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Mapping Tensions of Non-Indigenous Clinicians Working with Indigenous Peoples in a Counselling Context

by

Samara Wessel

A THESIS

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Abstract

Despite the need for intervention following the discovery of thousands of Indigenous children's unmarked graves across Canada in 2021, access to culturally safe mental health services for Indigenous Peoples is limited. Predominant Western treatment methodologies tend to operate from a colonial lens, privileging biomedical models that pathologize Indigenous clients for challenges that are sociocultural in nature. While psychological training programs, particularly in counselling psychology, have recently emphasized multicultural training, the adequacy of such programs in preparing clinicians for working with Indigenous people is still in question. Inadequate training can negatively impact counsellor performance and result in further marginalization and discrimination. Given these concerns, this thesis explores the tensions that non-Indigenous counselling psychologists encounter when working with Indigenous individuals to identify how non-Indigenous therapists can align themself with the principles that guide Indigenous approaches to wellness. In line with Indigenous ethics, a circular approach is used. Individual interviews with two Indigenous (one Cree and one Anishinaabe) Collaborators provided insight into the relevance and structure of the talking circles with five registered psychologists. A concept map of salient points was created to explore participant responses. The Indigenous collaborators were then invited back to a second interview to provide input on the findings and insights into how they related to Indigenous conceptions and approaches to wellness. This study discusses the implications of the findings for individual counsellors, organizations, and the discipline to provide culturally safe and relevant care to Indigenous individuals. Finally, it provides suggested areas for future research.

Preface

This thesis is original, unpublished, independent work by the author, S. Wessel, which receive ethics approval from the University of Calgary Conjoint Faculties Research Ethics Board (CFREB) on July 26, 2022 (Ethics application #: REB22-0232). The following study was not funded by any external sources, thus there are no conflicts of interest to state.

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Finally, I wish to thank my partner, Alex Young, for moving provinces and providing unwavering support throughout this process. Thank you for your hours of editing and positive encouragement. Thank you to my parents for supporting me through this journey and to my sister, Hailey, for being a constant cheerleader and a light in the dark.

Dedications

I dedicate this work to my mother, Judy Wessel, who worked tirelessly and made countless sacrifices to get me to where I am today. Your unwavering belief in me and encouragement made this possible.

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List of Abbreviations

BC	British Columbia
CPA	Canadian Psychologist Association
DTE	Downtown Eastside
FNIGC	First Nations Information Governance Centre
IRP	Indigenous Research Paradigm
RC	Relational Constructionism
RTC	Reflexive Thematic Analysis
TRC	Truth and Reconciliation Commission

CHAPTER ONE: INTRODUCTION

Situating Myself

As a white settler growing up in the Okanagan area of British Columbia (BC), traditionally the unceded territory of the Syilx, Secwépemc, and Nlaka'pamux peoples, I am cognizant of the privilege that I hold. I have been blessed to grow up in an area as beautiful and bountiful as the Okanagan for which the outdoors and nature has greatly shaped my conceptions of wellness. My parents are divorced so whenever I would visit my father in a neighbouring Okanagan town, he would take me on hikes where we would fish and camp. This connection to wildlife always brought me a sense of calm and peace. To this day, whenever I am feeling overwhelmed or burdened, I return to the woods where I feel a deeper connection or a sense of being rooted. The tendrils of these roots connect to the plants, animals, and other living beings providing a sense of wholism and connectedness. I find this feeling of connectedness harder to contact in the hustle of our capitalist consumer culture, which often results in feelings of isolation, competitiveness, and individualistic tendencies. Perhaps it is for this reason that I find myself gravitating towards a more communal approach in my therapeutic and research work.

As a young child, I was raised with two first-generation residential school survivors. However, it was not until I was an adult that I learned this. Traversing the educational system and everyday life with these individuals, I saw that their experiences were different from mine, but I never truly understood why. My formal education regarding Indigenous relations and colonialism was dismal. It was not until I was working as a mental health and addictions support worker that I received a more in-depth review of the realities of residential schools. Yet, the residential schools are only a small part of the horrific history and the continued oppression of Indigenous People in Canada. In addition, despite having Indigenous family members, the

knowledge and understanding within my familial household was low. Growing up in a single income, lower socio-economic household, I was not aware of my white privilege, or the systematic structures that oppress not only Indigenous Peoples but all people of color. I was raised with the ideology that ‘if you work hard, good things will happen’ and one must ‘pull oneself up by one’s bootstraps.’ This dogma is devoid of the power and privilege that shape and influence an individual's ability to ‘excel’ in our society. Instead of recognizing the systemic structures inherent in our society, this ideology posits that it is the fault of the individual for not succeeding. As an adult I have come to recognize the misgivings of these viewpoints. I strive to continue learning about and being consciously aware of the power and privilege that I bring into my work, research, and daily interactions. It is from this lens of learning and awareness that I approach my thesis work.

How I Came into this Work

After completing my undergraduate degree in psychology, I worked as a mental health and addictions support worker for several years, primarily servicing Vancouver, BC's Downtown Eastside (DTEs). Within Vancouver, the DTEs has the highest proportion of Indigenous people (31%) in the whole city (Reporting in Indigenous Communities, 2016). As such, many of the clients that I encountered were Indigenous. As a non-Indigenous mental health practitioner, I witnessed firsthand the impacts of colonialism and its continued oppression and marginalization of Indigenous people. I was continually confronted by the lack of culturally appropriate services available to the people I served. The prescribed treatment approach was consistently grounded in an individualistic approach to mental health and substance misuse wherein the cause of the problem was framed as residing within the individual, disregarding larger societal and community factors often associated with them.

The well-known proverb, "the road to hell is paved with good intentions," was evident among the mental health workers in the DTEs. In my experience, the majority of clinicians and support workers with whom I came into contact with were well-meaning and altruistic in their desire to help. That said, they were nescient to the harm that adhering to Western approaches to mental health and wellness was inflicting on Indigenous people. The organizations these staff members belonged to and others I interacted with, usually provided a seminar or training course on Indigenous Peoples and the history of colonialism. However, these were limited to half-day training sessions that lacked insight into how staff should approach working with Indigenous individuals. Recognizing this gap led to my desire to explore potential areas of tension within service provision, to identify pathways for non-Indigenous clinicians to work ethically with Indigenous individuals.

Philosophical Orientation

In approaching this work, I am cognizant of the history of harm associated with non-Indigenous researchers investigating Indigenous Peoples (Mosby, 2013; Smith, 1999) and the ongoing concerns surrounding the continued use of Western approaches to address the mental health needs of Indigenous Peoples (Linklater, 2014). Being mindful of these concerns, my philosophical and theoretical lens encompasses relational constructionism (Gergen, 2011; Hosking, 2011a) and the communally constituted concept of self (Lacerda-Vandenborn, 2020; *Communal Self* herein) respectively. The individualistic conception of selfhood that dominates psy-disciplines primarily ignores the historical, social, cultural, and political contexts that influence an individual's health and well-being (Lacerda-Vandenborn, 2020). Dr. Lacerda-Vandenborn (2020) conceptualizes the communal self as an alternative conception of selfhood, one that is grounded in an understanding that selfhood is not an individual activity; we are not

born into or exist in a vacuum. The communal self finds roots in critical hermeneutics and Indigenist philosophy while simultaneously pulling from socio-cultural and critical theoretical perspectives (Lacerda-Vandenborn, 2023). Informed by these philosophical perspectives, the communal self predicates that selfhood is "a socially constituted accomplishment, fostered in social interactivity within systems meanings situated in a larger historical, social, cultural, and political context" (Lacerda-Vandenborn, 2020, p. 29). In this manner, communal selfhood is concerned with, and grows out of, cultural situatedness, agency, and ideology and power (Lacerda-Vandenborn, 2023). Ontologically, the communal self is an iterative process of meaning-making and becoming through its interactions with preceding cultures, societies, traditions, practices, and histories, which epistemologically cannot be understood outside of these contexts (Lacerda-Vandenborn, 2023).

In what concerns decolonization, Lacerda-Vandenborn (2020) argues that the communal self is consistent with the Indigenous concept of self-in-relation. She posits that the communal self creates an ethical space between Indigenous and Western perspectives where non-Indigenous scholars and clinicians who neither identifies with Western perspectives nor ethically can speak to Indigenous perspectives can situate themself and actively take up decolonizing and reconciliatory actions (Lacerda-Vandenborn, 2020). It is from this space that I approach this thesis. The communal self allows me to ethically position myself to acknowledge the history and legacy of colonialism and walk alongside Indigenous perspectives, without appropriating Indigenous knowledges and practices (Lacerda-Vandenborn, 2020).

Furthermore, the communal self is closely related to relational constructionism (RC), which places social and relational contexts as paramount to creating knowledge and understanding (Gergen, 2011). Within an RC framework, knowledge and meaning are

constructed through language and social interactions, which are inherently tied to various cultural, historical, and institutional factors. I will elaborate further on RC in the methodology chapter of this thesis. Together the communal self and RC allow me to apply a critical lens and work in a decolonial manner to map the tensions of non-Indigenous psychologists working with Indigenous clients.

Motivation for this Work: Indigenous Peoples and Counselling Psychology

Indigenous Peoples worldwide suffer a disproportionate number of mental and physical illnesses compared to their non-Indigenous counterparts (Kirmayer & Valaskakis, 2009; Kral et al., 2011; Marrone, 2007; Nelson & Wilson, 2017; Smylie & Firestone, 2016; Waldram et al., 2006). The linking factor uniting the more than 476 million Indigenous Peoples across the globe (United Nations, n.d.) is their shared experiences of colonization and a loss of traditional lands (Brown-Rice, 2013; Nelson & Wilson, 2017), historical traumas (Smallwood et al., 2020), and racism (Paradies, 2016). In 2021, the Canadian Census counted over 1.8 million Indigenous people, 5% of the total population in Canada, and is projected to grow over the next two decades (i.e., exceed 2.5 million persons; Statistics Canada, 2022). Given the rising population, in combination with the high rates of mental health concerns prevalent among Indigenous Peoples, it is reasonable to believe that non-Indigenous counselling psychologists will work with an Indigenous client at some point in their career. Therefore, it is imperative that non-Indigenous therapists are informed about the impacts of Canada's colonial history and are equipped to provide culturally appropriate services to Indigenous clients.

The profound inter- and multi-generational historical trauma (Brave Heart et al., 2011; Chansonneuve, 2005; Duran et al., 1998; Linklater, 2014) caused by the residential schools, displacement from ancestral lands, and the physical and cultural genocide of Indigenous Peoples

is well documented (Truth and Reconciliation Commission of Canada [TRC], 2015a). Moreover, literature from around the world has continually linked social inequalities that stem from colonialism with adverse health outcomes (e.g., infant mortality, high rates of acute or chronic pain, and high rates of injury; Commission on Social Determinants of Health, 2008; Elias et al., 2012; King et al., 2009) and adverse life events (e.g., high rates of homelessness, experiences with the child welfare system, and involvement in the criminal justice system; Linklater, 2014). Along with experiencing increased health and social inequities, the prevalence of mental illness is significantly greater among Indigenous Peoples than among their non-Indigenous counterparts (Ansloos & Dent, 2021; Gone & Trimble, 2012; Nelson & Wilson, 2017; Kirmayer et al., 2000). In Canada, Indigenous Peoples experience higher rates of depression, substance misuse, violent victimization, and suicide (Ansloos & Dent, 2021; Boksa et al., 2015; Kirmayer et al., 2000). Nelson and Wilson (2017) emphasize that to this day, colonialism operates on several levels (e.g., structural, distal, and proximal) within Canada, which continues to oppress Indigenous Peoples. Moreover, researchers (e.g., Duran & Duran, 1995; Gone, 2013; Kirmayer et al., 2000; Waldram, 2009) have argued that colonialism is both a factor contributing to mental health issues among Indigenous communities, and a system that can shape mental illness according to its own standards and definitions (Nelson & Wilson, 2017). For instance, since the majority of research on Indigenous mental health centers on colonial, non-Indigenous concepts, there is potential to misrepresent Indigenous mental health (Nelson & Wilson, 2017).

Despite the urgency for supportive services, it is widely acknowledged that the predominant Western treatment methodology does not serve Indigenous populations well (Hodge et al., 2009; McConnochie et al., 2012; Mehl-Madrona, 2007). Sones et al. (2010) highlighted that the absence of culturally appropriate care and the lack of Indigenous healing options greatly

impact Indigenous Peoples' mental health and wellness. Ojibway scholar Renee Linklater (2014) considers that compared to Western psychology, Indigenous wellness philosophies are wholistic approaches that consider spiritual, emotional, mental, and physical aspects. Conversely, Western psychology tends to focus solely on the mind and behaviour, treating the mind as a separate entity from the body (Linklater, 2014). Moreover, given the historical and ongoing marginalization and oppression of Indigenous Peoples, there is often mistrust of white healthcare professionals (Allan & Smylie, 2015; Barlow et al., 2008). Mental health services are often viewed as inaccessible and culturally insensitive (Uchelen et al., 1997). Those who do seek care are further subjected to racism, alienation, and traumatization (Barlow et al., 2008; Linklater, 2014). It is common for Western clinicians to misinterpret culturally influenced Indigenous behaviour as psychopathology (Linklater, 2014). For instance, an Indigenous youth who may present as passive and not forthcoming, may be misinterpreted by a psychologist as displaying resistance, passive-aggression, and depression-like behaviours. This misinterpretation may possibly result in an erroneous depressive or personality disorder diagnosis if the youth's cultural background is not taken into account (Brant, 1990). Moreover, it has been noted that compared to white clients, First Nations clients are more than twice as likely to not return after a first counselling session (McCormick & France, 1995). Given these concerns, scholars posit that adherence to Western approaches maintains the colonization process and continues to medicalize the experiences of Indigenous Peoples, further pathologizing them for something that is socio-cultural in nature (Duran, 2006; Linklater, 2014). As such, it is paramount that mental health clinicians consider how to provide culturally appropriate services for Indigenous Peoples.

Despite the overwhelming literature outlining the barriers to access and delivery of mental health services for Indigenous clients, there remains a paucity of research on culturally

safe counselling practices adopted by non-Indigenous clinicians working with Indigenous clients. Bowden and colleagues (2017) highlight that inadequate training can result in a number of serious issues. From a professional standpoint, being ill-equipped to work with Indigenous Peoples can negatively impact counsellor performance and the therapeutic alliance. Most importantly, from a client's perspective, it may result in further suffering and oppression. To address this disparity in mental healthcare, the TRC (2015b) Calls to Action reinforced the need for psychological educational programs to address clinician readiness to attend to Indigenous Peoples' mental health. While the Canadian Psychological Association (CPA; 2018) responded with an Indigenous Taskforce document, in the field, this has not been taken up in its entirety, or in a nuanced manner. That is to say, Indigenization and decolonization of practice remains localized to particular aspects of Indigenous ways of healing. Few counselling psychology training programs offer specific courses on Indigenous mental health (Ansloos et al., 2022; Bowden et a., 2017). While many programs have started incorporating multicultural counselling coursework, the abovementioned distinctiveness of Indigenous experiences is not adequately addressed in the multicultural literature (Bowden et al., 2017). Indigenous wellbeing is often lumped into multicultural competence training. A main source of difficulty in this conflation is that it fails to address the unique experience of oppression among Indigenous Peoples and their deeply problematic (historical) relationship to the Crown, which cannot be said of other cultural groups in Canada. With respect to culturally sensitive counselling, clinicians trained in cross-cultural or multicultural approaches may hold differences in paradigmatic perspectives, creating barriers to providing effective counselling services (Stewart, 2008). Mohawk psychologist and scholar Rod McCormick (1996) outlines the necessity for counselling providers to understand Indigenous Peoples' traditional worldviews in order to communicate effectively and counsel

Indigenous clients. He posits that different worldviews result in different perspectives on mental health causes and treatment (McCormick, 2001). Further, scholars (e.g., Blue, 1977; France et al., 2004; Garrett & Herring, 2001; McCormick, 1996) suggest that to provide effective care, clinicians must be knowledgeable about the historical, social, and political implications Indigenous Peoples confront as well as be educated in culturally based local traditions and the cultural notions of Indigenous mental health (Stewart, 2008). As such, more research is required to determine how non-Indigenous clinicians can best implement counselling approaches to address the needs of Indigenous clients.

This Research

Indigenous Peoples have been the subject of study for over a century, often by non-Indigenous researchers (Assembly of First Nations, 2009), and copious amounts of research highlight the disparities between Indigenous and non-Indigenous people (Kirmayer & Valaskakis, 2009; Kral et al., 2011; Marrone, 2007; Waldram et al., 2006). While the literature base demonstrates the ineffectiveness of Western approaches to mental health with Indigenous clients, there remains a paucity of approaches that non-Indigenous clinicians can implement to work with Indigenous clients in an ethical manner. For this reason, the current study aimed to better understand how non-Indigenous counselling psychologists can ethically work with Indigenous individuals by examining the tensions and barriers non-Indigenous counselling psychologists encounter when working with Indigenous clients. This information was synthesized into a map intended to be used as a tool to guide ways in which counsellors can ethically align themselves alongside Indigenous helping models to provide culturally safe care to Indigenous clients. To that end, I consulted with two Indigenous (one Cree and one Anishinaabe) Collaborators before engaging with five non-Indigenous counselling psychologists who

participated in this research. Although limited, my prior exposure working with Indigenous Elders in Vancouver helped inform my communications with the Indigenous collaborators, and how I approached the talking circles with the non-Indigenous counselling psychologists.

In Chapter 2, I offer a succinct literature review on Indigenous conceptions of wellness, the impacts of colonialism on Indigenous Peoples' health and well-being, differences in conceptualizations and worldview between Indigenous and non-Indigenous people, and cultural safety when working with Indigenous individuals. In Chapter 3, I provide an overview of the philosophical and theoretical approaches utilized in the study. Namely, relational constructionism and communal selfhood. I also offer a description of methods used to gather and analyze the data. Chapter 4 includes a presentation of the findings for each phase of the study. Lastly, in Chapter 5, I will discuss the findings in relation to the existing literature base, and outline their implications for the field of counselling psychology. I conclude the study proposing areas of future research directions, and a personal statement.

Finally, throughout this thesis, I have made a conscious effort to limit the use of the term *client*. Referring to the individuals we assist as clients transforms the counselling process into a transactional exchange, reinforcing the notion of expertise and widening the power imbalance between the person seeking help and the clinician. While this discussion is beyond the scope of this paper, what suffices for the purposes of this research is my positioning. Consider Lacerda-Vandenborn (2023) for the many connections between the individualistic understandings and ideals promoted by psy-disciplines and neoliberal governmentality. Psychological disciplines, among others, are charged with creating and promoting enterprising (and individualistic) concepts and language that sustain individualization, away from social context and social justice. A simple expression used in mental health, such as "a 'client' should 'invest' and 'manage' their

mental health" reveals this language and ideals. Rustin (2015) argues that the favouring of individualist approaches, such as cognitive behavioural therapy and other standardized methods, contains elements of marketisation, as therapeutic interventions are branded and sold as packaged commodities. In light of this, I attempted to minimize the use of the term wherever possible. The reader will note that most of the occurrences of the term appear in the literature review chapter (Chapter 2) and the findings from the data analysis (Chapter 4).

CHAPTER TWO: LITERATURE REVIEW

Indigenous Peoples' well-being is intricately linked to historical and ongoing colonialism. For this reason, the following chapter aims to provide an overview of the literature as it pertains to Indigenous Peoples, colonization, and counselling psychology. I begin by briefly discussing Indigenous Peoples' conceptions of wellness and healing, focusing on concepts such as wholism and interconnectedness. Next, I highlight the effects of colonization on Indigenous Peoples, emphasizing their remarkable resistance and perseverance in the face of attempts to eradicate their culture and existence. I consider that despite the closure of the last Indian Residential School in 1996, the legacy of colonialism persists through systemic oppression and racial aggressions within society. I also address some of the implications of historical and ongoing colonialism on mental health to evidence the urgent need to ensure that Indigenous Peoples have access to high-quality mental health care. Despite enormous and persistent need, current Western systems of mental health have not served Indigenous Peoples well. Specifically, most Western approaches to mental health adhere to biomedical models that situate illness and a deficit-based lens at its center, perpetuating colonial harm (Thiessen et al., 2020). I advance that in addition to issues of availability, there are marked differences in Indigenous philosophical understandings of wellness. Considering the contrasting worldviews and methodologies at play, I highlight the risks that non-Indigenous clinicians pose to Indigenous individuals seeking psychological assistance. In support of this view, I provide literature demonstrating the difficulties Indigenous individuals often encounter when seeking counselling services and the commonly reported negative experiences including racism, discrimination, and dismissal of traditional cultural healing. Lastly, I highlight the issues surrounding the use of cultural competency, which can create a dichotomy of being either component/incompetent. Instead, I

propose the use of cultural safety, which empowers the client to determine whether a counselling encounter is safe. By considering these areas, we can strive to enhance the effectiveness and appropriateness of mental health counselling for Indigenous Peoples.

Before proceeding, it is important to note the diversity among Indigenous Peoples. While the United Nations Declaration on the Rights of Indigenous Peoples (n.d.) does not have an official definition of "Indigenous," the term is commonly used to refer to the descendants "of those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived" (p.1). Moreover, Indigenous Peoples have "unique traditions, they retain social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live" (United Nations Permanent Forum on Indigenous Issues, n.d., p. 1). As a result, Indigenous Peoples are often referred to by other names within their respective countries (Nelson & Wilson, 2017). Within Canada, the Constitution (Canadian Charter, 1982) defines Indigenous Peoples as First Nations, Métis, and Inuit Peoples, all of whom have unique histories, languages, cultural practices, and spiritual beliefs (Government of Canada, 2022). The over 630 First Nations communities represent more than 50 Nations and languages, thus highlighting the diversity among the Indigenous Peoples in Canada (Government of Canada, 2022). For consistency, the term Indigenous will be used throughout this thesis. However, the use of the term should not be taken as dismissive of the diversity among Indigenous groups, nor as representative of all Indigenous Peoples.

Indigenous Peoples and Wellness

Since time immemorial, Indigenous Peoples have held knowledge in ways of healing and wellness (Linklater, 2014). Indigenous ways of healing encompass therapeutic knowledge and healing practices such as rituals and ceremony, plants and herbal remedies, and prayer, all of

which are grounded in a wholistic understanding based on the spiritual (Cohen, 1998; Gone, 2021; Linklater, 2014). The principle of wholisim in which all things are interrelated permeates Indigenous conceptions of health and wellness (Cohen, 1998; Linklater, 2014) and commonly involves relations to land and nature, language, ancestry, and community (Fiedeldey-Van Dijk et al., 2016; Hatala et al., 2019). Linklater (2014) describes the concept of interconnectedness as focusing "on the internal aspects of a person and extending far beyond individual existence" (p. 84). She goes on to explain that,

> Indigenous healing begins with a person's Spirit and encompasses everything that culminates in a person, such as their emotional, mental and physical parts of the self, and furthermore, how they are situated among their family, community, nation and all of Creation (p. 85)

Hence, the sum of the whole is greater than the parts and balance between the physical, the emotional, the mental, and the spiritual is necessary for good health (Cohen, 1998; Linklater, 2014; Struthers et al., 2004; Waldram et al., 2006).

