consider when working with Indigenous clients. One simple rule to remember is that for many Indigenous people relationships are primary and building those takes time, as illustrated by Ada, "if they know you're there for them they're going to open up to you. […] You're asking 'how yer doing'. You can't get in there any faster". A second suggestion all three counsellors recommended was, that if possible, having food available is appropriate. The second note was not a comment on assumed poverty but instead recognizing that, especially in groups, "it is traditional to feed people". This too was acknowledged to have barriers to implementation, "it just requires a little bit more time, and in our society more money".

4.5. Organizational Experience

The counsellors noted there were many things that can happen at an agency/organizational level that both encourage or stifle IK and practice.

Even within Indigenous counselling programs students are taught that they should expect as Lisa put it, "Amero-European" methods to be the default when working at organizations. Ada described the difference between a mainstream K-12 organizational view from an Indigenous view was the lack of a wholistic perspective, "the academics and the counselling piece can feel very separate unless they've been

formally diagnosed with something". Lisa noted that any time a non-EBP is used in a mainstream counselling agency "you've just got to justify and explain it somehow".

Part of this seemed to be related to funding structures that counselling agencies are a part of. Both Christine and Lisa had worked in a health governance organization at one point and said one of the reasons for the ubiquity of Western practices is because insurance companies "liked" them. Ada experienced pressure from funders directly when trying to use traditional methods or knowledge, "you know, I need to know exactly what therapies [with descriptions] their doing to know why I am giving you the money". A further issue Ada identified as part of the K-12 counselling context was that of diagnosis/pathologizing being required for much of the funding. She deemed this to be potentially dangerous to Indigenous clients as she is in agreement with Duran's (2019) perspective that the act of diagnosing has similarities to Indigenous naming ceremonies where diagnosis embeds an identity of sickness within a client and community (Duran, 2019). Christine and Lisa ascribed some of the hesitation for organizations to encourage IK or practices as resultant of research not being available for review by those that okay the use of healing practices/treatments in organizations, "a major barrier was the need for research to be done that provided evidence as to the efficacy of traditional and cultural practises in addressing major mental health issues". While Ada experienced pushback in clinical settings, in the K-12 setting she found Indigenous practices came much easier to implement due to a change in B.C. curriculum which allow practices to be linked to learning competencies. She pointed out that the requirement for an Indigenous component in education allows her to use socio-emotional pieces of IK when working with students.

When it comes to what workers and therapies should be available to Indigenous clients, the counsellors felt that agencies could offer useful services with or without Indigenous counsellors – but in doing so must be considerate of the situations and history:

> "With First Nations counseling it is not enough for people to have basic counseling skills to be able to make a difference in people's lives. They need to be culturally sensitive and knowledgeable. They need to know about the historical context of health concerns of Aboriginal people. This includes social injustice and severe economic inequality." - Christine

When working in non-Indigenous ran organizations Lisa and Ada both said having the organization trust them and give them autonomy over how they worked without "policing" was key to feeling like they were able to best serve their Indigenous clients.

One of the issues raised by the counsellors was the variability between organizations for implementing IK and healing, hiring Indigenous practitioners, or making community connections. The TRC calls to action seem to have been treated as aspirational and not a necessity on a strict timeline to implement; Ada, "there's always an issue with a prioritization of that - inclusion of cultural practice or traditional knowledge. […] at least within counselling because there is no technical mandate for that." This has led experiences of tokenism as Lisa describes, "I'm an identifiable Indigenous woman who's got a Masters degree and good experience so they can say 'look we've got a qualified Indigenous person'". Lisa also points out overwork in organizations needing to meet certain Indigenous position quotas, "an Indigenous person working in these [non-Indigneous] institutions, you get overextended on every regard." Desire to help Indigenous people within these non-Indigenous organizations led two of the counsellors to attempt to subvert the systems. Lisa, who has worked in many different public organizations was blunt in this regard, "my goal initially was to do the best I can, to get as far as I can, to infiltrate the system to provide relevant services to people like me". Ada felt more vulnerable and was at odds with some of the steps necessary to get her clients the supports they needed because of tensions around diagnosis:

> "I'll be honest, I think probably, I live in a grey area of what I'm allowed to do and not allowed to do. You know if a student, to get an assessment or needs to get diagnosed with something or, I can help them get a score on a questionnaire so they can get the assessment they need to get [to access supports]. I help them get it."

