# SEVEN WHITE PRACTITIONERS: HOW DO THEY UNDERSTAND AND WORK WITH ABORIGINAL TRAUMA?

by

**Janice C. Forde**

B.S.W., University of British Columbia, 1988

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

August 2015

## Abstract

This thesis lays out the historical and social sources of trauma in the lives of Aboriginal people and juxtaposes them against dominant culture's understanding of trauma and treatment as primarily pertaining to the individual. Concepts like *historical trauma* are presented and explored, leading to a critique of the DSM (The Diagnostic Statistical Manual of Mental Disorders) as unhelpful, and possibly harmful, in its focus on individual pathology. It is argued that without reference to systemic and structural sources of genocidal oppression, standard trauma treatment may prove more damaging than helpful. Interviews were conducted with seven non-Aboriginal women counselors to determine if and how their approaches to trauma treatment reflected an appreciation of colonialism as a source of historical and current trauma. Interview transcripts were subjected to thematic analysis, revealing a pronounced understanding of the traumatic impacts of social injustice on Aboriginal people and the limitations of western counseling approaches.

## Table Of Contents

## Glossary

**Colonial trauma response** - Formulated by Evans-Campbell (2011), this concept attempts to highlight the unique situation of Aboriginal people whose experience of trauma tends to be multi-dimensional, incorporating the interaction of historical with current collective and individual trauma.

**Complex post traumatic stress disorder** - A counterpart to "simple PTSD", this is an alternative diagnostic concept developed by Herman (1992) to capture the more serious and persistent symptoms of those subjected to chronic, on-going trauma such as child sexual abuse, combat experiences, torture and confinement.

**DSM** - The Diagnostic Statistical Manual of Mental Disorders, published by the American Psychiatric Association, provides a widely used classification of mental disorders, relied upon by clinicians and researchers for its diagnostic criteria. It has undergone several revisions since its initial publication in the 1950s and is now in its fifth edition, published May 18, 2013. Controversy surrounds its validity and reliability, most notably among feminist critics (Brown, 2006; Burstow, 2003; Herman, 1992).

**Historical trauma** - Sometimes referred to as intergenerational grief and loss, this is the legacy of genocidal actions and other forms of persecution and deprivation imposed upon a culturally or socially distinct group. It results in emotional suffering

among the descendants of survivors, through transmission of grief across the generations. See Braveheart (2000, p. 246).

**ICD** – The International Classification of Diseases and Related Health Problems Is the health care classification system of the World Health Organization (WHO) which directs and coordinates international health care for the United Nations.

**Insidious trauma** - Similar to microaggressions, this feminist concept was developed to capture the impacts of continuous exposure to sub-threshold traumatic stressors. See Burstow (2003, p. 1308).

**Microaggressions** - These are the persistent, everyday instances of discrimination and marginalization typically experienced by members of disadvantaged minority groups. Among Aboriginal people, the accumulated impacts of racially motivated "slights", taken within the context of ongoing social and cultural disruption and loss, can seriously exacerbate existing individual and collective trauma. See Bryant-Davis, (2005) and her discussion of microaggressions and covert racism.

**PTSD** - Post traumatic stress disorder is the array of symptoms laid out by the DSM, first introduced in the DSM-III (1980), that persist for one month or more following a traumatic experience and which tend to overwhelm the adaptive and coping capacities of people. The traumatic precipitator was originally conceptualized as a

catastrophic stressor "outside the range of usual human experience". Revisions in subsequent editions of the DSM have expanded its definition beyond a category of extreme stress.

**TDWNA** - *Traditional dominant white North American,* coined by Burstow (1992, p. 72) with reference to western style counseling of Aboriginal people.

**Trauma or traumatic event** – Defined as an event that evokes feelings of "intense fear, horror or helplessness" by earlier versions of the DSM, subjective responses to a traumatic event have been dropped by the DSM-V (2013), allowing for a somewhat broader understanding. It still falls short of Feminist and Aboriginal conceptions of trauma, however, which tend to conflate trauma with wounding or injury. See Carter (2007, p. 16) and Matskis (1996, p. 17). Traumas of Inter-personal violence and abuse create the most severe psychological impacts (Herman, 1992).

## Dedication

This thesis is dedicated to the women and men of the Carcross/Tagish First Nation who honoured me with the sharing of their personal and traditional stories, their struggles and their hopes for the future. The many connections and friendships afforded me over the years have been invaluable to my growing knowledge and understanding of Indigenous experience and aspiration.

## Acknowledgements

It is with sincere appreciation and gratitude that I recognize the faculty, staff and my fellow students who inspired and assisted me on this challenging journey. Special thanks are owed to Bernadette who contributed so much to my time at UNBC through her unfailing support, friendship, and collaboration. Also deserving of thanks is Chris for his up-beat company and project partnership, and instructor Susan Burke for exposing me to valuable Aboriginal resources for my work. I owe a great debt of gratitude to my committee members, Dawn Hemingway and Lela Zimmer who, despite the complications of long-distance communication, kindly agreed to lend their guidance and assistance to this undertaking. And above all, I remain forever grateful for the boundless support, energy and inspiration of my professor and supervisor, Si Transken. Her unflagging encouragement and faith in my abilities, especially when I doubted myself the most, were critical throughout this lengthy process. Finally, I wish to thank all the remarkable women who agreed to participate in the research interviews, generously sharing of their time, experience and reflections.