While similar healing philosophies are held among Indigenous Peoples, their wellness practices are not monolithic; and vary in determining or identifying unbalance between nations and healers (Struthers et al., 2004). A well-known model some North American Indigenous Peoples use is the Medicine Wheel (Charlton, 2020). The Medicine Wheel is a circular shape containing four quadrants (Bopp et al., 1984) that can be used to represent the four cardinal directions (north, east, west, south); the aspects of self (i.e., physical, emotional, mental, and spiritual); the stages of human development; the four sacred medicines: tobacco, sage, sweetgrass, and cedar; and relationship with other beings (e.g., animals, plants, spirits; Beaulieu, 2011; Linklater, 2014; McCabe, 2008). Regardless of the components and variation in

interpretation, Cree scholar Michael Hart (1999) posits that the Medicine Wheel reflects key concepts of wholeness, balance, connectedness, harmony, growth, and healing. The philosophy inherent in the Medicine Wheel is that integration of the four aspects of self is necessary for meaningful experiences and the activation of healing processes (McCabe, 2008). In this way, Indigenous 'medicine' and 'spirituality' are intricately linked and cannot be separated (Waldram et al., 2006). Waldram and colleagues (2006) highlight that within Indigenous cultures, illness is understood as both stemming from natural and supernatural causes. They note that "the world is seen as a place in which harmony and balance exist between and among human beings and other spiritual or 'other-than-human' entities, and serious illness is indicative of a disruption in this balance" (Waldram et al., 2006, p. 131). As such, balance and harmony are paramount to Indigenous healing philosophies (Linklater, 2014; Waldram et al., 2006). When approaches to wellness focus on single quadrants such as the heavily physical and cognitive approaches utilized in biomedical models to mental health, individuals continue to experience a sense of unbalance. From a Western perspective, this would be akin to choosing to treat a single symptom from the ones listed by a given patient.

Colonialism and Mental Health

Before exploring the implication of colonialism, it is important to emphasize that Indigenous Peoples have demonstrated tremendous resiliency, resistance, and survivance in the face of colonial subjugation and the physical and cultural genocide inflicted upon them. Despite ongoing attempts of assimilation and acculturation, Indigenous languages, traditions, practices, and communities remain. Current efforts towards cultural revitalization, including the resurgence of Indigenous languages, Indigenous self-determination and governance efforts, and movements

such as the Land Back campaign and Idle No More protest movement, are a testament to Indigenous Peoples' strength and determination in the face of continued colonial violence.

While Indigenous Peoples have demonstrated remarkable resilience and perseverance, colonialism has had a significant impact on Indigenous Peoples' health and wellbeing (Gracey & King, 2009). For over a century, Indigenous Peoples in Canada have endured extreme physical and cultural genocide (TRC, 2015a). The Canadian government systematically removed, displaced, and dispossessed Indigenous Peoples of land, banned language, spiritual and cultural practices, persecuted spiritual leaders, and government officials confiscated and destroyed sacred objects (TRC, 2015a). As outlined in the seminal Truth and Reconciliation reports (2015a):

> The central goals of Canada's Aboriginal policy were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the Treaties; and, through a process of assimilation, cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada. (p. 10)

Among the most heinous ways of disrupting cultural knowledge and traditions was the forcible removal and separation of children from their families. This has been accomplished through Indian Residential Schools, the Sixties Scoop, and persists today through the child welfare system in what has been deemed the Millennial Scoop. These policies and measures ultimately aim(ed) to eradicate Indigenous Peoples and assimilate them into the dominant Canadian culture (TRC, 2015a).

While attending Residential Schools, 'students' were often subjected to abhorrent and grotesque forms of physical, psychological, and sexual abuse (Barker et al., 2017, TRC 2015a). Upon arrival, their hair, which often held spiritual significance, was cut. They were given new names and numbered, segregated from the opposite gender, and not allowed to interact with their

brothers or sisters (TRC, 2012). Poor living conditions and diet made many susceptible to illness, and epidemic diseases were rampant. In his essay, Indian Affairs 1876-1912, deputy minister of Indian Affairs Duncan Campbell Scott publicly admitted that “it is quite within the mark to say that fifty percent of the children who passed through these [residential] schools did not live to benefit from the education which they had received” (Scott, 1914, as cited in TRC, 2015c, p. 365). In recent years, this fact has become more salient for the non-Indigenous population with the horrific findings of the remains of 215 Indigenous children buried on the site of a former Indian Residential School in Kamloops, B.C., in May 2021, and the many thousands of others that followed across Canada. The implications of Residential Schools and the continued apprehension of Indigenous children into child welfare systems have had a reverberating effect impacting all levels of Indigenous Peoples’ social structures, including parents, partners, children, grandchildren, and their communities (TRC, 2015a).

Colonialism and Cultural Suppression

Colonial subjugation is intimately connected with the privileging of Euro-settler ideologies of health and wellness. At the time of first contact, Euro-settlers commonly viewed Indigenous traditional healing as illegitimate (Akena, 2012) and Indigenous culture as “savage and brutal” (TRC, 2015d, p. 4). This fueled the belief of superiority among European civilization and Christian religions (TRC, 2015e). As critical scholar Paulo Freire (2000) predicates, the dominant group—or the one who holds the most power—determines the values and norms a society upholds, while the oppressed group’s beliefs, culture, and language are not considered. In the context of wellness, this is observed in the dynamic of Euro-settlers and Indigenous Peoples, wherein Indigenous healing practices were interrupted and suppressed (Robbins & Dewar, 2011). The Canadian government outlawed traditional medical practices and ceremonies such as

the Sun Dance and the Potlatch (Robbins & Dewar, 2011). Cultural suppression was further engineered by banning Indigenous languages. Given the oral tradition of Indigenous cultures, banning Indigenous languages disrupted cultural transmission through stories, ceremonies, songs, and the ability to communicate with older generations and Elders (Barker et al., 2017). In doing so, Indigenous Peoples and their communities were rendered unable to address physical and mental health problems in a culturally determined manner. It forced them to rely on Euro-Western approaches, which are often viewed by Indigenous scholars as inappropriate (Linklater, 2014; Mehl-Madrona, 2007), and as sustaining cultural eradication and oppression (Duran, 2006; Gone, 2007). Indeed, Gone (2013) highlighted a conversation with a reservation traditionalist in which he denoted:

> The origins of these "mental health" problems as arising not from polluted genes or broken brains—or even as a legacy of wounded childhood or collective psychic trauma—but rather as a consequence of the colonial subjugation of Indigenous ceremonial knowledge and practice. (p. 314)

This quote further underscores the harm imparted by colonial involvement, the continued undervaluing of Indigenous healing traditions, and the lasting implications of continued adherence to Euro-Western psychological healing practices.

Colonial Legacy

While Indigenous Peoples have thwarted attempts of forced cultural subjugation, the violence and oppression have had profound transgenerational effects on the health and well-being of Indigenous Peoples and their communities (Wilk et al., 2017). For instance, the disruption in parenting caused by Residential Schools meant a loss of traditional parenting approaches, which were replaced by the punitive experiences inherited from Residential Schools

(Kirmayer et al., 2003). Instead of receiving warmth and intimacy throughout their childhood, children who attended residential schools were subjected to maltreatment and neglect (Barnes & Josefowitz, 2019; Kirmayer et al., 2003). These experiences, compounded with the devaluing of Indigenous identity, the loss of language, knowledge, and traditions, left many Indigenous children experiencing guilt, shame, and accumulated stress (Barnes & Josefowitz, 2019; Corrado & Cohen, 2003; Kirmayer et al., 2003; TRC, 2015e), which resonated on a collective level impacting family and community (Kirmayer et al., 2003).

Despite the closure of the last Residential School in 1996, their legacy and the assimilative governmental policies continue in the present day. Indigenous Peoples continue to endure racism and systemic discrimination, which is reflected most profoundly in Canada's child welfare and criminal justice systems where Indigenous Peoples represent 52.2% and 33% of the population involved in those services respectively (Statistics Canada, 2022; TRC, 2015a). A recent survey identified that Indigenous Peoples were more likely to experience discrimination compared to both non-Indigenous and non-visible minorities (33% versus 16%), with levels of reported experiences of discrimination increasing from 23% in 2014 to 33% in 2019 (Cotter, 2022). Extensive research (Duran & Walters, 2004; Njoroge et al., 2021) has firmly established the detrimental impact of persistent racism, discrimination, and oppression on the psychological well-being of Indigenous Peoples.

Implications on Mental Health

Given the historical and ongoing oppression of Indigenous Peoples, it is not surprising that there is a longstanding literature base establishing that Indigenous Peoples suffer from disproportionately high rates of mental illness (Gone & Trimble, 2012; Nelson & Wilson, 2017). The construct of historical trauma (Brave Heart, 1998, 1999) has been utilized to explain the

health disparities among Indigenous Peoples. It universally denotes the legacy of colonization and the resultant subjugation of Indigenous Peoples (Gone et al., 2019). Maria Yellow Horse Brave Heart (1998) a Lakota scholar and social worker defines historical trauma as cumulative trauma, including Post-Traumatic Stress Disorder (PTSD) and psychic trauma that spans the individual's life and across generations. Scholars (Boksa et al., 2015; Gone et al., 2019) posit that the implications of ongoing intergenerational historical trauma have led to shared vulnerabilities and increased psychological concerns among Indigenous Peoples and communities.

While suicide itself is not a mental illness, it is often considered the pinnacle of distress. The effects of suicide are not isolated and have reverberating implications on the health and well-being of family, friends, peers, and community, especially when suicides are carried out in large numbers within communities (Centers for Disease Control and Prevention, 2023). Within Canada, Indigenous Peoples have higher rates of suicidal thoughts and attempts (Boksa et al., 2015; Kirmayer et al., 2000; Kral et al., 2011), grief and loss (Stewart & Marshal, 2015), alcohol and substance use disorders (Snijder et al., 2020), violent victimization (Cunneen & Rowe, 2015), homicide victimization (Monchalin et al., 2019), and higher levels of psychiatric disorders (Kirmayer et al., 2000). For instance, one study found that within their sample, nearly half (49%) of the Indigenous participants met the criteria for PTSD compared to their non-Indigenous participants (26%; Bingham et al., 2019). When examining suicide, Indigenous Peoples' rates are two to three times higher than non-Indigenous peoples in Canada. The rate of suicide among First Nations individuals, is three times higher and roughly twice as high among Métis people (Kumar & Tjepkema., 2019). Moreover, for First Nations people living on reserve, the rate of suicide is twice as high as those living off reserve (Kumar & Tjepkema, 2019). Alarmingly, among the Inuit population, suicide rates are nine times higher (Kumar & Tjepkema, 2019) and

are among the highest in the world (Hajizadenet al., 2019). In addition to mental health disparities, Indigenous Peoples are more likely than non-Indigenous Canadians to suffer from a range of health problems such as tuberculosis, diabetes, heart disease, hypertension, and long-term disability (Kirmayer et al., 2003). The alarming disparities among Indigenous Peoples caused by historic and ongoing colonialism underscores the necessity for culturally safe and accessible mental and physical health care services.

Western Psychology

Given the disproportionately high rates of mental health concerns among Indigenous Peoples and the malefic reverberations of intergenerational and historical trauma, the need for services is paramount. Despite recognition of this need, the majority of services available are grounded in Western paradigms that commonly ignore Indigenous cultures, histories, and current ongoing issues (McConnochie et al., 2012). For decades Western psychology has adhered to the biomedical model, which views mental health issues as “diseases of the brain” (Deacon & McKay, 2015, p. 231). This biologically based framework supports and maintains research in uncovering biological causes and has resulted in therapeutic treatment attempting to target biological dysfunction (Charlton, 2020). As such, medications that treat the “brain disease” or “chemical imbalance” causing the psychological problem have increasingly replaced psychosocial interventions as the primary treatment modality (Deacon & McKay, 2015). Furthermore, this approach emphasizes both reductionism and mind-body dualism (Engel, 1977), a metaphysical stance that the mind and body are distinct entities (Descartes, 1952). A significant impediment arising from the reductionist biomedical framework is the disregard for social, psychological, and behavioural facets of health (Engel, 1977). Instead, this model assigns the cause of illness to the individual.

In an attempt to address the fundamental flaws of the biomedical model, Engel (1977) advocated for the biopsychosocial model of illness. As the name suggests, the model expands understanding of health and wellbeing to include interactions between biological, psychological, and social factors (Charlton, 2020). Within counselling psychology, the biopsychosocial model has garnered significant attention. While this model is a step towards a more wholistic approach to mental health and wellbeing, there remain fundamental differences between Indigenous understandings. This is not to say the biomedical model is without merit. The biomedical model does have a place in aiding our understanding and supporting mental well-being. The critique advanced here refers to the ways in which the biomedical models have been elevated above all others and as the first intervention. Given recent years have seen a push for the critical analysis of the biomedical model (Deacon & McKay, 2015) especially when in relation to its use with Indigenous Peoples and their communities, it is important that thesis such as this one raise concern over the limitations of such mainstream approaches.

Individualism and Differing Worldviews

Psychology was created within capitalistic socioeconomic systems and is firmly embedded within Western individualism (Vermes, 2017). Vermes (2017) describes individualism as "the right of a person to pursue and maximize his/her own interests, over those of society, are paramount" (p. 48). As this definition suggests, critiques of individualism highlight the unscrupulous competition and the idea that individuals should be self-contained, such that they are self-sufficient and subsequently isolated (Waterman, 1981). Some psychological theorists (e.g., Maslow, Erikson, Rotter, Kohlberg) have reconceptualized individualism into normative (ethical) individualism, which promotes the pursuit of personal

goals while considering the needs and values of others (Waterman, 1981). However, Sue and Sue (1999) warn that this worldview may not be congruent with the worldviews of others.

Within counselling, it has been acknowledged that understanding the client's worldview is necessary for ethical and effective counselling that addresses the needs of the client (Arthur & Steward, 2001; Ibrahim, 1991: Sue, 1978). It is believed that our worldview influences our belief systems, assumptions, decision-making, problem-solving tactics, and conflict resolution (Ibrahim, 1991). As such, our worldview plays a key role in mediating the relationship between the helper and client (Ibrahim, 1991). McCormick (2001) highlights that differing worldview between client and provider result in divergent conceptions of the source and treatment of mental health issues. Hence, it is imperative to understand the client's worldview. In regard to Indigenous clients, it is important to assess the degree to which they adhere to a traditional worldview. As it will be expanded on the subsequent sections, Indigenous Peoples' connections to their traditional worldviews may have been severely impacted by colonization. In Linklater's (2014) work, she highlights an Indigenous practitioner's process for engaging therapeutically with a client as starting with understanding the individual's worldview as well as how the individual thinks about healing. The practitioner stated that this allowed him to gain an understanding of whether the client has a more linear perspective or wholistic perspective of the world, which is a crucial step in healing work (Linklater, 2014).

Indigenous Peoples and Counselling Psychology

Indigenous individuals and communities experience a number of barriers when seeking and receiving counselling services. Before receiving services, many Indigenous Peoples encounter difficulties accessing services within, or close to, their communities, and are often required to travel long distances (Cianconi et al., 2019; Mental Health Commission of Canada,

2017; Pomerville, et al., 2016). In situations where access is possible, the services often face significant challenges due to limited resources. These challenges manifest in various ways such as lengthy wait times, high rates of staff turnover, and inadequate communication infrastructure (Mental Health Commission of Canada, 2017). Even if services are available, differences in paradigmatic worldviews and ignorance of the historical and cultural contexts of Indigenous Peoples have led to fundamental differences between Indigenous and Western conceptions of mental health and healing. This creates significant barriers for Indigenous people accessing services (Stewart & Marshal, 2015). As described earlier, Indigenous conceptions of health and well-being are wholistically based. Hence, their needs may not be adequately addressed or recognized by the mind/body dichotomy of Western medicine (Westerman, 2004). Scholars (e.g., Duran, 2006; McConnochie et al., 2012; Westerman, 2004) argue that given these differences, the Western biomedical model is inappropriate or irrelevant to treat Indigenous Peoples.

Additionally, and in stark contrast to the Western biomedical model and individualism, serious unwellness is commonly attributed to external forces involving spirituality and relations with others (Westerman, 2004). This lack of cultural understanding among non-Indigenous clinicians has resulted in a combination of misdiagnosis, underdiagnosis, and overdiagnosis of Indigenous Peoples (Linklater, 2014; Sones et al., 2010; Westerman, 2004). For instance, Brant (1990) argued that clinicians often report expressions of cultural behaviours among Indigenous children as being passive, difficult to assess, and not forthcoming. These (mis)interpretations lead to misdiagnosis, creation of improper treatment plans, and the continued over-pathologization of Indigenous Peoples (Fellner et al., 2020; Linklater, 2014). The fact that Indigenous Peoples, and other minoritized cultures, have historically had little involvement in the development and validation of assessment measures used for diagnosis (Jones, 1996), means

misdiagnosis is “almost a surety” (Johnson & Cameron, 2001 p. 218). Moreover, there is an appalling history of abuse perpetrated through the medical system including forced medical experimentation such as nutritional experiments, vaccine testing, experimental surgical and drug treatments, and uninformed and coerced sterilization (Collier, 2017; Greenwood & MacDonald, 2021; Mosby & Swidrovich, 2021). In addition, given the role psychological expertise has played in child apprehension and custody adjudications in child welfare, there exists mistrust of mainstream mental healthcare (Sones et al., 2010). As a result, many Indigenous people do not seek medical or mental healthcare services.

Given the variation in understanding and approaches to addressing mental health, it is no surprise that Indigenous Peoples frequently perceive mental health services as ineffective. Indigenous people are significantly more likely to express having unmet needs than their non-Indigenous counterparts (Hodge et al., 2009) and are often confronted with inequitable services (Sones et al., 2010). Despite the *Canadian Code of Ethics* (CPA, 2017) outlining clinicians’ responsibility to uphold ethical values and responsibilities, systemic racism and discrimination still exist within our mental health services (Nuttgens & Campbell, 2010). Indigenous clients report experiencing stereotyping and profiling (Duran, 2006; Roach et al., 2023; Trimble & Thurman, 2002), patronizing attitudes (LaFromboise et al., 1990), lack of respect for their culture (Sones et al., 2010; Trimble & Thurman, 2002), fewer referrals to other services (Sones et al., 2010), and disregard for the historical, socioeconomic, and political factors that impact Indigenous Peoples (McCormick, 2009). These may be some of the reasons why Indigenous individuals choose to not return after a single session (McCormick & Honore, 1995), and mental health services are underutilized by Indigenous Peoples (Stewart et al., 2013). This implies that the current approaches towards engaging with Indigenous individuals should be reconsidered.

Currently, there is no prescribed method within the literature guiding non-Indigenous psychologists in their work with Indigenous clients (McCormick, 2009; Fellner, 2016). Indeed, Wendt et al. (2022) caution against prescribed guidelines for how to conduct therapy with Indigenous clients. Rather, given the diversity across Indigenous Peoples and their communities, one of the popular approaches to working with Indigenous clients is using culturally adapted interventions. That is, adapting original interventions to include the needs and cultural factors of the target minoritized group (American Psychological Association, 2017; Wendt et al. 2022). However, it has been argued that the culturally adapted interventions remain grounded in Eurosettler perspectives (Fellner, 2016; Wendt & Gone, 2012; Wendt et al., 2022). Despite potentially increasing the cultural sensitivity of the intervention, they continue to promote a Eurocentric worldview, preserve colonial values, and have the potential to reproduce cultural essentialism. As such, cultural adaptations to evidence-based interventions are seen as remaining "relatively superficial or cosmetic alteration[s], in terms of the packaging and presentation of otherwise conventional counselling interventions" (Wendt & Gone, 2012, p. 211), highlighting the need for more culturally appropriate approaches.

Cultural Competence

Recent years have seen a push within counselling psychology for more multicultural training and competency development. The predominant approach to multicultural training in North America is a single 13-16 week course taken during your educational training (Collins et al., 2015; Malott, 2010), with only a small portion of the class dedicated to Indigenous Peoples, if at all. While the CPA taskforce (2018) made recommendations for counselling psychology programs to implement mandatory program competencies regarding Indigenous cultural literacy, only a limited number of Canadian programs offer an Indigenous-specific course (see Ansloos et

al., 2022 Appendix A), most of which are elective coursework and not mandatory for degree completion. Ansloos et al. (2022) argue a coordinated and extensive endeavor should be undertaken to attain educational consistency across Canadian counselling programs. Inherent in multicultural training is the development of cultural self-awareness, cultural responsiveness, knowledge and skills, and increasing clinician empathy (Bowden et al., 2017; Cohen et al., 2022). Bowden and colleagues (2017) highlight that "while these competencies are critical for all counselling relationships… the historical, social, and cultural experiences of [Indigenous Peoples] in Canada highlight unique aspects to working with [Indigenous] clients that are not fully addressed in the multicultural counselling literature" (p. 44). Certainly, the very fact that the Crown is so intricately linked to Indigenous Peoples presents unique challenges that are not applicable to other cultures.

A deep and comprehensive account of the complicated relationship between Indigenous Peoples and the Crown (Burrows, 2020) is beyond the scope of this paper. For the sake of this thesis, it is important to highlight that Indigenous Peoples in Canada have been severely impacted by their constitutional relationship with the Crown. The current relationship is formalized through the *1982 Constitution Act* (Canadian Charter, 1982), which outlines land claim agreements, Treaty rights, and Indigenous identity. This document builds upon the *1876 Indian Act of Canada.* Among the many problematic legal provisions of that document is the legal threshold for Indigenous identity or "Indian status." The Indian Act gave the government the power and the means to control, regulate, and consequently infringe upon, Indigenous identity. For instance, prior to Bill C-31 (Government of Canada, 2018), an amendment to the *Indian Act* that amended First Nations Women status, First Nations women who married a non-Indigenous man (non-Indigenous or non-status) lost their Indigenous status. First Nations women

marrying someone outside of their Indian Band would also be required to transfer their membership from their band to their husband's band. Moreover, Métis and Inuit Peoples did not fall under the constitutional provisions, being therefore further marginalized by the federal government. Infringements to Indigenous identity persist to this day. For instance, currently, registered adults pursuing a status card (e.g., a federal document confirming registration under the *Indian Act*) have to renew their card every 10 years and children, every five years (Government of Canada, 2022). Other federally mediated controls involve access to basic rights (e.g., medical and dental) and eligibility for the Non-Insured Health Benefits program (Government of Canada, 2023).

An ingrained concept within multicultural counselling is cultural competency. The concept was originally introduced in the 1980s, emerging from inequalities in the health status of marginal groups and has since been expanded upon (Duke et al., 2009; Truong et al., 2014). There is no universally accepted definition of cultural competency. However, the most commonly cited definition stems from Cross and colleagues (1989). They define *cultural competence* as "a set of congruent behaviours, attitudes, and policies, that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effective in cross-cultural situations" (p. 13). Within this framework, Cross et al. (1989) conceptualize cultural competency as a continuum. On one end of the continuum, sits cultural destructiveness defined as "the most negative end of the continuum" (p. 14). It encompasses "attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture" (p. 14). On the opposite end of the continuum is cultural proficiency, a perspective that "hold[s] culture in high esteem, [that] seek[s] to add to the knowledge base of culturally competent practice by conducting research and developing new

therapeutic approaches based on culture" (p. 17). Cross et al.'s (1989) definition of cultural competency has grown to develop variation in terminology and understanding (see Curtis et al., 2019 for a table highlighting different definitions of cultural competency within the literature). Within mental health, the American Psychological Association (2023) currently defines *cultural competence* as skills and knowledge appropriate for use with a given culture and a clinician's capacity to work in cultural settings outside their own.