These attempts to change the system are not always successful with all three counsellors experiencing pushback when attempting to make changes within organizations: "[I've dealt with] Ministry of Children and Family Development so often and their horrible system, so in their system, they had a separate system for Indigenous families. Anyways, it was awful and not respectful at all"; "I don't feel that I need to share with a bunch of people who I don't ever see, who are just you know, admins. I don't know what they are going to do with my cultural pieces"; "they [administrators]

didn't want a bunch of people who wanted separate policies [for Indigenous clientele] so they cut funding and fired the board." And while some changes have occurred it can be wearing. Lisa described how this constant sense of exertion has affected them over time:

> "Basically, I just found that people didn't get it. The problem is, now I work in the system, and I also have to work within the system [confines]. My colleagues and I don't really relate. I don't feel like I fit in. I feel like an outcast, it's really hard on me. So, while [clients] are really happy with me because I'm very much… I really care. I try to help people in every way that I can. Help them to maneuver the system, figure it out, talk about their problems. The system itself is totally non-Indigenous that's for sure."

Aside from organizations providing autonomy to their counsellors, what helped the counsellors was having themselves, and Indigenous practices, treated with respect; "actually the person that was hired after me was a pipe carrier, so they [organization] definitely were very respectful". Organizations supporting IK were praised "we were the first clinic in a health authority to incorporate traditional cultural healing practices with a mainstream counseling program", and it was mentioned that incorporating IK and traditional practices was easier in "smaller environments where everyone worked so closely".

Coming out of the discussion of workplaces, one of the beliefs shared by the three counsellors was that several of the organizational structures they have worked in tended to be non-Indigenous and utilize a colonialist approach to defining problems for client and family functioning. Lisa noted that in their own training on how to view Western therapies with an Indigenous lens was important as part of the decolonization of the systems they worked in because the systems themselves are flawed:

> "they are hierarchical, patriarchal, competitive, capitalistic, so they are everything that is non-wholistic and it's destroying us. And really this is where we do need the Indigenous principles embedded. […] they created residential school. So how do you stop all that? I have no idea so I think maybe we all have to heal all together. And that's why I'm saying it'd be good if we could work together."

4.6. Organizational Change

Organizations adopting a trauma-informed approach was seen as necessary going forward. This was not considered to be exclusive to Indigenous clientele but

something that an organization has to consider in terms of Indigenous staff experience as well, “and because a lot of them [Indigenous staff] said they didn’t have any idea about what had happened [family experience of residential school system] because their Grand moms won’t talk about it at all.”

When confronting pushback on how they have worked, two of the counsellors described referencing the TRC report as helpful, “You have to show how what you’re doing is evidence based. You make it happen and hey, you can always point to Truth and Reconciliation since they love to throw that around.” There has been positive movement seen over time by Christine and Lisa. They mentioned that the ability to better serve Indigenous counsellors received a boost first with the advent of Health Canada, then again with the First Nations Health Authority [FNHA]. The FNHA received positive praise for it’s work during the restitution talks around the TRC for sending counsellors into remote communities that otherwise would not have had representative counselling opportunities. Ada too listed the TRC as having a positive impact in the K-12 system regarding the fostering of a positive Indigenous identity, “I think a lot of that did come out from the Truth and Reconciliation and the commitment to incorporate Indigenous practices, knowledges, and teachings. Because even within each course in BC curriculum there always a component of Indigenous knowledge”.

Chapter 5.

Discussion

With this thesis being exploratory in nature, the themes from the findings were as broad as necessary to match the research questions. As the number of participants was small generalizations for recommendations cannot be made from just this study alone. Instead, it is important to note that the themes reflected previous research and recommendations thus still providing insight and guidance, for agencies and practitioners alike.

Like chapter 2.7 - specific findings on enabling processes, attaining Indigenous specific training was rare but valued among counsellors who experienced it. While it may be tricky for training institutions to attract appropriate trainers on-site, expanding the list of cross-institutional courses available to students may be one such way to increase accessibility to IK paradigms for Indigenous counselling students. This is a recommendation as it clearly had an impact on participants and is something called for in the TRC calls to action 22 and 23 which ask that within the Canadian health care system Indigenous healing practices are available in a sustainable fashion.

As in the literature, all the counsellors interviewed shared lived experiences of racism. Indigenous identity was something that transformed over time and is now positive for them. Thus, positive Indigenous identity was considered extremely important to target while they acknowledged Indigenous clients may take longer to get to that stage due to the increased time relationship building takes, something that runs afoul of most agency time-limited counselling requirements. Unfortunately, getting Indigenous clients to even engage in counselling is complicated by the current state of healthcare offerings in B.C.