## Introduction

Treatment for trauma related symptoms such as PTSD and complex PTSD tends to focus on an individual's unique and personal experiences of trauma which adversely impact that individual's ability to achieve an adequate level of functioning and satisfaction with life. However, I will argue that when providing services to Aboriginal people with personal trauma and addiction issues, it is vitally important to recognize the limitations of an individualized focus. (This is equally true, I believe, for members of all ethnic and social groups subjected to systemic oppression and injustice, as referenced in the section *Racism and Trauma*). Not only should caregivers demonstrate cultural sensitivity and competency in their practice with Aboriginal people, they must be cognizant of the larger historical and social context in which individual trauma is situated. As Haskall (2009) asserts, "traumatic impacts are rooted not only in the specific experiences of any individual's unique life story and experiences, but also ... are structured by the historical legacy and contemporary realities of social inequalities" (p. 50). The crushing impacts of colonialism are not relegated to the past, as evidenced by the appalling third world living conditions of many northern Aboriginal communities such as Attawapiskat (CBC news, Nov. 29, 2011). In reference to the devastating consequences of colonialism, it is clear that "All of these factors have had, and continue to have, profound effects on the health and well-being of Canada's First Nations. Moreover, they are compounded by a widespread social denial ... [by non-Aboriginal people]" (Haskall, 2009, p. 50).

I want to investigate the approaches that non-Aboriginal women counselors employ when offering trauma treatment to Aboriginal women. I limit this study to women counselors for two reasons: The majority of counselors/social workers are female, and as a feminist, I am especially interested in how the experiences of other women counselors inform their thinking and their practice as it relates to this study. I want to develop a sense of how much (or how little) the historical reality of oppression, as well as the struggle of Aboriginal people to survive current adverse social conditions and pervasive racism, help shape the ways in which trauma and addiction are treated by non-aboriginal women counselors. In general, do non-Aboriginal care providers identify the interplay of trauma, historical trauma and racism in the lives of their clients? Does the treatment they offer reflect an understanding of the differences between the ways in which trauma impacts the lives of Aboriginal and non-Aboriginal women? How do they assess their effectiveness in evaluating and treating the impacts of multi-dimensional trauma among their Aboriginal women clients?

Note: The terms *white* and *non-Aboriginal* typically convey somewhat different meanings. In the context of this thesis, *white* tends to imply North Americans of European descent, and especially those who fit the definition of WASP (white Anglo-Saxon protestant). Until fairly recently, before the rapidly changing ethnic composition of North American cities (e.g., Vancouver, BC) being *white* was considered normative and, I would argue, is still largely considered as synonymous with dominant culture. For this reason, *white* is a useful term for the purposes of this

thesis. It is also true, however, that *white dominant culture* practitioners are not the only ones whose values, motives, and comprehension of Aboriginal struggle under colonialism can be at odds with that of their First Nation clients. For this reason, the terms *non-Aboriginal* and *white* are used interchangeably, allowing for a more comprehensive picture of those potentially aligned with western training and values, than would be conveyed by one term alone.

The terms *Aboriginal, indigenous* and *First Nations* are also used interchangeably to more fully encompass an important array of implications. Aborigine, derived from the Latin *ab* and *origine,* means "from the beginning" so refers to the original ones. *Indigenous* is a true synonym of *native* and directs our attention to the area or place to which a people belong. *First Nations* is perhaps the most political term and is currently the most prevalent in discussions of land claims, Aboriginal rights, colonialism and the like.

## Rationale

Because of the collective, historical, and current social trauma that impacts the lives of so many Aboriginal people, traditional trauma therapy, with its individualized focus, is clearly insufficient to alleviate the suffering of traumatized Aboriginal people. For this reason, it is incumbent on all of us who might be called upon to assist Aboriginal clients with "PTSD" and addiction issues, to explore which kinds of approaches would be most in keeping with an anti-colonialist practice, and be most valuable in assisting traumatized Aboriginal clients to cope more effectively with the debilitating impacts of the multiple traumas that have impacted their lives.

There is an emerging body of literature which addresses the unique situation of Aboriginal people whose individual traumas are inextricably bound up with the on-going social realities of poverty, racism, inequality, loss of language and culture through forced assimilation, and all the other impacts of colonialism (Haskell & Randall, 2009, p. 49). There is little, however, that directly addresses the question of what role, if any, non-Aboriginal counselors might play in the healing journeys of Aboriginal people. What are we currently doing, learning, or failing to learn in our trauma work with Aboriginal survivors? It is my contention that current models of trauma and trauma response limit our ability to arrive at adequate treatment approaches for Aboriginal people when we take into account the concurrent and complicating impacts of multigenerational and historical trauma (Evans-Campbell, 2011, p. 317). It is vital that we come up with an expanded trauma framework to help guide our practice with Aboriginal people, given their unique set of

circumstances as a people whose recent history and current social conditions are shaped by the damaging impacts of colonialism.

It is my hope that researching the approaches to trauma treatment of non-Aboriginal counselors will provide some indications of the extent to which non-Aboriginal trauma counselors think about and seek to act upon the complex problem of interacting levels of trauma among their clients.

