

“I’M NOT THE EXPERT”: WAYS MENTAL HEALTH PROVIDERS DECOLONIZE THEIR  
PRACTICE

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By

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## **Abstract**

To date, little research has been devoted to understanding how mental health professionals decolonize and Indigenize mental health services, either in a private practice setting or mental health services. The purpose of this study was to expand on existing literature by documenting ways in which non-Indigenous mental health professionals decolonize mental health services. Semi-structured interviews were completed with nine professionals who shared their stories about how they decolonized and Indigenized their practice and/or mental health services when working with Indigenous clients. The methodological framework used was the basic interpretive qualitative research design (Merriam, 2002), which investigated the dynamics of counselling Indigenous clients in a therapeutic situation. Next, ways of being more culturally informed while working with Indigenous clients from the perspective of mental health professionals were explored. Thematic analysis (Braun & Clarke, 2006) was used to identify, analyze, and develop themes in the data. Six themes emerged: decolonizing; being a cultural ally; practicing holistically; understanding and respecting Indigenous ways of knowing and doing; appreciating vital components; and commitment to lifelong learning. Findings are described alongside implications for practice and potential future research directions.

*Key Words:* decolonizing, Indigenization, non-Indigenous mental health professionals, Indigenous clients

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## **Chapter One: Introduction**

Indigenous Peoples are the fastest-growing cultural group in Canada (Stewart & Marshall, 2017). From 2001 to 2006, the Indigenous population in Canada increased by a rate five times that of the non-Indigenous population (Stewart & Marshall, 2017). In 2016, 1,673,785 people, totalling 4.9% of the Canadian population, reported an Indigenous identity (First Nations, Métis, or Inuit; Statistics Canada, 2018). By 2036, the Indigenous population is estimated to be 6.1% of the Canadian population (Morency et al., 2015). Additionally, there is an increase in Indigenous Peoples living in urban locations in Canada (Stewart & Marshall, 2017). These population increases indicate there will also be a greater need for mental health services (Canadian Counselling and Psychotherapy Association [CCPA], n.d.). According to the Truth and Reconciliation Commission (TRC, 2015), health care, including mental health care, should be recognized as a treaty right for Indigenous nations. Therefore, it is important that mental health professionals develop competency in working with people from diverse cultures (Corey et al., 2017) and expand their knowledge about Indigenous Peoples and communities.

Mental health is an important aspect of overall health for Indigenous Peoples; however, Indigenous cultural considerations of mental health and healing are very different from those in most settings where North American mental health providers work, including counselling contexts. Due to these differences, mental health professionals typically experience challenges as they seek to meet the varying needs of the Indigenous population, especially when learning about and providing access to the healing resources that exist within Indigenous cultures (Gone, 2004). It is difficult for counsellors to learn about Indigenous healing resources because in the United States, counsellor training has been developed exclusively using a Western paradigm (Gone, 2004). Therefore, Indigenous communities have only been able to access certain Western types of treatment and prevention approaches, including those that focus on individuals and diagnostic

labels rather than on Indigenous ways of knowing that are needed to restore health and well-being for Indigenous individuals, families, and communities (Smith, 1999). Consequently, these worldview differences can form a barrier that interferes with providing effective counselling for Indigenous clients.

Some scholars, such as Duran (2006), claimed that when mental health professionals provide counselling services to Indigenous individuals from a non-Indigenous perspective (i.e., Western ways) this can perpetuate the cycle of oppression and colonization, as this perspective does not acknowledge Indigenous cultural views of mental health and healing. Therefore, mental health professionals need to learn and understand culturally relevant knowledge about Indigenous mental health and healing and become familiar with Indigenous healing approaches, such as “*community as healer*” (Katz, 2017, p. 308), Indigenous perspectives on spirituality, Indigenous healers, and healing ceremonies (Katz, 2017). Failure to recognize this historical tradition might lead to inappropriate practices that impede a positive therapeutic alliance and outcomes for Indigenous Peoples.

This study focused on how mental health professionals decolonized and Indigenized mental health services. Decolonization means recognizing the importance of Indigenous worldviews, knowledge, and perspectives (Indigenous Corporate Training Inc., 2017). Providers need to focus on Indigenous Peoples’ cultural and spiritual beliefs and practices as they work to decolonize and Indigenize the mental health profession (Fellner, 2016).

### **Researcher Interest**

Qualitative researchers make their worldviews, assumptions, and biases known to help their readers understand their stance (Morrow, 2005). The inspiration for this study came from many sources. First, I was interested in conducting research on how mental health professionals

decolonized and Indigenized their practice so that further colonialism can be avoided. Hopefully, this research will contribute to practitioners becoming more culturally competent in the knowledge, cultures, and practices associated with the ways of Indigenous Peoples and communities. Second, I have educated myself on various Indigenous cultures and the significance of Pow-wows, Sundances, smudging, women's moon cycles, and other cultural rituals and traditions. I have taken several Indigenous Studies courses, including a 400-level class about issues of cultural preservation. Although I am not Indigenous, I am interested in both understanding the practices that provide culturally safe healing spaces for Indigenous Peoples and continuing to be an ally.

### **Statement of Purpose**

As Canada's Indigenous population grows, the need for mental health services will also increase (CCPA, n.d.). It is imperative for mental health professionals to provide culturally responsive practices to diverse clients. Cultural competence is defined as "the ability to understand, appreciate, and interact with people from cultures or belief systems different from one's own" (DeAngelis, 2015, para. 1). Therefore, practitioners' level of awareness, knowledge, and interpersonal skills are needed to function successfully in a multicultural society. It is important that clinicians effectively intervene on behalf of clients from diverse backgrounds (France et al., 2004). Cultural competence is so important that it is considered one of psychology's core competencies (DeAngelis, 2015). I want to explore how mental health professionals decolonize their services to address Indigenous "holistic wellness" (Fellner, 2016, p. 202) and meet the varying needs of their Indigenous clients (Fiske, 2008). I also want to explore cultural competence, as mental health professionals need to be familiar with Indigenous cultures, spiritual practices, customs, and traditions to help provide enhanced mental health

services (Kitts, 2017). Consequently, the current study is significant as mental health practitioners need to decolonize their practice by incorporating Indigenous perspectives on survivance, resilience, and interconnectedness, as well as understanding how colonization affects Indigenous Peoples (Duran, 2006).

The purpose of this study was to gain insights into the experiences of non-Indigenous mental health professionals regarding ways they decolonized their practice and mental health services to better meet the needs of Indigenous clients. As well, their approaches for providing culturally competent counselling to this population were explored. Three key research questions guided this inquiry:

1. How do non-Indigenous mental health professionals experience decolonizing their mental health services (other terms might include “Indigenizing,” “developing anti-oppressive practice,” and “developing cultural allyship”)?
2. In what ways do non-Indigenous mental health professionals practice cultural humility and strive to provide decolonized, anti-oppressive services to Indigenous clients?
3. How do non-Indigenous mental health professionals acknowledge systems of power and privilege and advocate for social justice issues for their Indigenous clients?

### **Defining of Terms**

In this section, definitions for the critical terms in this study are provided. “All My Relations”: This term refers to care for the “harmony and well-being of life; all things are regarded as ‘persons’ and as ‘relatives.’ Personhood not only applies to human persons, but plants, trees, rocks, and visible and unseen forces of nature are also considered as ‘persons’” (Dumont, 2014, pp. 8-9).

Allies: Individuals who actively attempt to eliminate various forms of oppression that give them privilege. These individuals are typically Eurosettlers who work to support Indigenous agendas as created by Indigenous Peoples themselves (Fellner, 2016).

Anti-Oppressive Work: Anti-oppressive work recognizes the oppression that exists in society, works to alleviate its harmful effects, strives for equality, and addresses these imbalances in communities (Anti-Violence Project, n.d.).

Anti-Racism: This concept involves more than just being “not racist” (In Plain Sight, 2020, p. 11). It involves “identifying, challenging, preventing, eliminating, and changing the values, structures, policies, programs, practices and behaviours that perpetuate racism” (In Plain Sight, 2020, p. 11). To be anti-racist means comprehending how society today is founded in colonialism and racism; therefore, it is important to be dedicated to learning and be willing to act to bring about inclusion, impartiality, and fairness (In Plain Sight, 2020).

Colonialism: Historically, this term is associated with those from forceful military domains conquering the lands of people with less military control, ill-treating them, and wrongfully pillaging their material resources while simultaneously behaving in a superior manner and perceiving themselves as being more pious than others (Katz, 2017). Furthermore, colonialism “violently suppresses [Indigenous Peoples’] governance, legal, social, and cultural structures, and forces them to conform with the colonial state” (In Plain Sight, 2020, p. 10).

Community: The World Health Organization (n.d.) describes Indigenous populations as communities that dwell in “geographically distinct traditional habitats or ancestral territories” (para. 1). These unique Indigenous populations “descended from groups present in the area before modern states were created and current borders defined. They generally maintain cultural and social identities, and social, economic, cultural and political institutions, separate from the

... dominant society” (World Health Organization, n.d., para. 1), as well as often see themselves as being one with the land and not separate from it (Colding & Folke, 2000).

**Cultural Competence:** Cultural competence is “the ability to understand, appreciate and interact with people from cultures or belief systems different from one’s own” (DeAngelis, 2015, para. 1).

**Cultural Humility:** “Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique” (Tervalon & Murray-Garcia, 1998, p. 117). Cultural humility is necessary to develop a culturally safe environment. Professionals need to have self-awareness of their biases, viewpoints, and privilege, as well as examine the objectives of the client-practitioner relationship. Practicing cultural humility allows Indigenous voices to be heard and creates a relationship that is “based on respect, open and effective dialogue and mutual decision-making” (In Plain Sight, 2020, p. 11).

**Culturally Safe Environment:** Only an Indigenous person receiving care can define this type of environment. Essentially, a culturally safe environment is an environment where the individual feels safe, appreciated, valued, is not prejudiced against, and where there is open and respectful communication (In Plain Sight, 2020). In addition, “it is a physically, emotionally, socially, and spiritually safe environment” (In Plain Sight, 2020, p. 11), where the person’s identity is neither questioned, disregarded, or rejected. To be culturally safe necessitates positive anti-racism attitudes, tools, and methods, as well as continually practicing cultural humility (In Plain Sight, 2020).

**Decolonization:** Decolonization is not a rejection of colonialism. Rather, it rejects the colonial relations of power that threaten Indigenous ways of being. Decolonization “demands the valuing

of Indigenous sovereignty in its material, psychological, epistemological, and spiritual forms” (Sium et al., 2012, p. 5).

Ethnocentrism: This is the propensity to view one’s group as more dominant and more advanced compared to other groups, which tends to create “intergroup bias that fuels prejudice, xenophobia, and intergroup violence” (Carsten et al., 2011, p. 1262). Thus, the “superior group” criticizes other people, groups, and/or cultures by their own cultural values, thus inferring their inferiority (Carsten et al., 2011; Greymorning, 1997).

Historical Trauma: Refers to “cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences” (Brave Heart, 2003, p. 7).

Indigenization: Requires non-Indigenous people to recognize Indigenous perspectives and to acknowledge all perspectives are equivalent to one another. In other words, it involves the legitimacy of Indigenous worldviews, understandings, and viewpoints (Indigenous Corporate Training Inc., 2017). It should be noted that “there is not a homogenous Indigenous worldview, and that each Indigenous nation or community will have their own worldview” (Indigenous Corporate Training Inc., 2017, para. 10).

Indigenous: Because First Nations, Métis, and Inuit Peoples are a heterogeneous group with a wide range of languages and cultures (Scarpino, 2007), this study uses the term “Indigenous” to acknowledge persons from all three groups and honour this diversity.

Indigenous Spiritual Ceremonies and Practices: Refers to “precious gifts given to Indian people by the Creator” (Ontario Human Rights Commission, n.d., para. 7). Some examples of cultural activities are as follows: drumming; full-moon ceremonies (Lavallée, 2007); sweat lodges;



smudge ceremonies; talking, sharing, or sacred circles; and moon-circles (Ontario Human Rights Commission, n.d.).

**Indigenous Traditional Healers, Elders, and Teachers:** These community leaders use traditional healing methods to assist people in healing. According to eMentalHealth (n.d.), “some healers work with plants and medicines, some may counsel, and some use ceremonies such as the sweat lodge” (para. 1).

**Intergenerational Impacts:** The damaging effects of the sexual and physical abuse experienced by Indigenous Peoples who were involved with the residential school system have had an intergenerational impact on their children, grandchildren, and great-grandchildren (Aboriginal Healing Foundation, 2006). Additionally, residential school survivors might struggle with attachment in their relationships and consequently still struggle to this present day. These severed attachment relationships have negatively impacted many individuals, families, and communities (Manitoba Trauma and Information and Education Centre, 2021).

**Medicine Wheel:** The Medicine Wheel is significant for many Indigenous cultures and consists of four aspects (i.e., mental, physical, emotional, and spiritual) of the human existence that must be balanced in order to achieve well-being and healing (Lavallée, 2007).

**Mino-pimatisiwin:** A Cree word that translates as “the good life” and involves nurturing and respecting all relationships to achieve harmony (Centre for Aboriginal and Rural Education Studies, 2018).

**Post-traumatic Stress Disorder:** A psychiatric diagnosis involving insistent, distorted cognitions about the origin or consequences of the traumatic event(s) that leads individuals to blame themselves or others. There is a persistent negative emotional state, such as fear, horror, anger,

guilt, or shame. In addition, there is a marked decreased interest or participation in important activities (American Psychiatric Association, 2013).

Self-Determination: Indigenous rights of self-determination involve Indigenous Peoples' right to "freely determine their political status and freely pursue their economic, social, and cultural development" (United Nations, 2008, p. 3).

Survivance: The term "combines 'survival' and 'endurance' while recognizing Indigenous survival as active presence in our contemporary context ... Survivance, much like Indigenous ways of knowing, is a way of living and an ongoing series of acts of determination"

(LaPensée, 2014, p. xvi).

The Sixties Scoop: This refers to a practice that began in the late 1950s and ended in the 1980s, where thousands of Indigenous children were removed from their family of origin and placed in non-Indigenous foster homes or adopted (Russell, 2016; Sinclair, 2007).

Two-Spirit People: Refers to Indigenous persons who categorize themselves as having "both a masculine and feminine spirit, and is used by some Indigenous people to describe their sexual, gender, and/or spiritual identity" (Researching for LGBTQ2S+ Health, n.d., para. 1).

Wahkôhtowin: This "is a Cree word that means 'everything is related'"(Indigenization Strategy, 2017, p. 1). This concept of interrelatedness illustrates that "all of life, including all humans, are connected together in a complex web of relationships, and what happens to any one part of the web of life affects everything else" (Indigenization Strategy, 2017, p. 2).

### **Assumptions**

Leedy and Ormod (2013) postulated, "Assumptions are so basic that, without them, the research problem itself could not exist" (p. 62). As a student of qualitative research, I assume that mental health professionals use counselling practices to assist Indigenous clients in

discovering their own strengths and resources (Saleebey, 1996). I also assume that depending on the situation and context, mental health professionals might use cognitive-behavioural therapy (CBT), brief-solution focused therapy (especially if there is a limit on the number of sessions), and grounding exercises (Saleem, 2015). Merriam (1998) argued that the key philosophical assumption of qualitative research is that reality is constructed when individuals interact with their social realms. Additionally, I assume that my research is context-bound and that patterns are clarified in order to understand a phenomenon (Simon, n.d.).

As a researcher, I self-reflect on my own cultural assumptions to acquire “cultural humility” (Walker et al., 2010, p. 60). I acknowledge the privilege of having the cultural identity of Whiteness, and I am aware Indigenous Peoples might identify me as “one of the colonisers” (Bennet et al., 2011, p. 25). I address this possibility by not believing I have all the answers and by avoiding the attitude that this study will “save” Indigenous clients. I agree with Smith (1999), who argues that White researchers come from a vantage point of the colonized, and even the term “research” is intricately associated with European colonialism. In fact, Smith claims that this term can plausibly be considered one of the dirtiest words in the Indigenous world’s language. I hope the outcome of the current study supports Indigenous Peoples in their healing journey and that non-Indigenous mental health professionals gain knowledge and understanding of how harmful colonization has been for Indigenous populations. Finally, I attempt to frame my research in a way that emphasizes the social processes that have denigrated Indigenous Peoples rather than focusing on the concerns or problems of Indigenous individuals or communities (Ermine et al., 2004; Smith, 1999).

In the remaining chapters, I outline the ways mental health professionals have decolonized and Indigenized mental health services for Indigenous Peoples in Canada. In

Chapter Two, I critically review and summarize the following: the literature on the historical Indigenous perspective on mental wellness; current mental health concerns for Indigenous Peoples; racism; trauma; the colonization and decolonization processes; decolonization and Indigenization of mental health practices; and a culture-based approach to healing. In Chapter Three, I explain social constructivism, which is the epistemological framework underlying the basic interpretive qualitative research design. In this chapter, I also discuss the design features of the study (i.e., participants, recruitment, interview probes, etc.). In Chapter Four, I represent the thematic findings from the analysis of my conversations with nine participants. Lastly, in Chapter Five, I discuss the contextual understanding of how participants decolonized their practice and mental health services and highlight implications for practice and future research directions.

## **Chapter Two: Literature Review**

There is much literature that describes how Indigenous Peoples experience an assortment of mental health issues, such as depression, anxiety, suicide, and substance misuse, at higher rates than other Canadians (Government of Canada, 2006; Health Council of Canada, 2005; Smye & Mussell, 2001). In 1999, suicide was the leading cause of death for First Nations persons aged 10 to 44 (Health Canada, 2003, as cited in Health Council of Canada, 2005). Roderick McCormick, an authority on health and suicide at Thompson Rivers University in British Columbia, argued that a combination of extreme poverty, lack of schooling, and lack of basic needs contributes to the increase of suicides among Indigenous youth (Randhawa, 2017).

In this chapter, I review the relevant literature by first explaining how Indigenous Peoples understand mental wellness. Next, culturally appropriate mental health practices with Indigenous Peoples and mental health issues in Indigenous communities are addressed. I then explore the effects of violence, trauma, and colonization on Indigenous Peoples, followed by suggestions from the literature on ways mental health professionals can best contribute to decolonizing and Indigenizing the helping profession. Finally, I explore the importance of culturally-based healing approaches.

### **Historical Indigenous Perspective on Mental Wellness**

Indigenous Peoples of almost every culture view mental wellness as a state of balance, harmony, and connectedness between people's physical, mental, emotional, and spiritual well-being, and their environment (CCPA, n.d.; Royal Commission on Aboriginal Peoples [RCAP], 1996). Indeed, many Indigenous cultures believe that individuals themselves are healers; they believe there is a mysterious part of the self called the "inner healer" (Cumes, 2013, p. 61) that exists deep within individuals.

In addition to the inner healer, people in the community designated as Indigenous healers are also accessed for mental health healing. Indigenous healers can connect with individuals' troubled spirits and assist them in their healing journey (Mehl-Madrona, 2003). Indigenous health perspectives involve a holistic understanding of the self; therefore, an Indigenous health policy involving Indigenous Peoples' direct input plays a prominent role in creating health and wellness strategies aligned with their cultures (Ontario Ministry of Health, 1994).

### **Mental Health Problems Emerging from Canada's Assimilation Practices**

The Truth and Reconciliation Commission (TRC, 2015) asserted that Canada's assimilation policy resulted in the cultural destruction of Indigenous communities, leading to extensive mental health issues experienced by First Nations, Métis, and Inuit persons. Kirmayer et al. (2009) contended that the assaults on Indigenous cultures and the oppression Indigenous Peoples have experienced have resulted in high rates of alcoholism, suicide, depression, and violence among Indigenous youth. The history of colonization, which began in the 1500s and continues to this day, demonstrates a direct relationship between colonization and mental health. As an example of this link, Robbins and Dewar (2011) discussed how the Canadian government and its legislation mocked and persecuted traditional healers. As a result, Elders and medicine people were forced to practice their traditional ways and ceremonies in secret.

Cultural genocide and dislocation resulted from colonial trauma, including residential school abuse, forced relocation, and the Sixties Scoop. Understandably, Indigenous Peoples have experienced decades and even centuries of unresolved pain and grief, loss of cultural identity, high rates (compared to non-Indigenous populations) of anxiety, depression, grief and loss, post-traumatic stress disorder (PTSD), substance misuse, sexual abuse, family violence, and deaths by suicide (Duran, 2006; Kirmayer et al., 2009; Waldram, 2004). The Royal Commission of

Aboriginal Peoples (RCAP, 1996) argued that because knowledge is lacking about the kinds of interventions and services that will best help Indigenous Peoples, mental health professionals need to make their services more holistic so Indigenous experiences with mental health are grounded in Indigenous ways. Thomas and Bellefeuille (2006) maintained that preparing both Indigenous and Western mental health practitioners with the understanding, values, and skills required to endorse holistic well-being within Indigenous families and communities is a high priority.

The diverse aspects of socioeconomic status (SES) should be considered “in determining health” (Reading & Wien, 2009, p. 13). Shepherd et al. (2012) stated that mental health issues such as substance misuse, depression, and suicide are even more difficult to address when positioned against a socioeconomic background of poverty, lack of proper housing, unclean water, lack of funded educational supports, high rates of unemployment, and environmental degradation (i.e., Indigenous Peoples’ being unable to secure their right to hunt, fish, and trap; Collins & Murtha, 2010). Two main explanations are offered for why there are lower levels of SES among Indigenous Peoples: SES considerations can cause the onset of mental health issues (social causation), or the decline in mental health causes a downward movement in social status (health selection; Shepherd et al., 2012). Link and Phelan (1995) and Page et al. (2009) argued that both theories support the relationship between socioeconomic conditions and mental health within Indigenous populations.

As mentioned previously, there are multiple alcohol and substance misuse issues among Indigenous populations (Duran, 2006; Kirmayer et al., 2009; Waldram, 2004) due to the cultural genocide they have experienced. Unfortunately, according to Smye and Mussell (2001), there is a deficiency in timely, harmonized treatment and support for those Indigenous persons who

struggle with alcohol and substance misuse issues both across agencies and communities. In addition, those with severe mental illness requiring emergency care have difficulty accessing treatment for their mental illness. Furthermore, challenges exist in receiving funding to travel to these treatment facilities. There are very few rehabilitation programs and a lack of follow-up for those individuals fortunate enough to receive care at treatment centres. Recovery rates tend to be low as individuals often return to the same set of circumstances that led to the problem in the first place. Furthermore, survivors affected by the residential school system have little access to resources to address their mental health concerns. Mental health care providers often fail to understand the traditions, values, and health belief systems of Indigenous Peoples and their communities, resulting in Indigenous knowledge being diminished and disregarded (Smye & Mussell, 2001).

## **Racism**

Unfortunately, racism persists in Canada. From stereotyping to persecution, racially marginalized communities continue to experience racial discrimination on multiple levels, from their daily interactions to the racism embedded in government-created policies (Henry et al., 2000). First Nations, Métis, and Inuit Peoples in Canada have acutely experienced the impact of lived and structural systems of overt and covert unjust racism. Overt racism is deliberate; however, covert racism is unintentional and refers to when “misinformation or wrong assumptions lead to inaccurate assessments or inappropriate treatments” (Pedersen, 1995, p. 197). The National Collaborating Centre for Indigenous Health (n.d.) explains structural racism:

Structural racism explores how paternalistic and disempowering federal policies and institutions perpetuate and deepen discrimination against Indigenous groups. These damaging systems and institutions include the policies of the federal Indian Act, the



appalling abuses inflicted through the residential school system, and ongoing race-based discrimination and injustice experienced by Indigenous people involved in the justice and health care systems. (para. 5)

It is hoped that mental health professionals have the fundamental values to oppose these racist acts and policies. Indeed, the Canadian codes of ethics in both counselling and psychology advocate against racist practices (Canadian Counselling Association, 1999; Canadian Psychological Association [CPA], 2000).

However, there is always the potential for racism, even if unconscious, when counsellors work with visible minorities. Counsellors who postulate that they have no racist attitudes (Pedersen, 1995) are considered to demonstrate racism that “emerges as an *unintentional* action by well-meaning, right-thinking, good-hearted, caring professionals” (Pedersen, 1995, p. 197). In Bennet et al.’s (2011) study, one Indigenous participant shared that it is vital that non-Indigenous counsellors “think about racism” (p. 30). Therefore, to avoid endorsing colonialism and to prevent racism, mental health professionals must be continually self-aware of their beliefs and prejudices, as to not further oppress their Indigenous clients (Nuttgens & Campbell, 2010).

### **Importance of Language**

Language is not just a way to communicate but also forms a connection between people and their past, “and grounds their social, emotional, and spiritual vitality” (Norris, 1998, p. 8). Alfred and Corntassel (2005) and Wilson (2004) maintained that language is imperative to Indigenous Peoples’ existence and resurgence. Alfred and Corntassel argued that besides Indigenous Peoples’ relationships with their land, families, and ceremonies, language is also a way to decolonize and begin to re-strengthen themselves. According to Boughton (2000), the more control individuals have over their lives, the less stress they experience. Indigenous

Peoples view language as one of the ways to decolonize, which, in turn, allows them to have a greater sense of control resulting in less stress in their lives. Stress has been documented to be related to the grief and despair of cultural loss (Boughton, 2000). Alternately, if stress stems from cultural loss, reclaiming one's tradition, culture, and language can result in healing.

Language, in some instances, can also cause harm. Certain Western mental health terminology, such as the label of depression, becomes problematic since this label does not have a direct translation in many Indigenous languages (Cohen, 2008). Cohen (2008) argued that “terms of sadness are descriptive and fluid rather than diagnostic and rigid” (p. 129). Cohen claimed that depression, melancholy, grief, and sadness can have various connotations in different cultures and languages. Often, an Indigenous healer is cautious about using “*any label at all*, even in his own language, lest he ‘hex’ the patient with negative words and *nocebo*, the power of negative expectations” (Cohen, 2008, p. 127). Johnny Moses, a Samish and Nuuchahnulth medicine man from Washington, D.C., argued that diagnostic labels might even cause harm to the person who receives the label. In his Indigenous language, the labelling is called *Ta KA Ta Nah*, “dropping a soul and watching it shatter” (Moses, n.d., as cited in Cohen, 2008, p. 128). According to some Indigenous healers, when mental health professionals label someone, they shatter the person's soul. It is expected that Indigenous healers use positive, healing, and encouraging words to bring that healed state into the individual's present reality (Cohen, 2008). Therefore, these findings demonstrate how important it is for mental health professionals to recognize the consequences of diagnostic labels and encourage Indigenous clients to reconnect with their original languages (if they so desire) via verbal and/or written expression to help them decolonize.

## **Mental Health Service Provision with Indigenous Peoples**

According to McCormick (1996, 1997, 2009) and More (1985), Indigenous Peoples often do not use Western mental health services, and indicated reasons for this, including the fact that many Indigenous Peoples report using traditional healing services or even an Indigenous therapist. Unfortunately, however, there are few Indigenous mental health professionals in Canada, and some Indigenous Peoples have no desire to explore traditional ways of healing. Since so many Western therapists are trained in Euro-Western programs (France et al., 2004; Trimble & Thurman, 2002), Eurocentric treatment practices, combined with counsellors' lack of knowledge and understanding of the needs of Indigenous clients, might not be helpful to the clients (Duran, 2006). Furthermore, Duran (2006) argued that "the therapist's insistence on imposing a different worldview on the patient can be understood as a form of violence against the patient's knowledge life-world" (p. 9).

## **Mental Health Services in Urban Cities**

According to Fellner (2016), "more than half of Indigenous Peoples in Canada live in urban areas, and that number is expected to continue increasing" (p. 36). Norris and Clatworthy (2003) claimed that Indigenous Peoples living in urban dwellings tend to experience "housing deficiencies, low incomes, and low rates of homeownership" (p. 69). These factors can result in "residential instability" (Norris & Clatworthy, 2003, p. 63). There are "high rates of two-way migration both 'into and out of cities,' as well as high mobility 'within cities,' given the implications of residential instability for the well-being of Aboriginal people in cities" (Norris & Clatworthy, 2002, p. 63). Thus, "a major challenge for indigenous Peoples living in cities is to maintain social cohesion" (Kirmayer, 2009, p. 13). Several recommendations have been made regarding how mental health services can better serve Indigenous Peoples living in urban cities

(Fellner, 2016). Fellner, using a decolonizing framework, maintained that to meet the mental health needs of Indigenous clients, it is vital to address which services and treatments are not working in mental health service provision. In addition, part of addressing Indigenous wellness in urban spaces include exploring the following: “love, good relationships, Indigenous knowledges, living a good life, responsibility, identity and belonging, and land” (Fellner, 2016, pp. ii-iii) and “systemic changes that support transformations in clinical services” (Fellner, 2016, p. 322). As well, counsellors must be aware that there is a strong connection between Indigenous Peoples and the land (Cohen, 2008). The next section discusses how Indigenous Peoples are both the victims and perpetrators of crime.