The *In Plain Sight* report from 2020 makes it clear that systemic racism still exists within health care in B.C. (Turpel, 2020). As mentioned previously, Indigenization of services does appear to be occurring in B.C. with staff training, funding shifts, and service assessment (Multicultural Advisory Council, 2021). However, these initiatives are in the midst of being integrated and not always evenly felt by health practitioners or the public. Lisa recalled a frustrating event that occurred in her (non-Indigenous led)

workplace when she was trying to offer support to non-Indigenous colleagues with Indigenous clientele: “They [administrative staff] said ‘but yeah but they are your colleagues so that’s not really your role’. They [colleagues] actually liked coming to me and if I can help them help [their clients] then everyone wins.” This strictly hierarchical position is against the wholistic spirit of IK and TRC calls to action 22, 23, 27, 28, 57, and 62 around training and education across multiple fields of work. The K-12 system also suffers from its strict hierarchical structure, requiring counsellors to be the ones pushing upwards for change, “there’s not a connection to classroom teachers, to their counsellors, its very just separate, off to the side.” These experiences illustrate why the recommendation to ensure anti-racism training is maintained and not considered a one-off event is important. Ongoing training is crucial as processes within organizations may need to be changed, but which processes enable racism may not be immediately understood.

Even Indigenous-led organizations can have limitations. Lisa recollected working for one in which counsellors were given insufficient payment compared to other positions, “they don’t pay enough. […] Somehow, they always expect counsellors to be paid less but they never ask massage therapists, or doctors or anybody else to be paid less, just counsellors.” They explicated further indicating they found the structure to be too similar to Western-led agencies, “they leave a lot to be desired because I was registered with them before as a counsellor but it’s just so bureaucratic”. This last observation caught my attention as it reminded me of Audrey Lorde’s idea that while you may temporarily utilize a dominant culture’s methods and systems to good effect, changing to a more appropriate system for your context/culture is necessary as “the master's tools will never dismantle the master's house” (Lorde, 1984, pp. 106–109).

For agencies wishing to aid Indigenous counsellors and clientele, some sobering and thoughtful ideas the counsellors brought up should encourage consultation before simply acting. For example, there may be many different Indigenous nations represented in an area, for Indigenous clients accessing services, agencies must be aware that hiring an Indigenous counsellor does not mean they will necessarily be offering Indigenous healing practices or knowledge. Reaching out to local nations is recommended and should be done by the agency especially if the Indigenous counselling staff does not have the appropriate cultural training. This mirrors findings from the decolonization Section, 2.7. Offering Indigenous counsellors’ autonomy is also

a good fit if their Indigenous counsellors can respectfully offer the services properly, or they themselves know Indigenous knowledge holders that can. This was heard from both Kim and Ada as well as in the Oulanova & Moodley (2010) study referenced in Section 2.7. Agencies should be supporting Indigenous knowledge and practices; the TRC calls 18-23 around making healing available can be cited if external funders or accreditation organizations wonder why non-EBP are being utilized (Truth and Reconciliation Commission of Canada, 2015). The key piece learned from the participants is that both Indigenous clients and staff will have had varied life stories and upbringings, and to offer IK or practices requires work.

Organizations need to ensure their Indigenous counsellors are not overworked and have supports available to them to prevent feelings of isolation, otherness, and fatigue. This is just as applicable in a larger organization where the amount of non-Indigenous staff is dominant, and there may be only one Indigenous counsellor. How this would be accomplished was not something any of the participants had ideas for other than online engagement between peers. Ensuring Indigenous staff are not overworked is a recommendation primarily targeting agency administrative staff, who may be reticent to allow their Indigenous counsellors time off for training or breaks because of a shortage of Indigenous counsellors. Even if an organization was to be without an Indigenous counsellor for a time, it would be better than the alternative, counsellor burn-out – which can be a permanent loss of staff, and is seen in environments where overwork and/or lack of control over their work-life is prevalent (Aydemir & Icelli, 2013).

In relation to participant experiences and the literature, I think it is important to mention my experience with recruitment for this study. In my formal psychology education, it was routinely mentioned that distance from participants in research and in counselling practice is crucially important. As seen in both the literature and the participant comments, this is exactly against the relational expectations of many Indigenous community members, whether they live within rural communities or urban settings. During recruitment I heard on multiple occasions that people did not want to be involved in research, something likely informed by us not having a pre-existing relationship. At the beginning of the interviews two of the counsellors expressed uncertainty about taking part of this study because while they wanted to participate, they did not want their organizations involvement and were aware that anonymity is more

tenuous for minorities in the field. While the amount of research available on enabling processes for IK and traditional practices is scant, this does mirror experiences Oulanova & Moodley (2010) had in Section 2.7 above regarding fears around an organization's view of Indigenous practices vs EBPs as well as the small number of recruitable participants they had. One of the counsellors I spoke with wished there was more information about me online so they could verify my background and credentials. Had I an existing relationship with a common party, or known reputation with the counsellors, I cannot help but wonder if this reticence would have disappeared. It also highlights the doubt around how workplaces can be trusted to respect the TRC calls to action, and the B.C. multicultural advisory board's efforts to ensure respect and diversity in the workplace.