My study will also review those approaches that Aboriginal people, working from within their own societal and cultural contexts, find most beneficial for their healing work around trauma. My findings indicate that a focus on re-establishment of familial and social connections (McCormick, 1997), involvement in traditional practices (Brave Heart, 2000; Haskell, 2009), a recognition of connections between contemporary trauma and historical injustice (Brave Heart; Gone, 2009), and collective action for increased community control (Haskell), all contribute significantly to both the buffering of traumatic impacts and a reduction in the severity of adverse trauma responses.

I also explore the idea of racism as a source of trauma, looking at the cumulative impact of "microaggressions", and the ways in which current experiences of racial discrimination and/or harassment can trigger and interact with personal and historical trauma.

## Background

Aboriginal people in Canada, as elsewhere, have endured on-going attacks on their culture, social structures, and belief systems through colonization (Hart, 2009, pp. 26, 27; Smith, 1999, pp. 7 &19). Their subjugation and oppression has taken many forms, one of the more pervasive and damaging being the forced internment of Aboriginal children in so-called residential schools whose purpose was to strip them of their cultural identity, to "kill the Indian in the child" (Fournier & Crey, 2011, p. 173-177, Sinclair, 2009, p. 20). Generations grew up bereft of the necessary parental attachments we now recognize as so vital for healthy psychological development (Haskell, & Randall, 2009). Broken connections to land, culture and traditions, coupled with a pervasive racism that relegated First Nations people to the margins of dominant society, served to undermine a positive Aboriginal identity (Kirmayer, Simpson, & Cargo, 2003, p. s18).

Social ills of all types have been traced to this legacy of colonialism. The incidence of "family violence", addictions, suicide and child sexual abuse are greatly over represented in Aboriginal populations (Health Canada, 2009). Women have been disproportionately impacted by violence and abuse, encountered both within and away from their First Nation communities (Smith, A., 2011).

Many First Nations women carry within them both the hidden pain of personal wounding from violence and abuse, often beginning in childhood, and the weight of historical, collective grief and loss. And yet, typically, it is women who have demonstrated the greatest resiliency and offered the greatest resistance to the

colonialist agenda (Stevenson, 2011, pp. 48-49). Women were traditionally, and continue to be, the healers and care givers of their nations. Grass roots Aboriginal women, armed with little more than their courage and determination, undertook the work that grew and spread and positively transformed their communities in places like Alkali Lake and Hollow Water (Sivell-Ferri, 1997).

## Statement of the Research Question

With this study I investigate the approaches that non-Aboriginal women counselors employ in their work with Aboriginal women seeking help from trauma related difficulties. I want to develop a sense of how much (or how little) the historical reality of oppression in the lives of Aboriginal women is recognized and helps shape the ways in which trauma and addiction are treated by non-Aboriginal women counselors. Although not directly asked of the potential participants in the study, I hope to discover the following: "Do non-Aboriginal women counselors provide trauma treatment to Aboriginal trauma survivors which references the broader historical and inter-generational trauma of Aboriginal people in general?" And if so, "How is this aspect of treatment conceptualized and delivered, and what is its perceived value in facilitating recovery from trauma related difficulties?"

The overarching research question is formulated from these interests. "What kinds of approaches do non-Aboriginal counselors use in their trauma work with Aboriginal clients?"

# Literature Review

## PTSD and Complex PTSD

The study of human responses to trauma is relatively new and is a rapidly changing field, especially in regard to our understanding of neurochemistry and brain development. It was in the aftermath of the Vietnam war that the concept of PTSD and the modern field of trauma research was ushered in (Dayton, 2000, pp. 125-127). In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV TR, 2000), trauma and PTSD are approached as discrete and individualized experiences and responses. Criteria for the diagnosis of PTSD fall into three areas of neuro-psychological manifestations; specifically, symptoms of hyper-arousal, such as hyper-vigilance, sleeplessness and impaired affect regulation; persistent re-experiencing of the trauma, including flashbacks and nightmares; and avoidance of trauma related thoughts or associated stimuli, and/or a numbing or shutting down of affect (see Appendix 1, adapted from DSM-IV-TR).

PTSD is not the only problematic response to trauma, and is typically associated with a number of co-occurring mental health issues such as depression, addiction and dissociation (Matsakis, 1996, p. 18). The clinical definition of trauma and PTSD, which require that one meet very restrictive criteria for formal diagnosis, has been expanded on over the years by those working in the field. For Matsakis (1996), for example, "trauma refers to the wounding of your emotions, your spirit, your will to live, your beliefs about yourself and the world, your dignity, and your sense of security" (p. 17). Those whose responses to trauma do not include

the full range of PTSD symptoms, may still suffer from equally disruptive emotional and psychological effects.