### **Violence and Trauma**

Violence and criminal offences result from the experiences Indigenous Peoples have suffered, specifically intergenerational trauma resulting from the residential school system (TRC, 2015). Indigenous Peoples are overrepresented in Canada’s criminal justice system as victims and as those who commit crimes. In 2014, 28% of Indigenous Peoples over the age of 15 reported experiencing violence in the past 12 months, compared to 18% of non-Indigenous Canadians. In 2017/2018, 30% of admissions in the provincial prison system were Indigenous adults and 29% of admissions to federal custody (Government of Canada, 2019). It is no surprise that those who experienced and witnessed grave acts of violence in residential schools frequently enacted violence later in life (TRC, 2015), especially toward Indigenous women. In fact, the Ontario Native Women’s Association (1989) maintained at least three-quarters of Indigenous women have experienced family violence.

According to Menzies and Lavallée (2014), Indigenous women are considered one of the most victimized members in Canadian society, continually being discriminated against because of their race, gender, and class. The TRC (2015) wrote extensively about the violence against

Indigenous women. The authors of the TRC report claimed that in 2012, 43% of general admissions of women to the prison system were Indigenous women. However, the justice system continues to fail these women and girls by not valuing their lives and allowing sexual assaults to continue at the hands of government officials, police officers, lawyers, and judges (Palmer, 2019). In addition, Indigenous women report being a victim of violence three times more often than non-Indigenous women (TRC, 2015).

Trauma is one of the main healing issues that Indigenous Peoples face in many communities (Hill, 2017). Hill (2017) contended that one of the most prominent and painful experiences that Indigenous Peoples experience is a history of sexual abuse. As Hill pointed out, this experience becomes a trauma they carry their whole lives. Often the justice system process is too painful and frightening for sexual abuse victims to endure, creating a situation where there is no justice for those who have been sexually abused and assaulted as children, teens, and/or adults. Additionally, many sexual abuse survivors experienced hideous sexual crimes at the residential schools at the hands of priests and nuns. Consequently, when a trusted member of a church commits violent sexual acts against children, these children lose their spiritual faith (Hill, 2017). Hence, these research findings reveal that it is essential that mental health professionals understand the importance of spiritual healing for trauma recovery.

### ***Treatment Modalities***

Although Western paradigms of treatment, such as cognitive-behavioural therapy (CBT), might not be consistent with Indigenous spirituality (CPA, 2018), some traditional Indigenous healers have embraced CBT, combining it with traditional teachings (BigFoot & Schmidt, 2010). The key idea in CBT is that changing cognitions helps with feelings of anxiety, depression, or anger (Beck, 1995). Comparatively, Indigenous healers also believe in teaching clients to have

good thoughts, helping them to prevent the mind from focusing on negative thoughts.

Nevertheless, one main difference between Western-based CBT and the Indigenous-based approach is that in the latter, the whole Indigenous community participates in helping individuals heal (Hill, 2017).

In addition to CBT, other therapies that help with addressing trauma are somatic-based therapies, such as eye movement desensitization reprocessing (EMDR) and somatic experiencing (SE; Graham, 2019). Shapiro (1989) developed EMDR to desensitize traumatic memories through rapid eye movements. Dr. Peter Levine developed SE in the 1970s to address the effects of trauma, helping “people move past the place where they might be ‘stuck’ in processing a traumatic event” (GoodTherapy, 2018, para. 1). According to Graham (2019), an Indigenous psychologist and scholar, these therapies are valuable strategies when working with Indigenous Peoples who have experienced trauma.

### **Colonization and Decolonization**

Colonization has directly resulted in centuries of subjugation, compulsory assimilation, and degradation of Indigenous Peoples in Canada, leading to historical, intergenerational, and/or colonial trauma (Duran, 2006; Duran & Duran, 1995; Kirmayer et al., 2009). Part of exploring ongoing colonization is for mental health services to acknowledge that colonization continues to present an obstacle to the well-being of Indigenous Peoples (Fellner, 2016). To address the widespread colonization that still exists today, clinical and counselling student programs should include the following:

Facilitate students’ understanding of historical and temporary influences of colonization on both mental health service provision and clients’ presenting concerns, including ongoing colonization through: the child welfare systems; the justice system; education at

all levels—primary, secondary, and post-secondary; ... [and] ongoing occupation of Indigenous lands and environmental destruction. (Fellner, 2016, p. 324)

This would prepare clinical and counselling students to effectively address these colonial systems. As well, the Canadian government did not fulfill several of the treaty promises, and as a result, Indigenous Peoples suffered tremendously, while the colonists and their descendants reaped the benefits (TRC, 2015). As reported by the TRC (2015), colonialism continues to this present day, negatively affecting White settlers' and Indigenous Peoples' relationships. With these colonial systems still in place, this results in collective and intergenerational trauma, as well as health inequalities (Duran, 2006; Kirmayer et al., 2009; RCAP, 1996). Mental health professionals need to understand both the historical and present-day effects of colonization (Duran, 2006; Kirmayer et al., 2009; RCAP, 1996) to better counsel Indigenous Peoples

The TRC (2015) made the connection between the removal of Indigenous children from their homes and their placement in foster homes with the incarceration of many of these children as adults. One participant in Fellner's (2016) study stated, "Jail is only an extension of residential school[s]" (p. 131). Furthermore, the TRC (2015) argued that the relentless postulations and allegations in residential schools that Indigenous cultures and languages were inferior also affected the students' mental health. As the TRC pointed out, long-abiding colonialist ways have impacted Indigenous Peoples' mental health. Some examples of how colonialism has disrespected Indigenous wellness include introducing new diseases, interfering with obtaining traditional foods, and housing people on reserves that were crowded and unclean. Residential schools also contributed to substance misuse, "but also to factors shown to be linked to alcohol abuse, such as child and adult physical, emotional, and sexual abuse, mental health problems and family dysfunction" (TRC, 2015, p. 221).

### *Decolonization and Indigenization of Mental Health Services*

The Indigenization Strategy (2017) focuses on decolonization in education, but it is still relevant and necessary for mental health professionals to learn about decolonization and reconciliation, even though they may be unaware that they lack this knowledge. It is advised that mental health professionals who work with Indigenous populations commit to learning about the process of decolonization and Indigenization, which will challenge them regarding new ways of “thinking, learning, and doing” (Indigenization Strategy, 2017, p. 9) in counselling. The concept of *wahkôhtowin* can ground mental health professionals in the knowledge that we are all related and “that what hurts any of us, hurts all of us, and what honours and uplifts some of us, honours and uplifts us all” (Indigenization Strategy, 2017, p. 4). Therefore, decolonization and Indigenization established in the notion of *wahkôhtowin* involves more than superficial modifications of programs and policies (Indigenization Strategy, 2017). Rather, there needs to be a revolutionary change in what organizations and institutions do and how they do it (Indigenization Strategy, 2017), which is relevant to mental health systems and mental health professionals’ relationships with their Indigenous clients.

Bennet et al.’s (2011) study explored social work practice with Aboriginal Peoples and communities. These authors interviewed 19 Indigenous and non-Indigenous social workers in Western Australia, Australian Capital Territory, and Northern Wales, who had between five and 30 years of social work experience of service delivery with Indigenous Peoples and communities. The participants included seven Indigenous social workers, eight non-Indigenous social workers, one Māori social worker, and three Indigenous Elders who worked as cultural advisors and mentors with Indigenous and non-Indigenous social workers. One of the study’s findings was that the “development of critical self-awareness is a form of decolonization”



(Bennet et al., 2011, p. 25). One Indigenous participant in Bennet et al.'s study stated that both Indigenous and non-Indigenous people need to learn to decolonize themselves. For non-Indigenous mental health professionals, this might mean recognizing their White privilege, acknowledging the power differential between Whites and non-Whites, and being cognisant of the advantages that White people have (Young, 2005, 2008). A non-Indigenous participant in Bennet et al.'s study admitted that it was arrogant of her to think that just because she had a degree, this meant that she could save her Indigenous clients. Decolonization and Indigenization should be a continuation of learning and expanding one's horizons (Indigenous Strategy, 2017). As mentioned previously, Indigenization Strategy (2017) focuses on decolonization in education, but it is also applicable for mental health professionals to commit to honouring Indigenous perspectives, comprehending Indigenous teachings, and encouraging clients who want to decolonize themselves.

Part of decolonizing and Indigenizing involves centering the Indigenous voice. Many Indigenous persons' ancestors' voices were forced into silence because of the Canadian government's assimilation policies and practices. Other voices might have been silenced due to a need to protect their children and grandchildren. Many Indigenous Peoples have personally experienced the intergenerational trauma of this silencing (McNab, 2007; Wilson, 2004). One of the roles mental health professionals have is helping Indigenous Peoples to reclaim their voices. Fellner (2016), an Indigenous psychologist and scholar, claimed that "the Indigenous voice is critical in my own decolonizing, Indigenizing, and healing" (p. 5). Moreover, it is essential that Indigenous Peoples "decolonize from the debilitating impacts and ongoing legacy of denial by states of indigenous peoples' inherent sovereignty, laws, and titles to the lands, territories, and resources" (Economic and Social Council, 2014, as cited in Truth & Reconciliation Commission

[TRC], 2015, p. 247). In addition, the TRC (2015) argued that several Peoples are still learning how to decolonize from residential school experiences since these schools were intended to colonize Indigenous students to make them more like White people.

Marie Battiste, an Indigenous scholar and educator, argued that decolonizing is a “two-prong process’ that involves both deconstructing colonial ideologies and their manifestations, and reconstructing dominating discourses with counter-stories from the perspectives of colonized Indigenous peoples” (Battiste, 2012, as cited in Fellner, 2016, p. 126). This would include deconstructing aspects of mental health services that do not meet the needs of Indigenous Peoples and reconstructing Indigenous holistic well-being services from Indigenous Peoples’ understandings (Fellner, 2016). Guenette and Marshall (2008) argued that “the recovery and promotion of Indigenous Knowledge and ways of knowing is a critical aspect of decolonization” (p. 107). Dei (2000) explained that the transfer of Indigenous knowledge includes cultural values, belief systems, and perspectives that Elders impart to their communities. In Guenette and Marshall’s (2008) study, Marshall (the second author), a counselling psychologist with 30 years of experience, has not only observed the damaging consequences of colonization and the residential school system but also the “tremendous resilience and determination to revitalize traditional knowledge, language, and cultural practices” (p. 109). Guenette and Marshall (2008) interviewed one of their First Nations students who stated that his Peoples “just want to be heard, have a chance to tell their story” (p. 116). This comment aligns with both humanistic and narrative theoretical orientations to counselling, which demonstrates how Indigenous ways of knowing and Western approaches can intersect (Guenette & Marshall, 2008).

Fellner (2016) argued that because Canada is still a colonizing society, which includes mental health care services, decolonization is difficult. According to Fellner (2016),

decolonization within mental health services involves “love, faith, and compassion” (p. 127) in relation to oneself and one’s work. Fellner claimed that these values helped her overcome the many obstacles she has faced, and they can assist in helping “undertake this crucial work of decolonizing and Indigenizing mental health services” (Fellner, 2016, p. 127). It would also be helpful for mental health professionals to know about community-based movements, such as the Truth and Reconciliation Commission (TRC, 2015) and Idle No More (Fellner, 2016).

According to Duran and Duran (1995), mental health professionals can run the risk of behaving in colonialist ways with their clients if they do not understand the negative consequence of colonialism. Thomas and Bellefeuille (2006) claimed that one of the most significant issues facing the field of Indigenous mental health today is the lack of information on the types of interventions and services that will best serve Indigenous Peoples of Canada. The next section further explores how mental health professionals can decolonize and Indigenize mental health services.

### ***Māori Health Perspectives***

The Indigenous Peoples of Canada and the Māori (Indigenous Polynesian) culture of New Zealand share analogous experiences, as the British were responsible for colonizing both groups (Cywink, 2017). In the 1970s, Māori leaders were distressed that the Māori people were not getting the proper care within the mental health system. For example, “patients and their families complained that they were being disempowered by a system where the misapplication of diagnostic labels and the employment of culturally insensitive therapies offended Māori world views and alienated Māori patients” (Durie, 1977, as cited in Durie, 2011, p. 29). However, within twenty years, New Zealand was able to Indigenize mental health care in both hospitals

and community services, which led to “changes in clinical, administrative, psychotherapeutic, and organizational aspects of psychiatry” (Durie, 2011, p. 29).

This Indigenization of New Zealand’s mental health care has resulted in the development of the model, *Te Whare Tapa Wha* (Durie, 2011). This model consists of four components and is considered a holistic method to meeting the mental health needs of the Māori population. The first component is spiritual (*taha wairua*), which acknowledges “the importance of culture to identity as well as the significance of long-standing connections between people, ancestors, and the natural environment” (Durie, 2011, p. 30). The second component is cognitive and emotional (*tah hinengaro*), involving the “Māori ways of thinking, feeling, and behaving” (Durie, 2011, p. 30). Third, *taha tinana*, includes physical health, and finally, *taha whanau* involves social wellness, including family (Durie, 2011). This model has been significant because it allowed the Māori people to experience an identifying voice in health care services, where they have more control over the health system that was primarily dominated by health professionals. For instance, Māori leaders and health practitioners are now being involved in the clinical, managerial, and governance domains (Durie, 1994). Additionally, Durie (2011) pointed out that traditional healers such as Elders are now included as part of the Māori mental health services.

Starting in 1907, traditional healers in New Zealand were forbidden to practice their traditional ways, leading to a decrease in Indigenous approaches; however, this did not end traditional practices, as many healers continued practicing secretly. Since 1964, traditional healing was re-introduced, with an attempt to combine Indigenous ways of knowing with Western methods (Durie, 2011). Some authors such as Hill (2017) believed that the word “healer” is a misnomer because healers do not actually do healing work; rather, any healing that

occurs comes from the spirit world. In essence, the healer is only the mediator, and it is the Creator and the spirit helpers who assist the individual in healing (Hill, 2017).

### ***Medicine Wheel***

While various Indigenous communities such as the Māori community have their own teachings about mental health, Graham and Stamler (2010) contended that the Medicine Wheel is widely used as a healing and teaching instrument that conceptualizes Indigenous concepts on wellness through a holistic approach. The circle represents the cyclical nature of human life (Chansonneuve, 2005). Like the Māori model, the Medicine Wheel includes four aspects (physical, mental, emotional, and spiritual), and each aspect has its own teachings (Graham & Stamler, 2010). Although different communities might have different connotations and terms for the above four aspects, some of the concepts are standard practice (Svenson & LaFontaine, 2003, as cited in Graham & Stamler, 2010). One universal philosophy from an Indigenous perspective is that mental health is only one component of well-being (Twigg & Hengen, 2009). Twigg and Hengen (2009) maintained that mental health professionals need to consider that each aspect of the Medicine Wheel is equally significant and subsequently should integrate more holistic approaches as best practice in Indigenous mental health programs and service delivery. Chansonneuve (2005) explained that if a person is not healthy in one area of the Medicine Wheel, the other parts are also affected, which creates an imbalance in one's life. Well-being is restored by identifying and admitting imbalance exists in one's life and addressing each of the four aspects. For example, the mental aspect could involve abstinence from drugs and alcohol and maintaining a positive attitude (Graham & Martin, 2016).

In Graham and Stamler's (2010) study that explored the benefits of the Medicine Wheel as a holistic approach, 11 out of 14 Indigenous participants stated that as part of the mental

(intellectual) aspect of the Medicine Wheel, alcohol and smoking cessation, and dealing with trauma would need to be addressed for them to reach a healthy state of mental wellness. The emotional aspect might include limiting one's stress level. Spiritual health might involve spiritual connections such as attending and participating in various ceremonies (e.g., sweats, Pow-wows, Sundances) and learning a traditional language. However, despite a strong revival of Indigenous spirituality, non-Indigenous people continue to lack awareness of and knowledge about Indigenous spirituality (Graham & Stamler, 2010). Finally, the physical aspect includes physical exercise, a nutritious diet, and adequate sleep (Doucette et al., 2004).

### ***Holistic Focus***

Although there is a view among Indigenous Peoples that Western culture only views mental health as one aspect of wellness, more recently, a holistic view of mental wellness has become more prevalent among non-Indigenous scholars (Graham & Stamler, 2010). Many Indigenous scholars and professionals no longer use the language of “mental health.” Rather, the focus needs to be on the “holistic” wellness of Indigenous Peoples, families, and communities (Fellner, 2016). Fellner (2016) shared that at her doctoral internship at the Indian Health Board in Minneapolis, United States, the counselling department was flexible and practiced holistically by “engag[ing] in traditional medicine making, sweat lodges, drumming and singing groups, talking circles, and the regular integration of cultural practices such as smudging” (p. 209). Fellner would also have discussions about the Medicine Wheel with her Indigenous clients, explaining how all four aspects of health (i.e., spiritual, mental, physical, and emotional) are related to each other. Linklater (2014) argued that holistic approaches such as the Medicine Wheel can help mental health providers and clients create a plan that incorporates various needs and goals.

Unfortunately, many mental health professionals do not look at psychology through an Indigenous lens (Fellner, 2016). The “all my relations psychology” (Fellner, 2016, p. 209) approach is in stark contrast to the individualism of Western psychology. This approach focuses on the importance of relational Indigenous viewpoints to well-being and the healing process (Fellner, 2016; Ross, 2014). However, according to Fellner (2016), it is important for mental health professionals to “tak[e] what is useful in psychology and apply it from Indigenous perspectives in a way that works for our [Indigenous] communities” (p. 211). For example, Dr. Eugene Gendlin, founder of focusing-oriented therapy (FOT), emphasizes awareness skills where clients turn their attention to a “felt sense” (Gendlin, 1978, p. 81). FOT is well known by experts who deal with complex trauma and PTSD (Phillips & Phillips, n.d.). With FOT, clients can be safe observers and experience the bodily sense at their own pace without re-traumatization (Gendlin, 1978). Furthermore, FOT helps people to decrease self-criticism, overcome stuck feelings, learn to better self-regulate their emotions, and deal with past trauma (Gendlin, 1978). Thomas and Bellefeuille (2006) argued that FOT is an effective therapy for Indigenous Peoples, as it is humanistic and person-centred, reflecting the “core values of respect and non-interference” (p. 3).

According to Schiffer (n.d.), FOT has been adapted for Indigenous persons and is called Aboriginal focusing-oriented therapy (AFOT). Its founder, Shirley Turcotte, explained that AFOT helps “in moving towards wellness” (Schiffer, n.d., para. 6). Using AFOT, clinicians help Indigenous clients experience more than just emotion, as there is now the possibility to experience the whole situation by sensing into the body (Gendlin, 1978; Hendricks, 2007). According to Schiffer (n.d.), Indigenous communities have embraced FOT due to its “humanistic, person-centred approach to healing” (para. 2).

For some Indigenous Peoples, what constitutes psychological wellness is debated since Indigenous psychology approaches wellness from a different framework (Fellner, 2016). For example, in Fellner's (2016) study, one participant, who is an Elder, Métis Knowledge Keeper, and counsellor, stated, "I don't think of people as 'needing healing'" (p. 213). This participant believed that individuals need to have more education about what is occurring for them, and she helps them realize their "incredible interconnectedness, their knowing, their resilience, their incredible hardiness, their compassion, and their amazing spiritual abilities that might have been misunderstood as being illnesses" (Fellner, 2016, p. 213). The participant shared that "such a strength-based perspective is characteristic of Indigenous approaches to healing, as is seeing the fundamental goodness in people" (Fellner, 2016, p. 214). Therefore, "iyiniw kiskêyihtamowin: Plains (y) Cree for Indigenous knowing or knowledges" (Fellner, 2016, p. xiv) does not pathologize, but rather concentrates on encouraging the individual's strengths and talents (Hart, 2002; Linklater, 2014; Ross, 2014).

Fellner (2016) relays the story of one Indigenous woman who described her experience in substance misuse recovery and how she was supported by a medicine woman to realize that her spirit helpers were horses who helped with her panic attacks. The woman explained that these helpers replaced doctors and antidepressants (Fellner, 2016). Thus, rites of passage and ceremonies are some of the various ways Indigenous Peoples deal with mental health issues. According to Fellner (2016), "such stories convey the deeply spiritual nature of working from Indigenous perspectives" (p. 207). Unlike some Western approaches, Indigenous mental health is connected to physical, emotional, and spiritual health (Fellner, 2016).

Fiske (2008) maintained that programs, such as Tsow-Tun Le Lum on Vancouver Island, have used certain interventions, such as psychodrama, emotional freedom techniques,



storytelling, and genograms to provide an Indigenous holistic wellness model to the healing process. According to Fellner (2016), “Indigenized interventions may also be applied within a framework of Indigenous, all my relations psychology that is grounded directly in iyiniw kiskêyitamowin” (p. 224). For example, in Fellner’s (2016) study, one participant shared that she practices with the intention that the client is not alone in the session. In other words, this signifies the importance of treating the therapy as a collective, which might mean “sensing into whether the ancestors are there, or whether the trauma piece is there” (Fellner, 2016, p. 224). For instance, if a client in despair visits a therapist, the therapist acknowledges that despair is present but that the client is not the despair. Hence, this despair is a dialogue and that it might want to “talk” with the client—“and whether that’s intergenerational despair or whether that’s a despair coming, ‘cause from an Indigenous perspective it could be past, present, or future” (Fellner, 2016, p. 224). This same participant claimed that there is a way of being able to discern if the despair is “something that’s from far away, or whether that’s from the now, or whether that’s a becoming” (Fellner, 2016, p. 224). She believed that the emotional healing work one does now in the present moment will benefit future generations. The participant also shared that once Indigenous clients realize that they are more than their trauma, they connect with their spirituality and can focus on the perspective that “their traumas are not there just to hurt them, but rather to help them” (Fellner, 2016, p. 224). Working with Indigenous clients in this way can be described as connecting with collective (a trauma shared by a group of people; Van Gelder, 2019), ancestral, intergenerational, and historical trauma (Brave Heart, 1998; Duran & Duran, 1995). According to Ross (2014), “with hard work we can nurture our spirit, learn to recognize our gifts and begin to honour our responsibilities” (p. 252). Thus, these findings illustrate how

imperative it is that mental health professionals educate themselves on Indigenous spirituality as part of the positive psychology approach.

Part of decolonizing and Indigenizing involves addressing key issues and making changes within mental health services, such as creating cultural space, developing policies to implement a human rights framework, and developing accountability measures. The Government of British Columbia argued that the province's health authority is already making such changes by implementing a policy that acknowledges culturally appropriate spaces (Province of British Columbia, 2015). Part of the role of mental health professionals is to advocate for Indigenous healing programs and funding such as the Aboriginal Healing Foundation (2015), which funded 12 regional centres to address the legacy of residential schools in Indigenous communities. Although many successful programs were created, all centres had lost their funding by September 2014 (Aboriginal Healing Foundation, 2015). This left many survivors and communities still in critical need of healing support. In addition, the federal government stopped funding the National Aboriginal Health Organization in 2012 (Macdougall, 2013), another valuable organization that was dedicated to improving Indigenous Peoples' health and wellness (National Collaborating Centre for Aboriginal Health [NCCAHA], 2011).

### ***Traditional Teachings and Practices***

While the harmful effects of colonization have led to losing traditional teachings and practices, Indigenous Peoples around the world are striving to recover and revive them (Chansonneuve, 2005). According to Chansonneuve (2005), non-Indigenous counsellors and therapists need to be willing to seek guidance from respected Indigenous Elders and other traditional healers in referring Indigenous clients to culturally-based services when necessary. Culturally-based methods to healing are as follows: "holistic; include a central role for Elders

and traditional people; use the structure of the circle and outdoor physical settings; and include traditional teachings and medicines, storytelling and ceremony” (Chansonneuve, 2005, p. 71). As reported by Stewart (2008), mental health professionals need to support those Indigenous clients who wish to attend ceremonies. As for preference in the process of revitalizing traditional practices, some Indigenous persons and communities choose spiritual beliefs and teachings that existed prior to Christian beliefs, while others incorporate their traditional practices with Christianity (Chansonneuve, 2005).

The participants in Fellner’s (2016) study, argued that “when possible, organizations should offer ceremonies that are specifically intended to address trauma” (p. 329). Indigenous clients living in urban centres can be offered rites of passage ceremonies that might include “both traditional rites of passage (e.g., fasts) and rites of passage that serve the specific needs of clients (e.g., ceremonies for youth in care such as welcoming ceremonies, returning to the land ceremonies, transition ceremonies, etc.”; Fellner, 2016, p. 329). Furthermore, Fellner (2016) claimed that Indigenous Peoples have “ancestral resilience, survivance, strengths, [and] gifts. We are so much more than collective and intergenerational traumas” (p. 217). She further contended that clinical programs’ coursework needs to include education on Indigenous ways to well-being and healing, as well as “Indigenous perspectives on case conceptualization, assessment, and diagnosis” (Fellner, 2016, p. 324). This involves “applying a de-pathologizing, survivance/basic wellness/resilience lens, spiritual considerations in understanding client experiences (e.g., honouring visions and spiritual experiences that may otherwise be labelled as hallucinations or delusions), a collective and intergenerational lens, and Indigenous conceptualizations of giftedness” (Fellner, 2016, p. 324).

Nimmagadda and Bromley (2006) suggested that for mental health services to be Indigenized, Western and Indigenous mental health professionals should meet to share information about clients, struggles, and accomplishments. This assists Western professionals in understanding how Indigenous persons view the world, and this exchange of information helps to centre communities' ways of knowing and being. Nimmagadda and Bromley cited the following example: several health professionals preparing to publicize a series of group therapy sessions on family violence learned that in some cultures, domestic violence is a delicate subject and is possibly even a forbidden topic to discuss. This knowledge persuaded the professionals to change the title of their group to "healthy relationships" (Nimmagadda & Bromley, 2006, p. 68). By the sixth group therapy session, group members were exploring "unhealthy relationships" (Nimmagadda & Bromley, 2006, p. 69) and domestic violence. With the help of Indigenous social workers, these mental health professionals used their creativity to plan therapeutic services that were decolonized.

### ***The Two-Eyed Seeing Approach***

The CPA (2018) claimed that psychologists need to recognize that Indigenous epistemologies are critical, as are the roles of cultural practices and traditions in the process of healing. This recognition involves respecting the knowledge and wisdom Indigenous Peoples already have acquired, along with the teachings of Elders and Knowledge Keepers. For example, Chief Charles Labrador's concept, the two-eyed seeing approach, was initially examined in the literature in 2004 by Elder Albert Marshall from the Eskasoni Mi'kmaw Nation in Nova Scotia, Canada (Bartlett et al., 2008; Marsh et al., 2015). The two-eyed seeing approach combines Western and Indigenous traditions and wisdom in scholarship and research (Marsh et al., 2015). According to Marsh et al. (2015), the two-eyed seeing approach addresses the accumulative

emotional and psychological harm affecting several generations, including the ongoing racism, discrimination, and inequities Indigenous Peoples continue to face. As well as understanding the effects of colonialism, psychologists are advised to learn “relevant wellness concepts, such as cultural continuity, two-eyed seeing, Mino-pimatisiwin, and decolonizing research” (CPA, 2018, p. 10).

### ***Challenging the Dominant Narratives***

Many scholars argued that it is critical that mental health professionals recognize that decolonizing the helping profession is not just about adopting culturally relevant therapeutic processes but that it also involves challenging the dominant narratives about Canada’s collective histories (Pete, n.d.). Decolonizing and Indigenizing includes encouraging Indigenous Peoples and communities in their desire for self-determination and sovereignty (Pete, n.d.). Another term for Indigenization is “adaptation” (Nimmagadda & Bromley, 2006, p. 66), which stresses how “language, local knowledge, and belief systems influence the intervention model to achieve a goodness-of-fit” (Nimmagadda & Bromley, 2006, p. 66). In essence, this exchange is a two-way process where local knowledge is innovatively applied to transform a standard of social work intervention into what best fits with the needs of the local community.

Nimmagadda and Bromley (2006) argued that mental health professionals need to find ways to bridge Western and traditional values, norms, and customs to respect the decolonization and Indigenization process. These authors contended that mainstream agencies such as family-service agencies and community mental health agencies serve the needs of the general public but do not necessarily serve the needs of diverse groups. For example, Nimmagadda and Bromley maintained that very few Southeast Asian-Americans ever reach out to these mainstream services. The same can be said for Indigenous Peoples of Canada (McCormick, 1996, 2009;

More, 1985). Therefore, these findings demonstrate that it is vital that mental health agencies hire Indigenous clinicians who can serve Indigenous persons who reach out and seek counselling.