Some scholars (e.g., Duke et al., 2006; Kumagai & Lypson, 2009; Rajaram & Bockrath, 2014) have critiqued cultural competency for promoting the dichotomy of competent and incompetent, suggesting that clinicians can master a certain level of cross-cultural knowledge and skills. Kumagai and Lypson (2009) posit that the term "competence" in education is often determined through learning outcomes, thus limiting the goals of cultural competency to the knowledge of cultural characteristics, beliefs, and practices as well as effective skills and attitudes for working with minority groups. Hence, cultural competence becomes a checklist, a series of 'dos and dont's' of cultural practices (Rajaram & Bockrath, 2014). This framework of gathering knowledge of non-dominant cultures runs the risk of objectifying minority populations, perpetuating an 'othering' mentality, reinforcing stereotypes (Kumagai & Lypson, 2009), psychological and cultural essentialism (Powell, 2012; Wendt & Gone, 2011), and an oversimplification of culture (Jenks, 2011; Kumagai & Lypson, 2009).

Furthermore, a significant issue of cultural competency is the need for more consideration of power and privilege inequities (Kumagai & Lypson, 2009; Rajaram & Bockrath, 2014). Sonn (2004) highlights:

> Although knowledge about our own cultural background is a feature of the development of cultural competence, it seems that insufficient attention is paid to examining the

> implications of taken for granted social and cultural identities and the power afforded by those identities for working with disenfranchised groups. (p. 4)

Fricker (2007) argues that hermeneutical inequality contributes to unequal power distribution involved in interpreting values and understandings of marginalized cultures. In other words, the dominant culture is imposing their own interpretation and values rather than considering the marginalized cultures' perspectives and experiences. For these reasons, I turn to cultural safety.

Cultural safety was proposed in the 1990s by a Māori doctor, Dr. Ramsden, along with a number of Māori nurses (Papps & Ramsden, 1996). They defined *cultural safety* as “a focus for the delivery of quality care through changes in thinking about power relationships and patients’ rights” (p. 493). Through a culturally safe approach, Indigenous Peoples’ contemporary health experiences are viewed through the context of colonization by acknowledging the social, historical, political, and economic disparities caused by colonialism (Moucessian, 2020). Cultural safety moves away from the notion of simply acquiring cultural knowledge and the view of static cultural traits emphasized by cultural competency approaches. Instead, it acknowledges the diversity within and between cultures (Moucessian, 2020).

A fundamental feature of cultural safety is the examination of power differentials both within society and interpersonally (Curtis et al., 2019). Cultural safety requires clinicians' ongoing reflexivity to examine their own biases, attitudes, assumptions, stereotypes, and prejudices, as well as reflection on the how their culture influences clinical interactions (Curtis et al., 2019; Moucessian, 2020). Importantly, cultural safety posits that the client determines what is culturally safe and whether a clinical encounter is safe (Curtis et al., 2019; Papps & Ramsden, 1996). As such, it shifts the power in the therapeutic relationship, allowing the client to define what is culturally relevant to their needs and values rather than applying a one-size fits all

approach to cross-cultural counselling (Crocket, 2012; Moucessian, 2020). Moucessian (2020) posits that “by responding to issues of power, cultural safety becomes an action-oriented, political concept that can uphold Indigenous sovereignty and question dominant social hierarchies.” Given cultural safety’s focus on shared power relations, it is advantageous in cross-cultural Indigenous counselling (Nguyen, 2008).

CHAPTER THREE: RESEARCH METHODOLOGY

The purpose of this study was to explore the barriers and tensions that non-Indigenous counselling psychologists encounter when working with Indigenous individuals and how non-Indigenous therapists can align with the principles that guide Indigenous approaches to wellness. To do so, I collaborated with two Indigenous Knowledge Holders, or (Indigenous) collaborators henceforth. The collaborators helped to inform part of the format and content of the methodological approach used in this thesis research. I utilized a qualitative research design in order to capture the unique experiences of both the non-Indigenous psychologists and the Indigenous collaborators.

This chapter outlines the methodology employed to complete this study. I begin by outlining the research paradigm (i.e., relational constructionism), and how it relates to Indigenous research paradigms. I then provide an overview of the research procedures, including a rationale for the use of concept mapping methodology for data analysis. I end the chapter with a discussion on how I ensured quality within this research.

Research Paradigm

Increasingly, Indigenous and non-Indigenous researchers are employing Indigenous research methodologies in qualitative research. However, the use of Indigenous methodologies in Western settings and the use of Indigenous methodologies by non-Indigenous researchers is nuanced and debated (see Kovach, 2015, Martin, 2008; Rigney, 1999, Wilson, 2003). Scholar Lester-Irabinna Rigney (1999), a descendent from Narungga, Kaurna and Ngarrindjeri peoples of South Australia, posits that historically, non-Indigenous people have dominated the discourse regarding Indigenous Peoples. While non-Indigenous researchers have contributed to the Indigenous political cause, Rigney (1999) proposes that Indigenist research (a concept he put

forth) should be conducted by Indigenous researchers. Indigenist paradigms are rooted in Indigenous philosophies with all stages of the research being guided by Indigenous knowledge (Hart et al., 2017). To inform Indigenist research, Rigney (1999) drew from critical theory and feminist liberation epistemology emphasizing the struggle against oppression. He asserts that the lived experiences of an Indigenous researcher allow them to more readily speak to the issues of equality and social justice. He highlights that for research to responsibly serve and give power to Indigenous populations, the researcher must be "simultaneously engaged in research and the Indigenous struggle" (p. 117). While Rigney (1999) recognizes that non-Indigenous researchers can contribute to the self-determination of Indigenous Peoples, he believes that "Indigenous research by Indigenous Australians takes the research to the heart of the Indigenous struggle" (pg. 177) making the researcher more accountable to Indigenous communities.

In contrast, Shawn Wilson (2008), an Opaskwayak Cree scholar, argues that Indigenist paradigms can be used by any researcher if they abide by the tenets prescribed in the paradigm. Wilson (2004) outlines these principles, including Indigenous ontology, epistemology, axiology, and methodology. Indigenous ontology, according to Wilson (2004), recognizes multiple realities grounded in relationship(s), with epistemology being based upon those relationships such that the "relationship with something (a person, object, or idea) is more important than the thing itself" (pp. 139-140). Axiology emerges from this understanding as relational accountability, which entails being accountable to one's relations and ensuring the research benefits Indigenous community. The methodology must align with axiology and includes respect, reciprocity, and responsibility (Wilson, 2004). Wilson (2008) asserts that through the continued use of Indigenist paradigms Indigenous knowledge is created, something that cannot be achieved through most Western paradigms. He argues that it is not the researcher's ethnicity

or racial identity that makes research Indigenist, rather it is the commitment to abide an Indigenous paradigm, philosophy, and worldview.

While mainstream, positivist approaches continue to promote the “epistemic privilege of the scientific paradigm” (Kovach, 2015, p.47) and further the Western agenda, emancipatory anti-oppressive Western paradigms (e.g., critical hermeneutics, critical theory, postmodernism, relational constructionism) offer counter approaches which can support decolonizing efforts (Kovach, 2015). Lacerda-Vandenborn (2020) argues that scholarship founded in hermeneutics, socio-cultural, and critical pedagogy critique mainstream Western approaches and share Indigenous views suggesting that *some* Western paradigms can be viewed as challenging the same problematic misconceptions that Indigenous science identifies. Ali et al. (2022) posit that Western research can be supported through collaboration with Indigenous co-researchers to help bridge the gap in worldviews.

When deciding whether to use an Indigenous Research Paradigm (IRP) or a closely aligned Western paradigm, I considered several factors: 1) the contested nature of non-Indigenous researchers using Indigenous Research Paradigms (e.g., Rigney, 1999); 2) the knowledge necessary to appropriately honour Indigenous research paradigms (e.g., Kovach, 2015; Wilson, 2008); 3) the data being derived from non-Indigenous peoples; 4) the nature of this project not being related to any one Indigenous community (when communities or nations are involved, research is typically aligned with these local Indigenous perspectives and approaches); and 5) the role of the communal self in bridging the ethical space between Indigenous and Western perspectives and supporting the philosophical shift from an individualistic self to a communal self. Taken together, I determined it was more appropriate to

ground myself in a Western paradigm that closely aligns with IRPs. I have chosen relational constructionism[1] for this research as it shares several similarities with IRPs.

Ontological Alignment

Relational constructionism (RC) is an interpretive approach that emphasizes the importance of social and relational contexts in shaping knowledge and understanding. It argues that knowledge and meaning are constructed through language and social interactions, which are shaped by various cultural, historical, and institutional factors (Gergen, 2011). As such, RC assumes a relational ontology (e.g., the nature of reality is fundamentally based on relationships; Hosking & Bouwen, 2000) such that "all social realities—all knowledges of self and of other people and things—are viewed as interdependent or co-dependent constructions existing and known only in relation" (Hosking & Bouwen, 2000, pg. 129). Accordingly, our understanding of the world is not solely determined by objective factors or individual perception, but is actively co-created through our interactions with others in a continual process creating *relational realities* (Hosking, 2011a). Hosking and Pluut (2010) describe relational realities as stemming from "organizing processes, identities and relations" (pg. 60) such that "self-other and relations (persons and worlds) are in ongoing construction in local-cultural, local-historical, language-based processes of inter-action" (pg. 63). RC differs from other philosophical approaches in that it focuses on the 'how' rather than the 'what is.' Hosking (2011a) highlights that "Unlike post-positivism, RC makes no predictions and has no interest in control; unlike critical realism it is not offering explanations or actionable knowledge" (p. 57). Rather, RC offers a framework for understanding how ongoing relational processes shape specific relational realities.

[1] Constructivism asserts that individuals mentally construct the world through cognitive processes while constructionism emphasizes social interactions and the use of language in constructing reality (Andrews, 2012)

Ontologically, RC shares several similarities to Indigenous ontologies, particularly in their recognition of relationships as the basis of reality (Gergen, 2011; Hosking, 2011a; Wilson, 2004). As Wilson (2004) posits, "relationships [are] the foundation of our ontology" (pg. 242) and similar to the continual development of relational realities that Hosking (2011a) discusses, Wilson (2004) states "our reality in itself is a process" (pg. 153), refuting a static reality. Accordingly, both RC and IRPs emphasize the interconnectedness of all things adopting a wholistic perspective and rejecting reductionist explanations (Hosking, 2011b; Wilson, 2013).

Epistemological Alignment

Epistemologically speaking, relational constructionism assumes that knowledge cannot be considered as a tangible entity that can be acquired, exchanged, or stored independently (Hosking & Buouwen, 2000). Instead, knowledge is viewed as a socially constructed and dynamic process that is shaped by social and cultural contexts. Accordingly, knowledge is created through a collaborative process of meaning-making where 'knowledge' is determined by what is valued within the community (Gergen, 2011). As such, knowledge is seen as a product of social interaction and cultural practices, rather than a fixed and objective reality.

A common critique charged at relational epistemology is that the material world exists outside of relationships, such as the sun, plants, bodies of water and that with careful study we can learn more about these. In Gergen's (2011) book Relational Being, he responds to these critiques,

> I may plausibly agree that "something exists" before co-action. But when we attempt to specify what this "something" is—animal, vegetable, or mineral—we draw from the resources of relationship. Depending on one's community we may call "this" a molecular composition, a female, a biological entity, a work of art, a child of god, an image in my

> head, or Mommie. However, outside any community or discourse, what would “this” be? (pg. 204)

As Gergen (2011) posits, we are unable to explain what the “sun” or “mommie” is without relational co-action and discourses to help create knowledge clusters. Hence, it is through communal understanding that we determine what is valuable and in turn knowledge. This process may look different depending on different community agreements. This epistemological stance aligns with Wilson’s (2013) view of Indigenous knowledge such that “Indigenous research works from a worldview that understands knowledge is relational: Indigenous People are not *in* relationships; they *are* relationships. This is Indigenous truth and reality” (p. 311). This reflects Gergen’s (2011) argument that knowledge arises from and is intricately linked to communal values. He adds that becoming part of a given community requires some consensus about what knowledge is and how it is acquired.

Axiological Alignment

Axiologically speaking, an important aspect of relational constructionism is the attention to power dynamics within research and enacting responsibility to equalize imbalances. Hosking and Pluut (2010) highlight that from this perspective, research is seen as an ongoing re-construction between the researcher and the participants. In this regard, there is a power shift such that the role of the researcher and the participants are more fluid; the researcher is one among many who contributes expertise (Hosking & Pluut, 2010). Within RC, power is considered an ongoing quality of all relational processes and realities (Hosking, 2011a). It emphasizes the importance of understanding how power relationships shape social interactions, and how they can impact the construction of meaning and knowledge. The attention to power dynamics in RC is aligned with the importance of “researchers being accountable to and for

maintaining health relationships" (Wilson, 2013, p. 311). Relational constructionism does not hold scientific rationality above others, particularly it makes possible the notion of doing research 'with' others rather than the traditional scientific approach of conducting research 'on' or 'about' others (Hosking, 2011a). This attention to 'research with' is particularly poignant when discussing Indigenous Peoples who have been the subjects of scientific inquiry since European contact and have endured a longstanding history of intentional and unintentional harm being perpetrated at the hands of researchers and research output (Jaworsky, 2019). RC's emphasis on power aligns with the axiological principles of the communal self, providing a foundation for my ethical stance. This enables me to recognize the historical significance and enduring impact of colonialism, and to engage with Indigenous perspectives while respecting their knowledge and practices, without appropriating Indigenous knowledges and practices (Lacerda-Vandenborn, 2020).

Methodological Alignment

Lastly, within an Indigenous research paradigm, data is seen as being generated through the building of relationships. To transform data into Indigenous knowledge, the analysis and interpretation of data necessitates being accountable to these relationships (Wilson, 2013). This viewpoint contradicts most mainstream Western scientific methodological approaches such as positivism, which attempt to minimize dialogic exchange to increase experimental control (Hosking, 2011a). In a similar approach, RC provides an opportunity to invite multiple local rationalities through dialogue with others (Hosking, 2011a). While there is no specific relational constructionist method, given the inherent relational processes, RC tends to privilege qualitative research as it provides opportunity to relationally engage (McNamee & Hosking, 2012). From this perspective, the chosen method is an opportunity for engagement that allows for relational

responsiveness. As such, common methods used with an RC approach tend to include narrative, storytelling, discourse analysis, interviewing, and ethnography (McNamee & Hosking, 2012).

Bringing it Together

In summation, RC closely aligns with IRPs in its prioritization of relational processes in (re)constructing reality and informing knowledge. Relational Constructionism pays particular attention to how narratives of general knowledge are influenced by particular cultures. For instance, McNamee and Hosking (2012) highlight that what is privileged or discredited is part of the practices that (re)construct that particular culture creating local-cultural norms, values, and patterns of influence that inform our understanding. Recognizing power structures in research, RC encourages researchers to examine the relational realities in which they want to participate and whether they want to elevate practices and values of positive science or create space for other voices to be heard (McNamee & Hosking, 2012). Accordingly, RC provides a wholistic framework for the current qualitative exploratory study, which maps the narratives of non-Indigenous counselling psychologists working with Indigenous individuals. Throughout this project, I sought guidance from two Indigenous collaborators to ensure that I was being relationally responsive and not reverting back to mainstream Western approaches and ways of thinking. Their perspectives offered important guidance. Initially, they offered their wisdom on how to ethically conduct a talking circle and ways to frame the leading questions. After data collection, they provided invaluable contributions to the interpretation and relevance of the data. Importantly, they provided insight that may not be visible or salient to myself as a non-Indigenous person. In the next section I will discuss the process of this research project.

Procedure

Circular Approach

In line with Indigenous approaches, any research concerned with Indigenous Peoples and/or Indigenous matters must be conducted in partnership with Indigenous Peoples and their communities. Given historical and current research is fraught with ethical infringements impacting Indigenous Peoples (Kovach, 2021), it is imperative that a non-Indigenous person, such as myself, entering into Indigenous research seeks guidance from Indigenous guides. For this reason, the current study was informed and guided by two Indigenous collaborators. To meaningfully include the Indigenous collaborators' perspectives, the study was conducted in three phases, and in a circular fashion. Phases One and Three consisted of individual research conversations with the Indigenous collaborators, and Phase Two included a talking circle with five registered counselling psychologists. The circular approach allowed for guidance on how to ethically conduct a talking circle, as well as to provide an Indigenous perspective on barriers to counselling services that was used to inform the questions for the talking circle with the non-Indigenous counselling psychologists (phase two). The third phase provided an opportunity to discuss with the Indigenous collaborators the findings from the talking circle. They provided insights into how an Indigenous person may interpret the non-Indigenous counselling psychologists' perspectives and how these clinicians can better align with the principles that guide approaches to wellness from an Indigenous perspective. Through the circular approach I asked, "What should I do?" rather than "This is what I should do" (Ellis, 2007). This method allowed me to enact relational ethics in which I was able to acknowledge the interpersonal bonds and maintain conversation between the collaborators and myself to promote respect, dignity, and connectedness (Ellis, 2007).

Participants

Indigenous Collaborators

Two Indigenous (one Cree and one Anishinaabe) collaborators took part in phase one and three of this study. The collaborators were recruited through previous relationships with my supervisor, Dr. Lacerda-Vandenborn. In keeping with OCAP® (ownership, control, access, and possession; First Nations Information Governance Centre [FNIGC], 2023)–which will be discussed in the next section– I asked the collaborators how they wished to be identified, and for a short biography. One collaborator chose to be identified by an acronym and the other by their real full name and picture. Their biographical paragraphs are offered below without any changes.

AKK–An Anishinabe Knowledge Keeper: Born and raised in Manitoba, a Grandfather, First Nations ceremonial leader, First Nations sovereigntist, Helper for Indigenous wellness, and a worker for the reclamation of Indigenous ways of knowing, balance and wellness – Mino Pimatiziwin.

Angela Lavallee is a First Nations woman, mother, grandmother, sundancer and graduate of University of Winnipeg Bachelor of Arts program majoring in Conflict Resolution and Criminal Justice. She is a recent graduate from the Factor Inwentash School of Social Work at University of Toronto studying the Master of Social Work – Indigenous Trauma and Resilience. She is a woman who has overcome many forms of violence and has taken a journey that led her to healing from her painful experiences. Angela is an active community member currently residing in Winnipeg, Manitoba. In 2015, Angela's nine-month-old granddaughter, Zaylynn Emerald Rain entered the spirit world. Like so many of our

Murdered and Missing Indigenous Women, Girls and Two-Spirited, the loss of Zaylynn came with many forms of injustices and unanswered questions. As challenging as it was, it was the death of her loved one that ignited the passion for Angela to work towards a degree. She is currently the Keeper of the Spirit Coordinator at the Ma Mawi Wi Chi Itata Centre. The name Ma Mawi Wi Chi Itata translates from Ojibway into the phrase, "we all work together to help one another." "Ma Mawi Wi Chi Itata Centre is a strength and value-based family resource organization delivering community-based programs and services within the philosophy embodied in our name." In addition, she served years as the chairperson of Wahbung Abinoonjiiag "the children of tomorrow." Wahbung Abinoonjiiag was established to empower children and their families to break the cycle of violence." She is a past co-chairperson of the Manitoba (MM)IWG2S+ Coalition. She is a certified trauma therapist who makes space for people who activated their healing energy and who seek out trauma support. She incorporates the Indigenous ways of knowing and being into the heart work. Angela volunteers her time supporting women, girls and two-spirited folks who are faced with battling all forms violence, inequality, addictions, systematic injustices and who need a safe space to be acknowledged, loved, empowered, and valued.

She is also the founder of Soles on Fire, a vision of an annual run to bring awareness, prevention, and intervention on violence on women and girls and most importantly to celebrate and honour life. On October 4, 2018, Soles on Fire held its 1st annual 5km run at The Forks in Winnipeg, Manitoba. She is also part of Collective of Voices who had initiated the vision of the Redress Warming Hut "Rainbow Butterfly". Her work, volunteer and education decisions are led by her passion to help others. She does her volunteer work with the support and love from her community.

The collaborators were invited to participate in the talking circle with the non-Indigenous counselling psychologists with participation ranging from observation to facilitation. Unfortunately, while the collaborators expressed interest in participating in the talking circle, neither were able to fit the circle into their already busy schedules.

Non-Indigenous Participants

The inclusion criteria for the participants were: (1) self-identification as non-Indigenous, (2) being a registered psychologist or registered counsellor, and (3) a minimum of one-year experience in the field for at the time of recruitment. Given this research is exploring the tensions that non-Indigenous counselling psychologists encounter when working with Indigenous individuals, it was necessary that participants self-identify as non-Indigenous. The self-identification was not limited to white as other non-Indigenous ethnicities, while potentially similarly colonized, do not share the unique ongoing and historical colonization that Indigenous Peoples have been subjected to. The requirement to be a registered psychologist or counsellor meant that the clinicians could speak directly to experiences within counselling psychology. The minimum of one year experience requirement ensured that the clinicians had enough experience to draw upon during the talking circle. A total of five mature registered, actively practicing psychologists who self-identified as non-Indigenous (four Euro-settlers, one South Asian) were recruited from a mental health organization in Calgary, Alberta that serves diverse populations, including Indigenous individuals and communities. The participants included three males and two females with four participants holding master's degrees in counselling psychology and one holding a doctoral degree in educational psychology. Four of the participants were employed as mental health therapists and one participant was the acting clinical supervisor at the organization.

They had vast experience as counsellors, and all had prior experience working with Indigenous individuals.

While small, the sample size is not uncommon for exploratory qualitative studies of a master's scope. For a small project, Braun and Clarke (2013) suggest a sample size of six to 10 for interviews and two to four for focus groups. While they do not provide a recommended sample size for talking circles, other researchers have recommended maintaining a small circle (Hart, 1996; Scott, 1991). The guidelines for talking circles (Four Worlds Development Project, 1990) suggest an optimum group size of 10–15 participants. However, since the talking circle was hosted via Zoom, it was recommended to maintain a smaller group size (Lobe & Morgan, 2021).

This study received ethics approval from the University of Calgary Conjoint Faculties Research Ethics Board (CFREB) on July 25, 2022 (Ethics ID: REB22-0232). Prior to instigating this study, I completed the *Fundamentals of OCAP®* course through the First Nations Information Governance Centre (2023) in May 2022. The FNIGC (2023) provide the following definition:

> The First Nations principles of OCAP® establish how First Nations' data and information will be collected, protected, used, or shared. Standing for ownership, control, access and possession, OCAP® is a tool to support strong information governance on the path to First Nations data sovereignty…OCAP® asserts that First Nations alone have control over data collection processes in their communities, and that they own and control how this information can be stored, interpreted, used, or shared. (para. 2)

Maintaining the principles of OCAP® was a fundamental consideration throughout the entirety of this study and will be discussed in later sections of this chapter.