In 1992 Judith Herman's *Trauma and Recovery* was published and became the bedrock for this emerging area of research and practice. It is still referred to by virtually every trauma expert working or writing in the field. After years of practice with severely traumatized people, Herman developed a new diagnostic category called "complex PTSD" which looks at the effects of prolonged or chronic exposure to trauma. Childhood abuse and maltreatment are among the most prevalent precipitators of complex PTSD that also include exposure to combat, imprisonment, torture, spousal abuse, and childhood maltreatment (Herman, 1992, p. 276). Those suffering from complex PTSD face a far more lengthy and arduous journey to recovery. They may exhibit both the symptoms of "simple" PTSD and far more serious and enduring impairments of psychological and emotional functioning. The primary, long-term effects are as follows:

1. Affect dis-regulation - This involves the inability to effectively control one's emotional responses (e.g., lack of distress tolerance) and to self soothe
2. Changes in consciousness and attention - Concentration and focus are impacted, negatively affecting learning and general recall
3. Alterations in self-perception - One may see him/herself as inherently unworthy, incapable of achieving love or happiness
4. Alterations in relationships with others - Mutually satisfying connections with others are extremely difficult to form and maintain

5. Somatization (complaints of physical pain, etc.)

6. Alterations in systems of meaning, e.g., a sense of hopelessness (p. 121).

Recognition and acceptance of the complex PTSD conceptualization informs the theory and practice of virtually every current trauma expert (Briere, 2006; Pearlman, 2001; van der Kolk, 1996). Ongoing attempts to have complex PTSD included in the *Psychiatric Diagnostic and Statistical Manual*, however, have been unsuccessful. Bending to pressure, the committee charged with defining PTSD for the DSM-IV (1994), made some changes based on the work of Herman and other practitioners who have contributed to the research literature in the trauma field (van der Kolk, p. 203). Some of the elements of complex trauma, as proposed by Herman and others, have been included in a tangential way. "Nine of the 12 symptoms listed under the associated features of PTSD are derived from the CP [complex PTSD] theory and constellation [of symptoms]" (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1996, p. 540).

Despite the DSM-IV field trials conducted in 1991-1992 which demonstrated a need for a symptom constellation that PTSD alone fails to capture (Roth et al, 1996, p. 539), especially as manifest in survivors of childhood sexual abuse, it remains the case that "While CT [complex trauma] appears clinically meaningful, its name and criteria were not officially included in the DSM nomenclature, as they were in the ICD (International Classification of Diseases)" (p. 552). The PTSD diagnosis, then, remains limited in its scope, failing to capture the far more serious and long-term impacts of exposure to chronic interpersonal violence and abuse.

**Historical Trauma**

Most of the literature regarding historical trauma is related to studies of the families and descendants of Jewish Holocaust survivors (Fogelman, 1991; Kestenberg, 1990; Niederland, 1968; Solkoff, 1981). Maria Yellow Horse Brave Heart (1998) found striking similarities between the impacts of the Jewish Holocaust and what she came to term "The American Indian Holocaust" (p. 65). With reference to the history of her Lakota First Nation, Brave Heart identifies several analogous features; genocide precipitated by religious persecution (demonization of Judaism and Aboriginal ceremonies like the Ghost Dance), mass graves and the almost impossible task of mourning such an overwhelming loss, and finally, "the suffering of the survivors and descendants" (p. 65).

Brave Heart (1998) explores other similarities between the collective and historical trauma of American Indians in the US who live surrounded by their colonizers, and European Jews who live among the perpetrators of the Holocaust (p. 65). Their shared patterns of grief remain unresolved given the threatening presence of their oppressors/persecutors. Fogelman (1988) asserts that "Jews in Europe have not found an effective means of coping, integration, and adaptation. Most are in a stage of complete denial and stunted mourning of their losses ... This repression results in ... psychic numbing" (pp. 93, 94). Brave Heart implies that the same is to be said for Native Americans (p. 65).

Brave Heart approaches the treatment of individual trauma within the context of historical trauma, alternatively referred to as "disenfranchised grief", a kind of

"unresolved grief" over past wounds and losses that have never been sufficiently mourned (1998, pp. 68, 69). This is due in part to the weight of more recent accumulated trauma. Brave Heart came to realize that individual healing needs to include recognition of past pain and injustice and its on-going influence on the present, as well as some measure of resolution of that historic trauma. Building on that insight, she devised an intervention curriculum for troubled Lakota parents that facilitated awareness of how historical factors had impacted traditional parenting and how trauma had been transmitted inter-generationally. Her approach also focused on a reattachment to traditional Lakota values. Results were encouraging, and "parents unequivocally reported a perceived positive impact on their parenting" (1999, p. 118).

After years of working with traumatized people from her Lakota First Nation (where there was widespread suffering from "cumulative wounding across generations"), Brave Heart formulated a theory of "historical trauma response" (2000, p. 246). In her earlier work she referred to the phenomenon as "Intergenerational Posttraumatic Stress Disorder" (p. 247). Her further study of historical trauma gave rise to its application in both prevention and intervention.

The historical trauma response as defined by Brave Heart (2000) "is analogous to the *survivor syndrome* and *survivor's child complex* identified among those who endured the Jewish Holocaust, and their progeny" and consists of three main features (p. 247). The first is *transposition,* explained as the experience of ancestral suffering as though it were happening in the present. Brave Heart notes

that it can become the "organizing principle of one's life". (She spoke of how she and the Lakota people still carried the sorrow and despair associated with the massacre at Wounded Knee.) The second feature she talks about is *identification with the dead* that leads one to feel unworthy of living and only loosely connected to the here and now. It seems to be related to the survivor syndrome encountered in the Holocaust literature. The third feature she identifies is *"maintaining loyalty to and identification with the suffering of deceased ancestors, re-enacting affliction within one's own life."* She notes that Lakota culture, like many Aboriginal cultures, fosters a sense of connection with the spirit world, predisposing them to take on the suffering of their deceased (p. 248).