### ***Cultural Continuity as a Protective Factor***

Cultural continuity can be considered a way in which Indigenous Peoples decolonize. Cultural continuity includes how individuals fit within their cultures and how Traditional Knowledge is preserved and passed on to the next generations (Auger, 2016). Chandler and Lalonde (1998) argued that cultural continuity can be an effective “protective factor” (p. 192) against suicide. In some Indigenous communities, the rate of suicide is 800 times the national average, but in other communities, suicide is non-existent. The degree to which communities practice cultural continuity seems to account for these disparities; communities that practice cultural continuity have less suicide. Chandler and Lalonde (1998) created several markers that endeavour to restore cultures. According to Chandler and Lalonde, these markers include the following:

- (a) evidence that particular bands had taken steps to secure aboriginal title to their traditional lands;
- (b) evidence of having taken back from government agencies certain rights of self-government;
- evidence of having secured some degree of community control over
- (c) educational services;
- (d) police and fire protection services;
- and (e) health delivery services;
- and finally, (f) evidence of having established within their communities certain officially recognized ‘cultural facilities’ to help preserve and enrich their cultural lives. (p. 209)

These authors theorized that these six markers would serve as protective factors, which could help lower Indigenous communities’ suicide rates. One of their findings revealed that each of the

markers was linked to a decrease in youth suicides (Chandler & Lalonde, 1998). Chandler and Lalonde (1998) also proposed ideas for future research:

Gather new evidence on those actual community-based activities that more explicitly match what are ordinarily thought of as ‘cultural’ practices (e.g., language use, Native curriculum, rites of passage, etc.) and then marrying this data with accounts given by adolescents of the place of these cultural efforts within their own experience. (p. 216)

The authors indicated their hope that comprehending the uniqueness of Indigenous cultures can help “[reverse] the trend toward steadily increasing suicide rates among First Nations youth” (Chandler & Lalonde, 1998, p. 216).

### **Cultural Allyship**

The CPA (2018), in providing psychology’s response to the TRC (2015) report, contended that one of psychology’s guiding principles for working with Indigenous Peoples is cultural allyship, where psychologists are urged to claim that they are allies and advocate for those Indigenous Peoples who have experienced negative consequences of colonialism in Canada. It is not enough to be empathic toward Indigenous Peoples due to the hardships they have had to endure; it would be helpful if psychologists “prioritize the use of time to learn about and understand how Indigenous people conceptualize themselves and their families, communities, health, and the impacts of colonial systems on their histories and current lives” (CPA, 2018, p. 6). According to the CPA (2018), the task force claimed that cultural allyship needs to include familiarity with and understanding of the following concepts and historical events:

Cultural safety and literacy, understanding Indigenous epistemologies, the role of ceremonies, traditions, Indigenous spirituality, the impacts of colonization, the residential

school system, the 60s scoop, the present day dominant culture, as well as training in deconstructing the cultural assumptions of mainstream psychology. (p. 12)

Learning about these concepts would ensure the psychology profession is more educated about Indigenous cultures. An example of an effective Indigenous cultural safety training program for psychologists and mental professionals is “San’yas” (Provincial Health Services Authority in BC, n.d.), an online program that helps clinicians learn about Indigenous cultures. Psychologists can traumatize Indigenous clients if they are ignorant about historical and intergenerational trauma, as well as the social and historical contexts in which pathology appears, or if they do not grasp Indigenous understandings of self or health (CPA, 2018). Furthermore, in the past, psychologists viewed their training as more rigorous than Indigenous ways of knowing (CPA, 2018).

Therefore, as the CPA (2018) argued, psychologists need to be humble and address Elders and Traditional Knowledge healers and approaches with respect and be willing to learn from them and collaborate with them. Psychologists need to collaborate with Indigenous communities and plan with community leaders, Elders, and healers for what is needed for clients. Clients should be part of the collaboration in their treatment plans. Furthermore, feedback from the community can provide psychologists with information if the treatment was culturally relevant (CPA, 2018).

According to the CPA (2018), because the psychology profession developed in the same political and colonial context that allowed the residential school system to take place, it also participated in the process of cultural genocide. The CPA argued that the profession of psychology has been prejudiced, irresponsible, and discourteous towards Indigenous Peoples. Psychologists have not been involved in the “essential cultural safety and competency training



required to reflect on cultural values, implicit biases, and ethnocentrism that dominates the field, in order to engage in these relationships with true integrity” (CPA, 2018, p. 8).

### **How Psychology Works with Indigenous Peoples**

Kirmayer (2007) argued that psychotherapeutic approaches rely heavily on a Western cultural perspective where the worldview is one of individualism and control. In fact, Meehl (1959) contended that there has been some evidence that therapists acted like “crypto-missionaries” (p. 257) by “attempting to convert their clients to their own value system” (Slife et al., 2003, p. 56). According to Slife et al. (2003), multicultural therapists might inadvertently enforce their own cultural values on clients, such as “tolerance” (p. 59) and “open-mindedness” (p. 62). Aten et al. (2010) stated that to overcome this ethnocentrism in mainstream mental health treatment, mental health professionals need to consider and explore culturally diversified ways of healing in order to deliver culturally appropriate interventions. Due to the findings in *Psychology’s response to the Truth and Reconciliation Commission of Canada’s report* (CPA, 2018), the Canadian Psychological Association’s task force announced that the psychology profession in Canada needs to be accountable to Indigenous Peoples. The task force stated that psychologists have an obligation to enhance the wellness of Indigenous Peoples and communities. To understand what this means for counselling and therapy, the next section addresses the current research on working with Indigenous clients in counselling.

### **Counselling Indigenous Peoples**

Both counsellors and psychologists need to ensure that they are understanding and accepting Indigenous cultures and that their practice will benefit their Indigenous clients. Thomason (2011) surveyed 68 mental health and related professionals who had wide-ranging experiences counselling Indigenous persons. Of these professionals, 57% were Indigenous, and

43% were non-Indigenous (White, African American, Hispanic, Latino, Asian, etc.). Thomason listed several effective approaches that counsellors and psychologists need to use to confirm their work with Indigenous Peoples is culturally appropriate. First, Thomason recommended that they build healthy relationships with local Indigenous communities and, second, that they integrate spirituality into counselling. Third, there needs to be fewer administrative barriers for Indigenous Peoples receiving counselling. One of Thomason's (2011) survey questions was, "What should counselors do in the first session to build rapport with Native American clients?" (p. 2). Answers included the following: offer clients refreshments, such as water, coffee, or tea; keep intake paperwork to a minimum; offer clients the opportunity to explain their perception of their presenting concern; encourage the counsellor to self-disclose and share; and address how the clients' cultures have impacted their lives. Half of the participants expressed that Indigenous counsellors are more effective than non-Indigenous counsellors, and 18% claimed that effectiveness is determined by how culturally competent the counsellor is (Thomason, 2011).

In addition to building relationships with local Indigenous communities and providing refreshments, participants in the Thomason (2011) study stated that counsellors need to make Indigenous clients more comfortable with the counselling process by exploring with them how to get their needs met and how counsellors can assist them in this process. As well, clinicians need to be open to consulting with Elders and having Indigenous art on their office walls. Notably, 55% of participants in the same study indicated that it is critical for counsellors to include the topic of spirituality into counselling sessions with Indigenous clients; however, 41% indicated that this depends on whether clients' spirituality matters to them (Thomason, 2011).

In Thomason's (2011) survey, when asked if non-Indigenous counsellors should use Indigenous wellness approaches, such as talking circles and ritual purification ceremonies, most

participants (60%) indicated that this is not proper because it might be seen as condescending and could even be damaging. Multiple participants argued that the counsellor should suggest that the client be seen by an Indigenous counsellor or healer. Nevertheless, 30% of survey participants argued that using Indigenous health practices might be appropriate if done with care and if counsellors or psychologists have been trained in Indigenous ceremonies and practices and have tribal authorization. When asked what non-Indigenous counsellors should do to improve their understanding of Indigenous cultures and practices, nearly all participants stated that counsellors need to consult with Elders and an Indigenous mentor, take part in social and cultural gatherings, visit with community members, seek out training workshops, and associate with Indigenous persons (Thomason, 2011). Therefore, Thomason's (2011) findings demonstrate the various ways mental health professionals can provide the best possible service for their Indigenous clients.

Rountree's (2004) study explored the opinions of 12 experienced clinicians (eight Indigenous and four non-Indigenous) who provided counselling to Indigenous clients. The recommendations for clinicians included the need to consider clients' acculturation type, use a mixture of treatment approaches, be involved in Indigenous cultural activities, and pursue supervision and consultation from Indigenous members of the client's community. Smye and Mussell (2001) claimed that one of the priorities of mental health services is to be able to support Indigenous Peoples' needs by making sure the services are "culturally relevant [and] safe, i.e., respectful of the diverse 'cultures' of individuals, families and communities" (p. 5); moreover, these services must be strengths-based. According to Van Uchelen et al. (1997), the strengths of individuals, families, and communities are powerfully supported in Indigenous traditions.

In addition, a complete Circle of Care (MAAMWESYING, n.d.) with the consent of the

client needs to be integrated into services. Integration involves the need for health care providers to acknowledge and respect the value of family and community for personal healing and well-being. This includes health care providers having access to clients' health information to better meet their needs. Providers work closely with the individual to make decisions regarding their health (MAAMWESYING, n.d.). Therefore, these findings illustrate how imperative it is that mental health professionals be knowledgeable about the importance of culture, family, and community within Indigenous populations.

### **Summary**

Current research on how non-Indigenous mental health professionals decolonize and Indigenize their practice and mental health services is limited. This study aimed to address some limitations of previous research and explored how helping professionals decolonized mental health services for Indigenous clients and communities. To date, much research has focused on Western therapeutic practices to help Indigenous clients with their mental health. Non-Indigenous mental health professionals have seldom implemented Indigenous knowledge and ways of healing. Consequently, clinicians need to develop increased cultural competence so they can provide better counselling to Indigenous individuals. The experiences and recommendations of non-Indigenous mental health service providers working with this population are vital to the field of multicultural psychology since Western clinical treatment has been unable to incorporate the emotional and spiritual understandings of Indigenous healing practices (CPA, 2018). Due to the rapid growth of the Indigenous population in Canada, it is particularly important that mental health professionals incorporate a more holistic approach into their practice to better understand and work with Indigenous Peoples.

### **Chapter Three: Methodology**

The primary aim of this study was to understand the phenomenon of interest from the participants' perspectives rather than from the researcher's perspective (Simon, n.d.). The theoretical framework for my research, the basic interpretive qualitative research design (Merriam, 2002), includes the assumption that reality is subjective and multiple and that meaning is embedded in the participants' experiences. Therefore, the basic interpretive qualitative research framework was appropriate for the present study. Much of the existing research on Indigenous Peoples' mental well-being has been a product of Western colonial ways of knowing (Nelson, 2012). This study contributes further information about ways that non-Indigenous mental health professionals have decolonized and Indigenized their practice and mental health services to better meet the needs of Indigenous clients. A second goal was to explore the relevance of these findings for culturally competent counselling. The three key research questions were as follows:

1. How do non-Indigenous mental health professionals experience decolonizing their practice and mental health services?
2. In what ways do non-Indigenous mental health professionals practice cultural humility and strive to provide decolonized, anti-oppressive services to Indigenous clients?
3. How do non-Indigenous mental health professionals acknowledge systems of power and privilege and advocate for social justice for their Indigenous clients?

In this chapter, I discuss qualitative research and its applicability to the present study. Next, I describe the qualitative methodology used, which was the basic interpretive qualitative research design (Merriam, 2002). I discuss this approach in relation to participant recruitment, data generation, and data analysis. The rationale for using this methodology was to understand

the meaning mental health professionals have constructed about their experiences decolonizing their practice and mental health services.

### **Qualitative Research**

Qualitative research involves the study of a phenomenon or research topic in a context. Phenomena are studied in an exploratory manner, as researchers tend to examine areas that have not yet been studied or a topic that involves an investigation with a new angle (Hays & Singh, 2012). A qualitative approach also focuses on context, theory/hypothesis initiation and explanation, and uncommon cases (Kidd, 2002). Finally, it allows for the examination of a topic to a depth that quantitative inquiry does not (Kidd, 2002). For these reasons, a qualitative research design can be considered a beneficial tool for inquiry (Lee et al., 1999).

Merriam (2002) outlined four characteristics that are important for the basic interpretive qualitative research design. First, it is important that researchers understand how people make sense of their lives and lived experiences. Meaning is socially constructed by people as they interact with their social world, an assumption that is based on a social constructivist paradigm. Most social constructivists maintain the fundamental principle that individuals create knowledge from the interaction between their previous knowledge or beliefs and the new ideas, information, or situations they encounter (Merriam, 2002). Thus, it is necessary for researchers to support these interactions between new and existing knowledge (Airasian & Walsh, 1997; Brophy, 1992). As well, a constructivist paradigm understands knowledge as being created through interactions between people. This knowledge is first co-constructed between interactional partners and then interpreted (Haverkamp & Young, 2007).

The researcher plays a vital role in constructing knowledge in a constructivist paradigm and thus, the researcher's values impact the research process (Haverkamp and Young, 2007). According to Denzin and Lincoln (2005), "the word *qualitative* implies an emphasis on the

qualities of entities and on process and meanings that are not experimentally examined or measures (if measured at all) in terms of quantity, amount, intensity, or frequency” (p. 10). I explored *how* non-Indigenous mental health professionals decolonized their practice and in *what* ways they practiced humility. I specifically sought to understand non-Indigenous mental health professional participants’ lived experiences of how they decolonized and Indigenized their practice and mental health services. The current study is valuable, as it extends the literature on the various ways mental health professionals decolonized their practice to better meet the needs of their Indigenous clients.

In this study, my experiences and perceptions had a role in how I understood and interpreted the research data and required me to be self-reflective and self-aware. As well, my abilities as a qualitative researcher were facilitated by curiosity and an open mind. This attitude of openness helped me to collaborate with my participants and, in turn, might have helped participants feel accepted and respected.

The second characteristic of the basic interpretive qualitative research framework is that the researcher is the primary instrument for data collection and analysis. Through the lens of the constructivist paradigm, data are co-created through the interaction between the researcher and the participant, as both individuals bring their constructed realities to the issues being discussed. In this type of study, the researcher strives to understand how individuals make meaning of a situation or phenomenon. Because the researcher is the principal instrument of data collection and analysis, reflexivity is essential (Glesne, 1999; Merriam, 1998; Russell & Kelly, 2002; Stake, 1995). To be self-reflexive, I kept a journal to help me understand the phenomena I was studying and gain insight into how my own assumptions, biases, and behaviours impacted the inquiry. I also tried to refrain from projecting my own “feelings into the interviews” (Wilkie,

2015, para. 8) to avoid making assumptions about participants' experiences with their Indigenous clients (Wilkie, 2015). In addition, I acknowledged that my participants' experiences were very different than my own. Therefore, my own subjective experiences informed the data analysis (Fine et al., 2000; Lincoln & Guba, 2000).

The third characteristic addresses the methodological assumption of the researcher using inductive logic. Inductive logic or reasoning starts with collecting data that are pertinent to the topic of interest. Next, the researcher looks for patterns or themes in the data and essentially moves from data to theory (Scientific Inquiry in Social Work, n.d.). Due to the lack of research on the decolonization of mental health services, the results were data-driven. Researchers gather data to build concepts, hypotheses, or theories. This data is analyzed to identify recurrent themes in the data (Merriam, 2002).

The fourth and final characteristic relates to the outcome of the analysis process. From the inductive process, "the product of a qualitative inquiry is *richly descriptive*" (Merriam, 2002, p. 5). Words rather than numbers were used to describe what I gleaned about ways participants decolonized their practice. For this exploratory study, I conducted and audiotaped semi-structured conversational interviews using open-ended questions (Watt, 2007), which contributed to this descriptive outcome.

The strengths of the basic interpretive qualitative research design are as follows: provides accessibility; allows for coherent reasoning; ensures the research process is guided toward the context of the study; produces relevant findings; and facilitates the researcher's consciousness of any biases (Hunt, 2009). Seidman (1998) argued that without context, the researcher cannot properly explore the meaning of an experience and study the topic within its context.



## **Data Generation**

### ***Participants***

Participants were recruited using purposeful sampling, which involves selecting participants who are likely to generate the richest data possible (Denzin & Lincoln, 2005; Morrow, 2007). There were four participant criteria. First, participants needed to be certified or registered mental health professionals (e.g., social workers, psychologists, psychiatrists, counsellors). Second, they had to be 18 years of age or older and had to have decolonized their practice and mental health services or be in the process of decolonization. Third, they had to be willing to reflect on and discuss this process in detail. Finally, participants needed to allow the researcher to interview them for a one- to 1.5-hour interview.

The final sample included nine non-Indigenous mental health professionals who provide mental health services to Indigenous clients. Ten participants were interviewed, but one withdrew her data after reading the transcript from her interview that was sent to her via email. She stated that she was uncomfortable with the research proposal and most of the interview guide questions. During the interview via Zoom, she shared that she found that one of the questions was “colonizing.” Another participant, Olivia, who did not withdraw her data, shared that she would have been more comfortable if she was interviewed by an Indigenous person rather than a White researcher because the interviewer would have the lived experience of an Indigenous person.

### ***Procedure***

Once the University of Saskatchewan’s Behavioural Sciences Ethics Review Board (see Appendix A) granted approval for this study, I posted an advertisement for the study on the PAWS bulletin (see Appendix B), and on Facebook, a social media platform (see Appendix C). I also advertised on the following websites for various professional associations: Canadian

Counselling and Psychotherapy Association; Canadian Psychological Association; Psychologists' Association of Alberta; Saskatchewan Association of Social Workers; and Saskatchewan College of Psychologists (see Appendix E). Finally, I advertised at five different counselling centres: Catholic Family Services Saskatoon; the University of Calgary Student Wellness Services; the University of Regina Counselling Services; the University of Saskatchewan Psychology Services Centre; and the University of Saskatchewan Student Wellness Centre (see Appendix E). I also used "snowball sampling" (Hays & Singh, 2012, p. 169) as some participants informed members in their social networks about the study. Once I received the names of my prospective participants, I emailed them to connect, sending them a recruitment electronic poster describing the research project, eligibility criteria, and my contact information (see Appendix E).

### ***Interviews***

For this study, nine non-Indigenous mental health professional participants were interviewed either by Zoom or telephone. They consented to participate in an interview with me, lasting approximately one to 1.5 hours in length. This in-depth interview helped obtain a thick description of mental health professionals' reports about decolonizing their practice and mental health services. The interviews were audiotaped, and I transcribed them verbatim (i.e., without fillers such as "um," "yeah," "hmm," etc.). The length of the interviews was between 47 to 86 minutes. All interviews were completed by June 19, 2020.

A week or two before the scheduled interview, participants were emailed a copy of the consent form (see Appendix F) along with the interview guide (see Appendix G) to familiarize themselves with the questions and begin to formulate their thoughts and responses. They were asked to read the consent form and the interview guide, and if they had any questions or concerns about these two documents, they were to either email me or address them when we met via

Zoom or telephone. Before starting the interview, I asked participants if they had the opportunity to read the consent form. For those who had not, I reviewed the form with them and highlighted the essential aspects, including an explanation of the purpose and procedures of the study and participant rights. Eight participants gave their oral consent, which I documented for my records. One participant sent her consent form via email with her electronic signature. Participants were informed that their participation was voluntary and that they may withdraw at any time without penalty or explanation. Following the interview, the nine participants were sent the consent form via email that confirmed they had provided oral or electronic written consent.

Once participants completed the interview, they were given the option to receive a copy of the transcript of the interview via email. They were told that once they received their transcript, they had two weeks to add, alter, or delete any content in the transcripts. After two weeks, they no longer had the option to withdraw their data, as I needed to begin data analysis. Seven participants chose to receive a copy of the transcript; they gave their oral consent to review and release their transcript for the study (see Appendix H). I sent them this transcript review and release form via email or mail. I emailed them their transcript within two weeks of the interview. All participants were given a pseudonym to maintain confidentiality, and any identifiable features in the transcripts were removed or changed to protect anonymity and confidentiality. Confidentiality was further extended to any third-party individuals identified in the interview process, with additional pseudonyms used where necessary (Kaiser, 2009).

### ***Data Analysis***

The data were analyzed using thematic coding. Thematic analysis is a method for “identifying, analyzing, and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). Boyatzis (1998) outlined four distinct stages in thematic analysis. In the first stage,

researchers learn to “‘sense themes:’ that is, to recognize a codable moment” (Boyatzis, 1998, p. 9). To sense themes, researchers need to be open to all information while using all their senses to receive relevant information. In the second stage, researchers train themselves to consistently recognize themes or codes. To improve recognition, researchers read and re-read the transcripts until they become quite familiar with the entire body of data. Making brief notes and writing down thoughts and ideas might also assist in this process (Maguire & Delahunt, 2017). In the third stage, researchers immerse themselves in the information to appreciate the potential richness of the data. Immersion is best done as part of the other stages rather than as a stand-alone process. In the fourth stage, the researcher, having a theoretical framework, interprets the information and themes in a way that will assist in advancing knowledge. To ensure an intimate familiarity with the data, I read and categorized the responses multiple times. I used this method in my research to ensure no themes were overlooked (Marshall & Rossman, 1995).

My supervisor reviewed the themes and sub-themes and provided feedback on them. Ongoing discussion took place until there was a consensus between both reviewers. Thus, the analysis yielded a rich thematic description of the data set. The analysis moved from description to interpretation, where I, as the researcher, went back and forth between analysis and clarification of the themes (Frith & Gleeson, 2008). Finally, analysis involves theorizing, which builds upon description and interpretation. Here, researchers “engage in a two-step process: 1) the development of working hypotheses that they believe represent what they see in the accounts, and 2) situating this conceptual material into related research and theory” (Gilgun, 2015, p. 743).

During transcription, I found that some of the questions I asked participants at the beginning of the interview were not relevant to the analysis. However, they served the important purpose of beginning the interview and building rapport with the interviewees. Following Hesse-

Biber and Leavy (2006), I initially read and re-read the transcribed interviews while listening to the audio-recordings of the interviews. This enabled me to add missing details and get a sense of the tone or inflection used by participants when they spoke.

### **Establishing the Quality of the Research**

In the *Journal of Counseling Psychology*, a significant percentage of qualitative studies have used either a constructivist epistemological framework or a combination of constructivism and postpositivism (Morrow, 2005). In constructivist research, a collection of criteria has been recommended to provide trustworthiness (Morrow, 2005). I chose authenticity criteria (Guba & Lincoln, 1989) as they are “intrinsic” (Lincoln, 1986, p. 3) to and pertinent for this study. Authenticity criteria include fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity.

#### ***Fairness***

Fairness involves the voice (hooks, 1994). With fairness, the researcher strives to ensure that all participants have the same opportunity to express their voice during the interviews (Manning, 1997). Researchers need to give meaning to those voices that have been silenced (Kvale, 1995). In addition, fairness involves representing participant viewpoints equitably and avoiding skewed interpretations that might reflect the researcher’s biases (Morrow, 2005). I believe I was fair in presenting all participants’ opinions and information equally and without undue bias. I used participants’ direct quotes to communicate their thoughts and stories. Fairness is pertinent in qualitative research, “since, in a ‘value-bound’ inquiry, a researcher has to make every attempt to avoid a situation where some values are suppressed with their holders exploited and that others will be enhanced with their holders advantaged” (Amin et al., 2020, p. 1479).

Some techniques that encourage fairness include member checking, peer debriefing, informed consent, and reflexivity (Manning, 1997).

In this study, the fairness criterion was implemented as all participants had the same interview guide questions, and the same social constructivist theoretical approach was used to analyze the data. Participants received a detailed consent form and were asked prior to the interview if they had any questions or concerns about the consent form. Transcripts were returned to seven participants to check for accuracy and resonance with their experiences. This allowed participants to add any additional thoughts and stories or change the existing content (Lincoln & Guba, 1985). Participants were also invited to receive a copy of the report once I had defended my thesis.

### ***Ontological Authenticity***

In ontological authenticity, participants' constructions are "improved, matured, expanded, and elaborated" (Morrow, 2005, p. 252). According to Lincoln (1986), "the price of violating the ontological authenticity criterion is ... disempowerment" (p. 7). I communicated to my participants that their constructions of meaning would not be violated. During the interviews, I would often share with participants my interpretation of what they had expressed. I also endeavoured to empower my participants by reflecting their thoughts and emotions back to them, so they felt understood. Furthermore, participants had the opportunity to make any changes to their transcriptions that might have been considered inaccurate. During the analysis process, I tried to present participants' findings in an authentic way to capture their meanings.

Ontological authenticity also involves determining the level of awareness participants have about the complexity of the social environment (Lincoln & Guba, 1985; Manning, 1997; Seale, 2002; Tracy, 2007). The participants in this study were quite educated, with many

individuals having years of experience in the mental health field; as such, they were aware of the complexity in the social environment and had a good understanding of their self-concept and the decolonization process. Finally, ontological authenticity addresses the question of whether the experience of the research process improves the participants' conscious experience of the world (Erlandson et al., 1993). Participants expressed that they had learned a great deal from engaging in this research study. Some individuals shared that they have plans on how to further decolonize their practice. Therefore, ontological authenticity was achieved, as participants' awareness levels were raised.

### ***Educative Authenticity***

Educative authenticity is defined as “the extent to which individual respondents (and the inquirer) possess enhanced understanding of, appreciation for, and tolerance of the constructions of others outside their own stakeholding group” (Guba, 2004, p. 3). Both ontological and educative authenticity increase participants' understandings; however, the former increases awareness of self, whereas the latter involves a deeper understanding of others (Manning, 1997). Member checking, the clarification of the researcher's assumptions, and internal audits can help in the understanding of others. Member checking provides participants the opportunity to confirm the accuracy of what they intended to say (Manning, 1997). In addition, all participants were invited to receive a copy of the report once I defended my thesis.

According to Manning (1997), “member checking and peer debriefing ... can uncover unexamined researcher assumptions” (p. 104). I participated in educative authenticity by debriefing with my supervisor on numerous occasions. Another way to clarify the researcher's assumptions is through dialogical conversations (Lincoln & Guba, 1985). An interview is meant to be a two-way conversation where an interviewer facilitates conversation with the participant,

rather than a one-way conversation to gather information (Lincoln & Guba, 1985). Through conversation, I was able to help participants feel safe and share their ideas openly. Finally, internal audits can result in a deeper understanding of others. Internal auditors' "perspectives add valuable insights to the research findings" (Manning, 1997, p. 108). My supervisor and committee members assessed whether the "themes and interpretations [were] theoretically sound and coherent" (Manning, 1997, p. 108).

I also told participants what I was learning from the interview process and shared stories that I had found fascinating. For example, I shared about shamanic healing and spirit animals with some participants, which I learned about from other participants. These participants appreciated hearing these stories and our conversations on such topics. In addition, participants conveyed their appreciation for their Indigenous clients and for what their clients have taught them about Indigenous cultures and traditions. In educative authenticity, there is a "mutual construction of meaning" (Morrow, 2005, p. 253) between the researcher and the participant (Morrow, 2005). In essence, there is increased understanding as both researchers and participants become educated about different values and belief structures. According to Morrow (2005), "understanding of participant constructions of meaning depends on a number of factors, including *context, culture, and rapport*" (p. 253). Through conducting interviews, my hope was to better understand the context and cultures in which my participants work (i.e., their practice in the mental health field; Morrow, 2005).

### ***Catalytic Authenticity***

Catalytic authenticity includes the degree to which action is taken (Morrow, 2005). Gaining an increased understanding is not enough. Research inquiry "must also facilitate and stimulate action" (Lincoln, 1986, p. 8). Catalytic authenticity "builds the capacity of those



involved to take action ... [and] identifies potential change-making strategies” (Patton, 2002, p. 545). In other words, the research process should motivate and facilitate participants’ behaviour. I hope the implications of my findings encourage participants, educators, researchers, and other mental health service providers to take action in decolonizing their practice and mental health services to better serve Indigenous Peoples and communities. It should be noted that this report is a “living document open to amendment and exegesis ... never complete, only finished” (Manning, 1997, p. 110).

### ***Tactical Authenticity***

Tactical authenticity addresses the question of whether the participants are empowered to act on the research findings (Erlandson et al., 1993; Guba & Lincoln, 1989). This type of authenticity necessitates that the researcher understands that the participants’ meaning does not belong to the researcher. Tactical authenticity involves empowering the participants so that they do not feel like “‘subjects’ who must be ‘manipulated’ ... in the interest of some ‘higher good’” (Lincoln & Guba, 1986, p. 83). Tactical authenticity includes the participants’ stories they shared with the researcher, consent forms, dialogical conversation (between the researcher and the participants), and member checking (Manning, 1997). I hope to have achieved tactical authenticity by respecting and honouring the participants’ opinions and experiences. I honoured confidentiality during and after data collection. All participants’ names, places of employment, and other identifying factors have been changed. I also negotiated with participants about the kind of data that would be collected. For example, all participants were given the interview guide questions well ahead of time and were asked to email me any concerns and/or questions they might have. In the following section, I address ethical considerations.