Recruitment

Phase One and Three

Prior to involvement in this thesis, my supervisor, Dr. Lacerda-Vandenborn contacted the Indigenous collaborators, with whom she has had established working relationships, to gauge their interest in participating in this project. Dr. Lacerda-Vandenborn identified AKK and Angela Lavallee as suitable collaborators given their wealth of experience working with communities and having to navigate the tensions of operating within a colonial society. Both AKK and Angela have decades of experience working with Indigenous Peoples, families, and communities utilizing traditional approaches to wellness and instilling a trauma-informed lens. Having recently travelled to Manitoba to meet AKK and Angela, I witnessed firsthand the care and compassion that they exude into their work and the wholistic approach they embody all while traversing the challenges created by Western colonial systems. As champions in their communities, they provided invaluable insight into the tensions between the principles that guide Indigenous and non-Indigenous approaches to wellness.

After briefly introducing the project and gaining their consent, Dr. Lacerda-Vandenborn initiated introductions between myself, AKK, and Angela via text messaging. After initial introductions, they were contacted by email to provide a Zoom link for the interview conversation and the informed consent form.

In honouring Plains Indigenous protocol, I offered the participants a tobacco tie and a yard of ceremonial cloth in acknowledgement of the relationship and respect for the knowledge and insights they shared (Hart, 2009). Traditionally, tobacco is offered when making the original request. However, since both the Indigenous collaborators are located in another province (i.e.,

Manitoba), I offered the protocol after I had conducted the interview conversations, when I was in Manitoba and could offer the protocol in-person.

Phase Two

Recruitment for phase two utilized convenience sampling. Participants for the talking circle were recruited from a single mental health organization within Calgary, Alberta. The implementation of convenience sampling was prompted by the COVID-19 pandemic, which has placed immense strain on the mental health care system including lengthy waitlists and persistent demands on mental health care providers. This demand made it extremely difficult to recruit participants. The health care site in this study was chosen because the program director was known by myself, and provided an opportunity to request assistance with recruitment. After receiving recruitment approval from the program director, I attended a weekly team meeting with the counselling psychologists to formally introduce myself, discuss the project, and what participation in the study would entail. Participants were informed that participation in the study was completely voluntary and pre-existing relationships should not influence their decisions to participate. Following the meeting, an email was sent to the entire mental health team. This document contained a description of the study and research objectives, criteria for inclusion (i.e.., non-Indigenous, registered psychologist or counsellor, at least one year of experience), participant expectations, confidentiality measures, and instructions for those interested in participating or requiring additional information to contact myself or Dr. Lacerda-Vandenborn. Interested participants were sent an email containing the informed consent form (Appendix A) and a confidentiality agreement (Appendix B). Participants were asked to sign a confidentiality agreement to ensure that information about participants and their experiences shared during the talking circle were kept confidential.

Data Collection

Data was collected using broad guiding questions to facilitate relational conversation via Zoom over a secure University of Calgary network. The data collection entailed three phases; phase one and three included individual interviews with the Indigenous collaborators and phase two was a talking circle with non-Indigenous counselling psychologists. The interviews and talking circle were recorded and initial transcriptions were produced using Zoom's integrated transcription software. Each transcription was reviewed alongside the recorded video to clean the data using clean verbatim, removing filler words such, "um," "you know," and "like" (Simmonds & Vallgarda, 2021). This process was repeated twice by myself to ensure accuracy, and to gain familiarity with the data. The latter point is particularly important in qualitative research, as it involves immersion and critical engagement (Lester et al., 2020). Familiarity was gained by actively listening throughout the talking circle with the non-Indigenous participants, as well as reviewing the recording before beginning the transcription process. Familiarity was further gained throughout the analysis process. In the proceeding section, I will discuss the data collection process for each of the three phases.

Phase One

The Indigenous collaborators participated in separate individual research conversations. Phase One conversations were conducted in December 2022 and were approximately one hour long. Prior to starting the research conversation, I reviewed the informed consent form with the collaborators and received oral consent to participate. These conversations were intended to gain an Indigenous perspective on barriers to service wellness provision and guidance on how to appropriately conduct a talking circle, particularly via Zoom.

While a semi-structured interview protocol was created for ethics purposes, a reflexive style was used throughout the research conversations. General topics with broad guiding questions to facilitate the conversation (Brayboy & Deyhle, 2000) were discussed with the Indigenous collaborators (e.g., barriers they have encountered in their work, perceived barriers for non-Indigenous counselling psychologists, changes that could bring lasting change, and how to facilitate a talking circle). This allowed questions to flow in a more conversational style. I chose this method of interviewing because continually asking questions may be viewed as disrespectful by some Indigenous individuals (Price, 2004).

The research conversations were video and audio recorded and transcribed. Following the principles of OCAP© (FNIGC, 2023), the Indigenous collaborators received a copy of their conversation transcripts for their review and approval. During the research conversation, they were informed that they can omit anything or alter their responses in the transcript if needed. Further, they were informed of their right to withdraw participation from the study at any time. In addition, they were provided the write-up of the results to obtain their approval prior to inclusion in this thesis.

Phase Two

Five non-Indigenous registered psychologists participated in an hour and thirty minutes long talking circle hosted over the University of Calgary's secure Zoom network. As the research took place during a number of COVID-19 pandemic social distancing restrictions, that is to say many professional activities had not returned to being in person, the talking circle was hosted over Zoom. The online medium also increased accessibility for participants to attend. The talking circle was held during the clinician's weekly team meetings which historically were held online in order to facilitate clinicians who work out of the multiple sites the organization has across the

city to attend, as it reduced commute times. Prior to the talking circle, participants were provided a copy of the informed consent form and a confidentiality agreement. Participants returned completed forms before the talking circle via email. Guiding questions informed by the interviews with the Indigenous collaborators were prepared in advance to create a semi-structured interview guide (Appendix C). The semi-structured interview approach is widely utilized in qualitative research for its versatility and flexibility (Kallio et al., 2016). The semi-structured approach allowed for a more relational conversation rather than following a rigid interview structure (Kelly, 2010). Importantly, as Kallio et al. (2016) highlight, the semi-structured interview enables reciprocity within the interview relationship where the interviewer can ask improvised follow-up questions and provide space for participant responses. During the talking circle, participants were asked questions designed to identify (1) tensions that non-Indigenous counselling psychologists have towards working with Indigenous Peoples; (2) barriers and/or gaps in current service provision; and (3) current approaches to care with Indigenous individuals who access counselling services in their organization and others they may have experience with.

The format of the talking circle was informed by Cree scholar Michael Anthony Hart's (2002) book *Seeking Mino-Pimatisiwin* and the information provided by the two Indigenous collaborators. Following the suggestions outlined by Hart (2002), participants were informed that they are not required to speak if they did not want to. However, they were asked to keep their minds and hearts open to the learning process. In addition, participants were asked to pay attention to the speaker without interruptions and to respect what other participants said, their views, and how they express themselves (Hart, 2002).

It is important to note that the talking circle was held during the clinicians' weekly team meeting. As such, the time frame was relatively limited, which prevented the Indigenous collaborators from being able to attend the circle. While the collaborators were unable to attend, they had provided me approval to conduct the circle in their absence and important insight and instruction on how to facilitate the circle during our research conversations. Their guidance in combination with my previous experience sitting in circle assisted me in facilitating the talking circle on my own.

Phase Three

The second research conversations with the Indigenous collaborators were held in April and May 2023 over Zoom. Similar to Phase One, the informed consent and the principles of OCAP® were reviewed prior to the conversation and the collaborators provided oral consent once again before participating. The second research conversations were designed to gain perspective from the Indigenous collaborators on the data obtained from the non-Indigenous counselling psychologists. I presented a concept map derived from the talking circle data to guide their feedback. During the conversation, I discussed and explained the salient points on the concept map, pausing after each 'section' to provide an opportunity for the Indigenous collaborators to reflect and provide insight into the data. After reviewing all of the salient points with them, the collaborators were asked if they had any final feedback.

Making Meaning Through Concept Mapping

Within the psychological literature, there has been limited research exploring the tensions that non-Indigenous counselling psychologists encounter when working with Indigenous individuals and how clinicians can align themselves with principles of Indigenous wellness to provide culturally safe care. As such, this research is an exploratory project that serves to provide

a starting point for further investigation. At the outset of this project, I intended to use reflective thematic analysis (RTA; Braun & Clarke, 2022). However, given the previously mentioned recruitment constraints (i.e.., COVID-19 pandemic restrictions, clinician burnout, large client waitlists at mental health organizations), and time limitations inherent in a master's thesis, I was unable to facilitate multiple talking circles and interviews that would be necessary for RTA to offer something of substance. As such, RTA was deemed inappropriate as there was inadequate participant data. Instead, what emerged from the talking circle was a conceptual map highlighting salient points. This shift represents an organic approach, grounded in relationality, that is consistent with Indigenist research.

This thesis utilized a relational approach to concept mapping as outlined by Novak and Gowin (1984). Concept maps are "graphical tools for organizing and representing knowledge" (Novak & Cañas, 2008, pg. 1). While this approach was originally employed to examine children's understanding of science, it has been implemented in other social sciences and with diverse sample compositions. Concept hubs, which are defined as patterns or regularities found in events, objects, or documented occurrences, are linked to other concepts hubs or concept nodes via connecting lines used to depict ideas and articulate relationships (Conceição et al., 2017; Novak & Cañas, 2008).

Despite concept maps traditionally being used in quantitative research (Wheeldon & Faubert, 2009), recent literature has identified the utility of concept maps in the data collection, analysis, and presentation within qualitative research (Butler-Kisber & Poldma, 2010; Daley, 2004). A common issue raised regarding concept mapping in qualitative research is how to systematically integrate concept maps into the research methodology. As Butler-Kisber and Poldma (2010) posit, concept maps are designed to reconstruct participant ideas in a relational

manner through the examination of both the visual (concept map) and verbal description. As such, they suggest that concept maps are not an "independent form of analysis" (Butler-Kisber and Poldma, 2010, pg.12). Despite this critique, Wilson and colleagues (2016) argue that concept mapping allows for a more wholistic learning experience and Murry et al. (2013) note that the visual representation allows for increased accessibility of knowledge dissemination, understanding, and collaboration. I have taken steps to adapt the traditional approach to concept mapping in such a way to reflect a more relational approach. Drawing from scholars who have employed concept mapping as a useful strategy for documenting relational aspects of data in qualitative research (Butler-Kisber & Poldma, 2010), I refrained from hierarchical maps. Instead, I designed a graphical map to visually depict salient ideas or concepts. Essentially, mapping the terrain of the tensions between Indigenous and non-Indigenous approaches to wellness. As Daley (2004) posits, concept maps play a crucial role in qualitative research as they enable researchers to identify and narrow in on participants' meaning and the connections between/across concepts or knowledge bases. To that end, the visual depiction can be thought of as a topographical map of tensions that can be used as a starting point to further explore this area of research.

I utilized an interpretivist paradigm (Wilson et al., 2016) and a researcher-generated (Conceição et al., 2017) concept map approach. Employing an interpretivist approach aligns with relational constructionism as it acknowledges that "our perceptions and experiences are socially, culturally, historically and linguistically produced" (Finlay & Ballinger, 2006, p. 19) and is well-suited for an inductive approach (Trochim et al., 1994). In addition, a relational approach to concept mapping aligns with the axiological principles inherent in the communal self and relational constructionism. The data was collected from an organization that I have built a relationship with, the method of data collection (i.e., talking circle, and the circular approach to

the research conversations with the collaborators) represents a relational approach, and providing the non-Indigenous participant's and their organization with a summary of the findings promotes relational accountability. Data analysis for studies utilizing a relational approach commonly entails identifying themes, summarizing interview transcripts, and identifying interconnectedness among concepts (Conceição et al., 2017). The current study used the relational map to summarize salient points from the research conversations and talking circle transcripts and identify interconnectedness and relationship among the data.

Phases of Analysis

Phase One

Data obtained from initial research conversations was utilized to inform the structure of the talking circle and the guiding questions for the non-Indigenous counselling psychologists. To that end, interpretation and synthesis of the conversation data was conducted concurrently with data collection (Conceição et al., 2017). After cleaning the transcripts, they were reviewed multiple times to gain familiarity with the data before beginning analysis. Individual research conversations were first analyzed separately to identify salient points of interest within individual responses. The next step entailed comparing salient points across both collaborator's conversations. These were then amalgamated and transformed into questions or topics to drive conversation during the talking circle with the non-Indigenous counselling psychologists. While there were some general overlapping salient points between the two interviews, there were also unique contributions from each collaborator. Consensus and diversity of perspectives were considered in the talking circle question formation.

The information provided by the Indigenous collaborators regarding how to conduct a talking circle was used to inform the structure and provided guidance for myself as the

facilitator. A procedural map was created to help organize and summarize the data provided by the collaborators.

Phase Two

Similar to phase one, after the talking circle transcript was sufficiently cleaned, it was read several times to gain familiarity. Since there is currently a paucity of research exploring the tensions surrounding non-Indigenous counselling psychologists' working with Indigenous individuals that could reliably inform salient points or categories in the dataset, an inductive (i.e., salient points were identified solely from the content of the data) approach to creating the concept map was used. The guiding interview questions and research questions were reviewed throughout the data analysis process to continually orient myself to the aims of this research. Figure 2 provides a visual map of the salient points of tension identified in the talking circle with the non-Indigenous counselling psychologists.

Phase Three

Similar to phase one, the research conversations were analyzed separately to identify salient points of interest within individual responses before comparing salient points across both collaborator's conversations. Reflecting on the collaborator's perspectives, I incorporated the salient points from phase three into the existing talking circle concept map to create a multi-perspective map encompassing both the non-Indigenous participants and the Collaborator's contributions.

Ensuring Quality

Circular Approach

As mentioned above, in line with Indigenous ethics, this project utilized a circular approach to data collection and analysis. As a non-Indigenous person approaching work with

Indigenous Peoples, it is crucial that the ethical principles of Indigenous research are followed. Important in upholding ethical principles was ensuring engagement in ongoing conversation and building relationships with the Indigenous collaborators. Gaining the collaborators' perspective on the relational map as well as sharing the completed methods and results chapters assured that the collaborators supported the objective of the research, and had input on the presentation of results. This process has been called *encircling* (Wilson, 2008) and helps to establish accountability and credibility.

Following the talking circle, the collaborators were invited back for another research conversation to discuss the findings. They were again provided with a copy of the transcript from their conversation to review and revise if needed. The last step entailed providing the results write-up to the collaborators to read, review, and approve before publishing (Wilson, 2008). As outlined in OCAP® (FNIGC, 2023), Indigenous Peoples have an inherent right to control the use of their data and how they are being represented. This step allowed for collaborator feedback to ensure the findings were beneficial and/or helpful to Indigenous Peoples (Wilson, 2008). To enact reciprocity and relationality with the participants from the talking circle, they received a copy of the relational map so that they may use the map to identify areas where they can engage in professional development and support clinician growth.

Rigour and Trustworthiness

Rigour entails establishing clear research questions, engaging in appropriate data collection methods, and ensuring accuracy and transparency of the research process (Hadi, & José Closs, 2016). This research relied on a reflexive and relational conversational approach (Brayboy & Deyhle, 2000) to data collection, with the aid of a semi-structured interview guide.

The guide was created in conjunction with feedback from my supervisor, Dr. Lacerda-Vandenborn, to ensure the questions were as open-ended and relevant as possible.

Trustworthiness is established through a detailed and reflexive account of the study's procedures and methods, demonstrating how the researcher came to their conclusions (Roberts et al., 2019). I have demonstrated trustworthiness through credibility, conformability, and dependability (Lincoln & Guba, 1985). Credibility was established through prolonged engagement with the data, from collecting the data during the interviews and talking circle to writing the report (Lester et al., 2020). Additionally, a credibility question was included at the end of the interviews and talking circle (e.g., "is there anything that I didn't ask that you think is important to add?"). Further, throughout all the phases of data collection and analysis, I engaged in discussion and review of the data with my supervisor and the Indigenous collaborators in order to gain different perspectives on the data.

In this section, I have demonstrated dependability through the provided detailed description of the study, including the research design and implementation. Lastly, I have provided details about the setting, sample characteristics and size, sample strategy, interview procedures and topics, and in the results chapter of this thesis. I provide rich, thick descriptions of the generated salient points included in the concept map as well as have included the interview guide (Appendix C) to provide readers with clarity of the research process (Korstjens, & Moser, 2018).

CHAPTER FOUR: BRAIDING SWEETRGRASS FOR A STRONGER PATH

In this chapter, I begin to share the findings of this research. This study utilized three distinct phases to explore and examine the research question: *how can non-Indigenous counselling psychologists align themself with the principles that guide Indigenous approaches to wellness*? The study aimed to explore potential tensions in the principles that guide non-Indigenous approaches to counselling psychology that may inhibit or hinder non-Indigenous counselling psychologists from providing culturally and ethically safe care to Indigenous individuals.

I will proceed by highlighting the findings from each phase, weaving each phase into the next. I have labeled this chapter *Braiding Sweetgrass for a Stronger Path* as I imagine the circular approach (i.e., three phases) to data collection and analysis to be akin to creating a braid. I connected this braiding process to the Indigenous tradition of braiding sweetgrass. As Brant and colleagues (1996) discussed, sweetgrass is one of the four sacred medicines that is linked to remembering traditions:

> For many Aboriginal peoples, sweetgrass is the hair of Mother Earth; it provides clarity of mind and it purifies us. The threefold braid of sweetgrass represents the integration of body, mind and spirit; it is also symbolic of community strength. One strand of sweetgrass is easy to break, but many braided together are strong. (p. 1)

While the significance of sweetgrass differs slightly depending on the community, for Anishinaabe people, "the sweetgrass braid represents the strength that comes from working collaboratively, weaving various perspectives together for the purpose of a stronger path" (Ineese-Nash et al., 2022, p. 41). The weaving together of the Three Phases and the guidance provided by the Indigenous collaborators in this project is analogous to Ineese-Nash et al.'s

(2022) definition of braiding sweetgrass; separately each phase could provide insight into the research question, but when braided the phases weave together the knowledge of both Indigenous and non-Indigenous peoples creating a stronger more collaborative understanding and way forward.

Phase One: Preparing the Circle

The first stage of this research aimed to gain a clear understanding of the significance of circles, how to conduct them, and the associated protocols. Talking circles are based on the sacred tradition of sharing circles (Alberta Education, 2005). Cree scholar Jean Stevenson (1999) identified three types of circles: healing circles, talking circles, and sharing circles. Healing circles, as the name suggests, facilitate healing through the sharing of personal journeys, incorporating ceremony and prayer (Stevenson, 1999). Since healing circles are deeply connected to the traditional belief systems and healing practices of Indigenous Peoples, and are situated in traditions and ways of being of a particular community, it is considered inappropriate for a non-Indigenous individuals to facilitate them. For a traditional sharing circle, conductors must receive a prior blessing from an Elder to lead a circle (Alberta Education, 2005). Therefore, without the guidance and support of an Elder to facilitate, it is recommended that non-Indigenous people refrain from utilizing this sacred tradition. Instead, a less formal talking circle is suggested. While non-Indigenous people can engage in a talking circle, they must be careful not to culturally appropriate the circle by honouring and respecting its origins (Brown & Di Lallo, 2020). Indeed, Di Lallo (Métis from Buffalo Narrows) posits that “talking circles incorporate the concept of walking together, which involves finding the balance of walking between, or straggling the two often opposing worldviews” (Brown & Di Lallo. 2020, pg.368). In this sense, the talking circle can be seen as an expression of the communal self discussed in chapter one,

enabling an ethical positioning alongside Indigenous perspectives, while refraining from appropriating Indigenous knowledges and practices (Lacerda-Vandenborn, 2020).

My primary understanding of facilitating a circle was based on Michael Hart's (2002) book *Seeking Mino-Pimatisiwin*. In his book, Hart (2002) draws on the experiences of sharing circle conductors to understand their purpose and how they apply to helping and healing. He covers various aspects of sharing circles, including the recommended size of the circle (10-15 people), preferred location (i.e., where the quietest person can be heard), and seating arrangements (encourages circular seating). While Hart (2002) provides a general guideline for facilitating a talking circle, there remained a lack of clarity on how a non-Indigenous person can ethically facilitate a circle and how to maintain the circle's integrity on an online platform. The Indigenous collaborators, AKK and Angela, played a crucial role in helping me navigate this uncertainty and provided valuable insight and considerations for conducting an online talking circle.

Talking circles are a widely used and culturally appropriate method of data collection with Indigenous Peoples. Despite the data in the current research being derived from non-Indigenous participants, a talking circle was an appropriate method for data collection as it employs a conversational approach infused with a decolonizing lens that enables the facilitation of dialogue and the co-creation of knowledge that directly aligns with the research paradigm, RC, that is guiding this research (McBeath et al., 2021).

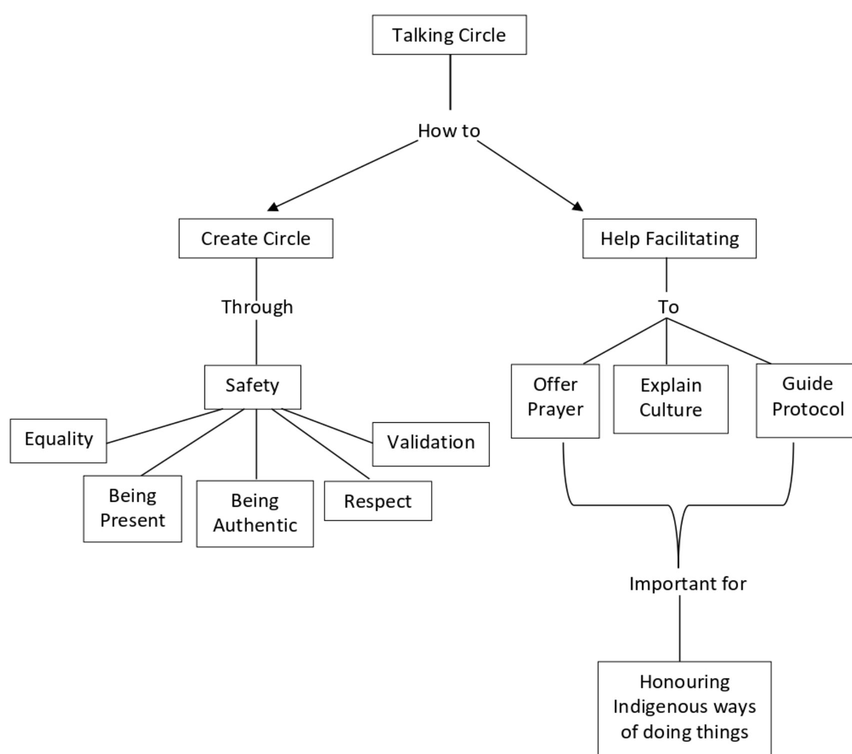
Structuring the Talking Circle

One of the main objectives of the initial research conversation with the Indigenous collaborators was to gain a better understanding of how to appropriately facilitate a talking circle. An added consideration was how to facilitate the circle over Zoom. Notably, one of the

collaborators had previous experience hosting circles via Zoom and other online platforms while the other had only hosted in-person circles but knew online circles were possible. After our initial conversation, I created a procedural map for myself and others who may consider facilitating one (see Figure 1).