After her 1992 study demonstrating the pervasiveness of "impaired grief, a consequence of massive cumulative trauma throughout history" among the Lakotas, Brave Heart developed, and then "examined the effectiveness of a culturally congruent four day psycho-educational intervention designed to initiate grief resolution for a group of 45 Lakota human service providers" (2000, p. 248). She used questionnaires pre and post test to measure changes in levels of sadness, grief, hopelessness, guilt and so on. Test results, as well as anecdotal feedback from participants, confirmed that:

> (a) education about historical trauma would lead to increased awareness of associated affects, and (b) sharing these affects in a traditional context would provide cathartic relief (Brave Heart, 2000, p. 249).

Brave Heart's study demonstrates the usefulness of historical trauma theory in regard to personal healing.

**A Social Context Complex Trauma Framework**

Haskell and Randall (2009) draw on the concepts of attachment theory and complex trauma, as well as the historical trauma theory of Brave Heart, in their formulation of another related approach to Aboriginal trauma which recognizes the need to transcend the purely individualized focus of most practitioners. They examine the trauma experiences of Aboriginal people in Canada through what they term " a multi-dimensional complex trauma lens" (p. 50). It illuminates the fact that the effects of colonialism and the resultant "historical" trauma not only continue to reverberate through the collective memory of Aboriginal people, but persist through the systemic discrimination and oppression which impact social conditions in the present day. "Many aspects of the lives of Aboriginal peoples, therefore, are *continuously traumatic.* This is a fundamental insight which cannot be over-emphasized, and which must be foregrounded in any discussion of the impact of trauma on Aboriginal peoples of Canada" (p. 50).

Haskell and Randall (2009) spend considerable time analyzing and elaborating features of complex trauma. They tend to focus on "the alterations of relationships with others" as significant in a context where secure attachments were disrupted through overt acts of colonialism, such as forced removal of children to residential schools and imposition of patriarchal values and social organization. "At the cultural level, disrupted attachments can also speak to the disconnect between

traumatized peoples and their sense of belonging to a community, to their sense of cultural identity" (p. 65). This is one major way in which individual and collective trauma intersect.

While drawing heavily on the theory of historical trauma, Haskell and Randall (2009) also speak of its limitations. They argue that Aboriginal communities "are currently traumatized as a result of contemporary social, economic and political conditions of their lives, and the ways in which individual lives are affected by ongoing complex trauma responses" (p. 74). They see historical trauma as one element in the traumatic circumstances of Aboriginal people and stress the importance of grasping "the ongoing presence of the historical in the present" (p. 74).

Of particular importance, the social context complex trauma framework "shifts the focus away from perceived flaws in the 'personality' or 'character' of survivors of abuse, and instead situates traumatized people's coping within the range of normal and typical human responses to trauma imposed from external forces" (Haskall & Randall, 2009, p. 77). All these related approaches to trauma as multi-layered or multi-dimensional, serve to reframe the notion of individual pathology by positioning individual and collective responses to harm within a temporal continuum of colonialist violence and deprivation.

**Colonial Trauma Response**

Evans-Campbell (2011), who has also investigated the intersection and interaction of historical and current trauma among Aboriginal people, formulated the

"Colonial Trauma Response" (CTR), which builds upon the trauma theory so far presented (p. 331). It encompasses historical trauma responses and their interplay with traumatizing events in an Aboriginal person's current life. As Evans-Campbell states:

> A defining feature of CTR is its connection to colonization. Indeed, CTR reactions may arise as an individual experiences a contemporary discriminatory event or microagression that serves to connect him or her with a collective and often historical sense of injustice and trauma (p. 332).

The work of Evans-Campbell is essentially congruent with Brave Heart, and Haskell and Randall, lending an elaboration of sorts to the central formulation. The creation of CTR is perhaps best understood as a means of better connecting the notion of historical and collective trauma to the particular social and political realities inflicted on Aboriginal people through colonialism. The terminology is different, but the message is the same. To help relieve the suffering of Aboriginal people, individualized trauma treatment is woefully inadequate and may even serve to worsen the impacts of historical/collective trauma if there is no acknowledgement of the enormity of the harms inflicted through colonialism. CTR's contribution is about where it focuses our attention: It highlights the ways in which a myriad of large and small injustices trigger and interact with deeper individual and shared traumas and come to be experienced as a relentless course of traumatic events over time.

**Racism as Trauma**

Studies concerning the impacts of racism also have huge implications for an

understanding of Aboriginal trauma. Bryant-Davis and Ocampo (2005) argued for acceptance of racist incidents as a form of trauma which leads us to the exploration of yet another stream of potential "soul wounding" (Duran, Firehammer, & Gonzalez, 2008). They did so by drawing parallels between experiences of racism and "the acknowledged traumas of rape and domestic violence" (Bryant-Davis & Ocampo, 2005, p. 479). They identify a number of shared cognitive, emotional, and physiological effects (p. 487). They also look at shared responses among survivors of all three types of assaults. An especially significant one is the feeling of shame and self-blame for failing to adequately respond to a threatening situation and defend oneself - especially in instances when shock and immobilization have taken over (p. 488).

Because we live in a society where rape and racist assaults are common, just being a member of a target group can produce significant stress (Bryant-Davis & Ocampo, 2005, p. 489). It is reasonable to assume that stress will increase as awareness of the prevalence of threat increases. Current implicit threats will resonate with past victimizations and historical injustice, greatly magnifying their emotional impact.