## **Ethical Considerations**

An ethics application was submitted to the Behavioural Science Research Ethics Board for approval and was received on April 23, 2020. All information regarding conflict of interest, participant recruitment, informed consent, data collection, right to withdraw, and safety precautions taken throughout the study are outlined in more detail in the participant consent form (Appendix F). There was no harm to the participants, and the study did not involve any deception. Although participants shared their thoughts and feelings, they did not express the need to debrief with me or my supervisor about any potential feelings of vulnerability or any potential emotional and/or psychological harm that might have resulted from discussing their experiences working with Indigenous clients.

To maintain confidentiality in the transcripts, only the participants' first initial was recorded for their responses. Participants' full names were used only in the informed consent and transcript release forms. These forms were stored in a locked filing cabinet separate from the transcripts and audio recordings. In addition, all names and identifiers have been changed for this study. All transcripts and audio-recordings were stored on my One Drive account with the University of Saskatchewan that only my supervisor and I have access to.

## **Summary**

In this study, I examined the accounts of how non-Indigenous mental health professionals decolonized their practice and mental health services. I used the basic interpretive qualitative research design to explore participants' meaning of their socially constructed world. Thematic analysis was chosen to develop themes and sub-themes. The authenticity criteria helped me be more reflective as a researcher. For example, I tried to give equal attention to each participant's voice and shared with participants what I had learned throughout the data collection. In Chapter

Four, I describe the research findings that resulted from interviewing nine participants in Western Canada.

## Chapter Four: Results

The purpose of this study was to describe non-Indigenous mental health professionals' experiences with decolonizing their practice. As is typical in the basic interpretive qualitative research framework and as elaborated on in Chapter Three, I focused on how mental health professionals ( $N = 9$ ) experienced and understood decolonizing their practice by analyzing the content of their transcribed stories. I also explored how they became cultural allies and overcame past biases and assumptions they might have had toward Indigenous Peoples. To review, my research questions were as follows:

- How do non-Indigenous mental health professionals experience decolonizing their practice and mental health services?
- In what ways do non-Indigenous mental health professionals practice cultural humility and strive to provide decolonized, anti-oppressive services to Indigenous clients?
- How do non-Indigenous mental health professionals acknowledge systems of power and privilege and advocate for social justice for their Indigenous clients?

I used thematic analysis (Braun & Clarke, 2006) to identify and construct common themes and sub-themes across participants' accounts. Six themes emerged from the data: decolonizing; being a cultural ally; practicing holistically; understanding and respecting Indigenous ways of knowing and doing; appreciating vital components; and commitment to lifelong learning. Figure 1 illustrates these overall themes and sub-themes.

All information that might have identified the participants, such as personal names, names of cities, and work locations were altered to maintain anonymity and confidentiality. I “cleaned up” transcriptions, removing repetitive utterances and phrases deemed not meaningful

to the data (i.e., filler material such as uh's, um's, hmm's, yeah, so, like, you know, right, etc.). At times, direct quotations were changed. For instance, ellipses are used in circumstances where information not related to the concept being discussed was omitted, while square parentheses indicate additional information that presents context for the reader.

## **Participants**

Interviews were conducted with nine non-Indigenous mental health professionals working in a mid-sized or large prairie Canadian city, or a small prairie Indigenous community. The participants were female and given the pseudo names of Jane, Holly, Emma, Sophia, Olivia, Mia, Elsa, Ava, and Charlotte. All participants were affiliated with a professional licensing organization. Their experience in the mental health field ranged from three to 30 plus years. Participants were employed as social workers, psychologists, certified counsellors, and a psychotherapist. Two participants were persons of colour, which brought a different perspective to the interviews, as one participant stated that she can relate “far more” to Indigenous Peoples than to White people, while another highlighted her “commonality” with her Indigenous clients as a visible minority.

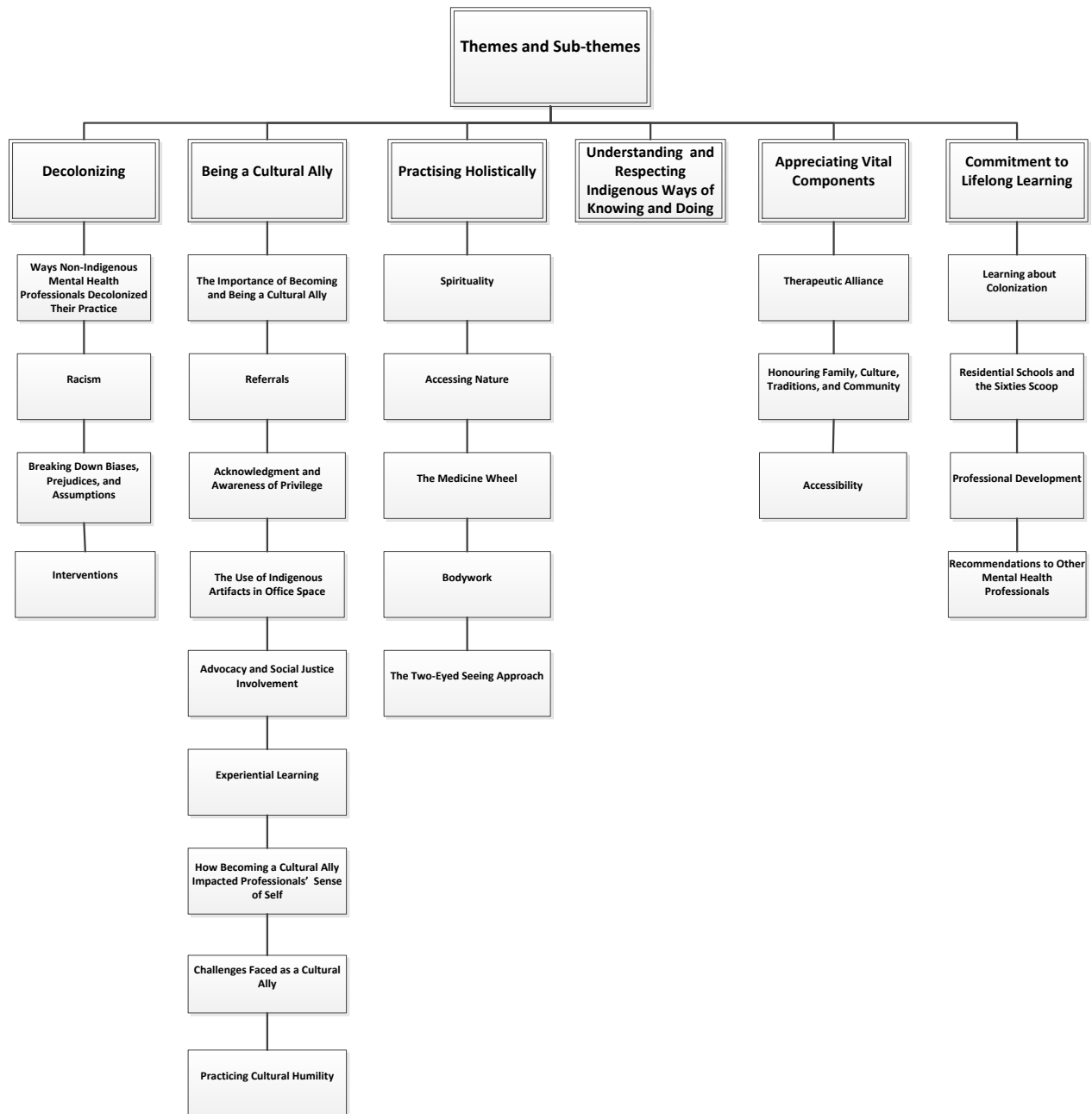
Participants’ theoretical orientations were diverse and included the following: biospiritual focusing (BSF), acceptance and commitment therapy (ACT), person-centred, feminist, narrative, and integrative approaches. Many participants combined and incorporated other techniques and orientations when needed, such as cognitive-behavioural therapy (CBT), eye movement desensitization and reprocessing (EMDR), somatic work, Indigenous spirituality, and nature therapy.

One of the difficulties of using qualitative analysis is that participants and their stories are presented as “disembodied themes and isolated data points” (Chaudhry, 2012, p. 105). I

attempted to avoid presenting participants' stories as such and was sensitive to their experiences and viewpoints. I was impressed with the honesty and sincerity of the women I had the privilege of interviewing. All participants were enthusiastic about discussing the topic of decolonization, and some individuals sought to make changes in their practice to be more educated and prepared to accommodate their Indigenous clients. I provide an outline of these themes and sub-themes in Figure 1 below. It should be noted that many of the following themes and sub-themes overlap.

**Figure 1**

*Themes and Sub-themes*



## **Decolonizing**

Participants used many different words to describe how they define the process of decolonizing their practice and mental health services, such as “Indigenizing” and “developing anti-oppressive practice.” Most participants expressed that decolonization of the mental health field is much needed and provided rich descriptions of how they decolonized their practice. Several sub-themes are discussed in this section: ways non-Indigenous mental health professionals decolonized their practice; racism; breaking down biases, prejudices, and assumptions; and interventions that are practiced.

### ***Ways Non-Indigenous Mental Health Professionals Decolonized Their Practice***

Participants decolonized their practice in several ways. Part of decolonizing Holly’s practice was admitting when she might have offended one of her Indigenous clients, as it “likely comes from a place of ignorance, not necessarily racism.” Holly shared that if any of her Indigenous clients want to participate in sweats or other traditional Indigenous ceremonies, she will do her best to help connect them to these traditional ways. She mentioned that there is an Elder she can consult with at the education institution where she works. Furthermore, if any of her clients mention that they smudge before coming to school, she makes a note of this information because of its importance to them.

Sophia decolonized her practice by taking steps to avoid behaving in colonizing, patriarchal ways. One of her roles is to accompany women to various places within the justice system. Therefore, she bridges the gap between her Indigenous clients and the justice system that she views as often being colonial and punitive. She also minimizes the gap between herself as a White professional and her Indigenous clients by being open and authentic, asking questions, and supporting her clients where they are at. She stated, “I think that’s a big piece in breaking down that colonization or colonial attitude. I’m not the expert. I don’t know all the things.” She also



articulated that she wishes to avoid becoming comfortable or complacent but wants to continually challenge herself to learn more about how to decolonize her practice.

Because of her skin colour, Emma has been able to find a unique way of decolonizing her practice. She shared how she is able to develop a bond with her Indigenous clients:

As a person of colour, I often find that we have that commonality already because we're not White, and we often get mistaken for Indigenous. Lots of times when I'm working with Indigenous people ... they'll ask me, 'What reserve are you from?'

Emma found that being non-White helps her build a strong connection with her Indigenous clients and develop a greater rapport with them.

Mia's lived experience with decolonization involved being one of the responders at an Indigenous community crisis situation, where she needed to be flexible in her approach. For example, if clients wanted to walk through the woods, she accompanied them. She even had a counselling session with a youth sitting in the back of her car while the mother sat in the front with her. Mia also shared her observations of what was unproductive or unhelpful in her counselling work. She witnessed counsellors "who were mostly White and who sat in small rooms in the school [where the crisis took place], which is not a good place for many of our community members. It already has a negative connotation." She stated that these actions did not meet the needs of the community, as they did not employ the strengths that already existed. Mia stressed that Elders were not brought in nor was there smudging or doing circles. She strongly believes Indigenous communities heal by their members being involved communally. Hence, the above examples reveal the many ways participants decolonized their practice, including supporting their clients with their cultures, working to create a good therapeutic relationship with their clients, and remaining flexible in the counselling process.

## *Racism*

Although participants were not asked directly about racism and systemic racism, several individuals shared some stories and experiences with this topic. Holly admitted that she has done “a lot of work in those areas [on her biases and prejudices],” which has been a “humbling experience.” She claimed that admitting these biases has made her a more accepting therapist. She argued that mental health professionals need to explore how they were raised and how they might unintentionally be bringing their biases into their practice. Holly also shared that the institution she works at has a strict attendance policy that contributes to systemic racism, such that her Indigenous students have to sometimes choose between staying in school or going to a relative’s funeral. Holly stated that she finds this policy “highly unethical.” Thus, Holly was able to overcome her racist beliefs and moved on to wanting to support her Indigenous clients in their cultural practices.

Like Holly, Ava too admitted to having biases. She checks in with herself as to why she has “a certain perception of something” or “maybe why I’m interpreting a situation a certain way—because I have my own cultural biases, and I need to be more open.” In addition, she claimed that she challenges those who use racial slurs and educates them on their racist beliefs.

Elsa discussed times when she has witnessed racism, such as when she observed Indigenous Peoples being followed around in stores. She shared a story on this topic:

I was in Walmart, and this was before COVID, but when you go out the door, you have to show your receipt ... And there was a couple in front of me, I assumed they were Indigenous because they had brown skin. They were well dressed, neat and tidy ... and had everything in the cart. It was obvious they had paid for everything, and they were stopped. They went through all their items and went through their receipt. And then I

came along, and he said, 'No, you're good' and waved me off. It was like, what the hell just happened? And I don't even think I was very well dressed that day ... so stigma and stereotypes that people make on a daily basis, and they [Indigenous Peoples] face that on a daily basis.

Like Elsa, Olivia has witnessed racism and prejudiced attitudes, but from her own immediate family. She stated that it affected her when she was young, as she "didn't have a lot of interaction with Indigenous people." It was important for her to learn about different Indigenous populations, both in North America and South America, in order to change her views of Indigenous Peoples. Thus, the above excerpts provide fitting examples of how racism is still prevalent in Canadian society and how imperative it was for participants to address their own racist attitudes and beliefs to become more compassionate, empathic clinicians.

### ***Breaking Down Biases, Prejudices, and Assumptions***

Several participants shared that one of the first steps in decolonizing their practice was to overcome their past biases, prejudices, and assumptions. For many individuals, these biases were learned during childhood. Charlotte stated that she grew up with the attitude that the "White man knows everything. And you really didn't hear anything about the Natives other than it was that [White people] were blaming them for being aggressive and fighting. Well, [Indigenous Peoples] were trying to protect their land." Olivia also spoke about her childhood. She grew up in a farming community in a small prairie town, where many farmers were threatened by Indigenous Peoples, and she heard negative language spoken about Indigenous Peoples. As she was young and impressionable, these prejudices affected her. She stated, "Of course, that would have an impact. It has to ... we often don't understand how deep that impact goes." As she gained more knowledge of Indigenous Peoples and communities, she was able to overcome her assumptions.

Thus, both Charlotte and Olivia had to overcome the negative stereotypes they learned about Indigenous Peoples in their childhood.

In contrast to the participants who had to deconstruct previous biases and assumptions in adulthood, Emma shared that she overcame her biases and assumptions in childhood. She explained, “It’s great that I’ve been able to live in a diverse neighbourhood where there were Indigenous people, and I grew up with Indigenous kids, and my son will also have that opportunity.” She also decolonizes her practice by continually monitoring her own biases and judgments and makes a conscious effort to understand her Indigenous clients.

Sophia described that even in her field of social work she hears statements, such as “those people are poor,” and “those people need help” when talking about Indigenous clients. She claimed, “I don’t want to come to the door with assumptions. You might be sitting across from me, and you might appear Indigenous, [and I can’t assume] I suddenly know what your experiences have been and what your needs are.” Therefore, Sophia spoke to the need for “helpers” to examine their assumptions.

Ava found that it was in some of her post-secondary classes where she became more aware of her biases. She became cognisant of her privilege and that she automatically has more opportunities in life because she is White. She stated, “People are going to evaluate my intelligence differently or my social status differently versus someone who may have the exact same education and have the exact same socioeconomic status. They will still be viewed differently than [me].” For Elsa, she broke down some of her biases and negative stereotypes through life experiences (e.g., staying at a women’s shelter) where she met Indigenous women and was exposed to Indigenous cultures. Although awareness occurred through different life

experiences, many participants arrived at the same conclusion regarding the importance of examining their biases and assumptions in order to practice in a decolonized way.

### ***Interventions***

Participants were asked about the impact decolonizing their practice had on their understanding of clinical interventions. Participants' interventions varied widely and ranged from being flexible in counselling sessions to engaging respectfully and curiously with clients. Jane shared her story about how an Indigenous friend referred an Indigenous youth to her. To create safety for this client who was experiencing intense emotions, some of Jane's interventions included refraining from notetaking and from asking the usual questions she would normally ask at the beginning of the first session. She also expressed that she gave "room for silence and emotional expression ... [and did] deeper listening." Ava, who has experience counselling two-spirit persons, found that her interventions involve being respectful of her two-spirit clients, as well as addressing them by their preferred name and pronoun, which can change, depending on the day. For example, some individuals might choose to identify with being feminine and have a different name one day compared to a previous session. For Jane and Ava, they valued being accommodating and incorporated welcoming interventions when counselling Indigenous clients.

Both Ava and Elsa shared that part of their intervention is the belief that clients are the experts in their lives. Ava stated that in decolonizing her practice, she has discovered that "there's more than one way to view the world" and that she can learn from her Indigenous clients. Elsa shared that she asks her Indigenous clients if they are interested in the information she has, but she never wants to have that attitude that she knows more than they do. Through decolonizing her practice, Olivia noticed a shift in her interventions in that she has observed that spiritual tradition is important for some of her Indigenous clients and is comfortable discussing

this with them. However, she does not expect her clients to teach her about their Indigenous cultures because she believes it is “not fair to them.” Her learning about Indigenous cultures “need[s] to be independent of the therapeutic relationship.” Sophia agreed with Olivia that it is not the Indigenous clients’ job to teach counsellors about their cultures. Sophia explained, “It’s a hard balance between learning a client’s experience and not letting them have to bear the burden of teaching you.” Thus, some participants revealed that several of their interventions involved respecting where clients are at and refraining from having clients educate mental health professionals about their cultures.

For both Sophia and Holly, part of the intervention is being curious and asking questions. Sophia shared that when trying to decolonize and be culturally competent, she has learned to ask more questions and have more curiosity because not all her Indigenous clients are connected to their cultures. Holly explained that for her, intervention involves “taking a new narrative approach.” For example, part of her approach is asking her Indigenous clients questions about their history, issues in the present moment, and how she can help them build their future. The above examples illustrate the shift participants made in their work with Indigenous clients.

### **Being a Cultural Ally**

To introduce the concept of cultural allyship, all participants were read the following statement: “To be a ‘cultural ally’ to Indigenous Peoples means acknowledging the privilege that settler cultures have and take for granted. It also means you challenge and work towards breaking down those barriers that continue to violate Indigenous Peoples.” In response, participants shared that being a cultural ally means being an advocate, overcoming biases, recognizing clients’ cultural backgrounds, and refraining from imposing one’s own worldview on Indigenous clients. This theme was categorized into the following sub-themes: the importance of becoming and being a cultural ally; referrals; acknowledgment and awareness of privilege; the

use of Indigenous artifacts in office space; advocacy and social justice involvement; experiential learning; how becoming a cultural ally impacted professionals' sense of self; challenges faced as a cultural ally; and practicing cultural humility.

### ***The Importance of Becoming and Being a Cultural Ally***

Although biases have already been discussed in the previous section on *Breaking Down Biases, Prejudices, and Assumptions* (p. 64), many participants indicated that being aware of their own biases also aligns with becoming a cultural ally. Jane stated that being a cultural ally means “embracing the culture—having sweats on the land.” She was introduced to smudging by an urban Indigenous shaman who drummed and blessed the land Jane owns. Jane not only incorporated smudging into her own practice, but she also continues to smudge every morning before going to the office. Jane also explained that one of the benefits of being a cultural ally is that “it certainly makes things very easy—they’re [her Indigenous clients] not having to respond and react to someone who isn’t [a cultural ally].” For Jane, being a cultural ally has resulted in better therapeutic relationships and has helped her be a more effective therapist.

Charlotte became a cultural ally by taking training in Indigenous healing practices, such as shamanism. She has also made a point to compliment her Indigenous clients if they are wearing Indigenous memorabilia and noted that most people seem pleased by this. Holly stated that she works very hard at becoming a cultural ally by making sure her office is not a colonized space. Her goal is to never recolonize her Indigenous clients, and she tries to always be aware that colonization is a part of her clients' histories. She expressed that she wants their experience to be different than what they might have encountered with other non-Indigenous people. She shared, “I want their experience with me to be ... positive. I want it to be welcoming. I want to show them that they have allies on this side of the world too, and I’m one of them.” Hence, both

Charlotte and Holly indicated the efforts they made to show their Indigenous clients that they were their allies.

Mia claimed that because she lives in an Indigenous community, this makes her a stronger ally compared to a contracted psychologist who does not live in the community. She explained that her relationships are different from somebody who does not live there. She also made the conscious decision to have many of her clients on Facebook, going outside of the textbook therapy practices to build rapport with her Indigenous clients. She shared a story about one way she practices outside the box:

That would probably be something that would be questioned by others that have not lived in this community and don't understand. But I do it because when there is somebody that I would like to work with, oftentimes I will meet resistance. Many people here are shy and nervous of specialists, particularly White specialists and so for me to come and say, 'I am those things, but look, we have 25 friends in common on Facebook. I live here too. I know the same people you know. I care about the same things you care about.' I think it makes a big difference. It's definitely opened some doors.

Mia had the awareness that Indigenous Peoples are often uncomfortable with White clinicians, and she made her practice more open and inviting by approving requests from community members who want to join her social media page.

For Olivia, being a cultural ally means taking on a role of activism by making sure she has a sliding fee scale, and one day when her practice is established, she plans to offer pro bono work to those Indigenous clients who cannot afford therapy. She also offers services from a distance, as not every one of her Indigenous clients can come to an urban city to see her. Additionally, she stated that becoming a cultural ally means "taking part in ceremony, for



instance, and going to a sweat and ... being a friend—taking different classes run by Indigenous people just for fun.” Consequently, for Olivia, being a cultural ally involves not only how she runs her practice but also partaking in ceremonies. Therefore, several participants saw the ally role as contributing significantly to enhancing the therapeutic relationship and hopefully helping Indigenous clients feel safe and accepted.

### ***Referrals***

For many participants, practicing cultural allyship means being able to refer their Indigenous clients to resources and supports in the community that could help them to connect more with their cultures and heal from past trauma. Emma works with Indigenous youth and encourages them to connect to various programs and agencies. She stated, “It’s always coming as an ally and joining with communities I think is really important because you don’t want to come in as this person or body that wants to tell people what to do.” When she can, she partners with various agencies to build relationships in the community.

Ava shared that she tries to be aware of the community organizations that are available. She has referred some of her clients to various Indigenous organizations to “guide them to someone who might be more knowledgeable than [me].” Charlotte, who works in a large Canadian city, has also referred people to an Indigenous centre where Indigenous Peoples can smudge or talk with an Elder. The feedback Charlotte received about these referrals has been positive, as some of her Indigenous clients have “found that very helpful and very comforting to them.” Charlotte has also referred her clients to professional shamans if she felt there was something demonic contributing to clients’ presenting concerns. Thus, participants saw the value in learning about the various Indigenous resources in their communities.

### *Acknowledgment and Awareness of Privilege*

Acknowledgment and awareness of their privilege have helped participants be better cultural allies. Several participants discussed their White privilege specifically. For Sophia, being a cultural ally means acknowledging her privileges as a non-Indigenous person and using this privilege to advocate for her Indigenous clients. For example, she shared that she can go to the police station and advocate for her Indigenous clients because she is White and is sadly taken more seriously than some of them. She stated, “I can use that privilege to walk into that police station with my [Indigenous] client and say, ‘Look, you need to listen to her. She has a story and it's serious. Take it seriously.’” She does not want to override the voice of her clients but uses her privilege to demand the justice system takes her clients seriously. She has also used her White privilege with Child Protection Services:

Sitting there and saying, ‘You need to listen to this person’s experience. Yes, they might live in a house with their grandma and mom and aunt and uncle, and their kid. You might say that's wrong, but why don't you listen to why that works for them.’ So just trying to use the ability to have a voice to give space for someone else.

She stated that if she can open a door and “stand there while they're walking through it, it helps to build [a] therapeutic alliance. I am standing in their corner. I'm not going to fight their fight for them, but they can do this.” Consequently, even though Sophia will use her privilege to advocate for her clients, she is also conscious to empower them to advocate for themselves and to support their agency.

Mia also acknowledged her privilege as an educated White woman who has a strong voice and speaks eloquently. She admitted that it would be easy to use her power to speak on

behalf of Indigenous Peoples in the Indigenous community where she lives. However, she explained that she wants to conduct herself differently for the following reason:

There're a lot of people who would hear these messages from me more easily but that doesn't mean it should be me who speaks because there are many, many people ... who are more so [a] representation of the North—who are Indigenous, who have grown up here and who are equally intelligent, and who are equally eloquent—although they may speak in a verbal pattern that is different from mine ... those are the voices that we should be listening to.

By providing this example, Mia highlighted how privilege can be used inappropriately, even with the best of intentions, and demonstrated her desire to respect the voices of Indigenous Peoples in her community.

Elsa openly speaks about her White privilege to her Indigenous clients. She expressed, “I have different experiences because I'm a White woman with white skin. And I [can] have those conversations with some of my clients too, and they appreciate[d] me being honest with them.” She spoke about needing to be aware of her privilege and works “really hard to keep that in the forefront. I don't pretend just because I don't exert my White privilege that I don't have it.” For Elsa, talking freely with her Indigenous clients about her White privilege has helped her to have an open and honest therapeutic relationship with them. The above examples speak to how necessary participants felt it was to always be cognisant of their privilege.

### ***The Use of Indigenous Artifacts in Office Space***

Although decolonization is more than having Indigenous artifacts in counsellors' office spaces, for several participants being a cultural ally means having items in their offices that provide comfort and familiarity to their Indigenous clients. Elsa explained that she has been able

to have conversations about her Indigenous artifacts with some of her Indigenous clients. However, she noted that she lets the client initiate that conversation, not herself. She explained that a few of her Indigenous clients made statements such as, “‘I really like that piece. That reminds me of when I was a child’ or ‘I remember when my grandma had that picture, or my kokum had that picture.’” They expressed feeling safe, comfortable, and accepted in Elsa’s office.

For some participants, an artifact, such as a book about spirit animals, became part of therapy and facilitated discussions. Jane had several Indigenous clients who talked about their dreams and the spiritual significance of them, or about when they sensed “not-so-good” spirits. Jane, who has done shamanic journeying, has her own spirit animals; therefore, she is able to use the book with her clients and discuss their spirit animals. She explained that “it validates their experience, so they know they are not crazy—that what they’re experiencing is entirely normal, and it’s a gift.” Elsa also had Indigenous clients who identified with various spirit animals. She too is familiar with the book and can relate to her clients and “knew what they were talking about.” She has said, “Tell me more about that. I’d like to understand more.” Discussing cultural artifacts are significant in the counselling relationship, as they helped both Jane and Elsa connect with clients by accessing their worldviews and spiritual beliefs.

Playing Indigenous music is another example of using artifacts in the office space. Charlotte shared that she plays Indigenous music in the background in her office during her counselling sessions to help clients feel more at ease. She claimed, “Ninety-nine percent of my clientele [are] Native ... the majority coming even to the first session are usually anxious ... So, I just think music can be one of the tools that can kind of calm people down.” Charlotte also uses Native oracle cards in sessions. She shared that she had read about ways to counsel Indigenous

Peoples and learned that the use of stories and pictures can help. However, she claimed that she must be careful in case people think she is veering too far into doing psychic work. For Charlotte, using Indigenous music and oracle cards supported her clients in feeling more relaxed and accepted.

Sometimes artifacts include objects of nature, such as the river stones that were used at a local counselling agency. Sophia, who facilitates many groups, asked the management at the agency where she works about bringing Indigenous artwork or other artifacts into the agency and group room. She further explained her experience:

I brought those [river stones] in [the group room] because I went to a ... conference and there was a speaker there and she talked about having things that make people realize that they're welcome there—having redwood pieces above your door because that can be significant ... [For] some Indigenous people, it connects them to the grandmothers and grandfathers and knowledge and Mother Earth.

Therefore, having Indigenous artifacts in the office space has contributed to creating a secure and nurturing environment for Indigenous clients.

### ***Advocacy and Social Justice Involvement***

Advocacy and social justice involvement are central in cultural allyship. Many participants shared the ways in which they are advocates and/or are involved in social justice. Charlotte stated that she has been approved as a therapist to counsel those who have missing or murdered Indigenous female relatives. Mia shared that she is “very loud” about advocating for her Indigenous clients, as she constantly talks about Indigenous rights on her Facebook page. Additionally, when she becomes registered with her licensing body, she wants to change the informed consent process. Because many of her Indigenous clients are youth and live with

relatives that are not their parents, she wants to advocate for better and quicker ways to obtain consent for these children to have psycho-educational assessments completed. Mia is also involved with social justice. Whenever she can, she tries to make a proper diagnosis for her clients because “it means financial stability and that financial stability makes a huge difference in the quality of life for many, many people.” Hence, both Charlotte and Mia stressed that advocacy for their clients is important because they want to see more positive changes for Indigenous Peoples.