Figure 1

How to Facilitate a Talking Circle



Facilitating the Circle

Common elements of a talking circle include ceremony, rituals, and symbolism as they facilitate shared meaning making, set the intention of the circle, and help create a safe space (Winters & America, 2014). Given these features, and being a non-Indigenous person, it was suggested by Angela that someone (i.e., an Indigenous Elder or Knowledge Keeper) be present during the talking circle to help facilitate:

> I think it would be really important to have somebody to support you to facilitate it, and just explaining the culture around the circle talking and how to do that with prayer and to honour Indigenous ways of doing things. - Angela

Along the same lines, AKK noted the importance of recognizing the traditions from the region or community you are hosting the circle in. He described that he will integrate the traditional protocol into his circle and provide a teaching around the significance of the protocol and its intended use: “I use the tobacco bowl in the sessions I do. So, I ask people to present that tobacco and I do tobacco teachings with that” (AKK).

In conducting an ethically appropriate talking circle it was impressed upon me that I must understand the cultural significance of the talking circle, and honour Indigenous ways of knowing and being. Part of honouring Indigenous ways of knowing and being is the importance of acknowledging wholism. That the mind, body, spirit, and emotions are going to be present within the circle. AKK identified that when he conducts a circle,

> It always begins [with] what I call the spirit and I work in the wholistic manner, that it’s reflective of our Indigenous ways. That it’s the spirit, the body, the mind, the emotions, right, the heart. That everything in there will be reflected in that circle.

Indeed, even the circular shape embodies wholism through facilitating the principles of being in relation and interconnectedness.

Given this feedback, and as a non-Indigenous person intending to host a talking circle, I thought it was pertinent to invite the collaborators to attend the circle with participation ranging from observation to facilitation. Both collaborators expressed an interest in attending the talking circle with the non-Indigenous counselling psychologists if their schedules allowed. Unfortunately, neither were able to attend.

Safety

One of the teachings shared by the collaborators was the utmost importance of creating a safe environment where participants felt comfortable to share. Knowing that what participants share in the sacred circle will be respected and validated allows them to share openly and without judgment. During a talking circle, participants are often sharing parts of themselves, discussing hurtful past events or traumas, and ultimately being vulnerable. While creating a safe space was primarily the responsibility of the circle facilitator, it was stressed that participants also contribute to the safety of the circle. In beginning the circle, AKK discussed the importance of setting the intention and roles that participants share. He indicated that the safety and contribution of each person is necessary, and detailed how they provide safety to everybody in the circle. One way is through validating one another; receiving another input other than the facilitator's reflection is vital to each one's safety. Part of the shared responsibility was participants' active engagement and presence while others share. Angela raised that a challenge in virtual circles is the participants' tendency to multitask. Although they are physically present, they might be mentally absent while others are sharing. In being present and engaged in the circle, participants demonstrate respect for their peers, and are more readily available to provide validation and offer support. Taken together, these aspects (i.e., respect, validation, and support) help to promote a sense of safety within the circle.

Regarding the shared responsibility of safety, there is a balancing of power dynamics between the participants and the facilitator. AKK highlighted that as a facilitator of the circle the only added responsibility that he will have over the participants is "ask[ing] for the permission to intervene" if and when a participant may be experiencing heightened levels of activation (such as having a response to a particular traumatic event). One of the challenges that was raised in

creating the safe space was how to monitor participant activation over Zoom, particularly when approaching the circle from a trauma-informed lens. AKK noted that when participants are starting to feel activated by their trauma, they are likely to experience somatic symptoms:

> When they start to feel in their body, and they start to feel the events, whatever historically happened to them, and their chest might get tight. They might experience pains in their neck, or their head might feel cloudy. Different things like that, and they start to hold their breath. And they start to lose focus on what's being shared and what is being said. So, you need to be able to intervene in that sense and to bring people back to where their center of healing is. Their center of safety. In a sharing circle online I'm trying to imagine what that might look like. How would you ensure that?

Given a large portion of communication is relayed through body language, conducting a circle over Zoom may result in an inability to accurately read participants' more nuanced reactions or subtle facial expressions. While body language is an important aspect in maintaining the safety of the circle, Zoom allows for direct observation of non-verbal body language cues of the upper body, improving the likelihood of catching a participants' non-verbal reactions (Lee, 2010).

Informing Talking Circle Questions

During the initial research conversation, I also sought counsel around topic areas I might explore with the participants that held special relevance from the collaborators' perspectives. Broad guiding questions helped facilitate conversation regarding possible barriers that non-Indigenous counselling psychologists encounter when working with Indigenous people, and how they can align with Indigenous principles of wellness. This part of our research conversations was used to create questions for Phase Two, the talking circle.

Getting a Wholistic Picture in the Counselling Context

Both of the collaborators expressed the importance of counselling psychologists creating a wholistic picture of the person, which included a fuller historical and sociocultural account of colonization. The collaborators stressed the importance of exploring how contact and colonization have impacted not only the individual but the family system and their community. Community was considered in terms of both where they are currently situated and their historical familial community. AKK advised that clinicians should examine "what happened to that community? What happened to that family? How did this person grow up in the community? [Did] they grow up in their family? And how do they [clients] approach whatever they're dealing with?" Similarly, Angela shared that a barrier she sees to non-Indigenous counsellors working with Indigenous Peoples stems from "not understanding an Indigenous way of doing things… to really understand an Indigenous person that you're supporting is to understand all piece to what has happened… It's solely essential to understand the lineage and the whole family." Importantly, the collaborators emphasized that while all Indigenous Peoples have experienced colonization, each person, family, and community has been uniquely impacted. It can potentially cause harm if counselling psychologists applying a one size fits all approach, or taking a pan-Indigenous approach (i.e., not recognizing the cultural, linguistic, and historical differences that exist among Indigenous nations and communities; Bodkin-Andrews & Carlson, 2016).

Connected to exploring the implications of colonization on the community is understanding how colonization may have impacted language and dialectic contexts. AKK highlighted how many Indigenous Peoples were prohibited from speaking their language and were forced to speak the language of the settler nation. He drew upon personal experience discussing how his parents "were taught English by French-speaking nuns who spoke broken English… That was the dialect that came to my community." Importantly, he emphasized that

beyond the pronunciation of words, it is also the context and sentence structure that may create barriers to understanding. Non-Indigenous people, especially clinicians, need remain cognizant of such cultural differences that may exist within verbal and non-verbal communication. For instance, AKK noted that if a psychologist is "using terminologies that they [clients] are not familiar with at all, then they'll more likely not communicate or ask questions." The lack of questions may be interpreted as understanding on behalf of the clinician. Interactions may further be misinterpreted through differences in body language. AKK relayed a story in which nodding in some Indigenous communities is a display of opening up the conversation to continue rather than a sign of understanding. As such, non-Indigenous therapists may misinterpret an Indigenous person's nodding for understanding information or agreement.

Questions that arose for the non-Indigenous counselling psychologists talking circle:

1) How confidently do you understand Indigenous and non-Indigenous relations?
2) Do you look at the larger context, such as the family system and community, when working with Indigenous clients?
    a) What does that look like?
3) In your experience, have you encountered language barriers or contextual misunderstandings when working with this population?
    a) What do you do when you encounter this barrier?

Privileging Western Conception of Wellness

Historically, common psychological practices have been grounded in the Western conception of wellness resulting in Indigenous approaches tending to be dismissed and minimized. As presented in Chapter 2, not only are Indigenous approaches to wellness being dismissed by the dominant culture but also by Indigenous people as well. AKK pointed to the

legacy of colonization and residential schools as encouraging the continual dismissal of Indigenous traditional healing:

> It's a challenge right now, with some of our communities, because people don't want anything to do with First Nations culture and they've been taught that it's bad. That was one of the horrific events that came out of residential schools, to believe that you're wrong. That your culture is wrong, your language is wrong. Everything about you is wrong.

The result of repudiating Indigenous knowledge and healing systems has led to the further privileging of Western science, especially within academic settings where clinicians are rarely exposed to traditional Indigenous approaches.

Furthermore, the privileging of Western practices means that Indigenous Peoples who may be suited to take on helper roles in their communities are not recognized because they may not hold the Western title or educational degrees. As Angela highlighted "people measure experts through colonial systems." In spite of this, Indigenous communities "have Knowledge Keepers and Elders who are doing that work in a beautiful way without the colonial credentials." However, these individuals are often not included in the First Nations Non-Insured Health Benefits (FNNIHB) service provider list. Instead, Indigenous individuals are being referred to non-Indigenous clinicians for services that could potentially be provided within the community. Questions that arose for the non-Indigenous counselling psychologists talking circle:

1) Do you see any differences between mental health and wellness?
    a) How do you perceive wellness?
2) Did you receive training on Indigenous wellness?

Attunement and Authenticity

A significant factor that was raised by the collaborators regarding working with Indigenous people, or any persons for that matter, was authenticity and attunement. Consistent across interviews was the importance of the positionality and the narrative the clinician is presenting. Angela pointed to the importance of "tapping into the privilege and how [clinicians] use the privilege", while AKK highlighted the importance of the "presentation of [oneself] and where [they are] coming from." The collaborators discussed the importance of being authentic in your desires to help. Angela noted that if a non-Indigenous person "struggles with their own biases with Indigenous people, then [they] shouldn't be working with Indigenous peoples till they're ready." Biases and prejudices can hinder the therapeutic relationship, which both collaborators emphasized was key to successful healing.

AKK further discussed how relationship is the foundation to working with Indigenous communities. In establishing the relationship, the collaborators pointed to relating with Indigenous people on a personal and authentic level. A barrier to authentic engagement that was identified by them was the notion of expertise. In Western circles expertise in psychological practices is expressed in the form of titles, roles, and colonial structures within the counselling space. AKK shared that "tak[ing] away that expert" eliminates the power imbalance and enables clinicians to meet with people on a personal level. Angela highlighted certain colonial structures and agendas that limit our ability to attune with the people we are helping. Specifically, she identified the colonial concept of time as impeding our ability to truly connect:

> We have one hour together and there's a big clock sitting behind you. It's ticking. Ticking. And my focus is to ensure that I did everyone on my paper… So, I'm not being attune to who you are. I'm more attuned to what I need to draw out of you so I can have the paper reflection to measure who you are. Yet, I'm missing such [an] essential piece to

> who you are in your pain. Then I can't even begin to understand that; I'm so stuck in this Western way of trying to define pain and what it looks like, that I'm seeing right through you and I'm looking at the colonial time behind you.

Another barrier Angela identified was not maintaining a trauma-informed space. For instance, in addition to the presence of clocks in the room, she mentioned the physical barrier of having a desk between the clinician and who they are seeing, as well as not providing an opportunity to smudge or have ceremony before or after a session. She suggested clinicians consider adjusting how they approach sessions stating that "the Western way of counselling and therapy are really activating [for] folks in a way that they want to go running." For instance, consideration regarding the language therapists are bringing into the counselling space such as using the term therapy or clients. Ultimately, both collaborators urged the importance of stepping outside of the colonial titles (i.e., psychologist, therapist), structures, and agendas in order to relate authentically, in a more human capacity.

Questions that arose for the non-Indigenous counselling psychologists talking circle:

1) What do you view as key components for building relationships with Indigenous clients?
2) When working with Indigenous clients are there any changes that you make in how you present yourself or the space you are working in?

Phase Two: Enacting the Circle

After spending a considerable amount of time reflecting on the dynamics of the circle and the topic areas I might explore, I moved to the next phase of the study, the talking circle. The purpose of the talking circle was to gain insights into non-Indigenous counselling psychologists' experiences working with Indigenous individuals and their understanding of the differences between Western and Indigenous approaches to wellness. The circle was held over Zoom during

the clinicians' regular weekly team meeting, with some clinicians volunteering to participate and being excused from the team meeting. The circle was allotted an hour and a half, after which the participants had to resume their work responsibilities. Unfortunately, due to scheduling constraints, the collaborators were unavailable to assist in facilitating the circle, so I took on the responsibility alone.

Before commencing, I began by acknowledging the traditional protocol and informed participants that, in the absence of support of the collaborators, we would forgo certain traditional protocols such as smudging and prayer. Instead, we initiated with a land acknowledgement and provided the opportunity for the participants to acknowledge the land of their ancestors. Although, no one took this opportunity. I then proceeded to highlight the process and expectations of a talking circle; I have included an excerpt from the circle to illustrate:

> Participation in today's circle is completely voluntary, and the level of participation may vary, depending on the person. So, you're not required to talk if you do not want to. I only ask that you keep your minds and hearts open to the learning process of the circle. And I also ask you to pay attention to the speaker without interruptions, and respecting what people say, what their views are, and how they are able to express themselves.

To facilitate the online format, I provided the clinicians with a general structure for the circle. I suggested that, since we were in a virtual space, participants could use the "raise hand" or "hand" emoticon to indicate their desire to speak. The individual currently speaking would metaphorically pass the talking piece to the next person, ensuring that there was no overlapping conversation and that participants collectively facilitated the circle. All the participants had their cameras on, so I did not have to request that they do so.

Initially, the circle progressed in as circular of a pattern as an online format would allow, with each participant taking turns to speak. However, it quickly began to deteriorate. Participants started to leapfrog, and maintaining the 'circular' structure became very difficult in the absence of a physical space. One significant factor contributing to this breakdown was the participants' lack of familiarity with talking circles. Only one of the participants expressed having had prior experience. Consequently, rather than waiting for their turn to speak, the participants started to engage in crosstalk, which is more typical to Western communication styles.

Once the structure of the circle was disrupted, I encountered difficulties in re-establishing order among the participants. Although I had participated in talking circles before, this was my first time facilitating a circle. According to Hart (2002), in face-to-face circles, a facilitator can sometimes use non-verbal cues, like maintaining eye contact, to redirect individuals and bring their focus back to the circle. However, achieving the same effect over an online platform proved almost impossible. While I considered verbally reminding the participants about the circle structure, I hesitated as I feared it might be interpreted as rude or come across as shaming. Perhaps this hesitation stemmed from the power dynamic present between myself and the clinicians. Despite being the researcher in this context, I was also a counselling practicum student, while they were registered psychologists.

Although the integrity of the circle was not fully maintained, the participants engaged in respectful and open sharing, demonstrating their presence and active involvement, which is consistent with the principles of a talking circle as outlined by both Hart (2002) and the Indigenous collaborators. Despite the crosstalk between participants, it brought forth responses and perspectives that my questions alone may not have uncovered. This added diversity and depth to the exploration of the research questions.

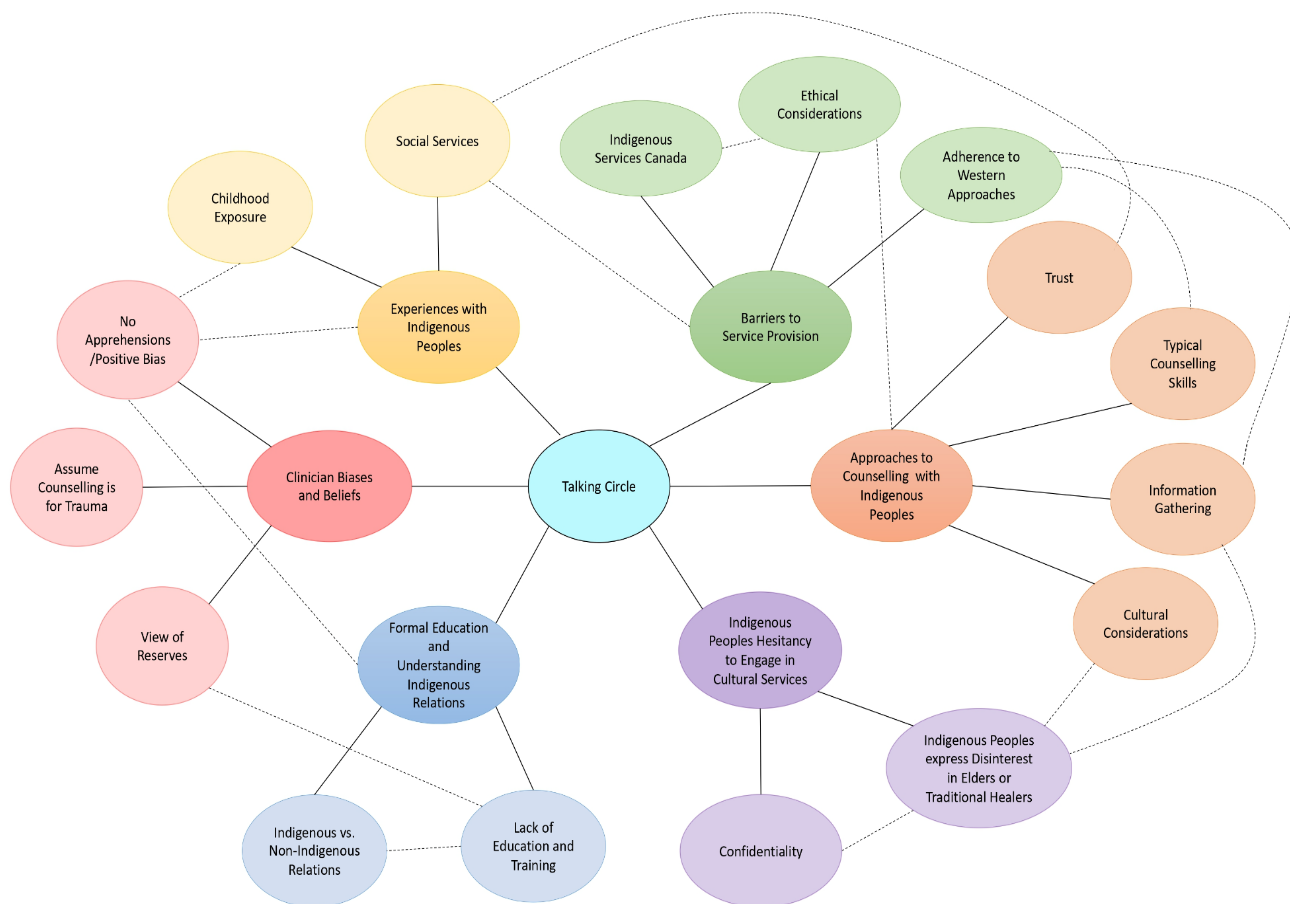
After transcribing the talking circle, I carefully read through it multiple times, making notes in the margins, and identifying points of interest. Between readings, I took time to deliberate on the identified point of interest and reflect on the overall discussion. Throughout this process, I continually reoriented and aligned myself to the research questions. In the end, I created three versions of the concept map. The initial map was relatively simple, highlighting only four salient points. At that stage, I was operating under the assumption that I was conducting a reflexive thematic analysis, so the structure of the first map resembled a thematic map in that it only highlighted dominant themes. However, after consulting with my supervisor, we agreed that such thematic analysis was not appropriate, and it would be more beneficial for the map to identify more granular points of interest (herein referred to as nodes). This led to the creation of the second map, which was used in the subsequent research conversations with the Indigenous collaborators. After further deliberation of the salient points on the map, I refined and revised the map once more, combining or condensing several points. The final map, depicted in Figure 2, highlights six salient points with 16 nodes. I define salient points as those where multiple clinicians reported similar experiences, or those that I understood to demonstrate significance. The salient points represent meaning rather than frequency. I determined meaning through adopting a critical and community-based perspective reflecting on what I was hearing from the collaborators and the non-Indigenous participants. The nodes offer specific details of the ideas and/or the nature of the argumentation provided under each salient point. The salient points are directly connected to their respective nodes via lines. Dotted lines represent meaning making and are used to identify relationships between certain nodes and salient points. For instance, the dotted line connecting the nodes “view of reserves” and “lack of education and

training" represents the perceived relationship that lower understanding of Indigenous Peoples and colonization is related to having unfavourable views of reserves.

Before proceeding, it is important to acknowledge that the non-Indigenous participants demonstrated a great deal of passion and care towards working with Indigenous individuals. The clinicians were actively engaging in self-education to learn more about Indigenous and non-Indigenous relations and the history of colonization in Canada. They sought to build and achieved in many of the examples shared, trusting therapeutic relationships grounded in empathy and respect for the individual and their culture. However, the purpose of this thesis is to explore the tensions, or challenges that hinder the provision of culturally appropriate and safe care. The research questions align with the priorities of Indigenous communities and are informed by the feedback from the Indigenous collaborators. Although the questions may appear to focus on deficiencies, it is essential to examine the challenges in order to ascertain the truth. Following the principles of the Truth and Reconciliation Commission, it is imperative to acknowledge the truth of Indigenous experiences before embarking on the path of reconciliation.

Figure 2

Tensions and Barriers to Working with Indigenous Individuals



Experience with Indigenous People

All of the participants (identified in this document by pseudonyms) reported having a significant amount of experience working with Indigenous clients, with two clinicians reporting over 10 years of direct experience. For instance, Oscar noted, "most of my private practice now is with Indigenous clients." Participants identified that the primary source of their interactions with Indigenous clients accessing counselling has been through social services such as hospitals, the justice system, or child and youth services. Alexis shared that many of the Indigenous clients she worked with were through "the emergency department, or who are referred by the courts because of drinking and driving." Similarly, Thomas discussed how most of his experience with Indigenous individuals stemmed from his time working in the youth criminal justice system. The

participants reflected that the overrepresentation of Indigenous Peoples in social services is the result of colonization and the residential schools. Alexis noted that,

> [most people] are needing our help mainly because of residential school history, and either their parents were in residential school, or they were in the residential schools themselves. And so, all the sequelae from that have led to all kinds of social issues.

Given the institutional mistrust that many Indigenous Peoples (rightfully) have, Dawson shared that in his experience,

> A lot of [Indigenous youth] wouldn't necessarily access some of the more institutional sort of access points so like coming into counselling per se, or going to see a doctor, but they would come in because they had community members or friends who would access the [organization name], and they build relationships with staff there.

Dawson recognized that the drop-in centre at his organization provided an institutional gateway where service providers could start to build the relationship and develop trust with the Indigenous youth, which eventually opened the possibility for service engagement.

While all of the participants had experience working with Indigenous clients, most of them stated that their interactions with Indigenous people began during childhood. Devika shared that growing up in Southern Alberta, there was a large number of Indigenous people with whom she became associated. However, she identified that the narrative around Indigenous Peoples was not very positive. Conversely, both Oscar and Alexis shared that they had positive exposure growing up with Indigenous people. Oscar shared, having a positive experience growing up "a three-minute walk from the [town] reserve." He noted his early childhood experiences have helped him feel "completely comfortable and I very much enjoy working with the Indigenous community." Likewise, Alexis reflected on how growing up her mother "had a lot of sympathy

for [Indigenous people]" and taught her about the difficult realities that Indigenous people live with.

Barriers in Service Provision

When discussing service provision to Indigenous people, the participants identified several barriers that they believed limited their ability to provide culturally appropriate and ethical care. Oscar, a clinician on the Indigenous Services Canada (ISC) service provider list, shared that he views ISC's strict boundaries as a key vulnerability in the provision of services for Indigenous Peoples. ISC provides access to a multitude of services and includes health care services for Indigenous people who do not have private insurance (non-insured health benefits [NIHB]). One of the primary factors Oscar identified as being constraining was the difference in payment, "right now the current fee is $170. The provincial fee for psychologists is $220. I've worked with numerous colleagues over the years who simply won't work with the Indigenous community because the salary is so much lower." Not only is the salary significantly lower, but Oscar identified a large portion of unpaid work that accompanies conducting ethical practice within the framework of ISC:

> I can't tell you how much free work I've done over the years because I've been so concerned about various clients and yet not being covered within the very limited and narrow terms of the contract…There needs to be an interdisciplinary approach to [the] provision of services to the Indigenous community.