The authors also point to shared societal responses to racist and sexual violence. The experiences of survivors are typically disbelieved or minimized since, as the authors argue, "If the survivor is not to blame, then society must face the psychologically overwhelming reality that life is full of injustices" (Bryant-Davis & Ocampo, 2005, p. 490). They also acknowledge the limitations of the parallel model,

e.g., that rape always constitutes a physical violation while racist incidents may not (p. 491). Further, as Bryant-Davis and Ocampo point out, "Another factor which complicates the racist incident and rape parallel theory is the intersectionality of race, gender and social status: Individuals may experience both racist incidents and rape. Rape is also sometimes itself a racist incident, producing multiple affects" (p. 491). Nonetheless, the relationship between sexism in society and sexual assaults, is very similar to the way that pervasive racism supports racist assaults and ethno-violence.

There is, perhaps, a greater degree of similarity between the effects and dynamics of exposure to domestic assault and racist incidents. In both cases violence typically occurs in multiple forms over time (Bryant-Davis and Ocampo, 2005, p. 492). Finding safety as a necessary precondition for treatment, may not be possible. Because victims live with constant but unpredictable risk of violence, extreme stress can be an almost constant companion. "Knowing neither what will happen nor how devastating the effects will be contributes to hyperarousal and anxiety. This marriage of expectancy and shock is unique to experiences of trauma such as domestic violence and racism" (p. 492).

Another commonality is society's tendency to victim blame and to question the behaviour of the victim who often internalizes the message that if he or she just handled things differently, the violence could be avoided. "The feeling of powerlessness ensues when one attempts to follow the numerous and often arbitrary rules yet continues to be violated" (p. 492). In many ways, the situation for

victims of racism is more dire. Where can they go to avoid contact with potential perpetrators? As the authors note, "To avoid racist incidents, one would have to avoid school, work, media, banks, stores, police, court systems - almost all social institutions" (p. 494). Still, despite its prevalence and severe impact on the psychological functioning of ethnic minority people, most clinicians and counselors fail to acknowledge and address racism as a potential source of trauma and depression (p. 481).

Robert Carter also researched and wrote about the damaging psychological effects of experiences of racism, connecting them to trauma in an effort to focus attention on the mental health impacts of race related stress. Like feminists who saw the value in formulating *rape trauma syndrome*, thereby separating out unique features of gender-based trauma not addressed in the PTSD diagnostic category, Carter presented his argument for the concept of race-based traumatic stress. As he observed, "the notion that racism is a stressor that can harm or injure its targets is not recognized in psychological or psychiatric diagnostic systems" and "Trauma researchers typically do not focus on racism as a factor in the development of post-traumatic stress disorder (PTSD)" (2007, p. 15). Carter felt strongly that when people are impacted negatively by what they perceive as an act of racism, the resulting emotional and psychological injury needs to be related to the causal situational circumstances rather than treated as a mental disorder (p. 16). He prefers the term *injury* to *trauma* because it "does a better job of capturing the external violations and assaults inherent in racism or in race-based encounters and

experiences. Moreover, the idea of psychological injury is associated with the idea that the person who is injured has had his or her rights violated" (p. 16).

Carter critiques the argument of Bryant-Davis and Ocampo "that there are parallels between the experiences of physical violence and racist incidents" (Carter, 207, p. 33), and asserts that experiences of racism are often more subtle and complex than these other accepted traumas. He makes a good point as regards rape trauma, which could have been formulated as sexual assault and defined more broadly to include experiences of sexual harassment or pervasive sexism. That would have been more in keeping with the argument that trauma can result from numerous "minor" incidents of racism and/or sexual harassment and intimidation. The parallel drawn with domestic violence, however, does seem to me to rest on that kind of broad understanding of abuse that encompasses far more than physical violence.

Despite some differences, both Carter and Bryant-Davis and Ocampo point out the shortfalls inherent in trauma theory and practice when it comes to recognizing and addressing the significant mental health consequences of racism. An important contribution by Carter (2007) is the unpacking and analysis of different forms of racism which he then connects to different psychological effects. "Carter is encouraging precision to adequately describe and assess the psychological impacts of racism on its victims" (Speight, 2007, p. 126).

All are dedicated to the proposition that the neglect of race-based trauma needs to be remedied and that clinicians and counselors "need to broaden their

perspectives to social issues that create stress for clients and patients, which would mean less reliance on the strict models of assessment offered by DSM-IV-TR and would also require giving more meaning and salience to the clients' reports of various sources of trauma and stress" (Carter, 2007, p. 94).

Cvetkovich (2012) reinforces this analysis and takes it to its logical conclusion. She asserts that "Once the causes of trauma become more diffuse, so too do the cures, opening up the need to change social structures more broadly rather than just fix individual people" (p. 33).

**Liberation Psychology**

So called liberation psychology represents the clearest departure from and challenge to mainstream Western paradigms of mental health theory and practice. Though well known in Latin America and elsewhere, liberation psychology is relatively new to the literature in North America. It goes far beyond the notion of cultural competency and "requires the counselor to attend to issues of social justice, cultural context, action research, and resistance" (Watts and Serrano-Garcia, as quoted in Bryant-Davis, 2007, p. 142). It is similar in its intent to community empowerment proponents, but involves "broader levels of analysis" (Varas-Diaz and Serrano-Garcia, 2003, p. 104). Liberation psychology focuses on social context and a critical analysis of peoples' circumstances "to enhance their awareness of oppressive situations and ideologies" (p. 103).