Ava spoke about how the agency where she works is attempting to incorporate the TRC’s (2015) recommendations. Sophia stated that she tries to be involved in various Indigenous activities. For example, she attends plays and discussions at an Indigenous theatre company and takes part in reconciliation activities. Sophia is also on the committee for a local reconciliation organization. She shared her feelings about being on this committee:

It has been beautiful and frustrating at the same time. I am constantly so invigorated by going and talking to people who are making changes and who are learning about their role in colonization and breaking that down. Sometimes I get an opportunity to talk to Elders or residential school survivors, and it's this beautiful opportunity to make connections that are going to last, I think, through the rest of my career ... Also, though, frustrating because then I come back with these grand ideas and [am] met with all the red tape and barriers.

She explained that many agencies want to check a box and say, “We did the reconciliation thing. We're done.” However, she believes strongly that it must be a “continuous thing, especially because we always have new students and new employees coming in—you can't just stop at one or two luncheons.” Thus, several participants made a serious effort to advocate for their

Indigenous clients, demonstrating that advocacy and involvement with social justice require ongoing efforts and are much needed to help better support Indigenous clients.

### ***Experiential Learning***

In addition to being a cultural ally, experiential, interactive workshops would likely benefit counsellors' and therapists' understanding of the hardships Indigenous Peoples endured because of colonialism. One such learning experience was the KAIROS (KAIROS Canada, 2020) blanket exercise program. The purpose of this exercise is to understand the shared history of Indigenous and non-Indigenous Peoples. Five out of nine participants attended this program that was facilitated by Indigenous staff at various locations in a mid-sized prairie city. Ava explained the KAIROS blanket exercise as follows:

[The KAIROS blanket exercise] looks at the history of colonization and how when the European settlers came to the land, the land was huge. And [the Indigenous facilitators] talk about how different illnesses like smallpox or things that [the European settlers] brought over with different diseases that [the Indigenous Peoples] were more susceptible to. And how reserves took away the land, and then residential schools took away their children ... the blankets are on the ground to represent the landmass. As reserves were created, their landmass shrunk exponentially, until the end, there is one blanket with five people on it ... [The purpose of the exercise was] to educate [the participants] and give them space to speak to what they knew about the history of Indigenous Peoples and how the colonization happened. It was very impactful.

The exercise deepened Ava's understanding of how separating families impacted generations and future generations of Indigenous communities. Ava stated that she was very emotional during this exercise as she imagined children being taken away from their families. She shared,

“It does continue to affect generations today—given that the last residential school closed in 1996—not that long ago.” She argued that because Indigenous families were torn apart, “the parents never learned how to be this way and helping them learn what’s it like to be a parent so that the children are helped, and the children learn healthier coping.” For Ava, this experiential exercise gave her a deeper comprehension about how the residential school system interfered with Indigenous parents being able to properly parent their children.

Sophia also shared that the blanket exercise was a very powerful and emotional experience. She noted that she read about residential schools and the Sixties Scoop, but it was not until she did the blanket exercise that she understood what happened on a “whole different level.” This exercise also brought her to a deeper level of empathy that no textbook reading about the cultural genocide of Indigenous Peoples could. For Holly, as a European settler, she needed to work through some guilt attached to the blanket exercise. Guilt is often a common emotion experienced when hearing about the dark history of Canada (Duhamel, 2021). Holly believes every mental health professional should experience the exercise at least once. She claimed that the exercise is healing for both sides:

Honestly, it brings us together instead of pulling us apart because [the Indigenous facilitators of the blanket exercise] do it in such a peaceful way. It brings home the point without anger or aggression. It’s very enlightening. It’s informative. And I think it’s a very peaceful way to bring both sides to the table.

Similarly to Sophia, Holly stated, “It’s one thing to read about it, but it’s another thing to actually see it and experience it.” Consequently, experiential learning, such as the blanket exercise, provided participants with valuable education on the dispossession of Indigenous Peoples.



Emma had a slightly different opinion about the exercise. She stated that it was a “good reflection exercise on Canada and Indigenous Peoples;” however, she added that more action needs to be done, that the exercise is “just the tip of the iceberg.” For example, she expressed that there needs to be more discussion on anti-racism from management teams. She is hopeful that, as more managers come on board and address anti-racism, “maybe the culture will shift on the team.” Thus, the KAIROS (KAIROS Canada, 2020) exercise is just one example of experiential learning that assists non-Indigenous mental health professionals to develop a deeper understanding of colonialism.

### ***How Becoming a Cultural Ally Impacted Professionals’ Sense of Self***

Several participants discussed that becoming a cultural ally impacted their sense of self, but these experiences varied. For many participants, becoming a cultural ally changed them for the better. Mia agreed with me when I validated that she is not the same person as when she first moved to the Northern community. She admitted that, at first, she did not understand the culture. She grew up in a White culture that adheres to schedules. As she continued to live in the community, she became more flexible. She stated, “If something happens in the community and that’s no longer the right time, then we [Mia and her client] both have an understanding that we’re going to find a better time [for their session].” Olivia too found that being an ally helped her become a better person by being aware of the biases that she learned from childhood. Additionally, as a person of colour, she found that she relates better to a group of people with darker skin, such as Indigenous Peoples, than with White people. Being an ally also opened her up to various ways of understanding and “looking at the world.” As a result of taking steps toward being cultural allies, Mia and Olivia became more flexible and understanding individuals.

Sophia found that combining allyship and motherhood has been challenging as far as her sense of self goes. She has often engaged in self-reflection about this:

Am I doing the work I need to do to make sure my children are not only understanding but being cultural allies? And so, in trying to decolonize my practice and my life and my family, it just brings up a lot of work that there is to do.

She tries to reinforce to her children not only the differences but also the similarities between White and Indigenous Peoples.

Emma's sense of self has been impacted, as she feels honoured to have the opportunity to work with people of colour, including Indigenous clients. She stated, "It makes me feel proud that my parents took that chance to immigrate to Canada and that I'm using my education to help others." Furthermore, she has used self-disclosure, when necessary, to talk about race and background. When appropriate, she has told her Indigenous clients that she too has been treated differently being of a different race and colour and has revealed how this has impacted her mental health. She has done this to let her clients know that she is not "some super [mental health professional] who has no problems. That's not who I am." For Emma, self-disclosure has been a way to help her Indigenous clients feel more accepted and comfortable. These varied experiences reveal how cultural allyship has helped some participants become better people by increasing their empathy and care.

### ***Challenges Faced as a Cultural Ally***

Although participants shared the positive aspects of becoming a cultural ally to their Indigenous clients, they also expressed the challenges they faced both professionally and personally. Challenges ranged from having the awareness that there is still much to learn about what it means to be a cultural ally to having others confront them and tell them that they were

being disingenuous. Ava stated that becoming a cultural ally challenged her personal beliefs because growing up she heard many negative stereotypes about Indigenous Peoples without knowing their personal and cultural history. As a mental health professional, she admitted she has much to learn. Elsa too asserted that she is in a continuous process of being challenged about her stereotypes and biases. She also wants to know more about Indigenous cultures and has humbly admitted to her Indigenous clients that there are areas she knows little about. She shared, “Being humble is challenging because as a counsellor, it’s like I’m supposed to know everything, but I don’t know everything.” Both Ava and Elsa viewed having a lack of knowledge as a barrier to becoming a cultural ally.

Olivia faced a different challenge. She explained that because she has demonstrated interest in meeting with Elders or going to sweat lodges, this has been interpreted [by some Indigenous Peoples] as disingenuous, and assumptions are made that she is doing these things for political reasons. She shared that she tries hard to understand Indigenous ways of being but has been judged as insincere. She further explained the following:

People haven’t gotten to know me and talked to me to see that, oh, this is totally sincere.

Yeah, that has been challenging ... It’s also like, ate away at my confidence a little bit.

So, I don’t know if I’ve overcome it totally.

When Olivia has shown interest in wanting to attend a sweat or engage in some cultural learning, she observed that she was more welcomed at a community level than at the university level. Olivia was asked what this means to her to be accepted on a community level but not on an academic level. This was her response:

I imagine ... there’s been a lot of resistance at the university level ... Maybe [Indigenous Peoples have] had to fight a lot harder to be accepted in the university setting, to be

looked at as equal ... and they're protective of that—and they also now are seeing that this movement for Indigenization. It's like, that's great you've done so well in developing your own research methods. So now ... the White settler is going to take those research methods and use them in a way that's not Indigenous—that not's respectful of ... that worldview ... I've heard that is a concern, and I can see that.

With Indigenous Peoples' history of colonization and assimilation, it is not surprising there is mistrust toward and skepticism of non-Indigenous professionals who show an interest in their traditions and ceremonies.

One of Sophia's challenges is to “constantly try and keep looking at the places in the bigger systems where there is still a lot of colonialism or ... I guess where my blind spots might be in terms of how things impact Indigenous clients.” Sophia discussed a specific example of the steps she takes to reflect on these blind spots:

If I'm working with an Indigenous client, I have to look for A, B, and C, but I don't necessarily remember that there are other things that might be working in there too. And it gets comfortable ... here are the steps that we do, I'm doing it, and go on ... [An example would be] when I'm thinking of groups, we've tried to kind of bring more Indigenous culture into some of the things we do in group. One of the things that we've started doing is when we talk about coping, using the Medicine Wheel as a holistic, coping kind of model. But, then it just got comfortable to use the Medicine Wheel as our ... Indigenous tool without thinking about the fact there are other models and there are other tools and there are other ways of looking at it.

For Sophia, she wants to eventually learn about other Indigenous concepts and tools she can use in her group counselling practice.

Another challenge is trying to introduce decolonization to the higher levels of the work she does or “the agencies that I’m working in.” When Sophia has tried to bring new ideas about how to decolonize the agency, she hears statements like “we can't practically do that” or “no, we don't have the money or space.” She admitted that at times she feels quite defeated when trying to decolonize her practice because of the lack of support from management. Thus, Sophia expressed frustration with trying to decolonize her practice but not feeling supported in this endeavour. These varied experiences illustrate that being a cultural ally is hard but important work.

### ***Practicing Cultural Humility***

Cultural humility is a critical part of multicultural competence and is gaining increasing recognition in the mental health field. Cultural humility involves self-reflecting on one’s culture and assumptions (In Plain Sight, 2020; Shaw, 2016; Tervalon & Murray-Garcia, 1998). Being conscious of privilege, biases, and prejudices appeared again when some participants spoke about how they practice cultural humility when working with their Indigenous clients.

Mia not only expressed her need to be conscious of her own White privilege, but she has also consulted others to help her in her practice, especially when she did not understand a situation. Olivia admitted that she does not practice cultural humility as well as she should or could. She spoke about needing to “dig deeper than what exists with race and to see maybe what’s similar, and also what you have that I don’t have ... so just to respect each other on a very personal level.” Both Mia and Olivia have tried to practice cultural humility by making efforts to gain more knowledge and understanding.

Other ways that cultural humility was practiced was through curiosity and active efforts to ensure clients feel safe. Sophia shared that she practices cultural humility by asking her

Indigenous clients questions, such as: “What has worked for you? What has your life looked like? What [have] been the coping skills you've learned in your life?” Holly shared her perspective on making her office a safe place:

I ... [am] always working very hard to make my office that safe place for them, so [Indigenous clients] don't have to worry about being judged ... but at the same time keeping in mind that our experiences are very different.

Importantly, the above examples demonstrate that cultural humility involves both self-awareness and self-critique.

### **Practicing Holistically**

Mental health professionals need to be familiar with some Indigenous traditional cultural practices to help their Indigenous clients with their well-being. Participants were asked how they practiced more holistically when counselling Indigenous clients, specifically in the mental, physical, emotional, and spiritual dimensions. The following sub-themes are discussed in this section: spirituality, accessing nature, the Medicine Wheel, bodywork, and the two-eyed seeing approach.

#### ***Spirituality***

Spirituality is a vital aspect in many Indigenous Peoples' lives (Duran, 2006; Ross, 2014), which was highlighted by several participants in their interviews. Charlotte mentioned that she has experienced shamanic treatments. Therefore, she is comfortable sending her clients to a shaman to help “remove those entities from the person.” Charlotte also revealed that some of her Indigenous clients are atheists and “don't go for stuff like that [spirituality].” She asks her Indigenous clients if they want a spiritual component to their therapy. She stated only about 20 percent said they want spirituality to be a part of their counselling. Additionally, Charlotte has asked some of her clients where they are at with their spirituality and received answers across the

spectrum:

I get different answers—from people who are atheist[s], people who don't care [are impartial to spirituality], people who are bible-thumping Christians. Other people are into Native teachings—a whole range of everything. I even had some clients who are quite psychic.

Charlotte integrates CBT with a spiritual component if this is what the client wants. For example, if she is working with clients on self-esteem, instead of using an affirmation, such as “I feel more confident,” she has them rephrase with “thank you God for giving me more confidence,” or “thank you Great Spirit.” Charlotte noted that she would like the mental health field to be more aware of the spirit world by being “more open to accept[ing] this kind of stuff because those healing practices for those issues do work.” She shared a story about hospitals that have implemented Indigenous ways of knowing:

There's a fellow in Brazil who started up a psychiatric hospital—people coming in who seem like they're mentally ill. They have the psychiatrist, and they have the medium both assessing the person. And if it's strictly [a] mental health problem, then they get mental health treatment. If it's more to do with the spirit world, then the medium can determine if this person is possessed by spirits or [if] they need a bit of both ... I can't tell how earth-shattering that is ... They've got 28 hospitals around the world that do this, and that's Indigenous belief systems there that they're implementing.

Whether she suggests a shaman or asks Indigenous clients about their spirituality, Charlotte remains open to exploring spirituality with her clients.

Sophia explained that she tries to work holistically with all her clients:

Even clients who aren't particularly spiritual. We'll talk about the spiritual component

being, it's a bit more than emotion, it's a bit more than psychological—it's kind of like your essence as a person. And I try and start broad and then let the client bring me into what our focus is.

She shared that she has had several Indigenous clients who expressed that religion is very important to them. She asked them, "What is it that gives you strength? Or what is that gives you guidance? And then let the client name whatever that is—whether it's the Creator or God or the Universe or whatever, and I go from there." Sophia prioritized letting her clients guide the conversation about what spirituality means to them.

While many participants reported on Indigenous traditional spirituality, Mia shared that in the Métis community she lives in, its members are primarily either Catholics or Christians. Instead of attending ceremonies such as Pow-wows or Sundances, the community would "much more likely actually to have a gospel weekend." From the wide range of experiences participants had discussing spirituality with their clients, this indicates there is no uniform way Indigenous clients practice their spirituality.

### *Accessing Nature*

Accessing nature appeared to be important for some Indigenous clients. Some participants had the flexibility of spending time in nature with their clients in therapy sessions as a way of practicing holistically. For example, Mia shared that when she was doing crisis counselling, she met the client's needs by going for walks in the woods. She described that counselling does not "have to be done in an office with two chairs." Sophia also has the freedom to incorporate nature into her therapy. She explained that if a client wants to "meet in a park and sit on the grass and listen to the breeze while we talked," the client has this option. Like Mia and Sophia, Ava offers to walk with clients by the river that is close to the agency where she works.



She even claimed going out in nature for sessions “seems more impactful [for her Indigenous clients] than for some of the White clients I’ve had.”

### ***The Medicine Wheel***

Several participants spoke about the Medicine Wheel as a tool they use in their practice to create a holistic approach. However, some individuals expressed discomfort with using the term or even discussing the wheel with their Indigenous clients. Ava does not like to use the term, “Medicine Wheel.” Rather, she uses the term, “wellness wheel” because to her it fits more with White culture. She claimed, “I don’t want to misappropriate it because I’m not an Elder, I’m not Indigenous ... So, the wellness wheel is one way I can connect—is how I see it.” Ava explores with her Indigenous clients the areas in their lives that are working well, so they are aware that “they are doing something right.” She wants to reaffirm her clients’ strengths and then she tries to have them work on their weaker areas. This strengths-based approach helps Ava focus first on the positives of a client’s life.

Olivia, who conceptualizes her cases using acceptance and commitment therapy (ACT), discussed how this approach includes the bullseye concept. She claimed that the “Medicine Wheel ... maps on really nice with the bullseye.” She shared that the bullseye diagram allows her to have her own tool to use as she talks with her clients about the Medicine Wheel. However, like Ava, she is cautious about using the Medicine Wheel, as she is not Indigenous.

Elsa also found that the Medicine Wheel works well for clients who are not Indigenous. She claimed that she often talks about the dimensions in the groups she co-facilitates. She stated that “you can identify it as the Medicine Wheel if you want or you can just say there [are] these four realms that all human beings have and that they're all important pieces of being whole and healthy.” Elsa, as a non-Indigenous White woman, also expressed some hesitancy to “teach

Indigenous teachings. I think sometimes it's disrespectful." Thus, similar to other participants, Elsa expressed cautiousness in using an Indigenous concept in her counselling practice.

While some clients were uncomfortable and hesitant with using the Medicine Wheel, Emma was not. In fact, she even asked an Elder about whether non-Indigenous professionals should be using this tool. She discussed the answer she received from the Elder:

Last week there was an in-service ... [a] unit in the Health Authority ... put on a presentation and I asked the Elder. He was a Métis Elder, and I asked him is it okay to use [the Medicine Wheel] as a non-Indigenous person. He said that 'it was knowledge ... It's not like Indigenous people own it. It's meant to be shared. It's meant to be used, respectively. Just recognize that that's the history of it.'

Emma told a story about one of her Indigenous youth clients who was trying to reconnect with her biological father; the youth's father had been making many changes in his life including connecting to more traditional practices. Emma suggested to the youth that one way she can connect with her father is to learn more about the Medicine Wheel from him. These varied experiences reveal participants' cautiousness about using this Indigenous concept, and if they used it, their desire to engage in an appropriate way.

### ***Bodywork***

Elsa, Jane, Emma, and Charlotte mentioned that they incorporate some type of bodywork into their practice. Several types of bodywork were used with Indigenous clients, including somatic work, eye movement desensitization and reprocessing (EMDR), biospiritual focusing (BSF—a form of focusing oriented therapy [FOT]), and music and dance therapies. Elsa spoke about her training in "somatic work" and "EMDR," and shared her experiences using these approaches:

So being aware of the body, which I think really fits for many clients who are Indigenous, being really in tune with what's happening in their body—not just staying in their head. I think being in your head seems to be more of [a] European concept where we can get cut off.

Elsa reported seeing great benefits from using bodywork with her Indigenous clients.

Similar to somatic work is biospiritual focusing (BSF). Jane, who has a body-oriented counselling practice, uses BSF to help clients understand how issues are stored in the body. She noticed that even though she practices holistically with both Indigenous and non-Indigenous clients, she observed that the spiritual aspect tends to come up more with her Indigenous clients. Emma expressed that she does not like to just do “talk therapy.” In addition to using elements of art, she likes to use music and movement in her practice. She shared, “If there's anything that I can help or direct them to, if dancing is therapeutic for them [or] some of the traditional art ... maybe I can educate myself in some areas.” Consequently, Emma had an expanded view of what constitutes bodywork in therapy that went beyond focusing on emotions in the body and included various creative outlets. Because there is a link between the body, emotions, and trauma, multiple participants expressed that bodywork is important to use when counselling Indigenous clients.

### ***The Two-Eyed Seeing Approach***

Some Indigenous scholars use the term “two-eyed seeing approach” to refer to the merging of Western psychological therapies and Indigenous traditional practices (Marsh et al., 2015). As part of practicing holistically, participants' responses varied from not integrating approaches to incorporating therapeutic drumming into trauma-based treatment. Not all participants felt they combined the two approaches in their counselling practice.

Jane explained that she is unsure if she combines Western approaches with Indigenous traditional ways. Because she uses a spiritual approach (i.e., BSF) with many of her clients, she shared that mainstream Western therapies, such as CBT are “the farthest thing from spiritual as far as I’m concerned.” Hence, Jane stated that many Western counselling approaches exclude spiritual aspects, whereas she focuses on the spiritual.

For Sophia, part of combining the two approaches is to offer her clients traditional ceremonies whenever she can. She works in an agency where there is a special room for those Indigenous Peoples who want to smudge. Consequently, along with using Western therapies (e.g., feminist and CBT approaches), she also offers her Indigenous clients an opportunity to practice their traditional ceremonies, such as smudging. Additionally, Sophia found that the feminist approach, which is her main theoretical orientation, combines well with traditional healing practices and has benefited her Indigenous clients; she also exclaimed that this approach honours people, is non-judgmental, and has an open, accepting view of people.

Emma practices the two-eyed seeing approach in several ways. First, she tries to explore her Indigenous clients’ culture to see if it is a strength for them. She contended, “If it’s a strength, [I] encourage them to continue [their cultural practices].” She also tries to connect her clients to an Indigenous person on her team or other community resources, if requested. Additionally, she incorporates community therapeutic drumming into her practice, as she believes it helps with self-regulation and can be integrated into trauma-focused treatments. Importantly, integrating traditional practices with Western approaches provides participants with the ability to offer strengths-based and culturally relevant approaches to their Indigenous clients.

## **Understanding and Respecting Indigenous Ways of Knowing and Doing**

Non-Indigenous mental health professionals need to be familiar with Indigenous ways of knowing and doing so they are aware of the importance of culture and Indigenous practices. Notably, because there are many Indigenous cultures, there is much “cultural diversity of Indigenous Peoples” (Indigenous Corporate Training Inc., 2019, para. 1). Participants were invited to share what Indigenous ways of knowing and doing they have encountered when working with Indigenous clients.

Both Charlotte and Jane stated that they often explore with their clients what they themselves have done that helps with the problem they present with. They encourage their Indigenous clients to keep doing whatever practices they are already engaged in. For example, Charlotte has asked her clients, “How does [this smudging] help you?” However, she is very cautious to not push her clients to practice any Indigenous teachings. Charlotte has encountered some clients who do not want anything to do with the Indigenous spirit cards she has in her office, while others “absolutely welcome it.” She stated, “They’re glad I got something of a Native belief system that we’re actually doing in [the] session. A couple ... asked me where I got the [oracle] cards from because they were going to get some.” This demonstrates the importance of letting clients lead by offering possibilities and options but allowing them to choose their own direction.

Jane has the freedom to ask Indigenous clients if they want to smudge in her private office, and many appreciate this “because they feel so much better after.” Other participants provide the option for clients to go to a special room to smudge at their request. Still, therapists must not assume that every Indigenous client wants this. Elsa, who works at an agency that has a smudging room, discussed clients’ varying preferences about where they like to smudge:

I think sometimes that would be maybe one of the assumptions that people make is that [Indigenous clients] want a room to be able to do that in, but many of the clients that I've worked with said that's something they do that's quite private and like to do in their own home.

If Elsa has an Indigenous client who wants to do some clearing of the room to create a better atmosphere, instead of taking her client to the smudging room, she offers them a sweetgrass atomizer that smells like sweet grass and is sprayed into the air. She stressed that this does not replace smudging but is an alternative to going to a “tiny room.” Hence, some participants have been creative in finding alternatives for clients to maintain their traditional practices.

Mia, who lives in a Métis community, stated that Indigenous ceremonies such as smudging are not commonly practiced there. She shared her observation that in her community, one of the Indigenous ways of knowing and doing is to build relationships that promote healing:

This is really a huge thing. If you have a kid that is off the rails—they're acting out, their contact is inappropriate, they're depressed, they're whatever, often the first response is to pair them with somebody in the community, usually an Elder, but not necessarily, who will spend time with them often doing traditional activities. So, it could be they go out trapping or fishing or ... building a boat or a skiff, or whatever, but that pairing of the relationship, and also that Traditional Knowledge, that connection to who you are, who your community is, what you're a part of, what's the larger picture, is very, very healing.

And I have seen it work with many, many kids.

Mia further expanded on the centrality of food in Indigenous communities. She claimed, “We turn to food constantly ... in times of crisis, you can almost guarantee that there's going to be food.” She further stated that “it's that communal sharing of the food that is deeply connecting

and deeply healing in profound ways.” Mia also discussed her belief in the link between the sharing of food and mental health:

The Western approach has not done enough to look into the importance of ... community and centring around food ... the growing of the garden, fishing ... hunting, scavenging, or searching for blueberries ... those approaches are actually beneficial for mental health. Building relationships and communal sharing of food are both Indigenous ways of knowing and doing that Mia has witnessed in the Indigenous community where she lives.

Ava noted that some Indigenous ways of knowing and doing she has learned about pertain to Elders and Mother Earth and these build “a sense of respect for both the community and for the client themselves, and how I need to respect that as well.” For example, she came to understand the importance of giving gifts, such as cloth or tobacco to show respect to Elders. Ava contended that when Elders share their knowledge with her, she learned that she, in turn, must offer them something like tobacco. Regarding the Mother Earth aspect of knowing, she learned to realize the importance of connecting with the land. Through the decolonization process, participants grew to respect various Indigenous ways of knowing and doing that lead them to have a deeper understanding of some traditional practices.

### **Appreciating Vital Components**

Participants were asked what components of mental health services they witnessed as facilitating successful outcomes for Indigenous clients. Some areas that were probed were culture, family, and community. The sub-themes are as follows: the therapeutic alliance; honouring family, culture, traditions, and community; and accessibility.

#### ***The Therapeutic Alliance***

Although the importance of the therapeutic alliance was stressed in many of the themes

and sub-themes, this is a critical issue in its own right. Participants made statements that identified the need to build a therapeutic relationship with their Indigenous clients. For example, most participants spoke about working hard to build trust by helping Indigenous clients feel safe and comfortable with them and in their office. In fact, several participants stated that they were aware that they do not know everything, that their Indigenous clients are the experts in their own lives, and that they want to follow their clients' lead in the therapeutic process. Furthermore, all participants' theoretical orientations involve person-centred, feminist, narrative, and integrative approaches that contribute to trust and rapport building.

Olivia stated that she needs to examine any assumptions she might have and not “bring those assumptions into the relationship.” For Ava, the therapeutic relationship with her Indigenous clients involves being sensitive to the ways she addresses them. She stated that “acknowledging and thinking about how you address somebody—calling them ‘my client’ might be too much and not be how they want to see it. You’re a support system instead. Things like that.” Accordingly, for Olivia and Ava, developing a therapeutic relationship involves being aware of biases and respecting how clients want to be addressed.

Receiving various training has also provided therapeutic value. For instance, besides training in shamanism, Charlotte has received training in dream work. She stated that it has been beneficial for some of her Indigenous clients who “want to work at [having their dreams analyzed].” In addition, part of Charlotte developing a therapeutic relationship with her Indigenous clients includes exploring “what their interests are.” For instance, she has encouraged some of her clients “to reach out to some of the Native artists. Let’s say they have artistic ability—to reach out to those groups. Get them involved in that, so they can promote [their] work.” Additionally, she supported another Indigenous client to take a university course in a



“historical Native language.” Because Charlotte received extra training and encouraged her Indigenous clients to explore their interests, this created an atmosphere to strengthen the therapeutic relationship between her and her clients.

Holly spoke about her strength in building therapeutic relationships with her Indigenous clients:

Call it luck. Call it what you want. I’ve had really good relationships with my Indigenous clients. I can’t put a real finger as to why, but the only thing I can think of is because I accept them ... exactly where they are.

The above examples suggest that participants prioritized the therapeutic alliance with their Indigenous clients, relationships that were characterized by believing their clients are the experts in their own lives, valuing Indigenous worldviews, and respecting and accepting clients for who they are as people.

### ***Honouring Family, Culture, Traditions, and Community***

Participants shared that family, culture, traditions, and community are very important for many of their Indigenous clients. Holly witnessed family as central to her Indigenous clients. She emphasized that if mental health professionals do not investigate family relationships using some version of family systems theory, counsellors are “going to miss out on a lot because ... family is so important [to Indigenous Peoples], and it’s such a big piece, and there’s so much loss and hurt associated with that too.” Furthermore, she observed that “who they call auntie may be a cousin or ... anyone that they’re really close to,” even a “family friend.” She shared that the concept of family needs to be broadened and understood to comprehend the individual, as they are part of this larger family system. She stated, “I think taking a look at that family piece is vitally important to be successful.” Holly’s personal experience demonstrates that when counsellors

have training in family systems, this might help them explore the collectivist values embedded in the concept of family rather than viewing clients through an individualistic lens.

Ava also witnessed that family is important to her Indigenous clients. She shared her experience of involving a client's relative in the therapy process. She spoke about an aunt who brought her two-spirit nephew to counselling. This nephew "wanted to address the fact that they were coming to terms with being two-spirited and how important it was to their culture, and how I could work with it and not be oppressive in any way." The successful outcome of these sessions was Ava's discovery about how to support one family's process:

The client who was two-spirited was able to express themselves more clearly. So, they were able to speak with other family members, as the term is "coming out" to their family members ... They felt more, I think ... it was ... like a sense of pride in who they were and not ashamed ... [the aunt] just wanted to make sure we were all working on the same page because the person was living with her at the time.