While Oscar was engaging in this "free work," he identified that he has colleagues that are not taking on this extra responsibility because they are "running a business [and] just can't afford to do that" (Oscar). This limitation of an ISC contract means that many Indigenous people

accessing services are not receiving the same level of care that may go into community or private practices.

Conversation regarding ethical limitations extended beyond ISC and included the restrictions put in place by the Canadian Psychological Association (CPA). Specifically, the participants expressed concern regarding the ethical guidelines for c*onflict of interest* (CPA, 2017). Conflict of interest is defined by the *Canadian Code of Ethics* (CPA, 2017) as psychologists must "not exploit any relationship established as a psychologist to further personal, political, or business interests at the expense of the dignity or well-being of their primary clients, contract examinees, research participants, students, trainees, employers, or others" (pg. 29; see III.28 in the *Canadian Code of Ethics* [CPA, 2017] for more information). Since the pandemic, mental health providers have seen an influx of people accessing services resulting in extended waitlists as well as wait times between sessions. Thomas noted that despite a client being discharged from services at an organization, psychologists are unable to work with the person in a private practice capacity. Alexis agreed saying, "we can see a patient once every three months. They want to see us privately and we say, I'm sorry I'm not allowed to… We can't even meet the demand. So, it's hardly a conflict of interest." As Alexis mentioned, there is often a prolonged period between sessions due to overburdened caseloads. Arguably, the extended wait time between sessions could also be considered an ethical infringement as clients are essentially being denied care.

Overburdened caseloads can also result in clinician fatigue, which Dawson outlined makes it "hard to sometimes adjust and to put the extra effort and work in sometimes to be sensitive to [cultural factors]." He noted the tendency to revert back to "what I usually do." According to Dawson, overburdened caseloads and clinician fatigue may result in counsellors

reverting to traditional Western approaches to care that may not be attuned to potential cultural differences. Dawson identified that "one of the lead barriers for some Indigenous people seeking help, because of that sort of the Western model of care." Given that Western approaches are often seen as perpetuating colonial harm (Linklater, 2014), when therapists are regressing to Western approaches it may lead to Indigenous people not seeking care or returning for follow-up sessions. Another implication of Western adherence that Dawson noted was the individualization of care,

> The colonization aspect of care delivery… One thing that stands out to me is, they're [Indigenous clients] quite communal in how they care for each other. So, when working with the youth, and they are disconnected from their parents, their grandparents will step in, or their aunts and uncles, and I think quite often child services will get involved and tragically sort of dismantle some of the healing that the family is doing at times.

The participants identified several barriers to culturally appropriate service provision for Indigenous individuals, highlighting some inherent flaws in the structure of service delivery and ethical guidelines that govern psychologists. While there was discussion regarding individual constraints (e.g., clinician fatigue), the participants saw the overarching structural issues as creating and maintaining service barriers.

Approaches to Care with Indigenous People

In congruence with what the collaborators shared in phase one, all the participants emphasized the importance of being authentic. To help build an authentic therapeutic relationship Oscar shared that he embodies "unconditional positive regard. Absolute acceptance of working with them, one human being to another. Sense of humility. We're all a human community and we work together." While Dawson identified that he "fall[s] back to client-

centered care." The participants highlighted skills in building the therapeutic relationship did not differ from the typical skills that clinicians are taught to embody in their western educational training. They outlined the importance of being authentic, empathetic, and active listening to help build the relationship.

In any counselling relationship an important factor in creating the therapeutic alliance is establishing trust. Thomas identified that "[Indigenous people] might not trust the white people because of colonization or oppress[ion]." He also noted that there is a great deal of mistrust within Indigenous communities stating that, "they don't trust each other, so sometimes it is a trust issue… not only towards the white male but basically towards anybody." Alexis pointed to the outcomes of colonization and the adverse conditions that many Indigenous people grow up in as setting the stage for mistrust. Oscar agreed and further suggested that given adversity "it makes perfect sense that [Indigenous people] in that context, developmentally, wouldn't trust or have a difficult time with that." Thomas shared that the general mistrust meant potentially working harder to earn their trust but once obtaining it, the person became open and honest in session. Given the confidentiality terms within the counselling relationship, Thomas noted that the person may trust the clinician more than others as this excerpt depicts: "they can trust me more than they can trust, I don't know their neighbors, or something like that, because they expect that I will keep the confidentiality."

When exploring possible differences that arise when working with Indigenous clients Devika shared that her role changed from creating and obtaining goals to simply listening,

> Just sort of being a witness to their story… I remember a patient actually saying that all she needed was for me just to listen, nothing more, which was very difficult. But she was quite clear in terms of what my role was.

Dawson reported encountering similar experiences where "more traditional goal setting doesn't quite fit sometimes [with] their experience." Instead of engaging in traditional goal setting, Dawson said he would often just listen to their story and identify their presenting concerns before "offer[ing] some structure towards the end to say, you know this sounds like this could be helpful." Listening and being a witness to Indigenous client's story was an orientation that most clinicians discussed. Alexis shared, "just being open to people, being open to their story. Being resourceful, helping them figure out what they can do to make their lives better." As Alexis identified, being resourceful and aware of alternative healing options within the community was an important factor. Similarly, Dawson noted, "there's sort of traditional practices and healing practices that sometimes they're just dying out, or they're not being integrated into care," meaning that clinicians are required to do their own searching for what might be available in areas outside of Western counselling.

While identifying cultural healing options is important in the delivery of care, it is pertinent that counsellors do not assume that because a person is Indigenous, they are interested in cultural practices. Living in Calgary, Thomas shared that the Indigenous people he works with are similar to the non-Indigenous people in terms of identification with Western culture and indicated that "everybody's unique…So just kind of listen to their story, and meet them where they are [at]." As AKK discussed in phase one, colonization's attempt to eradicate Indigenous Peoples resulted in dismissing and diminishing traditional approaches. As a result, many Indigenous people do not identify with traditional practices. For the same reason, it is important to gauge an individual's level of acculturation to Western culture rather than assume that a person would be interested in traditional approaches. As Thomas states, "there is a variety within this

population, there is a big variety… We cannot generalize that Indigenous people are like that. No, everybody is different."

One way of measuring acculturation is through information gathering, a key stage in any beginning counselling sessions. Typical approaches to information gathering included taking a history, creating a genogram (information on the interpersonal relationships within families), looking at developmental delays (e.g., learning to walk or speak later than expected for typical development), and reviewing any significant historical factors such as alcohol or drug use during pregnancy or involvement with social services. For instance, Oscar shared that he looks at both positive and negative life events,

> what [do] they [client] view as being an important strength in their life. What's going well for them? Name two or three or four items. What are the three or four worst traumas that they're experiencing or have experienced… It covers a lot of territory very quickly and it always involves the family, at least to get me a snapshot of what happened or didn't happen with the family or cultural context.

All the participants noted that while they take a family history, most of the Indigenous people that they work with are disconnected from their family, making it difficult to get a complete picture,

> I find that a lot of the people I work with are not really in touch with family. They're kind of isolated… So, unfortunately, bringing in the culture and the family, the community and the family, hasn't really been possible because they don't exist. - Alexis

Thomas elaborated on Alexis' point stating that "some of them, they don't want to be connected with the family because of these dysfunctional families, they just don't feel safe around them." He emphasized the need for therapists to meet clients "where they are at." While all the

participants acknowledged the importance of information gathering, none of them identified the need to explore the community history. Furthermore, when asked about whether the participants experienced language or contextual barriers, all of them reported that this has not been an issue they have encountered. However, they recognized that this may perhaps be due to the level of acculturation and location in a large urban city compared to a more rural or eastern location.

Indigenous People's Hesitancy to Engage in Cultural Services

As discussed previously, the history of colonization and attempted eradication of Indigenous cultures and approaches to wellness has resulted in minimization and dismissal of traditional healing practices. When suggesting cultural supports to Indigenous individuals, the participants reported encountering some level of hesitancy or disinterest. Oscar shared that some Indigenous people he has worked with have said:

> I don't want to work with an Elder or a Traditional Healer. I'm deeply concerned about the people that I've been exposed to, and I would rather not work with them. Basically, suggesting they're not well qualified… They prefer to work with a mainstream psychologist because of their concern with the healers within their own community".

Similarly, Devika spoke to her confusion regarding Indigenous people's hesitancy to engage in cultural supports. Oscar and Devika's experiences highlight the historical and ongoing implications of cultural suppression. Indigenous people's hesitancy to engage in cultural healing practices may stem from the longstanding prioritizing and privileging of Western perspectives and the minimizing of alternative approaches.

Another aspect of reluctance that was raised in regard to engagement with cultural services was related to confidentiality. Alexis recalled:

> I have a patient at one of the private clinics and she's First Nations… but she has a binge drinking problem. I've suggested to her that you go to Elbow River Healing Lodge, and she doesn't want to go because she works in the community. She doesn't want to be seen as somebody who requires mental health services because will that damage her ability to work with patients?

The other participants reported similar experiences with the people they serve, also noting that this extends to other ethnicities where there is a fear regarding confidentiality when seeing a clinician of similar ethnicity. Hesitancy to engage in cultural services should be understood as distinct from the salient point "barriers in service provision" as the hesitancy is an attitudinal barrier resonating from the Indigenous individual rather than a structural barrier.

Formal Education and Understanding of Indigenous Relations

In recent years there has been legislation (e.g., Teaching Quality Standard in Alberta, TRC (2015b) Calls to Action 62 and 63) that requires foundational knowledge regarding First Nations, Métis, and Inuit people be included in the curriculum (Alberta Education, 2020). Unfortunately, prior to these calls, education regarding colonization and Indigenous Peoples in Canada were limited, if not non-existent, within education systems. During our conversation, all the participants reported no exposure to Indigenous historical factors (e.g., Indian Act, residential schools, sixties scoop) when going through primary and secondary education. It was not until they were adults that most were exposed to the truth of Canada's history. Oscar shared, "I don't understand [Indigenous and non-Indigenous relations] very well historically, and one of my regrets is, I wish that we had more of that history as a child growing up." Alexis similarly remarked it "was never in the textbooks. When I was a grade 10 teacher, it was finally in the textbooks."

The lack of education has resulted in a fundamental misunderstanding regarding the distinct history of Indigenous Peoples in Canada. When discussing the participants' understanding of Indigenous and non-Indigenous relations, Thomas identified not understanding why I was making a distinction between Indigenous Peoples and other minority groups that have been impacted by colonization:

> I have a hard time, like if you said Indigenous and non-Indigenous, because that non-Indigenous is a variety of lots of other, let's say, even minority groups. And like for instance, the Chinese population, until the fifties, they were treated like second class citizens. They were used as slaves building railroads… So, First Nations are not the only minority that are struggling with addictions, with colonization, with all the traumas. So, there are other groups. And so, when we are comparing them to non-Indigenous then who are we comparing them to exactly?

After Thomas expressed his confusion, the other participants attempted to explain what made Indigenous Peoples experience of colonization distinct. Alexis pointed to the attempted eradication of Indigenous Peoples as the defining factor:

> Our ancestors have actively worked to, what's the term, destroy like since day one, since the settlers first came… There has been a systematic attempt to kind of disenfranchise First Nations people and portray them as stupid, their culture as having no meaning. And so, the end result of that has been this huge population who basically have had their social structure decimated.

When Thomas rebutted that other ethnicities (e.g., African, Chinese) similarly had their social circles destroyed due to slavery, Alexis emphasized residential schools as "the icing on the cake" that separated Indigenous Peoples from other ethnicities. Despite attempts to define what sets

Indigenous Peoples' experience of colonization apart from other ethnicities, none of the participants reflected on the historic and ongoing Crown relations, further highlighting the lack of education regarding Indigenous Peoples in Canada.

Despite undergoing extensive training to become a psychologist (i.e., master's degree in Alberta), only one of the participants, Devika, received training regarding working with Indigenous individuals. Devika shared that her university offered an optional course on Indigenous perspectives that was "more experientially based in my master's program… We [went to a] Sweat Lodge, and we were in a tipi and there were all the Elders. It was just a very different experience." Despite continuing education being a requirement of registration with the CPA, none of the clinicians had opted to take an Indigenous training. Dawson shared that one of the Indigenous specific training options he was aware of was "quite pricey and the training is quite lengthy. So, I think that is a barrier for a lot of practitioners that might want to provide that service." Instead, the clinicians noted engaging in self-learning or learning informally from colleagues. For instance, despite working for the ISC, Oscar reported that he has not "formally [attended training], but over the years I've done readings… Really self-taught." Four of the clinicians identified learning informally from Indigenous people,

> When I worked at [Site] the night staff she was, she wasn't an Elder, but she had her Ph.D. in Indigenous Studies and she was an Indigenous woman, so I probably learned more from her than a lot of people. - Dawson

Oscar also identified that "what I've learned sadly, is through my Indigenous clients over many, many years." Similarly, Thomas discussed learning from an Indigenous person he was seeing in a counselling context who was raised outside of his culture and was in the process of reconnecting with his heritage. Thomas noted that throughout this person's journey of

reconnection he was also being introduced and learning Indigenous perspectives. Thomas shared that "he actually invited me to their sweat lodge. So, I went with him… Listening to him and learning from him what he's learning from his Elders. That is my training." Unfortunately, Alexis shared that she had the experience of meeting with an Elder and when she "wanted him to come and give a talk to my mental health group, and nobody wanted it. So, that says a lot."

The lack of inclusion of historical factors in the educational system as well as opportunities for training in psychological programs highlights the continued privileging of Western priorities and concepts. While recent years have seen a shift, in large part due to the TRC (2015a) document, there remains dissent in the field of psychology to prioritize alternative approaches as can be evidenced by the lack of education and training opportunities.

Clinician Biases and Beliefs

Throughout the talking circle the participants both consciously and unconsciously discussed their potential biases and beliefs regarding Indigenous Peoples. For example, after describing the intention of the circle and of this research (e.g., to discuss apprehensions psychologist may have working with Indigenous clients), one of them stated that she doesn't "really have apprehension. I mean, maybe they have apprehension about me" (Alexis). Similarly, Thomas noted that he has a (perceived) positive bias:

> I would say, I have some positive bias, because, growing up in Europe, we were not in touch with [the] First Nations here in North America, but we have seen lots of Veneto movies…and quite romanticized their fight for the freedom against the white guys were bad guys, and trying somehow to steal their land. So, when we played Indians and cowboys everybody wanted to be Indians, because they were the good guys.

Moreover, consistent across all participants, was an underlying assumption that most, if not all, Indigenous individuals seeking counselling was in relation to trauma. Oscar shared that he "just assume[s] that the person that's coming in to see me has an extensive trauma history." Likewise, Dawson thought that most Indigenous individuals only come into counselling services when they are in "a state of need or crisis."

Throughout the talking circle, the participants approached the conversation in, what I would argue is a traditional western, deficit-based discourse of Indigenous Peoples. While there was some recognition of colonization's role in creating the structures that oppress Indigenous Peoples, there was very little discussion regarding their strengths, resiliency, or perseverance. An interesting, unintended point of conversation that arose was a discussion regarding reserves in Canada. The participants acknowledged the lateral violence that exists within the reserve systems, identifying gangs, violence, misuse of money, and political corruption among Chiefs. They also noted that these issues primarily exist due to the unlivable conditions (i.e., lack of work, no drinking water, untenable land) that reserves are situated on. Alexis identified an important aspect, "it's a result of colonization. How do we turn it back? And the thing is, we cannot turn it back sadly. And hopefully the communities themselves can turn it back, but they're going to need a lot of help." Alexis' point alludes to the importance of building capacity in Indigenous people and their communities. Arguably, counselling can be said to help build capacity within the individual, which in turn can help create stronger communities.

Phase Three: Weaving Together Perspectives

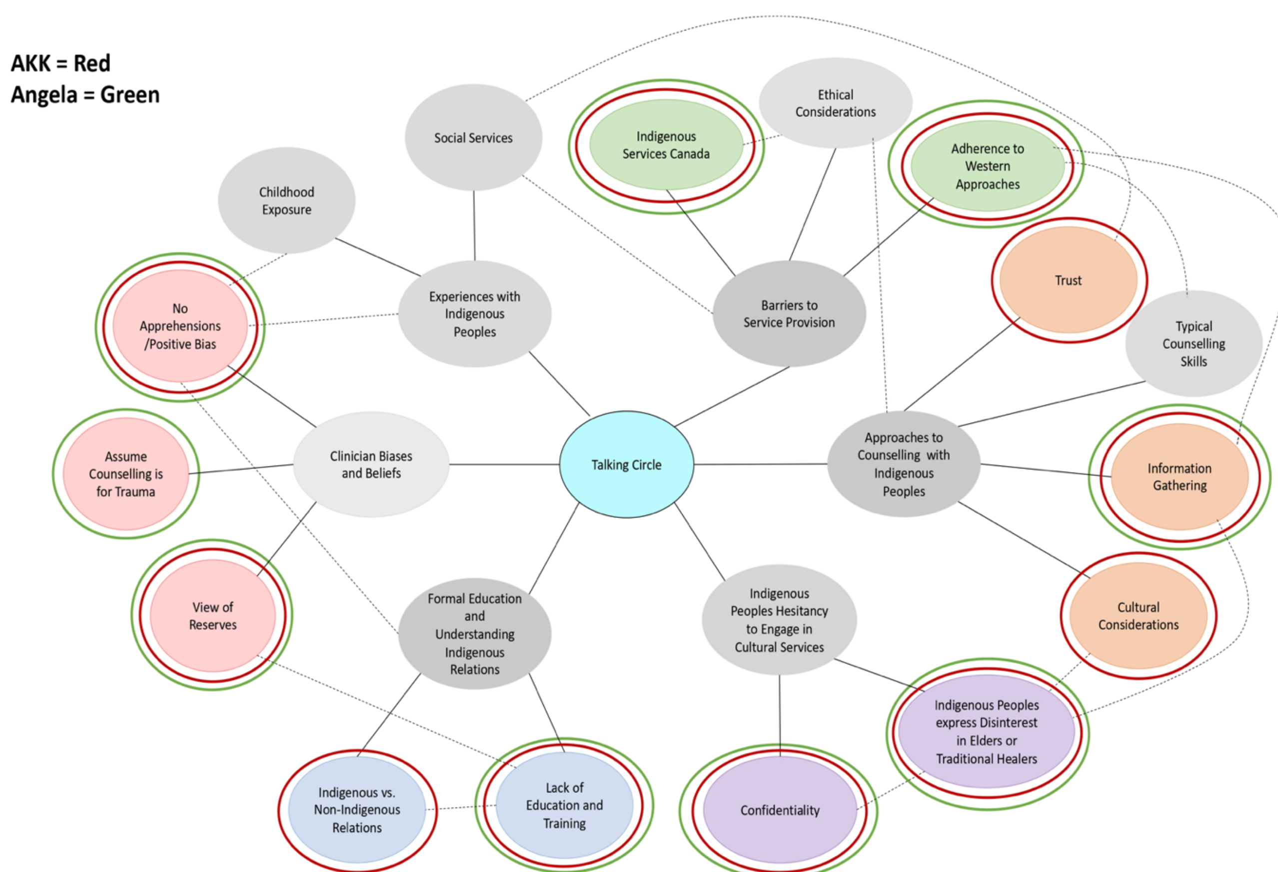
The final stage of this research consisted of reconnecting with the Indigenous collaborators to discuss the findings from the talking circle and gain an Indigenous perspective on the data. To facilitate the conversation, I shared the talking circle concept map (Figure 2) over

Zoom, and together we went through each of the salient points and their associated nodes. I offered a brief description of each node, pausing after each to provide space for the collaborators to share their perspective or thoughts that might be arising. After reviewing all the nodes, I provided the opportunity to discuss any final thoughts, feelings, questions, or concerns.

Once the research conversations were transcribed, I reviewed the transcripts several times alongside the concept map to ensure that I was aligning myself in relation to the talking circle data. After reviewing the research conversations, I circled the nodes that the collaborators commented on, using red to denote AKK and green for Angela (see Figure 3). In what follows, I will identify the nodes the collaborators discussed and offer their insight and feedback.

Figure 3

Collaborator Activated Nodes from the Talking Circle



Barriers to Service Provision

When reviewing what the counselling psychologists saw as barriers to service provision, both Angela and AKK reflected on Indigenous Service Canada. AKK pointed out that non-Indigenous counsellors may be unaware of alternative policies, such as Jordan's Principle, that can support Indigenous Peoples beyond the typical route of accessing services through ISC non-insured health benefits. This lack of knowledge hinders the utilization of available services and impedes the delivery of appropriate care by non-Indigenous practitioners. The challenges identified by Angela further compounded the underutilization of services. She highlighted how Indigenous healers are unable to register with the ISC provider list due to not possessing the required degrees. Angela emphasized that this exclusion stems from measuring expertise through colonial constructs, leading to an undervaluing of Indigenous ways of knowing. As such, traditional healers and their services are not included on the provider list. Angela viewed this as a "very huge gap in the system where people who have no concept of Indigenous ways of knowing and being are added to the [ISC service provider] list because they have Western degrees." Importantly, Angela stressed that "it's okay to put [non-Indigenous clinicians] on the list" but the lack of recognition and valuing of Indigenous knowledge has resulted in "so much inequality in that whole system."

Despite ISC and typical counselling services adhering to Western conceptions of expertise and perspectives, the collaborators noted that there are people in the community providing traditional healing practices. AKK emphasized that Indigenous community members are "taking a proactive approach" to integrate traditional practices, highlighting that the passing of *Bill C-92: An Act respecting First Nations, Inuit, and Métis children, youth and families* in 2019, which affirms the inherent right of self-determination regarding jurisdiction over child and

family services, will have important implications for Indigenous communities. Moreover, Angela stressed the importance of honouring both Indigenous and non-Indigenous ways in supporting people. She stated, "if we were to bring the beautifulness of both worlds, the work that could be done to eliminate the overburden caseload, to talk about ethical considerations, to support communal and individual people." Angela's words exemplifies the potential benefits of valuing Indigenous and Western concepts of wellness in overcoming the barriers to service provision, which was identified by the psychologists in the talking circle.

Approaches to Counselling with Indigenous Peoples

During the discussion on information gathering techniques used by the counselling psychologists, Angela expressed that she is "always curious about how questions are being asked about family history." She noted that, due to the dislocation and disruption caused by colonization, it is often challenging for Indigenous People to access their lineage. Angela emphasized the importance of counsellors being inquisitive and revisiting family history later in therapy. She highlighted that curiosity plays a crucial role in creating a safe space for Indigenous individuals to explore their family background. AKK similarly commented on the significance of understanding community history in information gathering. He emphasized that regardless of whether the client is actively involved in the community, they are inevitably influenced by the community's history and the intergenerational trauma. AKK recommended that psychologists working with Indigenous individuals should familiarize themselves with the client's community "because then [clinicians] get a sense of what happened to the family or families through the generation." Hence, therapists are encouraged to take a historical and intergenerational approach to trauma, such that they acknowledge and explore how colonization has affected not only the individual but also their family and the community as a whole.