This study is illustrative of how there is still little Indigenous focused counselling information available in the literature. What was discussed by participants reflected existing findings. It also should serve as a reminder to staff eager to serve an underserved population that things need to be done in the right way and not blindly attempted – something the participants felt quite strongly about.

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Appendix.

Letter of invitation

Ethics Application Number: **2019s0246**
[8/20/20]

Counselling & Traditional Indigenous Practices: Examining Enabling Practices and Processes

Greetings, you are being invited by the principal investigator (PI), Joe Tobin, Masters of Counselling Candidate, Faculty of Education (dtobin@sfu.ca) to participate in a research project entitled *Examining Enabling Practices and Processes*.

Study Purpose

The purpose of this study is to develop a better understanding of how the field of counselling incorporates traditional Indigenous healing or knowledge into counselling service offerings. By doing so this study may provide insight on how agencies and service providers can decolonize their practices and processes.

Research Questions (RQ)

> RQ1: What are the personal factors that enable the valuing of traditional Indigenous healing and knowledge as part of the counselling process?
>
> RQ2: What are the systemic factors that enable Indigenous counsellors or agency administrative staff to integrate Indigenous knowledge or traditional Indigenous healing within counselling practices?

As part of this project, you are being invited, to participate in an one-on-one conversational interview that will last approximately 45-60 minutes and will held via a video conferencing application or over the phone. Interviews will be held at a time convenient for you.

In the interview, you will be asked about your experiences with traditional Indigenous healing practices or knowledge and what aided you in utilizing them or encouraging their use. With your permission, the interview will be digitally-recorded to assist with the data analysis. You will receive a copy of your transcript for review and for your records. No audio recordings will be published.

Your identity and confidentiality will be respected in any final reports, presentations, and/or publications emerging from this research project.

The questions you will be asked during your interview are included for your information, and given the semi-structured and conversational nature, there may be other questions that emerge from the conversation.

Benefits of Participation

Though you will not experience direct benefits from participating in this study, your involvement will be contributing to a largely under-published area of academia and will hopefully inform others on how Indigenous counsellors or counselling centres can incorporate traditional practices.

As a participant, you will also be given a copy of your transcript and you can contact the PI, Joe Tobin to receive a copy of the final research report or any subsequent publications resulting from this project.

Risks to Participants

There are no foreseeable lasting risks to you as a participant in this study. There is the potential for temporary unsettling recollections during the interview. Because of this a list of support resources will be provided.

Remuneration/Compensation

You will not be paid for your time when participating in this study, but in gratitude, you will be provided a small token of appreciation ($20 gift card) for sharing your knowledge at the end of your involvement.

Confidentiality

Whether you want to be identified by name in this project is up to you. If you do not want to be named, your decision will be respected, and all information collected will remain confidential with regard to your identity. In that case, you will be identified by a pseudonym of your choice and identifying information on transcripts as well as final reports will be replaced with the chosen pseudonym.

You may refuse to participate or withdraw participation in this project at any time without consequence. Your involvement or non-involvement in this project is in no way related to, or will impact your relationship with the researcher and/or your status within your institution. If you choose withdraw at a later time your data will be removed.

All original data will be kept on a password-protected device, hard copy will be stored in a locked filing cabinet.

Contact for more information:

You may ask any questions you might have about the project with the PI, Joe Tobin. You may also contact Dr. Sharalyn Jordan or Dr. Alanaise Goodwill.

Contact for concerns about the study

You may ask any questions or register any complaint you might have about the project with Dr. Jeffrey Toward, Director, the Office of Research Ethics at Simon Fraser University.

If you are interested in participating in a one-on-one interview please do contact the PI, Joe Tobin. Also please feel free to share this letter of invitation to others you know who would be interested in this project.

Many thanks for your assistance,

Joe Tobin

Counselling & Traditional Indigenous Practices: Examining Practitioner Enabling Processes

1. Where did you first learn or experience traditional practices?
2. What do traditional practices mean to you, in the counselling context?
3. What helped you incorporate traditional healing or knowledge?
4. Were there ever any barriers?
5. What advice would you give someone looking to incorporate traditional practices or knowledge into counselling?

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