Consequently, including family in the therapeutic process can help Indigenous clients feel supported and accepted.

Several participants stated that their Indigenous clients' cultures are important to them. Even though Holly thought that family was the highest priority for her Indigenous clients, she stated that culture is also significant. She believes it is essential to explore "what parts of their culture they've accepted [and] what parts of their culture they have not accepted" and to adapt her interventions around this knowledge. She stressed that it is essential to never assume that when people are Indigenous, they are practicing Indigenous spirituality. She shared that "if they are, great; if they're not, that's okay too." Holly noticed that many of her clients feel disconnected from their culture and want to reconnect. She claimed that her job is to help them

reconnect to their cultures by exposing them to different Indigenous agencies, Elders in the community, and other resources.

Charlotte also observed that culture is important to some of her Indigenous clients. She stated, “Some people are ... really wanting to preserve their culture[s] ... some of [them] wanting to speak up more about it—like bring it more to the foreground because it’s been so much in the background in the past.” For example, she spoke about having had clients who were poets and who wrote articles. Charlotte was willing to support her clients in whatever way she could to help them become more connected to their cultures.

Olivia stated that the culture, family, and community are all important to her Indigenous clients. Even if her clients are experiencing struggles with their family, community, or culture, these aspects are still integral to their lives. She shared a story about a client and his connection to community:

One of my clients was having difficulty within their community, and it’s like, why is this so difficult for you? Because [the] community was really important to him ... And that was something that just had to be raised up, like examining the importance of that. She was able to support her client in working through this difficulty and helping him reconnect with his community. Olivia supported him in reconnecting in the following way:

Using my knowledge about that structure in the community and suggesting in a non-suggesting kind of way that the client seek out counsel within the community. It was interesting because this client, for example, it was in his personal history, his past to rely on ceremony ... but he didn’t rely so much on ceremony when he was seeing me, and just in our discussions he became more open to relying on that and it was very important to

him, but he wasn't relying on it. So, through our sessions and our discussion, I saw an increase in reliance on [ceremony].

Hence, supporting Indigenous clients with their families, cultures, and communities is considered vital to the therapeutic process, so that clients feel these aspects of their lives matter and are respected.

### ***Accessibility***

Accessibility is central to providing adequate health care. For example, Elsa shared that Indigenous clients need to be able to have options, such as access to an Indigenous counsellor and/or Elder if they wish. Even though her clients shared their stories with her, at times they just wanted someone to know what it was like to walk in their shoes instead of having to discuss their experiences. Elsa expressed that because she is not an Indigenous woman, she cannot know nor pretend to know what it is like to be an Indigenous person. She stated that the agency where she works lacks diversity and cultural experiences to offer clients, and she would like there to be more.

Indigenous persons often face major barriers when needing health services (In Plain Sight, 2020). Two participants highlighted the barriers and challenges their Indigenous clients experience. Both Emma and Mia spoke about the importance of accessibility as a vital component of providing mental health services to Indigenous clients. Emma shared about the various barriers that Indigenous Peoples face, especially during a pandemic (COVID-19). She explained that some of her clients do not even have a home phone, while others do not have transportation. She shared that the agency where she works provides bus tickets for those Indigenous youth to get to their counselling appointments. Furthermore, during the pandemic, this same agency started to feed some Indigenous families who “don't have a lot of money.” She

explained that “if there’s a way creatively—if there’s a budget for providing some of these resources, steering [her Indigenous clients] to the right community resources that they can get those things is really important.” Mia witnessed Indigenous parents who were unable to access their child’s medication or lacked the ability or means to take their child to a larger centre for an eye exam. Both practitioners helped find resources for their clients and/or their parents to navigate systems. These varied experiences reveal the challenges some participants faced when trying to help Indigenous clients access different supports.

### **Commitment to Lifelong Learning**

Many participants expressed the importance of their own education to ensure the best possible service to their Indigenous clients. Educating themselves about the background and history of Indigenous cultures and individual clients was paramount to decolonizing their practice. Importantly, clinicians need to have increased knowledge of how the effects of historically traumatic events have affected and are still affecting communities and individuals. This, in turn, might help inform both mental health interventions and counselling for Indigenous clients. Four sub-themes are explored: learning about colonization; residential schools and the Sixties Scoop; professional development; and finally, recommendations to other mental health professionals.

### ***Learning about Colonization***

Several participants expressed their views about the harmful effects of colonization and what they have learned about the ways Indigenous Peoples have been and are still being affected by colonialism. For instance, Charlotte spoke about European settlers who took away Indigenous Peoples’ lands, as well as “impos[ed] our standards of both our justice and what is fair. Sometimes, I think it was partially just greediness, self-righteousness—people thinking they are

more important.” Both Charlotte and Elsa felt disgusted about the ways in which Indigenous Peoples have been colonized throughout the decades. Charlotte voiced her disgust over the lack of truth in some of the history books. She shared that “the anthropologist[s] couldn’t tolerate the fact that [an Indigenous] woman was in charge with these [longhouses] ... they didn’t record the truth. They didn’t put down the fact that these longhouses—that the women were the chiefs.” Charlotte tries to honour her Indigenous clients’ traditions. She stated that “some people also need to hear that the Native culture is valuable, and we can learn from it. And [Indigenous Peoples are] part of the fabric of Canadian society, and their history has been suppressed.” Elsa expressed her disgust about the arrogance in colonization. She claimed that the “[residential school system is] a really good example of colonization ... deciding we as the dominant culture knows what’s best for everybody else. It’s really quite disgusting.” These examples reveal how Charlotte and Elsa strove to support their Indigenous clients by seeking education about the dark side of Canada’s history of colonialism.

Emma shared that part of decolonization is understanding Indigenous Peoples’ history and learning about clients’ experiences to understand how their family history impacted them. Jane claimed she has a good comprehension of colonization. She stated that she “understand[s] what colonization did and why there’s that disempowerment—that dispiritedness, that loss of connection with [the] Creator.” Therefore, both Emma and Jane felt it was crucial to their practice to have gained knowledge about how colonialism has affected Indigenous Peoples’ families and their spirituality.

Several participants shared they were educated on the history of Indigenous Peoples at university. Charlotte talked about taking courses on the history of native settlements. Elsa stated that when she took her first Indigenous Studies class, “[it] really changed my world—just having

an understanding in a way that I had never received education before around ... the history— looking at history from a different lens than I had been introduced to.” Ava also took Indigenous Studies courses, as well as anti-oppressive courses. She shared that this education has helped her understand her own unearned privilege as a White person, such as experiencing fewer hurdles in her life and situations that proceed smoothly.

Sophia expressed that she wants to keep “up to date with things like the Missing and Murdered Indigenous women inquiry and the Truth and Reconciliation calls to action and not just checking off a box and saying, ‘I did the work. I'm done.’” For her, it is about revisiting this learning and doing the internal work that is necessary. She shared that she “really do[es] believe that work is truly never done, and ... remind myself not to get too comfortable because there's always more that I can learn.” For this reason, Sophia discussed her plans to continue to decolonize and Indigenize her practice. Continual education about the harmful effects of colonization was important for participants to understand the historical and intergenerational effects of colonialism.

### ***Residential Schools and the Sixties Scoop***

Several participants stressed the need for counsellors to obtain knowledge about the harmful effects of colonial practices, such as the residential school system and the Sixties Scoop. Ava shared that some of her Indigenous clients have “hurt and pain from experiences they’ve had, such as residential school and how it has disconnected them from their families.” Because of these traumatic experiences, some of her clients have anxiety about approaching “other White people and asking for help.” She stated, “It’s been really interesting to see how I can help even though I’m not Indigenous myself.” Ava claimed that decolonization means “acknowledging that there [have] been atrocities that have happened throughout history due to colonialism, such as

residential schools or [the] Sixties Scoop ... so looking at that and acknowledging and moving forward and asking what they need to heal.” Therefore, Ava highlighted the intrinsic value of acknowledging people’s experiences and realities as a first step in moving toward healing.

Elsa shared that she has had conversations with her Indigenous clients about residential schools and the stereotypes and stigma many of them have faced. She explained that some of her clients wanted to explore healing around the residential school experience, “but what they wanted from me, as a White woman, was to acknowledge their pain and the wrongness of what was done.” The participants’ experiences with their Indigenous clients speak to the multiple ways colonialism has negatively affected Indigenous Peoples’ lives, including the intergenerational trauma they have experienced and the necessity of counsellor education on these colonial past events in order to help Indigenous clients heal from this trauma.

### ***Professional Development***

Continuing education on Indigenous topics and issues was a priority for participants, and several individuals expressed that learning about decolonization is a lifelong process. Elsa shared that she continues to educate herself on the topic of cultural sensitivity, which is “a constant piece of everything that I do.” She also attended a conference on the Red Dress program that brings “awareness around how women who are Indigenous are victimized because of the colour of their skin.” Olivia, a psychologist, claimed that she would “very much like to do some more continuing education, specifically by Indigenous psychologists [about] ... providing mental health care for Indigenous clients.” Thus, both Elsa and Olivia prioritized ongoing education for the purpose of increasing cultural sensitivity and providing decolonized mental health services.

Emma specified that she tries to take advantage of professional development in the areas she is interested in, such as how to work with Indigenous Peoples and decolonize mental health



practices, and anti-racism topics. Charlotte’s training involved shamanic healing, and she has taken additional courses in the Medicine Wheel. She shared that there are five psychologists in a large prairie city alone who implement shamanic treatment, but “you have to be careful who you tell this to because the way the Psych[ology] Association is, they’re so wrapped up [in] it’s got to be scientific.” In Ava’s continuing education, she learned about two-spirit people and has joined various Facebook groups, such as “Be A ConnectR (n.d.) ... they offer recommendations as well following the Truth and Reconciliation.” These examples of educational training illustrate how seriously some participants regarded their ongoing professional development.

### ***Recommendations to Other Mental Health Professionals***

Participants were asked about the essential recommendations they have for non-Indigenous mental health professionals who want to decolonize their practice. Several participants expressed the importance of educating oneself either through reading, having conversations with other Indigenous persons, using YouTube videos to learn about different topics, joining webinars, taking courses, and/or looking for continuing education credits on decolonization.

Olivia specifically suggested that a good place for clinicians to start is to work with a team that includes Indigenous mental health professionals. Ava recommended that other mental health professionals need to “absorb what [they are] educating and practice it—not just learn from the surface.” Sophia elaborated that clinicians should start talking to Indigenous Peoples about what is it like for them to have a counsellor who is not Indigenous. Further, she suggested asking Indigenous clients what assumptions and stereotypes people have made about them. Then clinicians can gain a greater understanding of the microaggressions they might be inflicting without even being aware. Sophia claimed, “That was a really important place to start ... you've

done a lot of the work, and you've decolonized a lot, but there are things you don't know.” The above examples demonstrate that it is important that clinicians are informed that decolonizing their practice needs to be a continuous process.

Holly stated that integration is important, such that clinicians should “do some things where you are actually integrating into the culture.” She explained, “If [clinicians] have the opportunity to participate in an Indigenous ceremony, take that opportunity ... where there’s a blanket exercise or it’s a feast or it’s a Pow-wow ... check it out for yourself.” Additionally, Emma recommended that mental health professionals embody a non-judgmental, non-biased approach when listening to and working with Indigenous clients, while at the same time, “really be mindful of what your own history is, your own privilege, your own hardships, your own experiences, and how that influences how you practice. Appreciate each other and just appreciate our strengths, appreciate our differences.” Therefore, participants recommended several ideas for non-Indigenous mental health professionals to expand on how they can improve their practice to better meet the needs of their Indigenous clients.

## **Summary**

This chapter highlighted nine non-Indigenous mental health professionals’ experiences in decolonizing their practice. Reflective of the basic interpretive qualitative approach, I endeavoured to understand the meaning that participants constructed about their lived experiences of working with Indigenous clients. The qualitative data were categorized into six themes, and all but one theme had sub-themes. The first theme, *decolonizing*, included ways the participants decolonized their practice, racism, overcoming biases, prejudices, and assumptions, and interventions they found effective. The second theme, *being a cultural ally*, highlighted the importance of cultural allyship, advocating on clients’ behalf, the challenges faced as a cultural

ally, and practicing cultural humility. The third theme was titled *practicing holistically*. Participants specifically identified ways they practiced more holistically, including exploring spirituality, accessing nature, the Medicine Wheel, bodywork, and the two-eyed seeing approach. The fourth theme, *understanding and respecting Indigenous ways of knowing and doing*, explored various Indigenous learning participants experienced in their practice, as well as how they observed Indigenous teachings and traditions. The fifth theme, *appreciating vital components*, discussed the importance of developing a therapeutic alliance, and the importance of family, culture, traditions, community, and accessibility that assists Indigenous clients in their healing journey. The final theme, *commitment to lifelong learning*, examined the importance of non-Indigenous mental health professionals having knowledge about colonization and continually engaging in professional development. Additionally, recommendations to other mental health professionals were discussed. In Chapter Five, I discuss the relevance of this study's findings for mental health practices and research and emphasize potential future research directions.

## Chapter Five: Discussion

This research project explored how non-Indigenous mental health professionals work together with their Indigenous clients to support clients' mental health and well-being. To accomplish this, I interviewed nine non-Indigenous mental health professionals who were open to discussing their experiences with decolonizing their counselling practice and mental health services. I invited participants to talk about what they found helpful with decolonizing their practice, as well as how they became cultural allies and practiced cultural humility.

I used the basic interpretive qualitative research framework (Merriam, 2002) to analyze and investigate participants' stories on how they decolonized their practice. Using thematic analysis (Braun & Clarke, 2006), six themes emerged, five of which had sub-themes. The first theme, *decolonizing*, illustrated the various ways in which non-Indigenous mental health professionals decolonized their practice. The four sub-themes were as follows: ways non-Indigenous mental health professionals decolonized their practice; racism; breaking down biases, prejudices, and assumptions; and interventions. The second theme, *being a cultural ally*, was divided into nine sub-themes: the importance of becoming and being a cultural ally; referrals; acknowledgment and awareness of privilege; use of Indigenous artifacts in office space; advocacy and social justice involvement; experiential learning; how becoming a cultural ally impacted professionals' sense of self; challenges faced as a cultural ally; and cultural humility.

The third theme, *practicing holistically*, included the sub-themes of spirituality, accessing nature, the Medicine Wheel, bodywork, and the two-eyed seeing approach. The fourth theme, *understanding and respecting Indigenous ways of knowing and doing*, explored the importance of non-Indigenous mental health professionals' knowledge of the various Indigenous teachings and how clinicians encouraged their clients to pursue these traditional practices. The fifth theme, *appreciating vital components*, included the following three sub-themes: therapeutic alliance;

honouring family, culture, traditions, and community; and accessibility. The last theme, *commitment to lifelong learning*, included the following four sub-themes: learning about colonization; residential schools and the Sixties Scoop; professional development; and lastly, recommendations to other mental health professionals to enhance their learning about decolonizing their practice. This chapter discusses the results presented in Chapter Four in the context of other literature. In addition, the strengths and limitations of the study are examined, as well as implications for counselling practice and directions for future research.

### **Decolonizing**

The purpose of the study was to explore non-Indigenous mental health professionals' experiences in decolonizing their practice. Although there is some research on how educators decolonize their classrooms, there has been scarce information collected on the decolonization of mental health practices and services. The initial literature review yielded only three studies that explored the decolonization and Indigenization of mental health services. Furthermore, most research on non-Indigenous mental health professionals' experiences with decolonization has been conducted in New Zealand and Australia. To my knowledge, this is the first study to have explored this phenomenon with non-Indigenous mental health professionals in Canada.

This theme, *decolonizing*, demonstrated what the term “decolonization” meant to non-Indigenous mental health professional participants. Notably, it can be difficult to operationalize the concept of decolonization. In fact, Fellner (2018) argued that she has “heard countless definitions and varied understandings of what decoloniality means and entails” (p. 284). Since many Indigenous Peoples have experienced colonial trauma from the residential school system, forced relocation, and the Sixties Scoop (CPA, 2018; Duran, 2006; Kirmayer et al., 2009; Waldram, 2004), I believed it was important to explore how non-Indigenous mental health

professionals viewed the topic of decolonization. Sium et al. (2012) stated that decolonization rejects the colonial attitude of power. Consequently, it is difficult work to decolonize, but it is vital that connections between non-Indigenous people and Indigenous Peoples be made so that both groups can flourish (Smith, 2008).

Many participants in the study articulated that decolonization is a much-needed process in the mental health field. They spoke about striving to deconstruct colonial attitudes and always aiming to learn more to avoid becoming complacent with their current level of knowledge. Clinicians need to know about cultural safety and be inclusive of different cultures (Health.Vic., 2020). Cultural safety involves creating an environment where Indigenous clients feel safe and do not have their identities and experiences denied (Health.Vic., 2020). Several participants in this study shared that some of their Indigenous clients did not know their culture while growing up but wanted to begin practicing their traditions. Although there were harmful effects of colonization and residential schools, Indigenous Peoples are determined to revitalize their knowledge, language, and cultural practices (Dei, 2000). Part of the clinician's role is to support them when they express interest in further exploring various aspects of their cultures.

As reported within this study, participants decolonized their practice in various ways. Several participants spoke about trying to find resources for clients who wanted to explore their cultures. Stewart (2008) argued that Indigenous Peoples find strength in their cultural identity, and because of the "cultural oppression and social marginalization" (Kirmayer et al., 2009, p. 7), Indigenous Peoples have endured at the hands of the colonizers, there has been high rates of mental health issues (Kirmayer et al., 2009). Conversely, those communities that emphasize cultural continuity report less suicide (Chandler & Lalonde, 1998). Some participants in the present study found that it was beneficial to consult with an Elder. This aligns with Thomason's

(2011) argument that to understand Indigenous clients, non-Indigenous mental health professionals could meet with Elders or Indigenous mentors. One participant wished that there was an Elder to support Indigenous clients at the agency where she works, as she believed this is a missing component at her workplace. Hadjpavilou et al.'s (2018) and Tu et al.'s (2019) studies revealed that when Indigenous persons were connected with an Elder, they experienced mental health improvements.

Some participants found that to decolonize their practice they needed to be flexible, which involved practices such as meeting clients in various locations other than an office. They also learned to be authentic and open and to ask questions. For example, participants spoke about being humble, admitting when they might have made a mistake, remaining open to clients' spirituality practices, and asking questions that were sensitive and respectful. Howell-Jones (2005) argued the importance of counsellors being open and curious when learning about Indigenous traditions and practices. Some participants expressed that they intentionally avoid participating in colonization and work hard to not be patriarchal or controlling by refraining from giving advice to their Indigenous clients. Being respectful to and flexible, open, and authentic with Indigenous clients aligns with Carl Rogers' (1957) core conditions, including "(1) congruence (genuineness or realness), (2) unconditional positive regard (accepting and caring), and (3) accurate empathic understanding (an ability to deeply grasp the subjective world of another person"; Pierce, 2016, para. 3).

Unfortunately, racism is still present in Canadian society. Although it is not as covert or prevalent as it was decades ago (Dixon, 2011), racism still exists. Canadian policies such as the *Indian Act* of 1876 "maintains the paternalistic attitude and colonialist relationships to this day" (Graham-Marrs, 2011, p. 24). Briefly, the *Indian Act* determines who is entitled to be registered

as “Indians” (Government of Canada, 2021). According to the *Indian Act*, an Indian is defined as “a person who pursuant to this Act is registered as an Indian or is entitled to be registered as an Indian” (Government of Canada, 2021, p. 2).

Although the *Indian Act* has had several amendments, it still functions as an assimilation policy for Indigenous Peoples in Canada, including the unfulfilled promises of treaty rights (Christian Aboriginal Infrastructure Developments, n.d.). One participant spoke about the unfair treatment of Indigenous Peoples in both the justice and child welfare systems. Additionally, Indigenous Peoples, both on reserves and in urban cities, continue to experience difficulties accessing health care. In urban areas, where health care is more easily accessible, Indigenous Peoples reported experiencing higher rates of discrimination strictly based on their Indigenous identity (Browne et al., 2017; Evans et al., 2014).

Several participants learned negative stereotypes about Indigenous Peoples from their childhoods. For some individuals, it was their parents who were racist, while others grew up in small farming communities where there were prejudiced attitudes toward Indigenous Peoples. For participants, being aware of racism involved working hard to practice self-awareness, as well as self-critiquing their thoughts, actions, and motivations. One participant shared that she asks herself questions about her perceptions and confronts and educates others about their use of racial slurs. Participants claimed that the more educated they were on the history of Indigenous Peoples in Canada (e.g., experiential learning, educational training, etc.), the more empathy they had toward their Indigenous clients. By seeing the world through “someone else’s eyes” (Dixon, 2011, para. 1), counsellor empathy can contribute to reducing racism.

All participants noted the importance of breaking down their biases, prejudices, and assumptions as part of decolonizing their practice. If mental health professionals are not aware of



these assumptions, then Indigenous Peoples will continue to feel oppressed (Indigenous Corporate Training Inc., 2017). Bennet et al. (2011) argued that the process of decolonization involves critical self-reflection and self-awareness of any “biases, prejudices, stereotypes, and assumptions that inform our world views” (p. 31). A few participants in the present study spoke about how their post-secondary education on anti-oppressive topics and Indigenous Studies helped them be more aware of their biases. As mentioned in the literature, psychologists need to be aware of their implicit biases to help achieve a strong therapeutic relationship with their Indigenous clients (CPA, 2018). Furthermore, reflective counsellors “are aware of their own strengths and limitations” (Poletto, n.d., p. 5). Client feedback can also be beneficial, allowing the clients to evaluate their counsellors on their approaches so they can change accordingly. In addition, counsellors need to maintain ongoing awareness that they must support clients’ values in their counselling practice, rather than their own values and beliefs (Poletto, n.d.). Peer review and professional supervision are other methods that can help clinicians increase awareness of their biases and assumptions (Poletto, n.d.). As well, one participant in Bennet et al.’s (2011) study suggested that clinicians need to be more aware of and understand their motivation in wanting to work with Indigenous Peoples. Reflective counselling also involves reflecting on the anxiety and doubt that might surface when working with Indigenous clients. Furthermore, being able to respond to clients’ angry responses at another person or the system with humbleness and sincerity develops “cultural courage” (Bennet et al., 2011, p. 26), leads to respectful practices, and helps to not internalize this anger (Bennet et al., 2011).

Many participants in this study voiced that part of their interventions involved being respectful toward Indigenous clients’ healing journey. The Canadian Psychological Association (CPA, 2018) argued the importance of developing humility when working with Indigenous

Peoples. Participants practiced humility by admitting that their Indigenous clients are the experts in their own lives and do not want to portray a “know-it-all” attitude. Several participants shared they want to make sure that they express genuineness in their interventions by asking questions that are appropriate, sensitive, and curious. Although not specifically stated, participants shared how their clients contributed to their own design of interventions. For example, some clients learned ways to connect more with their community, while another returned to participating in ceremony while in therapy. Participants’ interventions varied as they decolonized their practice, ranging from not taking any notes (Thomason, 2011), listening (Rogers, 1957), not expecting clients to teach clinicians about their culture, to acknowledging how two-spirit persons want to be addressed on a certain day.

### **Being a Cultural Ally**

The second theme was *being a cultural ally*. Cultural practices and traditions are vital to the healing process for Indigenous Peoples (Kirmayer et al., 2003). Participants practiced cultural allyship by gaining knowledge and understanding of Indigenous cultures and ceremonies, such as smudging and shamanic healing. Some individuals expressed the importance of taking part in ceremonies themselves to learn more about their clients’ cultures. For example, a few participants mentioned that they smudge at home.

Being a cultural ally might mean counsellors need to step out of their comfort zones and challenge any pre-conceived notions and stereotypes they might have about “race, ethnicity, oppression, power, and privilege” (Bowden et al., 2017, p. 54) in their lives. Furthermore, it is crucial that therapists become involved in ceremonies with sincerity and respect (Bowden et al., 2017). Some participants in the present study expressed that they are open and flexible in how they run their practice. For example, accepting clients as contacts on social media pages and

having a sliding fee scale might help clients feel more comfortable and accepted. Additionally, several individuals shared that they want their offices to be safe places for their Indigenous clients.

Unfortunately, Indigenous Peoples have often been reluctant to receive mental health care in some larger cities in Canada partly because clinicians have not practiced “cultural sensitivity” (Kirmayer et al., 2000, p. 181). In the present study, many participants practiced cultural sensitivity by being aware that they lacked the knowledge of ceremony and traditions and consequently were more comfortable guiding their clients to outside resources. The feedback that participants received was that their Indigenous clients appreciated that their therapists knew about and accessed various referral sources. In the opinion of Oulanova and Moodley (2010), it is vital that mental health professionals refer and collaborate with traditional helpers to help assist with their Indigenous clients’ mental health care. Therefore, valuing Indigenous agencies and resources positively contributed to Indigenous clients receiving the best care possible.

Acknowledging one’s privilege is an important aspect of being a cultural ally to Indigenous Peoples. Several participants shared that they are diligent at being aware of their White privilege when counselling Indigenous clients. This self-awareness of White privilege and acknowledgment of the power differential between Whites and non-Whites is vital for clinicians to decolonize their practice (Young, 2005, 2008). One participant tried to consciously use her privilege for good when she helped her clients have more of a voice in the justice and child protection systems. Others shared that they needed to remember that their experiences as non-Indigenous persons are very different from their Indigenous clients, as they do not experience the daily microaggressions their Indigenous clients endure. Hopefully, by being aware of their privilege, non-Indigenous mental health professionals can promote anti-racism and reduce the

power inequities that exist between privileged and oppressed groups (Paradies, 2005), such as Indigenous Peoples.

One of the ways that helps Indigenous Peoples access health care is to create a comfortable, welcoming place (Benoit et al., 2003) that includes cultural artifacts (Lantz et al., 2003). Surprisingly, four participants made a point of having various Indigenous artifacts in their office, including pictures (Thomason, 2011), books on spirit animals (Hart, 2002; Hill, 2017), Indigenous music, Indigenous nature spirit cards, and river stones. In response to seeing the Indigenous artifacts during counselling sessions, some Indigenous clients spontaneously shared stories about their childhood. Therefore, it is valuable for non-Indigenous mental health professionals to have “action-oriented knowledge” (Smith et al., 2006, p. 116) about various topics, such as spirit animals and/or the meaning of river stones.

Being a cultural ally is about being an advocate, which requires commitment and practice (Goodman, 2011). Some participants in the present study were committed to advocating for their Indigenous clients, specifically regarding the TRC’s (2015) calls to action. Fellner (2016) argued that mental health professionals need to be more familiar with community-based movements, including the TRC. Unfortunately, some participants expressed discouragement and wished their agencies or institutions would do more to implement reconciliation ideas, be stronger advocates, and support Indigenous clients. Consistent with this, Nimmagadda and Bromley (2006), who have worked with Southeast Asian-American populations, found that family-service and community agencies do not often meet the needs of diverse groups, such as Indigenous populations.

Another example of being a cultural ally is attending experiential workshops with genuine intent. Five out of nine participants took part in an experiential learning opportunity, the

KAIROS (KAIROS Canada, 2020) blanket exercise. This interactive learning experience has the potential to help non-Indigenous mental health professionals become greater allies for Indigenous Peoples. Several participants noted that this exercise was powerful and helped them have a deeper understanding of what Indigenous Peoples experienced with colonization. Furthermore, the exercise helped some participants gain a deeper level of empathy that no amount of textbook reading could achieve. According to Baldasaro et al. (2014), some of the benefits clinicians obtained from partaking in the blanket exercise included having a better understanding of how Indigenous Peoples of Canada lost their land, in addition to gaining a greater awareness of and respect for Indigenous cultures.

Being a cultural ally impacted several participants' sense of self. Many individuals shared that it has helped them become better people who are less judgmental, more compassionate, and more understanding of Indigenous cultures. One participant shared that being a cultural ally has helped her have increased compassion and empathy toward her Indigenous clients, rather than pitying them. Rather than pity, Gaita (1999) argued that the history of Indigenous Peoples needs to be acknowledged and time must be spent reflecting on this. Another individual in the present study, who is non-White, spoke about how she has used self-disclosure about her race and colour to help her Indigenous clients feel more accepted and comfortable. In Thomason's (2011) study, it was suggested that counsellors self-disclose about their lives to Indigenous clients, as it has the potential to "elicit client talk" (p. 2).

Multiple participants revealed that they had faced challenges as cultural allies. One participant shared that she felt judged by other Indigenous persons when she showed an interest in attending various ceremonies. She stated that they saw her as being insincere. This example reveals that it takes work for non-Indigenous mental health professionals to practice allyship and

that they cannot assume they will be considered an ally by all Indigenous persons. Consequently, clinicians have many more steps to take to be recognized as cultural allies to Indigenous Peoples.