Lillian Comas-Diaz (2000) is situated within this still developing trend of counter establishment mental health theory and practice. She advocates an

*ethnopolitical* approach when working with ethnically marginalized people, which calls upon counselors to take an anti-racist stance and to thereby move from an individualized focus to a collective one (p. 1320). She sees her *ethnopolitical* model as helping " intervenors to engage in political change geared toward developing a community espousing social justice and racial equality" (p. 1320).

As might be expected, Comas-Diaz is a vocal critic of the professional elite and the DSM-IV's PTSD diagnosis which is based on an "individualistic, ethnocentric, and ahistorical approach to psychopathology ... [which] tends to depoliticize systemic oppression, colonization, and racial terrorism" (2000, p. 1321). She advances an alternative formulation, *post-colonization stress disorder,* to capture the emotional and psychological effects that result from contending with "racism and cultural imperialism, whereby mainstream culture is imposed as dominant and superior" (p. 1320). Despite retaining the term *disorder,* Comas-Diaz asserts that "*post-colonization stress disorder* differs from post-traumatic stress disorder (PTSD) in that it does not pathologize the individual and highlights the importance of adaptive reactions in contending with profound social pathology" (p. 1321).

Eduardo Duran is prominent both as an Aboriginal healer and proponent of liberation psychology. He writes about the ways in which mental health professionals have acted as instruments of oppression, intentionally or inadvertently assisting Aboriginal people and other minorities to adapt to the oppressive social conditions imposed by the dominant power structure (2008, p. 288). For him, this

constitutes "an indictment of the counseling profession" (p. 288) and he calls upon counselors to engage in a rigorous self examination of their privilege and how it shields them from recognition of the many forms of oppression that impact their clients (p. 289).

> Becoming aware of the various forms of cultural oppression and social injustices that adversely affect the mental health of clients from devalued groups ... as well as the psychological development of many Western-trained mental health practitioners is an essential component of the process of *liberation psychology*. (p. 289)

Duran is influenced by Friere's idea of *conscientization*, which calls for a transformation of consciousness through "an on-going deconstruction of the life experiences of oppressed persons " (2008, p. 289) so that whole communities can begin the process of liberation. Collective grieving, learning and action characterize this process of shared healing and social transformation.

Duran, like the proponents of the various formulations of historical trauma, stresses the importance of historical context in counseling with Aboriginals. He goes so far as to say "the counseling profession's unwillingness to address clients' historical context contributes to psychological oppression of individual clients, their families, cultural communities, as well as the helping professions themselves" (2008, p. 290). *Historical honesty,* as Duran calls it, is a prerequisite for *liberation discourse,* which entails "taking a crucial eye to the processes of colonization which have had a deep impact on the identity of Original Peoples" (p. 290).

Speaking from the standpoint of liberation psychology, Bryant-Davis (2007) asserts that "The healing of psyches necessitates the dismantling and healing of the source of societal wounds of oppression; active perpetrators and passive privilege recipients of racial hierarchy require redress" (p. 142). Along with Black and Latin American psychology, feminist psychology shares this framework.

**Feminism and Trauma**

I think it apt to begin this section with some of Mullaly's reflections on feminist theory (1997). From his standpoint as a strong proponent of structural social work theory (or transformational theory, p. 101) he endorses and embraces much of what feminism has to offer. He views structural social work theory as "prescriptive in that its focus for change is mainly on the structures of society and not solely on the individual" (p. 104). Like the feminist theorists we will soon be hearing from, Mullaly shares a perspective that "chastises conventional social work for failing to develop a critical self-awareness and for often pathologizing oppressed people by offering individualistic explanations of social problems" (p. 106). He unconditionally states that "the feminist perspective is an epistemological imperative for structural social work. Feminist analysis not only decodes patriarchy and stresses the links between the personal and the political better than any other theory, it, like structural social work, emphasizes transformational politics" (p. 131).

As Bonnie Burstow (2003) asserts, "Feminist contributions to trauma theory have been immense" (p. 1295). Feminist efforts over the years to expose the daunting scope of wife abuse, child sexual abuse and sexual assault, naturally led to

an interest in how trauma is defined and understood. Feminists lobbied for changes to the DSM-III (American Psychiatric Association, 1980) with limited success. They were especially critical of the requirement that the precipitating traumatic event for a diagnosis of PTSD be "outside the range of usual human experience". Such a definition of trauma invalidates what feminists have long recognized as the trauma resulting from ongoing abuse, often almost normative in the lives of many women. As Brown (1995) notes, "The range of human experience becomes the range of what is normal and usual in the lives of the dominant class: White, young, able-bodied, educated, middle class. Trauma is thus what disrupts the lives of these particular men and no other" (p. 101). The definition of trauma was changed to incorporate this particular feminist concern, but another objection, which Burstow characterizes as "one that takes us further into political territory" (p. 1296) was not addressed. She states that the DSM-IV's insistence on -

> tying trauma to a physically dangerous event or events per se is inadequate, especially in the case of oppressed people. The point is, oppressed people are routinely worn down by the *insidious trauma* involved in living day after day in a sexist, racist, homophobic, and ableist society (p. 1296).