When working with Indigenous individuals, AKK emphasized that it is essential to approach the work authentically and to avoid tokenizing Indigenous culture. He stressed that any attempt to tokenize or trivialize Indigenous culture is demeaning and disrespectful. For non-Indigenous mental health practitioners, he encouraged them to engage authentically, supporting and validating different ways of being and knowing. AKK illustrated this point by giving an example of a client who wishes to discuss spirituality, emphasizing the importance of psychologists not minimizing the client's experiences and authentically validating their perspective.

Indigenous People's Hesitancy to Engage in Cultural Services

AKK anticipated that Indigenous clients might be hesitant to engage in cultural services due to the lasting effects of colonization. He explained that "one of the dynamics that came out of colonization was the lack of attachment to historical ways of wellness… Making [Indigenous Peoples] believe that our ways were not only not worthy, but also evil." The repercussions of colonial indoctrination continue to influence Indigenous people's reluctance or avoidance of traditional approaches to healing. Angela speculated that this hesitancy might stem from Indigenous people wanting to "accommodate the relationship between the psychologist" by "leaning into the biases" that favour Western approaches over traditional practices. She suggested that psychologists themselves may be perpetuating this bias by not weaving Indigenous perspectives into their treatment plan. Angela stressed the importance of creating a comfortable environment that encourages clients to ask questions and explore their own beliefs and values during sessions. Just as individuals seek out a counsellor they connect with, Indigenous clients may not immediately connect with an Elder or traditional healer. However,

Angela affirmed that “there is somebody out there in that role that they eventually will connect with.”

Regarding concerns about confidentiality raised by the clinicians, Angela shared that the “Western system bases [confidentiality] on all of these documents that we sign.” In contrast, with Elders and traditional healers “confidentiality and community are honoured in a sacred way.” These healers do not maintain writer notes or digital records instead, “it sits in their heart and their body and in ceremony. And that is something that will never be transferred to another entity” (Angela).

The collaborators also recognized that concerns about seeking help and maintaining confidentiality stems from a “dynamic of shame” (AKK) and the fear of not being seen in a positive light. AKK noted that the stigma of asking for help stems from a “Western lens that you have to be seen as perfect.” Angela pointed out that Western approaches to healing often perpetuate a hierarchical belief that the person in the helper role must be "healed" in order to effectively assist others. She emphasized that this perspective can be harmful to both the client and the therapist because therapists “are going to be so embedded in [their] own pain, and [they’re] not going to have the support because [they’re] told you should be okay.” Alternatively, both AKK and Angela highlighted Indigenous approaches to wellness, which recognizes that “there’s no shame in asking for help” (AKK) and are grounded in the belief that individuals who are unwell can utilize their teachings as medicine to help others.

Formal Education and Understanding of Indigenous Relations

The collaborators agreed on the devaluation and minimization of Indigenous knowledge within education systems and formal training. AKK shared his experience with Indigenous education and perspectives in university, noting that it primarily focused on “an anthropological

academic perspective," that "marginalize[d] the history" and prioritized "economic" perspectives. He emphasized that education and training should engage learners in a "full experience in terms of understanding or activities that help [learners] get a perspective of what happened to [Indigenous Peoples]." According to AKK, experiential learning holds more significance than attending lectures or brief professional development sessions on history, as it enables learners to develop a deeper understanding of the emotional and lived experiences of Indigenous Peoples.

Similarly, Angela reflected that she is:

> Always amazed by how people would go, and they would pay so much money into a Western system and study for so many years. However, when it comes to any cultural component training, it's either too lengthy or too expensive.

She observed that many people expect Indigenous knowledge to be freely available, which she interpreted as a devaluation of Indigenous knowledge and ways of being. This expectation unfairly placed the burden of achieving equality on Indigenous people and communities. Angela suggested that in addition to experiential knowledge such as attending sweats, or going to lodges and sun dances, it would be beneficial for individuals to "experience what it takes to sustain [Indigenous healing]… to understand what it means to sustain the land and to keep the lodge going and to go out and get the medicines and harvest them." By participating in the preparation of traditional healing practices and understanding the dedication involved, learners may begin to appreciate and value Indigenous knowledge.

Regarding psychologists' understanding of Indigenous and non-Indigenous relations, AKK acknowledged that it was not surprising to hear that the therapists "boxed us in altogether" with other marginalized groups. However, he emphasized that comparing the experiences of

other ethnicities to the colonization experienced by Indigenous Peoples “minimizes the experience we had as Indigenous people from Canada. What the Crown has perpetrated on us.” AKK referred to the Pass System as an example of Crown involvement, which enforced travel restriction on Indigenous Peoples by requiring authorized travel documents from Indian agents when leaving and returning to their reserves (Nestor, 2018). He drew a parallel to an article he had recently read about the impacts of the isolation orders during COVID-19 on families and mental health. He said, “I started thinking while I was reading this and I said, well, what you're describing is what happened to us but ours were generations.” The COVID-19 pandemic provided non-Indigenous people with a glimpse of the control tactics employed by the government during colonization. The consequences of social isolation orders during the pandemic have been well-documented, including an elevated risk for chronic conditions (e.g., stroke, cancer), adverse mental health outcomes such as anxiety, depressive symptoms, posttraumatic stress disorder, substance use, and increased domestic violence (Pai & Vella, 2022). By extrapolating these findings, we can start to grasp the devastating outcomes of prolonged isolation and dislocation from family and community that were inflicted upon Indigenous Peoples as a result of colonialism.

Clinician Biases and Beliefs

The last node reviewed was the counselling psychologists’ biases and beliefs. While some of the therapists expressed that they had no apprehensions or had positive biases towards Indigenous Peoples, the collaborators recognized that holding these viewpoints can hinder further self-reflection and personal growth. AKK acknowledged that “it’s okay to view yourself as being open minded. However, that’s not always the case.” Angela observed that individuals who make such statements often emit an “energy of being close off,” thereby placing the burden

of apprehensions on Indigenous Peoples. AKK emphasized, you must be "prepared to look at yourself in the mirror when something does come up… you may be shown a reflection that you don't like." Their comments underscore the need for ongoing self-reflection and the acceptance that unwanted thoughts and beliefs are normal, and it is through exploration and challenging these beliefs that personal growth occurs. Additionally, Angela pointed out that "sometimes it's really good to have assumptions," such as assuming that Indigenous individuals may have a history of trauma when entering counselling. However, she cautioned against assumptions becoming "the core of everything," emphasizing the importance of clinicians remaining curious and open to the client's unique story.

The collaborators also discussed how clinician beliefs manifest in their view of reserves. Angela noted that the clinicians' view of reserves places the blame on Indigenous communities for the conditions on reserve, instead of recognizing that these circumstances are a product of systemic shaping. She likened it to "forcing the circle way of doing [things] and trying to squeeze it into a triangle." AKK echoes this sentiment, attributing the current state of reserves to colonization, historical and intergenerational trauma, as well as Crown relations and policies that sought to "exterminate" Indigenous Peoples. He highlighted how their ancestral ways of wellness, self-care, and balance of life were interrupted and replaced by a hierarchical system creating a "governance system of poverty" within communities which promotes lateral violence. The collaborators reiterated the importance of education regarding the history of colonization and understanding the sequelae of these events.

Final Thoughts

As we conclude the Third Phase of data analysis, I would like to share Angela's concluding statement. She expressed her initial impression of the talking circle concept map,

describing it as busy. However, she acknowledged that the map's complexity was a positive aspect “because it does reflect everything.” Nevertheless, Angela pointed out a significant omission from the map, which was the absence of a thorough exploration of privilege and power. Although she noticed subtle hints of power dynamics and privilege lurking in the shadows of the salient points, she felt that the therapists never directly addressed or acknowledged them. Considering Angela's observation, I believe this reflects the inadequate education and understanding of colonization and Indigenous relations in Canada. Without a comprehensive understanding of the extensive abuses suffered by Indigenous Peoples, it becomes easy to disregard the ways in which power dynamics and privilege are perpetuated in our present society. In AKK's concluding remarks, he posed a thought-provoking question to the clinicians: "What are you willing to learn?" This question invites them to acknowledge their own gaps in knowledge and to actively seek out opportunities for growth and understanding.

CHAPTER FIVE: DISCUSSION

The purpose of this study was to explore the tensions and barriers non-Indigenous counselling psychologists perceive while providing services to Indigenous people. My intent was to identify how non-Indigenous professionals, such as myself, can align themselves with the principles that guide Indigenous approaches to wellness. An exploratory qualitative study such as this was warranted given the scarcity of the literature on this topic. To achieve this, concept mapping methodology was employed to identify salient points from both the non-Indigenous counselling psychologists and the Indigenous collaborators with experience in the subject matter. While research on the experience of non-Indigenous professionals delivering social services to Indigenous individuals exist in social work and education (Lacerda-Vandenborn et al., 2022), few studies have explored the tensions that non-Indigenous counselling psychologists encounter as service providers in counselling settings (Bowden et al., 2017). In this chapter, I consider the findings of the study in relation to existing literature and the associated implications of these findings. I also evaluate the strengths and limitations of my thesis research, and provide suggestions for future research. I conclude the chapter with a personal reflection. The presentation of findings in this section deviates from the structure employed in the results section. The intention is to embody a relational approach that reflects the active involvement of the collaborators throughout the data analysis process. It would be inappropriate for this section to rely solely on my voice, and to not reflect the contributions and insights of the collaborators. As such, the results have been amalgamated into four categories that represent the feedback and perspectives provided by the Indigenous collaborators and our shared meaning making.

Increasing Understanding and Challenging Colonial Perspectives

A main tension captured in the study was the general lack of understanding and education regarding the colonization of Canada, Indigenous-non-Indigenous relations, and Indigenous conceptions of wellness. Despite the efforts of the non-Indigenous participants to engage in self-learning, they acknowledged limitations in their knowledge. Both collaborators spoke about the need of being in relationship with Indigenous individuals, communities, and Knowledge Holders to guide understanding of what is written about Indigenous Peoples. The collaborators also emphasized the importance of raising awareness and understanding of Indigenous Peoples' realities and the systemic issues inherent in society as vital in the delivery of culturally responsive care. The TRC (2015b) Calls to Action #62 provides a blueprint for mandatory curriculum on both the historical and contemporary violence (e.g., residential schools, Treaties) imposed on Indigenous Peoples, as well as their strengths and contributions to Canada (e.g. music, art, literature, politics, military service during the War of 1812, and the First and Second World Wars). Despite such calls, the integration of Indigenous knowledge and teaching methods into K-12 and post-secondary classrooms remains meager. These subjects continue to be taught within a colonized system that favours ethnocentric thinking (Smith, 2016), with Indigenous approaches being characterized as alternative, or a footnote. Given the exploitative history of educational institutions, it is imperative that Indigenous education be taught in a manner that challenges colonial systems. Challenging begins with emphasizing the unveiling, questioning, and deconstructing of the ongoing colonial power dynamics that create and maintain various forms of oppression (Madden, 2015). This is consistent with AKK's suggestion that traditional classroom learning poses challenges in understanding the experiences of Indigenous Peoples during colonization, including the impacts of residential schools and the sixties scoop, as well as ongoing issues faced today. When we rely solely on statistics (such as linking colonization to

increased depression, suicidality, and substance misuse) to understand these experiences, we adopt a deficit perspective that places blame on Indigenous Peoples and communities. Rather, it is central that we recognize the broader socio-economic and historical contexts that have contributed to these issues (Ali et al., 2022). Reconciliation cannot happen before we understand the truth of colonization and the horrific subjugation of Indigenous Peoples in Canada, as is inherent in the name Truth and Reconciliation.

Related to the need to transcend textbook education, both collaborators emphasized the value of engaging in experiential learning opportunities for non-Indigenous individuals to gain a meaningful perspective. Speaking from personal experience, despite Indigenous-non-Indigenous relations being the focus of my research, it was not until I sat in ceremony with AKK in Manitoba that I truly understood the concept of community. The most impactful learning experience for me was when AKK led the circle through an experiential retelling of the removal of children to residential schools. Despite having cognitive knowledge of the horrific process and repercussions, experiencing the act in this manner created a deep sense of understanding through embodied knowledge, or felt sense (Peace & Smith-Adcock, 2018). Colonial academia has historically renounced embodied knowledge due to a perceived lack of objectivity. However, Indigenous scholars argue that the historical "emotional resonance still lives through them, because we are who we are because of this history that continuously haunts our storied bodies and lands" (Million, 2009, pg. 72). Given the embodied nature of this history, how can non-Indigenous individuals hope to comprehend the lived realities of Indigenous Peoples merely through reading textbooks? For psychologists to provide culturally safe and ethical care to Indigenous individuals they need a foundational knowledge of colonial history and Indigenous-non-Indigenous relations. It is recommended that they engage in experiential learning that

challenges colonial systems and aligns with Indigenous pedagogy. For instance, Métis scholar Yvonne Poitras Pratt and settler Patricia Danyluk (2019) suggest attendance at Indigenous events that are open to the public, such as attending a pow-wow or a National Indigenous Day event to foster walking with, and learning from, Indigenous Peoples. Other possibilities include engaging in Indigenous place-, or land-based education guided by local Indigenous protocols (Madden, 2015), interconnection and respect for the land (Hansen, 2018), and engaging in experiential retellings of historical Indigenous events in Canada. I direct your attention to Madden's (2015) review of 23 Indigenous education studies with/in Faculties of Education for more examples.

Within Canadian counselling psychology programs, the educational opportunities for graduate students to take a course on Indigenous perspectives is limited. For example, a preliminary scan of the 44 Canadian counselling programs revealed only six programs offered an Indigenous-specific course, most of which were offered as an elective rather than a mandatory class required for graduation or professional registration. The lack of educational opportunities is not only problematic from a perspective of being unable to forge a culturally safe space, but it also perpetuates marginalization, discrimination, prejudice, stereotyping, and racism towards Indigenous people seeking counselling services, resulting in further suffering and oppression (Bowden et al., 2017). These findings are reflected in the non-Indigenous therapists' lack of awareness regarding microaggressions and their contribution to perpetuating colonial ideologies.

For the field of psychology to fulfill the TRC (2015b) Calls to Action #7, 18, 19, and 22-24 it is critical that psychological training programs incorporate Indigenous historical and contemporary knowledge and wisdom in meaningful ways. Not only do the results of this study reiterate the need for more training opportunities, but they also stress the need for these classes to be taught in a manner that aligns with Indigenous pedagogy (i.e., land-based, storytelling). This

is in congruence with Fellner (Ansloos et al., 2019) who advocates that "course work should be land-based and experiential, reflective of traditional Indigenous pedagogies and curricula" (p. 270). Through such learning opportunities, students can be introduced to Indigenous ways of being and healing and actively participate in deconstructing colonial narratives and understandings that privilege Eurocentric science above Indigenous science. In addition to the significance of incorporating Indigenous-specific courses, it is crucial to integrate considerations regarding Indigenous peoples into every course within the professional program (Ansloos et al., 2019). This approach fosters critical reflection of mainstream Western approaches.

While it is important for counselling psychology programs to offer an Indigenous-specific course, there is inequality in the number of registered Indigenous psychologists. Following the release of the TRC (2015b) Calls to Action, there has been an increased effort to address the underrepresentation of Indigenous Peoples in the field of psychology. In 2019, Jeffrey Ansloos from Fisher River Cree Nation and colleagues identified only 12 Indigenous registered psychologists in Canada. While this number has likely increased over the last four years, it is a far cry from the total 19,591 registered psychologists in 2020 (Michas, 2022). Ansloos et al. (2019) identify a number of issues contributing to the underrepresentation of Indigenous students and faculty including recruitment concerns, inequitable admission policies, difficulty with retention, and minimal academic supports and mentorship. Cultural safety, and the relegation of Indigenization of curricula as secondary results in limited educational, personal, and professional relevance for the students (Ansloos et al., 2022). Therefore, it is imperative that counselling psychology programs increase the diversity of student and faculty members. Doing so will challenge the current myopic view of counselling programs and advocate for the advancement of inclusive pedagogical training.

Creating Space for Indigenous (Re)connection in Counselling Settings

The underrepresentation of Indigenous counselling psychologists and the lack of educational training in Indigenous ways of being and healing have contributed to the privileging of Western psychology. During the talking circle, the psychologists shared their experiences of Indigenous clients who disclosed reluctance to engage with cultural supports or services. AKK attributed this hesitancy to the long-lasting effects of colonization, which suppressed and minimized Indigenous ways of being and healing. Consequently, as Angela suspects, Indigenous clients may be dismissing traditional cultural approaches to maintain or accommodate the relationship with the therapist. Both the collaborators and scholars (Bombay et al., 2014; Kovach, 2009; Smith, 1999; Waldram, 1997) believe healing for Indigenous individuals lies in reclaiming Indigenous identity and recovering traditional values, beliefs, philosophies, and ideologies, through traditional healing methods (Marsh et al., 2018). Angela postulated that mental health professionals might unintentionally reinforce colonial bias towards Western psychology by not exploring cultural options as the therapeutic relationship progresses, often due to their discomfort with the unknown.

Within Western culture, there is an expectation of professional expertise (based on colonial standards) or a certain level of competence, creating a dichotomy of expert/non-expert or competent/incompetent. This mindset discourages clinicians from stepping out of their comfort zone or expanding their cultural knowledge (Curtis et al., 2019). As I argued in chapter one, an alternative approach is prioritizing cultural safety, inviting a client to determine whether they consider a clinical encounter is culturally safe, and what cultural safety looks like to them (Curtis et al., 2019; Papps & Ramsden, 1996). Embracing a culturally safe approach empowers the client to determine what is culturally relevant and challenges the therapist to adapt to the

client's needs, rather than relying on a one-size-fits-all approach to cross–cultural counselling (Crocket, 2012; Moucessian, 2020).

The collaborators also stressed the importance of psychologists gaining an understanding of the historical context of colonization within the individual's community. This understanding is crucial for comprehending how colonization has influenced the dynamics and functioning of the family system. This finding was reflected in Bruce's (1993) dissertation, which underscores the importance of non-Indigenous clinicians understanding current community concerns and colonial impact in order to inform the counselling process. Both the collaborators and scholars (e.g., Brave Heart et al., 2011; Boksa et al., 2015; Chansonneuve, 2005; Duran et al., 1998; Gone et al., 2019; Linklater, 2014) emphasize the impact of historical and intergenerational trauma on Indigenous individuals' wellbeing. While intergenerational trauma is widely acknowledged within counselling psychology research (see Chou & Buchanan, 2021), the counselling relationship is still viewed within an individualistic framework. An individualistic approach to counselling was evident in speaking with the clinicians about family dislocation and the disregard for community. Given that Western individualistic approaches to counselling makes a clear distinction between mind and body and wholly disregard 'spirit' (Reeves & Stewart, 2014), the question becomes, if intergenerational trauma is conceptualized as collective trauma, can an individualistic approach to counselling appropriately address the needs of the client? Indeed, Cree/Métis scholar Karlee Fellner and colleagues (2020) argue that the very principles of counselling psychology preserve colonial attempts to assimilate Indigenous people to dominant Western conceptions that contradict Indigenous wholistic perspectives. The findings from this thesis suggest that for clinicians to align with the concept of intergenerational trauma and

provide effective counselling, they must adopt a more wholistic approach that recognizes the clients' interconnectedness to family, community, and culture.

Indigeneity is the central focus of political conflicts aimed at dismantling colonial powers, as it has obstructed Indigenous communities from living in accordance with their own traditions and customs (Hart et al., 2017). Indigenist scholars shed light on the politically charged and strength-based aspects of Indigenous survivance, resurgence, and resistance. They highlight that unlike non-Indigenous perspectives that view land as a commodity and object of individual ownership, Indigenous peoples perceive land as the center of all relationships: a source of physical, mental, emotional, and spiritual well-being; a connection to ancestors and future generations; a rightful place in the universe; a source of epistemological humility; and an ethical relationship with all forms of life (Cajete, 2015). Understanding the tenets of wholism and interconnectedness are essential in acknowledging and beginning to dismantle hierarchical systems of power.

Breaking the Culture of Silence on White Power and Privilege

As articulated above, white privilege and power restrain Indigenous ways of being and healing. Therefore, when supporting Indigenous individuals, it is crucial that counsellors consider the situatedness of the individuals they are assisting in their historical, sociocultural, political, and economic contexts. A main point raised by Angela during our second research conversation was that power and privilege were evident in each of the salient points, despite never being directly acknowledged or addressed by the non-Indigenous participants. Indeed, this dynamic was observed from the very start of the talking circle when I provided an opportunity for the therapists to participate in a land acknowledgment. While there may be many reasons as to why people in a group setting may hesitate to offer the land acknowledgements, such as fear

of doing it incorrectly, mispronouncing Nations, etc., none of the participants made one. Land or territorial acknowledgements are formal statements recognizing the colonial context of the Indigenous territory/territories and is a step towards decolonization. By not offering an acknowledgement, however imperfect it may be, one is choosing a colonial perspective. Robinson and colleagues (2019) ask “what foundations are you (perhaps inadvertently) reinforcing” (pg. 21)? What these, and other professionals, may have not realized is that their choice represents their passivity in recognizing their role in upholding power structures and colonial systems that oppress Indigenous Peoples. For Indigenous Peoples and non-Indigenous allies alike, this passivity is a manifestation of microaggressions, which are commonplace daily verbal and nonverbal messages that denigrate minoritized populations (Hook et al., 2016). Although these forms of racism are often difficult to identify, their negative implications can be just as harmful as overt confrontations (Sue & Sue, 2003). Non-Indigenous people, primarily those belonging to the dominant culture, often lack awareness of the privileges they hold; they are unaware of how their attitudes and behaviours perpetuate discrimination against marginalized communities and maintain systems of power (Steinberg, 2005).

Other microaggressions were more easily spotted. At this point, I must emphasize that all therapists were operating from a place of good intentions and expressed genuine care for their clients. However, as Gitxsan scholar and activist Cindy Blackstock (2010) observes, “we are overrun by good people who think they are doing as much as possible for Aboriginal peoples” (p. 6). This attitude is known as ‘white saviourism’ (Staubhaar, 2015). White saviourism maintains the existing power dynamics and a sense of superiority, while alleviating white guilt through the illusion of compassion and a well-meaning intention to help (Finnegan, 2022). This was apparent in the discussion of the need to increase the safety and livability in reserves. Recall

when Alexis stated that Indigenous people on reserves are “going to need a lot of help,” or when Oscar relayed suggestions that Elders or Traditional Healers were not well qualified, and that clients preferred to work with a mainstream psychologist. While these statements do not state white saviourism outright and/or may not be values these professionals personally hold, they imply the dominant narrative of Indigenous communities as sites of problems and in need of “expert” (i.e., non-Indigenous) intervention. This narrative also perpetuates Eurocentric epistemic hierarchies, with Western professionals at the top and Indigenous healers at the bottom. Both participant statements disregard the agency Indigenous Peoples possess when engaging in self-determination of governance systems and social services. For example, the Carrier Sekani have successfully been self-governing and self-reliant for thousands of years (Clogg et al., 2016). The minimal treaties signed in British Columbia (e.g., seven modern treaties; Johal, 2023) combined with the success of the Indigenous nations (e.g., Carrier Sekani, Musqueam, Squamish, and Tsleil-Waututh Nations) underscore the agency of Indigenous Nations when they are not being inhibited and controlled by governmental policies such as the Indian Act. Hence, the statements made by the participants ignore the policies and power imbalances that perpetuate systems of oppression (Finnegan, 2022). Perpetuation of colonial logic follows when one fails to interrogate one’s own power and privilege, and the ways in which they contribute to the maintenance of the status quo, as individuals and as a collective.