Some participants recognized that they have progress to make in their decolonization efforts, as they still had some biases toward Indigenous Peoples. They stated that they must continually be aware of their biases, prejudices, and assumptions. One participant wished she knew more about Indigenous cultures, and others admitted that they still have much to learn. Mental health professionals' lack of understanding and knowledge of Indigenous Peoples can be a barrier for Indigenous persons to seek counselling (France et al., 2004). Indigenous clients can benefit when practitioners recognize the limits to their knowledge and keep this in mind as they counsel Indigenous persons.

Cultural humility means being aware of one's privilege and being "multiculturally competent" (Shaw, 2016, para. 1). When participants were asked how they practiced cultural humility, several individuals were not familiar with the term. For those not familiar with the term, I read them the definition of cultural humility that was in the interview guide. Many participants stated that they practice cultural humility by gaining awareness of their biases, privileges, and assumptions. However, some participants also stated that cultural humility involves openness, curiosity, being non-judgmental, attuned listening, and providing a safe place. Being open and asking questions helps counsellors to address and allow their clients to share their cultural identity (Shaw, 2016). Hook et al. (2013) argued that when mental health professionals work with Indigenous clients, they need to continually practice cultural humility by valuing clients' cultures, asking questions, and being curious about the client's cultural perspectives. Dei (2000) claimed that many Indigenous Peoples want to tell their stories. Several

participants shared how they became more empathic after attending experiential exercises and changing their own biased attitudes.

### **Practicing Holistically**

The third theme, *practicing holistically*, involved discussions about spirituality, accessing nature, the Medicine Wheel, the use of Indigenous artifacts, bodywork, and the two-eyed seeing approach. Several authors are focusing on the holistic wellness of Indigenous Peoples (Fiske, 2008; Hart, 2002; Linklater, 2014; McCormick, 1996; Mehl-Madrona, 2003; Ross, 2014). One way that the participants in the present study practiced holistically was to acknowledge the importance of spirituality in their Indigenous clients' lives. Spirituality permeates healing and trauma work and must be considered as part of a holistic approach to mental wellness (Duran, 2006; Ross, 2014; Paulsen, 2010). Many scholars have argued that spirituality is becoming increasingly important when counselling Indigenous clients (France, 1997; Garrett & Herring, 2001; Herring, 1992; LaFromboise et al., 1990; Pedersen, 1998, 2000; Sue & Sue, 2003). When colonization occurred, many healers were forced to secretly practice their traditions (Ontario Human Rights Commission, n.d.). Two participants have used their training in shamanism to support some of their clients. Another participant expressed that in the Indigenous community where she lives, the members are religious but not in a traditional sense; for example, they identify as Catholic or Christian. Some participants made a point of asking their Indigenous clients about their spirituality. One scenario that did not come up in the interviews was the example of Indigenous clients who combine traditional spirituality with their Christian beliefs.

Accessing nature is another way that some participants practiced holistically. Exposure to nature can help reduce anxiety and may improve one's overall mental health (Phillips, 2018). In

this study, depending on the participants' work environment (i.e., agency, institution, private practice), the flexibility to have sessions outdoors with their Indigenous clients was helpful. Some participants spoke about taking walks with their Indigenous clients in the woods or by a river or sitting at a park on the grass. One participant even noticed that being in nature appeared to have a greater positive impact on her Indigenous clients than on her non-Indigenous clients.

Although some participants accessed nature with their Indigenous clients, there was little discussion about nature or land-based practices. Considering connection to the land is a vital part of Indigenous well-being (Walsh et al., 2020), it is surprising that only one participant, who lives in an Indigenous community, went into depth about any land-based interventions. She spoke about Indigenous Peoples' connection to the land through hunting, fishing, building canoes, and berry picking. Land-based interventions are embedded in the land, involve Traditional Knowledge and ceremonies, and have spiritual significance (Plaskett & Stewart, 2010). Since being connected to the land is important for many Indigenous Peoples, mental health practitioners could use nature as a powerful tool for health and resilience.

The Medicine Wheel was one of the tools participants used as part of a holistic approach, depending on their comfortability. The Medicine Wheel has been used in various Indigenous communities as a healing method, where all four aspects (i.e., mental, physical, spiritual, and emotional) are related to each other, and the needs in each one must be met for personal growth and healing (Graham & Stamler, 2010). Some participants spoke about being uncomfortable using the Medicine Wheel, although if their Indigenous clients asked to use it, they would implement it in their practice. Nevertheless, according to Linklater (2014), it is important to be familiar with all four aspects of health and well-being, as is reflected in the Medicine Wheel. One participant shared that after she had discussed the Medicine Wheel with an Elder and asked



if it was proper for non-Indigenous professionals to use it, she became more comfortable with the tool and found it helpful to use with some of her clients. This finding indicates that the more clinicians become comfortable with the Medicine Wheel, the more they learn about it. Notably, one participant shared that she has found that the concept of the Medicine Wheel has been useful for her non-Indigenous clients as well. In sum, participants were careful not to misappropriate the Medicine Wheel by acknowledging that this teaching has an Indigenous origin.

A holistic approach to therapy involves more than the cognitive focus of counselling; it also includes the spiritual and physical aspects (Stewart, 2008). Several participants shared how bodywork was successful with their Indigenous clients. Some examples of bodywork involved somatic work, eye movement desensitization reprocessing (EMDR), biospiritual focusing (BSF), drumming, and dancing. One participant believed strongly that issues are stored in the body, while another found she needed to use more than “talk therapy” with her clients. One participant noted that bodywork seemed to work well for her Indigenous clients and suggested that remaining in one’s thoughts or cognitive process is more of a European concept. Fellner (2016) contended that a form of FOT called Aboriginal focusing-oriented therapy (AFOT) has been helpful for Indigenous clients who have experienced trauma.

The two-eyed seeing approach is another way that clinicians practice holistically. As discussed in the literature review, Marsh et al. (2015) argued that this approach helps clinicians understand the harmful effects of colonialism. One participant shared that she has combined Western therapies, such as CBT, with Indigenous spirituality. Beck (1995) contended that CBT has been a popular approach with Indigenous clients. However, it should be noted that some scholars are cautious when using CBT (Nowrouzi et al., 2015). Importantly, these scholars argued that when counsellors emphasize non-Indigenous cultural values when using CBT with

Indigenous clients and do not make vital “cultural adaptations” (Nowrouzi et al., 2015, p. 34), this can perpetuate the historical colonialist practices, which Indigenous Peoples have experienced (Nowrouzi et al., 2015). Other participants have used person-centred and feminist approaches with traditional practices by offering Indigenous clients the opportunity to smudge during counselling sessions. According to Nimmagadda and Bromley (2006), clinicians need to find ways to bridge Western and Indigenous traditional practices to respect the decolonization and Indigenization process. With the resurgence in traditional healing practices, counsellors need to integrate some of the traditional ways when counselling Indigenous clients (Heinrich et al., 1990).

### **Understanding and Respecting Indigenous Ways of Knowing and Doing**

The fourth theme focused on the importance of non-Indigenous mental health professionals understanding and respecting Indigenous ways of knowing and doing. Smith (1999) maintained that Western approaches to knowledge often clash with the concepts in Indigenous ways of knowing, such as Indigenous Peoples’ spiritual relationships to the land, universe, and rocks. Guenette and Marshall (2008) argued that decolonization involves the reclaiming of Indigenous ways of knowing. Several participants explored with their Indigenous clients how certain Indigenous traditions and ceremonies have helped them. It should be noted that not all Indigenous Peoples practice traditional ways, such as smudging, Pow-wows, or Sundances. For example, the participant who lives in a Métis community shared that going fishing or trapping with an Elder and emphasizing the centrality of food are ways that community members practice Indigenous ways of knowing and doing. Some participants shared that in order to learn more about the cultures of their Indigenous clients, they need to have opportunities to speak with Elders. Additionally, participants challenged themselves to learn

about various Indigenous ways of knowing and doing, such as gift-giving with tobacco, ceremonies and feasts, and the importance of Mother Earth.

### **Appreciating Vital Components**

A component in the provision of mental health services is the therapeutic alliance. One significant factor contributing to successful outcomes for Indigenous Peoples is the therapeutic alliance between Indigenous clients and non-Indigenous mental health professionals (Duran, 2006; Hirini, 1997; Nuttgens & Campbell, 2010; Smith & Morrissette, 2001; Walker & Sonn, 2010). All participants made statements that demonstrated the importance of the therapeutic relationship, which is built on “mutual trust and respect” (Pullen, 2010, p. 4). Several participants were aware that they did not know everything and considered their Indigenous clients the experts in their own lives. In addition, participants not only focused on Indigenous clients’ personal strengths but also on the ways that clients’ traditional practices, cultures, and communities help them in their healing process. Several participants were familiar with Indigenous healing approaches, which often involve Elders and healers (Katz, 2017). This knowledge about Indigenous healing traditions leads to strong therapeutic relationships and positive outcomes for Indigenous Peoples. In sum, participants noted how vital the therapeutic alliance was and wanted to help their Indigenous clients in any way they could, whether that was helping them explore their culture or finding the resources they needed.

A second component in this theme is the importance of family, culture, traditions, and community. Indigenous kinship and families are two unified strengths that draw Indigenous Peoples together (Graham & Martin, 2016; Working With Indigenous Australians First Nations, 2020). One of Graham and Martin’s (2016) study themes was “relationships” (p. 4). They interviewed 15 Plains Cree people and discovered that relationships positively impacted the

Peoples' mental health and well-being. These participants found that relationships met emotional needs, increased self-awareness, and provided personal growth and hope. Consequently, psychologists need to educate themselves about the importance of family and community in Indigenous Peoples' lives (CPA, 2018).

Most participants in this study shared that both family and culture are very important to their clients. One participant felt strongly that non-Indigenous mental health professionals must have some family systems knowledge to help their Indigenous clients, as family is often central to their identity and lives. Another participant invited the client's aunt to sessions and involved her in the therapeutic process. In addition to family, participants felt it was important to refer clients to various Indigenous agencies to help them feel connected to their cultures. One participant expressed that by exploring the importance of community with her Indigenous client, her client began to rely more on ceremony. In addition to family and culture, several participants mentioned the importance of community. According to Van Uchelen et al. (1997), the strengths of families and communities are supported in Indigenous traditions. Therefore, family, culture, and community all provide stability in Indigenous clients' lives (Van Uchelen et al., 1997).

A third vital component to successful mental health services is accessibility. Being able to access programs and services to improve mental well-being and help stop the increase in suicides is imperative for Indigenous Peoples (Government of Canada, 2020). According to one participant, a drawback in existing mental health services is the lack of options for her Indigenous clients. She believed that it was important for Indigenous clients seeking mental health services to have access to Indigenous counsellors. She shared that it would be favourable if her Indigenous clients did not always have to explain themselves and that they could talk to someone who understands them and their culture. One of CCPA's (n.d.) recommendations was

to provide funding to educate and train more Indigenous mental health providers in Canada. At present, there are “insufficient mainstream psychological systems that can appropriately identify vulnerable individuals within Indigenous communities and provide culturally appropriate mental health services in a timely manner” (CPA, 2018, p. 21). Therefore, it is imperative that mental health agencies hire Indigenous psychologists and counsellors to better meet the needs of Indigenous clients.

Two other participants also claimed that accessibility is an issue for many Indigenous Peoples. For example, some of their Indigenous clients have no access to a phone or medication. Poverty is a predominant factor for those seeking help, which includes those who cannot afford transportation (Davy et al., 2016). Indigenous Peoples often experience socioeconomic conditions comparable to those in developing nations (Health Council of Canada, 2005; Mitchell & Maracle, 2005). The barriers that Indigenous populations face are a direct result of colonization and lead to health disparities on a daily basis (Mitchell & Maracle, 2005).

Lambert et al.’s (2014) study revealed that Indigenous Peoples face cultural, social, and systemic barriers that impede their health literacy knowledge and health practices. In other words, they might not often have “the ability to obtain, process, and understand basic health information and services to make appropriate health decisions” (Kickbucsh et al., 2005, as cited in Minister of Health, 2010, p. iii). Some cultural barriers include the Western dominant culture using medical language and a model of health that overpower Indigenous views on health. Thus, this can create a breakdown in communication between Indigenous Peoples and their health care providers (Lambert et al., 2014). Several social barriers were poverty, lack of transportation, geographical isolation, and responsibilities such as childcare and eldercare. Systemic barriers included a lack of consistency in health care; for example, there is often inconsistency in clients’

relationships with health care providers due to high staff turnover at health care facilities (Lambert et al., 2014). Therefore, clinicians need to understand the many barriers Indigenous Peoples face and, at times, the lack of accessibility where they live.

### **Commitment to Lifelong Learning**

This final theme highlighted the importance of formal and informal education to remain culturally competent and sensitive. Education is one of the guiding principles for the profession of psychology when working with Indigenous Peoples of Canada (CPA, 2018). Non-Indigenous mental health professionals must work to understand how trauma from colonization affects Indigenous Peoples' mental health and the proper support they need to heal (Zapata, 2020). Across North America, professionals are striving to “decolonize mental health by working toward collective healing to salve the wounds of colonization” (Zapata, 2020, para. 7). According to the CPA (2018), if clinicians are ignorant about the historical and intergenerational trauma that many Indigenous Peoples have experienced, they could potentially traumatize their clients.

In this study, participants expressed the importance of learning about colonization and how much White settlers took away from Indigenous Peoples. One participant mentioned how appalled she is with the inaccuracy of some of the history books. Shui (2013), a Social Studies teacher, expressed how distressed he was about the ways textbooks have “marginalized” (p. 2) Indigenous Peoples. Another author, Sanchez (2007) argued that educators need to adopt and use proper textbooks that provide more accurate depictions of Indigenous Peoples.

The residential school system and the Sixties Scoop were two significant events that were part of colonization. The trauma of the residential school system has resulted in enduring intergenerational effects on Indigenous Peoples' mental health (Boksa et al., 2015), and the effects of the Sixties Scoop include “traumatic identity crises, psychological trauma, and

behavioural problems” (Sinclair, 2007, p. 75). Therefore, mental health professionals need to “bear witness to the facts of history” (Boksa et al., 2015, p. 365) and recognize that the effects are still felt and experienced to this day (Boksa et al., 2015). Subsequently, supporting Indigenous Peoples’ own decolonization process is much needed (Indigenization Strategy, 2017), specifically due to residential school experiences, broken treaty promises, and the ongoing denial of Indigenous rights, lands, and resources (Fellner, 2016). This way, the Indigenous voice can be heard (Tweten, 2018). Bennet et al. (2011) argued that mental health professionals need to gain Indigenous clients’ trust and respect. Participants shared that many of their Indigenous clients appreciated that their counsellors had some knowledge of various traditional practices and cultures, and they observed that this created rapport and built trust with clients.

Because of the treatment Indigenous Peoples have endured due to colonization, it is vital that non-Indigenous mental health professionals decolonize and Indigenize their practice and mental health services so as to avoid causing further harm. Two steps to do this are for practitioners to engage in continual education about the historical and ongoing effects of colonization and to participate in professional development. Some participants expressed that they do not want to be complacent and tell themselves they have finished the work of learning about colonization or decolonization. Several individuals shared that they received continuing education on Indigenous topics, such as the Red Dress program (Ontario Native Women’s Association, 2020), the Medicine Wheel (Ford-Ellis, 2019), shamanic training (Maisel, 2016), and two-spirit persons (Everett et al., 2013). Other educational experiences included joining various Facebook groups, such as Be A ConnectR (n.d.), and becoming a member of a reconciliation committee.

Participants had several recommendations to other non-Indigenous mental health professionals for how to decolonize their practice. The main suggestions were for clinicians to educate themselves through reading, conversing with Indigenous Peoples, becoming involved with ceremonies, and finding an Elder to talk and discuss questions with. Boksa et al. (2015) proposed that to support mental well-being in Indigenous communities, mental health professionals could take time to talk with Indigenous persons about their experiences with mental health and the reconciliation process, as well as “engage in respectful collaborations with traditional healers and knowledge holders” (Boksa et al., 2015, p. 365).

### **Strengths of the Study**

There are several strengths to this study. First, it contributes to the small but growing literature on how non-Indigenous mental health professionals decolonize and Indigenize their practice. Much of the information about this phenomenon has been examined by Durie (2011), a psychiatrist who has helped Indigenize Māori mental health services in New Zealand or by Bennet et al. (2011), who explored the experiences of social workers who worked with Indigenous Peoples and communities in Australia. Only one study in the research literature was conducted in Canada; however, it focused on Indigenous counsellors (Fellner, 2016). Participants in the present study included not only social workers but also certified counsellors, psychologists, and a physician.

The second strength was the use of the basic interpretive qualitative research framework (Merriam, 2002) as the methodological framework. The interview guide helped me find answers to my research questions about participants’ experiences and perspectives on how they decolonized their practice and practiced cultural humility, as well as how they acknowledged their privilege. I explored how participants decolonized their practice in a way that accessed



deeper meaning. The basic interpretive qualitative research framework assisted in understanding the complexities and challenges participants experienced in providing mental health care to Indigenous clients. Finally, using this qualitative method allowed me to gather rich accounts of various approaches participants took toward decolonizing their counselling practice, which can be used to educate others and inform policy.

The third strength, as mentioned by participants, is the growing need for non-Indigenous mental health professionals to be educated on ways to decolonize their practice and mental health services. Some suggestions mentioned include having Elders at various agencies, having more Indigenous counsellors on staff, participating in workshops on Indigenous topics, attending various Indigenous ceremonies (e.g., Pow-wows, Sundances, sweats), and being self-reflective, all of which contributes to providing more culturally appropriate services to Indigenous clients.

The fourth strength was the diversity of participant experiences. As mentioned above, not only did participants have different educational backgrounds, but they also had a varied range of experience levels in the mental health field; those with only three years of experience had stories to share that were different than those with over 30 years of experience. Additionally, there were different cultural backgrounds and theoretical orientations. This mixture of different backgrounds enriched the results and contributed to this research area.

### **Limitations of the Present Research**

There are several limitations in this study. First, all participants were female, which excluded a valuable male perspective. Different themes might have occurred if males had volunteered for the study. Second, interviews were conducted either by phone or Zoom. If there were in-person interviews, more depth and further elaboration on stories might have been achieved. Face-to-face interviews would also have allowed me to be more aware of social cues

and body language. Third, there was a regional limitation to the study. The sample size consisted of non-Indigenous mental health professionals living in Western Canada. Findings might have been different if there were participants from other regions of Canada. For instance, if participants were recruited from other geographical locations, more males might have been able to participate, as well as those with different experiences than the study's participants. Fourth, all participants needed to belong to a governing body. This stringent criterion eliminated those who might have had stories to share but were not allowed to participate. In fact, I had to decline two potential male participants from the study because they did not belong to a professional organization. As I discuss in the research implications section below, I hope the suggestions for mental health professionals will benefit Indigenous clients.

### **Implications for Counselling**

A central reason for inviting non-Indigenous mental health professional participants to share their stories on decolonizing their practice was to explore their valuable insights on counselling Indigenous clients. The participants' professional identities and personal qualities contributed to how they counselled their clients and decolonized their practice. For example, regardless of their theoretical orientation or educational background, all participants had a humanistic approach to therapy, demonstrated by "genuineness" (Rogers, 1957, p. 97) in the therapeutic relationship and "unconditional positive regard" (Rogers, 1957, p. 95) for their Indigenous clients. Thus, the helping process is a mutual relational endeavour that all participants engaged in. Below I discuss my findings to suggest ways that non-Indigenous counsellors and psychologists might consider establishing culturally appropriate clinical practices in the mental health field.

The research findings highlighted some implications for mental health professional educational training. Mental health professionals need to become educated in decolonizing and cultural humility frameworks to increase their knowledge, awareness, and skills, which would positively impact Indigenous mental health care (Lewis et al., 2018). Lewis and colleagues (2018) developed a 90-minute training program that is grounded in multicultural counselling competencies (Sue, 2001; Sue et al., 1992) and cultural humility (Tervalon & Murray-Garcia, 1998), and has a decolonizing framework (McDowell & Hernández, 2010). The first objective is knowledge, which includes learning about the history of Indigenous Peoples to understand the disparities that exist among them today. Next, the training program incorporates awareness, which involves a continual and deliberate examination of unconscious beliefs. Experiential learning is vital for counsellor awareness. Lastly, the program teaches “skills of self-reflection and self-critique” (Lewis et al., 2018, p. 335). Because “evidence-based interventions and empirically supported theories are typically not developed or adapted for Indigenous clients” (Lewis et al., 2018, p. 335), mental health professionals must understand the lens through which Indigenous individuals and families view the world, such as the importance of relationships (Constantine & Sue, 2006; Graham & Martin, 2016). Thus, this valuable training needs to be incorporated in mental health agencies and university training programs.

Similar to Lewis et al.’s (2018) decolonizing framework, Collins and Arthur (2010) developed a culture-infused counselling model for multicultural competency. These authors argued that culture-infused counselling provides a detailed explanation of the attitudes, knowledge, and skills needed to develop culture-infused counselling competence. Their culture-infused counselling model involves three core competency domains: cultural awareness of the self, cultural awareness of the other, and a culturally sensitive working alliance. Cultural

awareness of the self involves the counsellor having an “active awareness of personal assumptions, values, and biases” (Collins & Arthur, 2010, p. 220). According to Collins and Arthur (2010), five core competencies in cultural awareness include demonstrating awareness of the following: “[the counsellors’] own cultural identities” (p. 222); “differences between [the counsellors’] own cultural identities and those of individuals from other dominant or nondominant groups” (p. 222); “the impact of culture on the theory and practice of counselling/psychology” (p. 223); “the personal and professional impact of the discrepancy between dominant and nondominant cultural groups in North America” (p. 224); and lastly, the counsellors’ “level of multicultural competence” (p. 224).

Cultural awareness of the other involves counsellors having an “understanding the worldview of the client” (Collins & Arthur, 2010, p. 225). According to Collins and Arthur (2010), three cultural core competencies within this area include demonstrating awareness of the following: “the cultural identities of [the counsellors’] clients” (p. 225); “the relationship of personal culture to health and wellbeing” (p. 226); and lastly, “the socio-political influences that impinge on the lives of nondominant populations” (p. 227). As reported by Collins and Arthur (2010), culturally sensitive working alliance involves three core competencies: “establish trusting and respectful relationships with clients that take into account cultural identities” (p. 227); “collaborate with clients to establish counselling goals that are responsive to salient dimensions of cultural identity” (p. 228); and finally, “collaborate with clients to establish client and counsellor tasks that are responsive to salient dimensions of cultural identity” (p. 229). As “the field of multicultural counselling continues to expand” (Collins & Arthur, 2010, p. 231), non-Indigenous mental health professionals would benefit from this competency framework to better understand their Indigenous clients’ identities and cultures.

Another educational training program is *Indigenous Canada* at the University of Alberta (University of Alberta, n.d.). *Indigenous Canada* is a Massive Open Online Course (MOOC) offered at no cost that explores Indigenous histories and present-day issues in Canada. This course can help mental health professionals understand Indigenous and non-Indigenous relationships. In addition, there is an online program at the University of British Columbia called “San’yas,” which offers Indigenous cultural safety training for mental health professionals who want to increase self-awareness and strengthen their skills when working with Indigenous clients (Provincial Health Services Authority in BC, n.d.). As well, all graduate counselling programs, social work programs, and clinical psychology programs within Canada need to have anti-oppressive and Indigenous Studies courses offered to students so they will be better equipped in decolonizing their practice.

Since CPA’s (2018) response to the TRC (2015), there has been more focus on the ways that psychology in Canada can better meet the needs of Indigenous individuals and communities, particularly in terms of education and professional training. For example, to ensure Indigenous knowledge in the field of psychology, there needs to be a specific curriculum about Indigenous mental health in psychology programs (Fellner, 2018). As well, the process of Indigenizing “curriculum and pedagogy in community psychology and allied fields” (Fellner, 2018, p. 283) must involve Indigenous knowledge and viewpoints, allow for a space that benefits Indigenous students, and ensure “critical awareness and cultural competence” (Dudgeon & Pickett, 2000, p. 85). Decolonizing approaches might involve training in Indigenous mental health that stretches beyond the psychology profession’s traditional limits. For example, including more interdisciplinary co-operation and curricular and regulatory flexibility, and recognizing the

sovereignty of Indigenous mental health systems can help to decolonize the psychology profession (Dudgeon & Pickett, 2000; Dudgeon & Walker, 2015).

It is imperative that mental health professionals who work with Indigenous clients receive some education and training in trauma-informed practice (Centre of Excellence for Women's Health, 2013). Trauma can be defined "as experiences that overwhelm an individual's capacity to cope" (Centre of Excellence for Women's Health, 2013, p. 6). Indigenous Peoples in Canada have experienced persistent and devastating "intergenerational massive group trauma and compounding discrimination, racism, and oppression" (Brave Heart et al., 2011, p. 282). The four principles of trauma-informed practice include trauma awareness, emphasis on safety and trustworthiness, opportunity for choice, collaboration, and connection, and finally, strengths-based and skill-building (Centre of Excellence for Women's Health, 2013). For trauma awareness, counsellors need to know that people cope and endure after trauma in many different ways; counsellors must also be aware of the direct relationship between trauma and substance misuse, physical health, and mental health issues (Centre of Excellence for Women's Health, 2013; Hopper, 2010). The second principle involves an emphasis on safety and trustworthiness (Centre of Excellence for Women's Health, 2013). Counsellors need to ensure that clients feel physically, emotionally, and culturally safe, as those who survived trauma experiences often do not feel safe and possibly endured ill-treatment in significant relationships (Centre of Excellence for Women's Health, 2013; Fallot & Harris, 2009).

With the third principle of the trauma-informed approach, opportunities for choice, collaboration, and connection are provided (Centre of Excellence for Women's Health, 2013), demonstrating that "trauma-informed services create safe environments that foster a sense of efficacy, self-determination, dignity, and personal control for those receiving care" (Centre of

Excellence for Women's Health, 2013, p. 14). It is vital that counsellors have open communication with their clients, take steps to decrease the power discrepancies in relationships, allow clients to share their feelings without being afraid they will be criticized, allow clients to have treatment options, and finally, have a joint working alliance with clients (Centre of Excellence for Women's Health, 2013). Finally, the fourth principle is a strengths-based and skill-building approach, where counsellors use trauma-informed practice to help clients to "identify their strengths and to (further) develop resiliency and coping skills" (Centre of Excellence for Women's Health, 2013, p. 14). Notably, counsellors can educate about trauma and demonstrate skills for acknowledging triggers and remaining grounded and present (Centre of Excellence for Women's Health, 2013).

In the present study, several participants mentioned their Indigenous clients had experienced trauma and/or intergenerational trauma. Although most participants did not use the term, "trauma-informed practice," they did discuss elements of this practice approach, including trust, safety, connection, and the use of strengths-based theories. It appeared that most participants practiced in trauma-informed ways even prior to the TRC (2015). Therefore, counsellors need to comprehend Indigenous Peoples' historical and intergenerational trauma and the importance of trauma-informed practice (Centre of Excellence for Women's Health, 2013) to help their clients work through complicated grief and trauma (Brave Heart, 1998) and "emotional and psychological wounding" (Brave Heart, 2003, p. 7).

Many participants noted that their theories of practice help them to decolonize their practice. These theories of practice are based on humanistic and feminist perspectives on counselling, which emphasize care and empathic understanding. Indigenous communities welcome therapies such as focusing-oriented therapy (FOT). FOT is a "humanistic [and] person-

centred approach to healing, which reflects the core values of respect and non-interference” (Schiffer, n.d., para. 2). Therefore, it is beneficial for counsellors to have some training in humanistic approaches.

Another finding revealed that decolonizing one’s practice involves having knowledge about Indigenous cultures. In this study, some participants brought up the topic of spirit animals. Counsellors need to have information available on this topic in their offices, so when clients are sharing about various spirit helpers, counsellors can engage in an informative conversation about these helpers. In the existing literature, Hill (2017) argued that it is a person’s spirit helpers that assist with the healing process. Fellner (2016) shared a story about a woman whose spirit helpers, who were horses, assisted her in her recovery from panic attacks. These helpers can accompany, or sometimes replace, antidepressants and doctors (Fellner, 2016), which are traditional Western methods for treating mental health. Therefore, clinicians cannot underestimate the power of spirit helpers.

Counsellors wanting to decolonize their practice might want to take the opportunity to attend Pow-wows, potlatches, Sundances, feasts, and other Indigenous ceremonies. When Indigenous clients share their experiences of these ceremonies, it is helpful if their counsellors know and can relate to what they are describing. Thomason (2011) argued that attending various community events can help clinicians gain more insight and understanding into their Indigenous clients’ cultures and traditions. Although some participants shared that they did not have many Indigenous clients who are exploring their cultures, others shared that some of their Indigenous clients are just beginning to want to learn about their cultures.

Since there is a higher rate of suicide among Indigenous Peoples, especially Indigenous youth (Pollock et al., 2018), cultural sensitivity and continuity are very important. As a result of



conversations that explored culture and community, the client of one participant returned to ceremony and obtained a deeper understanding of the importance of community in his life. As clients share about their cultures and community, mental health professionals need to stay focused on how cultural practices can “hopefully [reverse] the trend toward steadily increasing suicide rates among First Nations youth” (Chandler & Lalonde, 1998, p. 216).

To decolonize their practice, counsellors need to understand that many Indigenous cultures have a collectivist philosophy rather than the individualistic ideology prevalent in North American society (Kirmayer, 2007). Several participants explained that family, culture, and community are important for their Indigenous clients, which reflects a collectivist ideology. In Bennet et al.’s (2011) study, participants shared that mental health practitioners need to shift from counselling in an individualistic way to counselling in a manner that involves family and community, with an emphasis on listening and understanding diverse viewpoints. Counsellors could adjust how they approach therapy with their Indigenous clients by considering the “resources and support of members of the immediate and extended family, trusted neighbours, credible local leaders of the community, or other professionals” (Kuo, 2004, p. 160). It is also vital that clinicians do not insist their Indigenous clients adopt their own cultural values (Slife et al., 2003). To be respectful of Indigenous clients and their cultures, clinicians need to comprehend the distinctive community environments their clients come from and educate themselves on what their clients value both personally and within their community (Indigenous Corporate Training Inc., 2019). One participant shared her experience of being a responder to an Indigenous community crisis. She felt that the non-Indigenous (mostly White) counsellors did not understand the strengths of the community, such as smudging and doing circles. Counsellors are encouraged to understand that healing occurs in a community context, and various

community ceremonies are vital to the healing process. Furthermore, counsellors need to keep at the forefront a recognition of the cultural diversity of Indigenous Peoples in Canada and that they are not just one homogenous group (Nuttgens & Campbell, 2010).

Many participants in this study mentioned that counsellors should reach out to Elders in the community when necessary. Counsellors and psychologists need to be prepared to expand their knowledge by consulting and accessing Elders, as suggested in the literature (CPA, 2018; Thomason, 2011). It is critical that mental health professionals and psychologists address Elders with respect and be willing to learn from and collaborate with them (Chansonneuve, 2005; CPA, 2018; Durie, 2011; Thomason, 2011). One participant wanted the agency where she works to give Indigenous clients the option of seeing an Elder if they would like. Another participant wished she knew of an Elder she could consult with. Hence, management teams need to prioritize having Elders for clients and staff to access.

The concept of spirituality is often not well integrated into clinical practice (Corey, n.d.). Non-Indigenous mental health professionals could expand on their knowledge by reading relevant literature on Indigenous spirituality. Clinicians need to be aware that many Métis people, as well as some First Nations or Inuit people, express their spirituality as Christians, while others practice more traditional spirituality such as shamanism and ceremonies—some individuals might even combine traditional spirituality with Christianity. One theme discussed in Bowden et al.'s (2017) study was the centrality of spirituality. A non-Indigenous participant in Bowden et al.'s study stated that being open to the paranormal and spirit medicine allows counsellors to support Indigenous clients with their spirituality. Thus, it is essential mental health professionals provide safe, open spaces for clients to explore their spirituality; however, therapists must not direct or force this exploration.

In the present study, several participants maintained the importance of being reflective in their practice. Most participants tried to be cognisant of their privilege when counselling Indigenous clients and how they do not experience the barriers many Indigenous Peoples face. Because decolonization is an ongoing process, mental health professionals must continually develop self-awareness about their biases and prejudices (Bennet et al., 2011). One way to engage in critical self-reflection might involve personal journaling. Another method is to have conversations with Elders and other Indigenous mentors. By connecting with Elders, Indigenous mentors, and Indigenous practitioners, counsellors can learn about and respect Indigenous perspectives and value systems (Bowden et al., 2017). Attending sweats, Pow-wows, and other ceremonies can also support self-reflection. Bowden et al. (2017) argued that counsellors need to take part in ceremony “alongside their clients and communities with whom they work” (p. 51). This helps counsellors to have a deeper understanding of the healing impact of spirituality when working with Indigenous communities.

Unfortunately, some participants shared that they did not feel management supported them in decolonizing their practice or place of employment. Management teams could support the learning process in various ways. First, they could learn more about the cultures of their Indigenous clients. For example, one participant spoke about the inflexibility of management at the post-secondary institution where she works, which does not allow Indigenous students more time off for funerals. Second, when mental health staff attend reconciliation meetings, some of their suggestions could be implemented to encourage greater reconciliation and decolonization in agencies, rather than being told by managers that it is not possible. Third, management can support the learning process and provide professional development days for staff members to attend sweat lodge ceremonies. According to Kowalzik (2010), when mental health professionals

participate in sweats, they “witness Aboriginal people in roles of authority and expertise” (p. 25). Fourth, management teams could reflect on where they have not decolonized services and help to create better Indigenous wellness services. Fellner (2016) argued that to meet the mental health needs of Indigenous clients, agencies and other mental health services need to address which services and treatments are not working. Fifth, management teams could diversify their agencies by hiring an Elder and more Indigenous counsellors. Finally, if management focuses more on anti-racism topics, this will likely increase counsellors’ awareness of racism.

Notably, the danger of engaging in cultural voyeurism has significant implications for mental health professionals. Cultural voyeurism is a “deliberate, recurrent, and proactive effort to acquire information about another culture or cultural phenomenon, sometimes from a distance and sometimes as a participant-observer” (Appiah, 2018, p. 234). Voyeuristic individuals are fascinated with other cultures to which they do not have “easy access” (Appiah, 2018, p. 234).

Importantly, it is essential that counsellors not “borrow” (Indigenous Corporate Training Inc., 2020, para. 4) aspects from Indigenous cultures. In several Indigenous cultures “strict and ancient protocols dictate who can sing certain songs, perform certain dances, [and] tell certain stories” (Indigenous Corporate training Inc., 2020, para. 4). Thus, clinicians need to keep in mind that borrowing is another example of colonialism, where the dominant society assumes that they can take from other cultures (Indigenous Corporate Training Inc., 2020).

Part of reconciliation is learning about Indigenous Peoples and their cultures, their pre-contact history, and the detrimental effects of colonialism (Indigenous Corporate Training Inc., 2020). In the present study, participants shared the learning they have engaged in about various aspects of Indigenous traditions, including shamanism, the use of mediums in hospitals, and spirit animals. However, they also expressed discomfort with adopting Indigenous ways of

healing—particularly, in this study, the Medicine Wheel. One participant did not want to even use the term “Medicine Wheel” due to a fear of misappropriating it. It appeared that most participants were cautious when presenting any Indigenous teachings to their clients; they were mindful of respecting Indigenous traditions and did not want to participate in any negative aspects of cultural voyeurism.

### **Directions for Future Research**

The findings of this study resulted in several implications for future research regarding non-Indigenous mental health professionals decolonizing their practice. First, although participants were given the interview guide questions a week or two before the scheduled interview to familiarize themselves with the questions, one participant had quickly read the questions prior to the interview, and another needed to remind herself of the questions at the time of the interview. As such, it would be informative for future researchers to use follow-up interviews to allow participants to further elaborate on some of their lived experiences. Second, interviewing male non-indigenous mental health professionals might help advance the findings of the present study by gaining different perspectives about the way male non-Indigenous mental health professionals decolonize their practice. Male therapists might have different ways of decolonizing and Indigenizing their practice.

A third implication for future research could involve an Indigenous researcher conducting the same study to determine if this would generate different data. One participant expressed that she wished an Indigenous researcher asked the interview questions, as she believed it would be more appropriate for an Indigenous researcher to ask about Indigenous topics rather than a White researcher. Fourth, implementing a study where Elders are accessed at various agencies in Canada might help researchers to explore whether non-Indigenous mental health professionals counsel their Indigenous clients in a more culturally safe manner when there is an Elder on staff.

Fifth, in a future study, a researcher could interview both male and female Indigenous clients to explore whether their non-Indigenous mental health practitioners met their needs and concerns. This would also allow for further feedback and insight for clinicians who are making efforts to decolonize their practice. Sixth, since participants in the present study did not mention much about land-based interventions, a future study could focus on the importance of Indigenous Peoples having a connection to the land through land-based interventions.

Lastly, in future research, I would choose to make different methodological choices. Although I had many professionals volunteer to participate, in a future study, I would leave out the criterion that required participants to belong to a governing body. If I had not selected this criterion, I would have been able to include male participants, as well as other mental health professionals who have experience working with Indigenous clients. Furthermore, although the basic interpretive qualitative research design was an appropriate methodological fit for this study, different themes might have emerged if other methodologies were used, such as narrative inquiry. For example, in a narrative inquiry, I would choose non-Indigenous counsellors who specifically work with only Indigenous communities in Canada. Narrative inquiry is a relational methodology where researchers “attend to experience over time, place, and social contexts” (Bowden et al., 2017, p. 40). Narrative inquiry is also culturally appropriate with Indigenous worldviews, as it aligns with the centrality of the story (Kovach, 2010).

### **Researcher Reflections**

During the completion of this thesis, I learned a great deal about myself. I had to be flexible and open, as my topic changed several times over the last two years. I initially wanted to study Indigenous mental health professionals’ experiences with counselling Indigenous women. However, through a discussion with an Indigenous professor and scholar, it was brought to my awareness that because I am not an Indigenous researcher and am not connected to an

Indigenous community, I cannot give back to Indigenous communities in a tangible way. Subsequently, I needed to change my topic. Thankfully, my supervisor, Dr. Stephanie Martin suggested another topic, the decolonization and Indigenization of mental health services. Although I was not familiar with the decolonization of mental health services, the more I researched, the more excited I became about how important this work is and how there is a lack of research on it. Dr. Martin and I were diligent in developing interview questions that encompassed many aspects of decolonization, including cultural allyship and cultural humility.

This project has moulded me into a more thorough and sensitive researcher. I enjoyed all aspects of data collection, including getting to know each of my participants, both on a personal and professional level. I was amazed at how committed these women are to making sure their Indigenous clients feel accepted and cared for. Several participants admitted their lack of knowledge about some Indigenous topics and recognized that they still had much more to learn. I learned tremendously from each of my participants' experiences and stories. I am now able to take this information and these stories into my future career as a psychologist and share what I have learned with others. I hope to find an Elder who could mentor me as I work with Indigenous clients. Going forward, I will search for ways I can attend more ceremonies, such as sweats and Pow-wows. Finally, I want to continue my own education on Indigenous topics and on ways to further decolonize my counselling practice.

## **Conclusions**

With the Indigenous population becoming the fastest growing cultural group in Canada, there will be an increased need for culturally sensitive mental health services. Notably, mental health professionals' understanding of decolonizing is always evolving and changing (H. Graham, personal communication, January 29, 2021); therefore, it is vital for counsellors to

remain abreast on the topic of decolonizing and Indigenizing the mental health field. I hope that the findings in the current study, including ways to decolonize one's practice, how to be a cultural ally, how to combine Western with traditional approaches, being aware of one's biases and prejudices, and ways to advocate for Indigenous clients, will contribute to educating non-Indigenous mental health professionals about decolonizing and Indigenizing their practice and mental health services. This study has implications for therapists who strive to provide the best service possible for their Indigenous clients.



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## APPENDICES

### **Appendix A: Ethics Application Approval**

**NAME:** Student-Researcher: Lorna Beech, Supervisor: Dr. Stephanie Martin

**TITLE OF PROJECT:** *Non-Indigenous Mental Health Professionals' Experiences of  
Decolonizing Their Practice*

**Behavioural Research Ethics Board (Beh-REB) Approval #: 1859**

**DATE:** April 23, 2020

**The Beh-REB has reviewed the Application for Ethics Approval for your research project.**



## **Appendix B: PAWS Bulletin Advertisement**

Non-Indigenous Mental Health Professional participants needed: Perspectives of how they have decolonized their counselling practice.

I am interested in exploring non-Indigenous mental health professionals' experience in decolonizing their counselling practice. By participating in this study, you are providing researchers with valuable information about how mental health professionals work with and for Indigenous Peoples, which means they need to not only understand how Indigenous Peoples conceptualize themselves, their families, communities, health and the impact of colonial systems, but how they support the healing journey of their Indigenous clients.

This interview will take approximately 1 to 1.5 hours to complete. All participants will receive a gift card from either Tim Horton's or Star Bucks as a token of appreciation for your participation.

If you are interested in finding out more about this study or would like to participate, please contact Lorna Beech at [mental.health2020@usask.ca](mailto:mental.health2020@usask.ca). This study has been reviewed and approved through the Research Ethics Office at the University of Saskatchewan (REB#1859).

For more information, contact:

Stephanie Martin, PhD, Professor  
Department of Educational Psychology and Special Education,  
[Stephanie.Martin@usask.ca](mailto:Stephanie.Martin@usask.ca)



### **Appendix C: Social Media Recruitment Notice**

**Facebook post:** My name is Lorna Beech and I am completing my Masters degree in Educational Psychology in the School and Counselling program at the University of Saskatchewan.

I will be conducting my thesis research on non-Indigenous mental health professionals' experiences in decolonizing their practice. If you or anyone you know would be interested in participating, please contact me at [mental.health2020@usask.ca](mailto:mental.health2020@usask.ca). Please do not message me or respond to this post.

For participant eligibility, please see the poster below and/or send me an e-mail. Participants will receive a \$20 gift certificate to Tim Horton's or Starbucks.

This study has been approved by the Behavioural Research Ethics Board at the University of Saskatchewan (REB#1859).

*Facebook post regarding participant eligibility information:*

I am looking for volunteers to take part in a study entitled: *Non-Indigenous Mental Health Professionals' Experiences of Decolonizing Their Practice*

#### **Participation criteria:**

- 1. Participants need to be certified or registered non-Indigenous mental health professionals (e.g., social workers, psychologists, psychiatrists, counsellors).**
- 2. They must be 18 years of age or older and have decolonized their practice.**
- 3. They must be willing to reflect on and discuss their experiences of decolonizing their practice in detail.**
- 4. They must be willing to meet with the researcher for a one to 1.5-hour interview.**

For more information about this study, or to volunteer for this study, please contact:

Lorna Beech  
University of Saskatchewan  
Department of Education; Educational Psychology and Special Education; School and Counselling Psychology program  
If you are interested in learning more about this study, please contact [mental.health2020@usask.ca](mailto:mental.health2020@usask.ca)



## **Appendix D: Recruitment E-Poster**

**Title of Project:** *Non-Indigenous Mental Health Professionals' Experiences of Decolonizing Their Practice*

Would you be interested in participating in a research study? The purpose of this study is to examine non-Indigenous mental health professionals' experience about how they have decolonized their counselling practice.

If you were to participate in this study, you would be asked to:

Take part in an approximately 60-90 minute, audio-recorded interview.

Provide feedback on the typed interview transcript, if you so wish to choose this.

Selected participants will be at least 18 years of age, currently in the process of decolonizing their counselling practice, and be certified or registered with a licensing or regulatory body.

As a token of appreciation for your participation, each participant will receive a \$20 gift card from either Tim Horton's or Starbucks.

If you are interested in finding out more about this study, please contact Lorna Beech at [mental.health2020@usask.ca](mailto:mental.health2020@usask.ca). This study has been reviewed and approved through the Research Ethics Office at the University of Saskatchewan (REB#1859)



## **Appendix E: Recruitment E-mail to Non-Indigenous Mental Health Professionals**

*Subject:* Seeking participants for a research study in counselling psychology. My name is Lorna Beech and I am a student in the Master of Educational Psychology in School and Counselling program at the University of Saskatchewan.

You are receiving this e-mail because you have shown interest in being a participant in my study. I am recruiting non-Indigenous mental health professionals for my thesis research and if you meet the criteria, you are invited to participate in an audio-recorded 1 to 1.5-hour research interview. The purpose of this study is to examine non-Indigenous mental health professionals' experience in decolonizing their counselling practice. By participating in this study, you are providing researchers with valuable information how mental health professionals work with and for Indigenous Peoples, which means they need to not only understand how Indigenous Peoples conceptualize themselves, their families, communities, health and the impact of colonial systems, but how they support the healing journey of their Indigenous clients.

To participate in this interview, you are required to meet the following criteria:

- Need to be certified or registered non-Indigenous mental health professionals (e.g., social workers, psychologists, psychiatrists, counsellors).
- Must be 18 years of age or older and have decolonized their practice.
- Must be willing to reflect on and discuss their experiences of decolonizing their practice in detail.
- Must be willing to meet with the researcher for a one to 1.5-hour interview.

If you are interested in participating in this research project or you have any questions, comments, or concerns, please contact me by e-mail at [mental.health2020@usask.ca](mailto:mental.health2020@usask.ca). You are also welcome to contact my supervisor, Dr. Stephanie Martin ([Stephanie.Martin@usask.ca](mailto:Stephanie.Martin@usask.ca)).

Thank you for your time and I look forward to hearing from you.

Sincerely,

Lorna Beech

This study has been approved by the Behavioural Research Ethics Board at the University of Saskatchewan (REB#1859)



## **Appendix F: Participant Consent Form**

### **Participant Consent**

#### **Name of Researcher and Email:**

Lorna Beech, B. A. (Honours Psychology), Graduate Student, Department of Educational Psychology and Special Education, the University of Saskatchewan (Email: [mental.health2020@usask.ca](mailto:mental.health2020@usask.ca))

#### **Name of Supervisor, Telephone & Email:**

Dr. Stephanie Martin, RDPsych, Professor, Department of Educational Psychology & Special Education, University of Saskatchewan (Ph: 306-966-5259; Email: [Stephanie.Martin@usask.ca](mailto:Stephanie.Martin@usask.ca))

**Title of Project:** *Non-Indigenous Mental Health Professionals' Experiences of Decolonizing Their Practice*

#### **Sponsor:**

Social Sciences and Humanities Research Council of Canada (SSHRC)

This consent form, a copy of which was given to you, is only part of informed consent. If you want more details about something mentioned here or information not included here, please feel free to ask. Please take the time to read this carefully and to understand any accompanying information. If you are receiving the consent form in-person, I will review the consent form with you.

**Purpose and Objective(s) of the Research:** The purpose of this study is to obtain insights of mental health service professionals' experiences of decolonizing their practice. As Canada's population increases with the number of Indigenous Peoples, there is a need for mental health professionals to decolonize their practice, as well as to practice cultural humility toward their Indigenous clients. The results of this study are expected to expand on existing literature.

**Procedures:** You will be asked to meet with me either in-person (as long as the University of Saskatchewan has lifted its suspension of face-to-face interviews) or by either WebEx, Skype, Zoom, or telephone, and discuss the areas of decolonization, cultural allyship, and how you practice cultural humility. The interview will take place at a time mutually agreed. The interview will last 1-1.5 hours. Interviews will be audio-recorded and transcribed for analysis.

**Potential Risks:** There is no risk apparent in this study. However, if participants need to debrief, the student-researcher and/or her supervisor will be of assistance. Participation is strictly voluntary, and participants are free to withdraw from the research at any time or choose to not answer interview questions. Data will be stored on OneDrive that only I and my supervisor, Dr.



Stephanie Martin, will have access to. The signed consent forms will be stored separately from data records. Though all data gathered through the study will be treated with confidentiality, individual excerpts from interviews will be used to represent the findings and they may be identifiable based on what you say. If you become emotionally upset during the interview process, the researcher will provide a break and ensure you are able to continue in the study, if you wish.

**Potential Benefits:** There are no direct personal benefits of participating in the study. Although, by partaking in this study you will have the opportunity to reflect upon your experiences of how you have decolonized your counselling practice. You will also be making a contribution to extending knowledge to help mental health professionals learn how to decolonize their practice in order to better counsel Indigenous clients. In appreciation for your time you will receive a \$20 monetary gift card. You will receive this even if you withdraw from the study.

**Confidentiality:** The researcher will take the necessary steps to ensure your confidentiality as a participant. Your name will be changed on all written documents produced from the interview data. All files containing interview data will be stored on a password-protected computer and within encrypted documents. Signed consent forms will be stored separately from data records. Consent forms will be stored separately from the interview data, so it will not be possible to associate a name with any given set of responses. The data collected during the study will be used in the completion of the researcher's Masters thesis. Data will be reported in aggregate form with direct quotations of interview data used to report results. The researcher will edit statements to ensure other individuals cannot identify you, but due to the context and small numbers of potential participants, there is the possibility someone familiar with you might be able to identify you based on your responses. Within two weeks after the interview, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcript as you see fit. In other words, it is asked that you provide feedback on whether the information in the transcript fits with your understanding of what was said in the interview. Within the 14 days of receipt of your transcript, you can decide to withdraw your data.

At the end of this consent form, there will be two checkboxes. Please check only one box. The first box states you desire to receive the transcript, while the other box states you do not want to receive it. If you do want to receive your transcript, you will give oral consent for transcript release and review form. It is asked that you provide feedback on whether the information in the transcript fits with your understanding of what was said in the interview. If you do not respond within two weeks, this be understood as approval of the transcript and will be assumed to have your consent to use your data. If time does not permit me to transcribe the interview, I will hire a transcriptionist from the Social Science Research Laboratories (SSRL) on-campus who will sign a confidentiality agreement.

**Storage of Data:** In order to protect the confidentiality and privacy of participants, all information obtained during the study will be stored in a locked filing cabinet. Following the completion of the study, data will be stored on OneDrive for 5 years post-publication, as per university policy, that only I and my supervisor, Dr. Stephanie Martin, will have access to. When the data is no longer required, the electronic data will be deleted using a program that will not permit its recovery and any physical data will be shredded. This includes digital voice data.

**Right to Withdraw:** Your participation is voluntary, and you can answer only those questions you are comfortable with. You may refuse to answer any individual question during the interview or withdraw from the research project for any reason, at any time without explanation or penalty of any sort. Should you wish to withdraw within 14 days of your interview, please inform the researcher and any collected data from the interview will be destroyed. As well, for those asking to review their transcript, you will have 14 days of receipt of the transcript to withdraw your data.

**Follow up:** A summary of research results will be made available upon request (approximately Winter 2021). To obtain results from the study, please contact the researcher at the email address at the top of this consent form.

**Questions or Concerns:** Contact the researcher using the information at the top of this consent form. The University of Saskatchewan Research Ethics Board approved this research project on ethical grounds. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office [ethics.office@usask.ca](mailto:ethics.office@usask.ca) (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Your signature below indicates you have read and understood the description provided. I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project. A copy of this consent form was given to me for my records.

I am wanting to receive my transcript before my data is used.

or

I am fine to leave my data as is and not receive a transcript.

_____	_____	_____
<i>Name of Participant</i>	<i>Participant's Signature</i>	<i>Date</i>

_____	_____	_____
<i>Name of Researcher</i>	<i>Researcher's Signature</i>	<i>Date</i>

Or

Rather than obtaining signed consent via email, for your convenience, you might consider acknowledging to participate within an email, and then I will follow with oral consent at the time of the interview.

**Oral Consent:**

I read and explained this consent form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

\_\_\_\_\_  
*Name of Participant*

\_\_\_\_\_  
*Researcher's Signature*

\_\_\_\_\_  
*Date*

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***

## Appendix G: Interview Guide

**Title:** *Non-Indigenous Mental Health Professionals' Experiences of Decolonizing Their Practice*

### Part 1: Introduction

Thank you for meeting with me today. Much of the research shows that Indigenous Peoples' mental wellness/well-being has mostly been a product of Western colonial ways of knowing, and mental health professionals are called-on to consider how their services/practices meet the needs of Indigenous clients. Many words are used to describe how professionals define this process, including decolonizing their mental health services (other words may include "Indigenizing," "developing anti-oppressive practice," and "developing cultural allyship"). Please see below for some definitions. I hope by learning from your experiences, we can inform other mental health professionals' practice.

**Decolonization is not a rejection of colonialism.** Rather, it rejects the colonial relations of power that threaten Indigenous ways of being. Decolonization values Indigenous sovereignty in its material (e.g., sovereignty over the land), psychological, epistemological, and spiritual customs (Sium, Desai, & Ritskes, 2012).

**Indigenization** is an intentional and focused process to work with and for Indigenous education and Peoples, while supporting the progression of a deeper understanding with non-Indigenous people (Calvez, n.d.).

**Anti-oppressive practice (AOP)** is both complicated and uncomfortable, as mental health professionals explore issues of justice and oppression that can be challenging and frustrating. AOP investigates the interconnections between who we are as humans and therapists, and biases, beliefs, and attitudes towards other (marginalized) groups of people (Thomas & Green, 2007).

**Cultural Allies** are individuals who actively attempt to eliminate various forms of oppression that give them privilege. These individuals are typically Eurosettlers who work to support Indigenous agendas as created by Indigenous peoples themselves (Fellner, 2016).

**Cultural Humility** involves a persistent commitment to self-evaluate and self-critique one's own culture and assumptions (Bischoff, 2003)

1. To start, what drew your interest in participating in this project?

**Part 2: Demographic information**

2. To help with contextualizing the results of this project, I would like to learn a bit about your training and practice:

What is your training background?

For how long have you practiced as a mental health professional?

Please elaborate on the type and extent of your experiences providing mental health services to Indigenous clients.

Please describe your model(s) or approaches to your work.

What type of professional development have you pursued that has been helpful in decolonizing your practice?

**Part 3: Focused interview questions**

1. There are various ways that mental health professionals understand the term ‘decolonization.’

What does decolonization mean to you as a mental health professional?

What impact does this have on your understanding of clients’ presenting concerns (please provide examples, without compromising client confidentiality)?

What impact does this have on your understanding of intervention (please provide examples, without compromising client confidentiality)?

2. To be a “cultural ally” to Indigenous Peoples means acknowledging the privilege that settler cultures have and take for granted. It also means you challenge and work towards breaking down those barriers that continue to violate Indigenous Peoples.

As a non-Indigenous mental health professional, what does becoming or being a “cultural ally” mean to you?

How has becoming or being a “cultural ally” challenged you as a person and professional (please provide details without compromising client confidentiality)?

How has seeking to become a “cultural ally” impacted your sense of self and your work?

3. “Cultural humility” is an important part of multicultural competence and is gaining increasing recognition in mental health service training and provision.

What does this term mean to you?

How do you practice “cultural humility” in your work with Indigenous clients (please provide some examples while maintaining client confidentiality)?

4. To achieve successful outcomes for Indigenous clients, what are the most vital components of mental health services (probe each area identified [culture, family, community, etc.] for specific information while maintaining client confidentiality)?

5. What Indigenous ways of knowing and doing have you encountered when working with Indigenous clients (probe for details based on participants’ answers). Please describe.

6. How have you practiced more holistically when counselling Indigenous clients (probe identified ways, such as mental, physical, emotional, and spiritual dimensions of experience)? Please describe.

7. Some Indigenous scholars use the term “two-eyed seeing approach” where Western and Indigenous traditions are combined. How do you combine Western mainstream psychological therapies with Indigenous traditional healing in your counselling practice? Please describe.

8. For many Indigenous Peoples, reclaiming their tradition, culture, spirituality, and language is vital for resilience and resurgence. How do you help your Indigenous clients in these areas? Please describe and provide examples (without compromising client confidentiality).

9. As a mental health professional and cultural ally, are there ways you advocate for and contribute to social justice for Indigenous Peoples (e.g., Truth and Reconciliation Commission; Idle No More)? Please provide details (without compromising client confidentiality).

10. What more do you think you need to do in the mental health service provision area to provide the best service possible for Indigenous clients? Please elaborate.

**Part 4: Closure**

12. What was it like for you to share your experiences as a mental health professional?

13. Is there anything we've missed about your experiences of decolonizing your mental health services that you'd like to share? If so, please elaborate.

14. What are your recommendations to other mental health professionals who wish to explore how to decolonize their practice?

*Thank you for contributing to this research! Your time and energy are most appreciated!*



**Appendix H: Transcript Release and Review Form**

Research Ethics Boards (Behavioral and Biomedical)  
Transcript Release and Review Form

**Study:** *Non-Indigenous Mental Health Professionals' Experiences of Decolonizing Their*

*Practice*

I, \_\_\_\_\_, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge the transcript accurately reflects what I said in my personal interview with the student-researcher, Lorna Beech I hereby authorize the release of this transcript to Lorna Beech to be used in the manner described in the Consent Form. I have received a copy of this Transcript Release and Review Form for my own records.

*Name of Participant* \_\_\_\_\_ *Date* \_\_\_\_\_

*Signature of Participant* \_\_\_\_\_ *Signature of Researcher* \_\_\_\_\_

Or

**Oral Consent:**

I read and explained this consent form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

\_\_\_\_\_  
*Name of Participant*

\_\_\_\_\_  
*Researcher's Signature*

\_\_\_\_\_  
*Date*