I acknowledge that I am not above this privilege blindness. A clear example of such is that at the outset of this study, we had originally named it “*Addressing Apprehensions of Non-Indigenous Clinicians.*” During my first research conversation with Angela, she drew my attention to the connotations of the word *apprehensions* which had not until then occurred to me: namely, that for Indigenous people this work recalls the painful apprehension of children and

youth from their communities. In my ignorance, I had not considered that this word may be activating for Indigenous Peoples. By this simple misuse of a word, I had revealed the privilege I hold as a settler not having experienced nor endured the abduction of children through the Indian Residential school and the child welfare system. My supervisor, who has worked with Indigenous communities in child welfare for almost a decade, also failed to flag the term. These examples demonstrate that no matter how far one is into one's decolonizing journey, the process of challenging and confronting privilege is lifelong (Freire, 2009). According to Regan (2010), the prevailing settler consciousness upholds colonial practices and narratives, enabling the dominant group to maintain control. Therefore, it is incumbent upon all members of society to embrace a stance of epistemic humility and find comfort in the discomfort. This is necessary to challenge colonial narratives and reshape the social imagination (Fricker, 2007). While this finding of underlying privilege and superiority among non-Indigenous counselling psychologists is not unique, it further reaffirms the necessity for non-Indigenous therapists to engage in self-reflection regarding the power they hold in a counselling setting and critically examine how they may be upholding colonial ideologies and systems of power on a regular basis. It is also worth considering whether the presence of one or both Indigenous collaborators at the talking circle would have impacted the conversation and the participants' willingness to express themselves freely and openly. Although the collaborators could have assisted in facilitating and upholding the circle's structure, the participants might have hesitated to discuss tensions and challenges they encounter in working with Indigenous individuals.

Identifying and Breaking Structural Barriers within Counselling Psychology

In addition to the individual work of self-decolonization, the counselling discipline as a whole must take stock of the ways in which it preserves colonial ideals and practices and change

them. Both the collaborators and the psychologists highlighted significant systemic issues inherent in the field of counselling psychology. The counsellors identified specific ethical concerns outlined by the CPA (2017) that inhibit their ability to provide services to certain clients, including guidelines relating to conflict of interest. This was supported by the collaborators who highlighted that there is often a conflict between Indigenous and Western ethical considerations. For instance, within Western psychology confidentiality is defined by the Canadian Code of Ethics (2017) and ensures that information about people seeking help and what is discussed will be kept private and safe. Counselling psychologists are expected to maintain confidentiality beyond the boundaries of the counselling office, refraining from engaging with the individual they serve in non-professional settings. For instance, they are advised not to initiate conversations or greet the individuals they serve unless the individual initiates interaction first (Davies, 2000). Acknowledging familiarity with the client without their prior consent can potentially constitute a breach of confidentiality. Conversely, Indigenous ethics are grounded in a communal perspective which posits one must maintain accountability to all their relations (Wilson, 2004). During our research conversation, Angela highlighted that the relational connection fostered in therapy does not cease to exist when the client leaves the office. She conveyed that within Indigenous cultures, lack of engagement or recognition outside of the counselling office can transform the relationship into a transactional process (i.e., "I am just a person who's putting money into [the counselling psychologist's] pocket" [Angela]), negating the desire for authenticity and relationality. As illustrated, Western confidentiality can lead to ruptures in therapeutic relationships (treating them as though you are not fully committed to the relationship) with Indigenous individuals. Khashaba (2019) corroborates Angela's perspective by discussing the expectation within Indigenous communities that the clinician is involved in the

community. This community engagement fosters collaboration and power-sharing rather than the relational distancing that is typical within Western practices.

The lack of relationality is counterintuitive to mental health, as it treats the therapeutic relationship as something that ought to be hidden, concealed, or shameful. The collaborators related these ethical concerns to differences in the conceptualization of mental unwellness among Indigenous Peoples, highlighting the stigma and shame that surround mental health in colonial culture. Indeed, a meta-analysis by Schomerus and colleagues (2012) suggests that the biomedical model of mental health may be negatively impacting mental health stigma through increased 'otherness,' reduced treatment optimism, and fostering an expectation of dangerous or risky behaviours. What is more, a systematic review examining mental health stigma and discrimination found that 16 to 44 percent of people living with mental health and substance use issues experienced discrimination from staff in mental health (Henderson et al., 2014). Hence, despite counselling psychology's mission to challenge the negative narrative surrounding mental health, our policies and practices may unintentionally support it. As Lacerda-Vandenborn (2020) posits, for institutional change to occur, conceptual understandings within the discipline must be reimagined. By embracing Indigenous conceptions of interconnectedness and adjusting our practices to operate within a wholistic framework, both counselling psychology and society as a whole can transition away from an individualized perspective on mental health. In doing so, we can change the narrative that mental health problems reside solely within the individual and begin to acknowledge how people are situated in the larger historical, social, cultural, economic, and political contexts.

Strengths and Limitations of the Study

This study sought to explore the tensions and barriers non-Indigenous counselling psychologists encounter in providing counselling services to Indigenous Peoples. This exploration is aimed at identifying how non-Indigenous professionals can align themselves with the principles that guide Indigenous approaches to wellness. A strength of this study is the honouring of Indigenous voices and perspectives through the involvement of Indigenous collaborators. The collaborators provided invaluable insight regarding barriers to counselling psychology and how counselling psychologists can align themselves with Indigenous principles of wellness. This thesis is an important contribution to the literature regarding research being conducted *with* rather than *on* Indigenous communities. In addition, I believe that this thesis can provide a framework for how to ethically engage in Indigenous research as a non-Indigenous student and/or researcher.

The primary limitation of this study is the small sample size ($n = 5$) of participants in the talking circle and the singular organization used for recruitment. As discussed elsewhere, it is hypothesized that the implications of COVID-19 and mental health provider burnout resulted in difficulty recruiting clinicians to participate. The small sample size meant using traditional approaches to qualitative analysis, such as thematic analysis, were inappropriate as themes could not be reliably produced. As a result, an exploratory concept map, which has limited research regarding its use in qualitative research, was employed. In addition, the salient points from the concept maps are unlikely to represent the experiences/tensions of all non-Indigenous counselling psychologists. Similarly, given the diversity among Indigenous Peoples, the contributions of the two Indigenous collaborators are unlikely to represent all Indigenous Peoples.

Directions for Future Research

The main objective of this exploratory study was to provide a map of the tensions that inhibit non-Indigenous counselling psychologists from providing culturally safe and ethical care to Indigenous individuals. My hope is that this map serves as a tool for non-Indigenous professionals and organizations to engage in an intentional process of decolonization. Within the literature, culturally appropriate approaches to counselling with Indigenous individuals looks vastly different. My aim for the concept map is that it can serve as a clarifying tool for further dialogue on what culturally safe and appropriate care for Indigenous clients looks like, and how counselling psychology can address barriers in service provision. As an exploratory study, the findings are intended to serve as a foundation for future research. While any one node in the map is a potential area of investigation, the ones that attracted the attention and commentary from both collaborators suggest these are the ones in most urgent need of exploration:

- Concerns with non-insured health benefits and Indigenous Services Canada
- Counselling psychology's adherence to Western approaches and the devaluing of Indigenous ways of being and healing
- How counselling psychologists approach information gathering during session and the lack of family and community exploration
- Exploring counselling psychologists' beliefs that Indigenous Peoples are disinterested in Elders or Traditional Healers and concerns regarding confidentiality
- Counselling psychologists and training programs lack of education and training opportunities regarding Indigenous Peoples and the undervaluing of Indigenous knowledge
- Exploring and challenging counselling psychologists' view of reserves and their belief of not having apprehensions

Next, would be the exploration of nodes individually mentioned by the collaborators:

- Building trust and cultural considerations in the provision of counselling services
- Understanding Indigenous-non-Indigenous relations
- Examining counselling psychologist' assumption of trauma when working with Indigenous individuals and how this belief may serve/hinder services

This map is designed to be used both individually, to help with the process of self-decolonization, and collectively. Counselling psychologists can reflect on points where perhaps they see themselves to engage in dialogue about the perspectives offered by the collaborators to begin challenging their beliefs and biases. Additionally, the map can be used by groups or organizations to guide professional development, change disciplinary practices, and to advocate for structural changes within CPA regulations.

Finally, to increase the representativeness and wholeness of the findings, it is recommended that future research could be conducted on this topic with a larger sample size consisting of psychologists from more than one organization. Including the perspectives of Indigenous therapists and healers could assist with achieving a more wholistic perspective regarding current barriers in counselling service provision. For decolonization to happen, partnership between Indigenous and non-Indigenous counselling psychologists is crucial to bring lasting change. As such, a collaboration between Indigenous and non-Indigenous counselling psychology perspectives is encouraged.

Concluding Reflections

Undertaking this thesis project was undeniably daunting. As someone with limited exposure to Indigenous research and predominantly accustomed to positivist methodologies, the journey has been a profoundly transformative process of (un)learning and growth. Looking back at my initial research discussion with AKK and Angela, I was consumed by self-doubt, fearing

that they might perceive me as insincere, merely another white Western researcher. However, their collaboration and support proved to be the most valuable learning experiences of my master's degree, forever altering my approach to counselling. This experience challenged what I knew of Indigenous-non-Indigenous relations and encouraged consistent personal reflection on my contributions to upholding colonial structures and systems of power. Reviewing the data from the talking circle with the Indigenous collaborators revealed subtle forms of racism and colonial thinking that would have otherwise gone unnoticed by myself. It encouraged me to critically examine the everyday minor (or major) transgressions I engage in and how they manifest in my counselling practice. Ultimately, the teachings from the collaborators provided a better understanding of what true reconciliation and decolonization entail, extending far beyond what I had learned within the confines of a classroom or textbook.

My aspiration is that this research will serve as an inspiration for other scholars to critically assess their research approaches and offer guidance on ethically engaging with Indigenous Peoples. Decolonization is an ongoing collaborative process that necessitates challenging the prevailing deficit-based narratives and eliminating the harmful practice of "othering." Often, people tend to cling to familiarity and avoid the unknown out of discomfort. However, genuine growth arises from embracing the discomfort and examining areas of tension. It is my wish that this thesis can provide support to those who desire to engage but may harbor trepidations about venturing into unfamiliar territories.

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Appendices

Appendix A

CONSENT FORM

TITLE: Addressing Apprehensions of Non-Indigenous Clinicians

INVESTIGATORS: Elisa Lacerda-Vandenborn, Ph.D. (Principal Investigator)
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This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this information. You will receive a copy of this form for your records.

BACKGROUND

Despite the need for intervention following the discovery of thousands of Indigenous children's unmarked graves across Canada in 2021, access to culturally safe mental health services for Indigenous Peoples is limited. While psychological training programs have an emphasis on multicultural training, the adequacy of such programs in preparing students for working with Indigenous people is in question. Inadequate training can lead to practitioners being ill-equipped to work with Indigenous populations; negatively impacting counsellor performance, the therapeutic alliance, and possibly resulting in further suffering and oppression of Indigenous clients.

Our objectives are:

This project seeks to explore non-Indigenous registered psychologists and counsellors' apprehensions towards working with Indigenous clients in order to identify how practitioners can ethically align themselves alongside Indigenous helping models and provide culturally safe care to Indigenous clients. To that end, we are inviting representatives from community organizations, such as yourself, to gather insights of both the capacity and wisdom available in the communities you serve as well as their needs.
You will be invited to participate in one online (Zoom) group sessions. This session is intended to explore barriers and apprehensions. that clinicians encounter while serving Indigenous clients as well as to highlight possible areas for improvement.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to explore: 1) the apprehensions that registered, non-Indigenous psychologists and counsellors have towards working with Indigenous clients; and 2) to identify

framework in which non-Indigenous clinicians can ethically align themselves in order to provide culturally safe care to Indigenous clients.

WHAT WOULD I HAVE TO DO?

You will take part in the following:

- Take part in one online group sessions that is approximately 1 hour in length.
- Note, the sessions will be video and audio-recorded for transcription purposes and the writing of a de-identifiable summary with high level themes and insights from the sessions.

Total participation in this study will take approximately one day.

WHAT ARE THE RISKS?

Risks in the study are primarily associated with the inability to fully guarantee participant anonymity and/or the organizations that you belong to in a group context. To mitigate risks of confidentiality:

1. We will work from a culture of trust that what is shared in the session is kept confidential
2. We will ask all participants to sign a term of confidentiality
3. We ask that you do not share names and titles of individuals in your organization. Instead, we ask that you use general terms (e.g., a manager, a fellow mentor, a youth support program).

There is a chance that you may feel emotional stress during or after the session. If you feel stressed or uncomfortable talking about stress with us or if you need more support, we have a list of community supports that can assist you at the end of this document.

WILL I BENEFIT IF I TAKE PART?

Although there are no direct benefits to participating in this study. You may benefit from learning experiences of individuals and organizations working in similar contexts as yours. You may also find it beneficial to discuss possible apprehensions that you may have towards working with Indigenous clients as it may help improve pre-existing therapeutic relationships. Lastly, community members served by your organizations could potentially benefit from the insights generated by this study.

DO I HAVE TO PARTICIPATE?

Participation in this study is completely voluntary. While you are in the group, you may stop taking part, if you do not feel comfortable. You are free to withdraw from this study at any time. You can withdraw your consent and/or data up to two weeks after the online session. If you choose to withdraw from the study please tell the Student Investigator, Samara Wessel, immediately. There will be no consequences to you if you choose to withdraw from the study or decline participation due to discomfort.

We also hold the right to ask you withdraw at any point, if we have concerns about safety, privacy, or well-being of other participants. If we have new information that may affect your willingness to take part in the study, we will inform you as soon as possible.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

There are no costs or monetary incentives associated with your participation.

<u>WILL MY RECORDS BE KEPT PRIVATE?</u>

All paper records, audio files, data, and documents will be kept in a locked drawer, in a locked room and electronic data/documents will be password protected. Only the research team will have access to your information and data (paper, electronic, and audio). A list connecting an assigned pseudonym with your personal information will be created in case we need to follow-up after the talking circles. All data collected from the talking circle will be maintained in a separate, de-identified document. When we share or publish information about this research, your identity will be protected from the public. All material for this project will be retained for a maximum of five years as per the University of Calgary's Specific Retention Rule (No. 2011.01). Given the group participation component of this project, your identity will also be known to other participants of the group.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. If you have further questions concerning matters related to this research, please contact:

Dr. Elisa Lacerda-Vandenborn
Or
Samara Wessel

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

______________________________	______________________________
Participant's Name	Signature and Date
______________________________	______________________________
Investigator/Delegate's Name	Signature and Date
______________________________	______________________________
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.
A signed copy of this consent form has been given to you to keep for your records and reference.

APPENDIX

Supportive Resources in the Calgary Area

24-Hour Support

- **The Calgary Distress Centre**
  24-hour crisis support over the phone or online chat.
  http://www.distresscentre.com
  403-266-1601

- **Health Link**
  24/7 health advice or information.
  Alberta Health Services
  Dial 8-1-1 for 24-hour access
  https://www.albertahealthservices.ca/assets/healthinfo/link/index.html

- **211 Alberta: Information and Referral Service**
  Over the phone/online chat, 24-hour service that assists in finding community and social services in Alberta.
  Dial 2-1-1 for 24-hour access
  http://www.ab.211.ca

Individual, Couple, and Family Focused Counselling

- **Mobile Response Team**
  Mental health and crisis intervention/prevention services over the phone or in-person.
  Alberta Health Services
  Access through calling the Distress Centre 403-266-4357
  Open 7 days per week 9:30am – 9:30pm
- **Access Mental Health**
  Referral resource for accessing counselling through Alberta Health Services.
  https://www.albertahealthservices.ca/services/Page11443.aspx
  10125 Southport Rd SW, Calgary, AB
  403-943-1500

- **Eastside Family Centre**
  Walk-in, free counselling on a single-session basis. Individuals, couples, and families.
  https://www.woodshomes.ca/programs/eastside-family-centre/
  403-299-9696
  Northgate Village Mall
  255 - 495 36 Street NE
  Calgary, Alberta
  Hours: Mon-Thur 11am-7pm, Fri 11am-6pm, Sat: 11am-4pm.

- **South Calgary Health Centre**
  Walk-in therapy on a single-session basis for clients of all ages. Covered by AB Health Care.
  31 Sunpark Plaza SE
  Calgary, Alberta
  403-943-9374
  Hours: Mon-Thur 4pm-7pm, Fri 10am-1pm, closed on weekends.
- **The Calgary Counselling Centre**
  Sliding-scale counselling for families, couples, and individuals.
  https://calgarycounselling.com
  105 12 Ave SE Suite 1000, Calgary, AB
  403-265-4980
- **Catholic Family Services**
  Sliding-scale/free counselling for families, couples, individuals, and children.
  https://www.cfs-ab.org
  707 10 Ave SW #250, Calgary, AB
  403-233-2360
- **The Calgary Family Therapy Centre**
  Specialized free family therapy services with a waitlist for services. Waitlist goes down in the Fall/Winter. Must have at least one child under 18 years.
  https://www.familytherapy.org
  1816 Crowchild Trail NW #600, Calgary, AB
  403-802-1680
- **Outpatient Mental Health**
  Psychotherapy services for individuals and groups covered by AB Health. Must have a supporting family doctor.
  Sheldon M. Chumir Health Centre
  1213 4 Street SW
  Calgary, Alberta
  403-955-6686

Supportive Resources in the Lower Mainland

24-Hour Support

- **Crisis Centre**
  24-hour crisis support over the phone or online chat.
  https://crisiscentre.bc.ca/
  crisiscentrechat.ca
  310-6789

- **Health Link**
  24/7 health advice or information.
  BC Health Services
  Dial 8-1-1 for 24-hour access
  https://www.healthlinkbc.ca/more/resources/healthlink-bc-files
- **211 BC: Information and Referral Service**
  Over the phone/online chat, 24-hour service that assists in finding community and social services in British Columbia.
  Dial 2-1-1 for 24-hour access
  https://bc211.ca

Individual, Couple, and Family Focused Counselling

- **Community Mental Health Services**
  Referral resource for accessing counselling through Vancouver Coastal Health.
  http://www.vch.ca/your-care/mental-health-substance-use/community-mental-health-services
- **Canadian Mental Health Association**
  Programs designed to improve mental health and well-being.
  https://cmha.bc.ca/programs-and-services/
- **Wellness Together Canada**
  Free 24/7 phone counselling and text support.
  https://www.wellnesstogether.ca/en-CA/service/talk
  1-866-585-0445
- **Family Services of the North Shore**
  Sliding-Scale professional counselling for North Shore residents.
  https://www.familyservices.bc.ca/find-support/counselling-support/
  604-988-5281
- **Oak Counselling**
  Reduced fee counselling services provided by volunteers with master's degrees in psychology or psychology-related fields. Individual and couples counselling.
  http://oakcounselling.org/
  604-266-5611
- **JFS Vancouver**
  Therapy services for youth, adults, seniors, couples, and families. Sliding-scale offered for Registered Clinical Counsellor or free services with supervised internet students.
  https://www.jfsvancouver.ca/services/counselling/
  2285, Unit #320, Clark Drive
  Vancouver, BC
  604-558-5726
- **Scarfe Counselling - UBC**

Free counselling services provided by counselling psychology graduate students for adults and children 10+. Clinic runs September to April.
https://ecps.educ.ubc.ca/counselling-centres/scarfe-free-counselling-clinic/
1874 E Mall
Vancouver, BC
604-827-1523

Appendix B

CONFIDENTIALITY AGREEMENT

TITLE: Addressing Apprehensions of Non-Indigenous Clinicians

INVESTIGATORS: Samara Wessel (Student Investigator)
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Elisa Lacerda-Vandenborn, Ph.D. (Principal Investigator)
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Werklund School of Education

Before you can participate in this study, we must obtain your explicit consent not to reveal any identifying information about the participants or their experience to anyone outside of the research team. If you agree to these conditions, please sign below.

____________________________ ____________________________

Print Name Signature

If you have any further questions or want clarification regarding this research, please contact:

Samara Wessel
OR
Dr. Elisa Lacerda-Vandenborn

The University of Calgary Conjoint Health Research Ethics Board has approved this research study. If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

Appendix C

Interviews and Talking Circle Protocol

Phase One: Interviews

A reflexive style will be used throughout the interviews such that rather than preparing questions in advance, questions will flow from a conversational style (Brayboy & Deyhle, 2000). I have chosen this method of interviewing because continually asking questions may be viewed as disrespectful by some Indigenous individuals (Price, 2004). Instead, general topics will be discussed with the Indigenous Collaborators with broad guiding questions to facilitate the conversation.

Goals: The goal of the first interview is to collaboratively structure the format for the talking circles with non-Indigenous clinicians as well as to identify potential barriers that the clinicians may encounter to create questions and content for the talking circles.

The conversations are expected to take around 1 hour, and we will take a 15-minute break in the middle.

I have some topics prepared and a few questions, which can be viewed as starting points for a conversation.

Topics:

1) Greetings and sharing of background information.
   a) Is there any information you would like to share regarding your background?
2) Discussion around barriers to care that Collaborators have witnessed throughout their professional experiences.
   a) In your line of work, what barriers have you encountered when serving Indigenous clients?

b) What barriers do you perceive non-Indigenous clinicians encounter when working with Indigenous clients?

c) What changes could be implemented tomorrow to bring about lasting change?

3) Format of talking circles and recommendations (particularly Zoom protocol).

a) How best can I maintain the structure and integrity of talking circles over Zoom?

b) Would you like to facilitate or be a part of the talking circles?

4) Is there anything that we didn't discuss that you think is important to add?

Thank you for the insights that you shared today. I will anonymize your contributions and provide you with a transcript.

Phase Two: Talking Circle

Goals: The goal of today's talking circle is to have an open discussion around potential barriers and apprehensions that may impede effective care for Indigenous clients. Today's session will be guided by previous interviews that I have conducted with two Indigenous Collaborators who have provided insight and guidance for the discussion. Throughout the talking circle we will discuss impediments in current service provision as well as possible alternatives/solutions to providing culturally safe care.

This conversation is expected to take around 1 hour, and we will take a break when appropriate. We have some questions prepared, these can be viewed as starting points for a participant-led conversation.

Questions:

1) Do you commonly work with Indigenous clients? If so, in what capacity?

2) What, if any, barriers do you encounter when serving this population?
   a) What do you do when you encounter a barrier?
3) How confidently do you understand Indigenous and non-Indigenous relations?
4) Did you receive training on Indigenous wellness?
5) What are some of the things you find important in providing quality mental health services for Indigenous clients?
6) Do you look at the larger context, such as the family system and community, when working with Indigenous clients?
7) What do you view as key components for building relationship with Indigenous clients?
8) In your experience, have you encountered language barriers or contextual misunderstandings when working with this population?
   a) What do you do when you encounter this barrier?
9) When working with indigenous clients are there any changes that you make in how you present yourself or the space you are working in?
10) Do you see any differences between mental health and wellness?
   a) How do you perceive wellness?
11) Is there anything that we didn't discuss that you think is important to add?

Thank you for the insights that you shared today. I will anonymize your contributions and provide you with a summary of the findings.