And like those proponents of racism as trauma, feminists recognize the pathologizing effects of a diagnostic category like PTSD which depends on an array of symptoms which are bereft of social context and which therefore individualize social problems (Burstow, 2003).

Feminist models of trauma position survivors within their socio/political contexts, emphasizing the vulnerabilities of individuals belonging to oppressed groups. According to Brown (2004), "certain forms of traumas are viewed by feminist theory as representing, at the individual or interpersonal level, the intended consequences of institutionalized forms of discrimination such as sexism, racism, classism, heterosexism, anti-Semitism, and so on" (p. 465). Trauma "symptoms", then, become understood as "traumatized ways of coping" (Burstow, 2003, p. 1311) when people's lives are impacted by untenable social circumstances. As Burstow observes, "getting rid of a deficit model entails not stressing the psychological at the expense of the political" (p. 1311).

Feminists focus attention on the trauma inherent in the cumulative impacts of numerous, almost daily attacks on the dignity and sense of identity of target groups like women and ethnic minorities. Brown (2004), borrowing from a concept developed by M. Root, refers to this as *insidious traumatization,* the almost constant experience of *sub threshold traumatic stressors* (p. 466). Ann Cvetkovich (2003) views this as one of the most significant contributions of feminists to our understanding of trauma (p. 32). A recognition of the cumulative impacts of everyday experiences of sexism moves us well beyond the diagnostic criteria of trauma as an identifiable catastrophic event. As Cvetkovich concludes, "More so than distinctions between private and public trauma, those between trauma as everyday and on-going and trauma as a discrete event may be the most profound consequence of a gendered approach" (p. 33). Reflecting on the complex, but often

invisible nature of those everyday experiences, Cvetkovich (2003) adds that "The nuances of everyday life contain the residues that are left by traumatic histories, and they too belong in the archive of trauma" (p. 280).

Brown (2004) also examines the concept of Freyd's *betrayal trauma*, another feminist theory which highlights the relational context in which a care giver or person of authority violates the trust of a vulnerable individual (p. 466). Herman's *complex post traumatic stress disorder* was formulated to capture the long term sequelae of these kinds of chronic interpersonal traumas. Brown considers that "Herman's (1992) positioning of this pattern of distress as post traumatic is an expression of feminist values...the problem is situated not in the character of the suffering person, as is true for the construct of personality disorders; rather, it is viewed as a pattern of coping and survival in response to a traumagenic relational milieu" (p. 467).

Radical therapists like Burstow (2003), however, tend to view any involvement with the DSM, even when motivated by efforts to critique and change it, as lending it undue authority and credibility. She calls for trauma practitioners to break free from the diagnostic categories imposed by the psychiatric and psychological establishments. She contends "we need theory that builds on our respective knowledges, that is free from psychiatric vocabulary and conceptualization, and that explicitly theorizes social structures and their role" (p. 1302). She advocates moving in the direction of *critical adult education* "with counselor and clients co-exploring the traumatizing and oppressive situations and structures together and clients taking up real tasks" (p. 1313).

**The Politics of Healing**

Apart from Brave Heart's work, and that of Duran (to be explored later), there is not a great deal in the literature which spells out treatment approaches specifically tailored to the needs of Aboriginal people, and far fewer that assess treatment outcomes (Gone, 2007, pp. 356-363). In a review of the literature related to American Indian and Alaskan Native mental health interventions in the States, Gone found only two quasi-experimental outcome studies which he claims "provided the only empirical outcome evidence in over three decades" (p. 10). Although he is influenced by the concerns of EBP (evidence based practice) advocates, he also states "we simultaneously believe there to be substantive reasons for reconsidering the call to EBP in Native American mental health service delivery" (p. 11). He looks at a number of criticisms raised by opponents of the EBP movement, including what he considers a radical perspective which focuses on the current 'post-colonial' political context of American Indian and Alaska mental health service delivery. Gone concludes that "the state of the art in regard to mental health intervention in the 21st century United States raises a series of political and ethical predicaments for Indian country, including the problem of cultural divergence in the context of persisting power asymmetries" (p. 13). Gone is open to the suggestion that local innovation may provide the most beneficial direction and delivery of mental health services, and is the preferred alternative to "the ideological peril of conventional therapeutic efforts" (p. 15). He would still like to see "empirical demonstration of positive

therapeutic outcomes" which may be unrealistic, given the social and political context of Aboriginal suffering to which he himself alludes.

A few years later, Gone (2009) conducted a study of nineteen staff and clients at a Native healing lodge. He employed open-ended interview questions regarding the healing approaches used to address "the legacy of Native American historical trauma" followed by a thematic analysis. He identified four major components of healing in the narratives of both the therapist and client participants. They are as follows:

1. clients were understood to carry childhood pain that led to adult dysfunction (including addictions),
2. such pain was to be confronted and confessed if relief was to be obtained,
3. this cathartic expression was seen to inaugurate a healing journey of lifelong introspection and self-improvement and,
4. this healing journey entailed reclamation of Indigenous heritage to remedy the damage of European colonization (p. 10).

The fourth component is of greatest significance for our purposes. Without prompting, participants in the study spoke of their personal pain as transcending individual circumstances. They saw their healing as involving a positioning of self within the context of colonization, particularly as manifested in the hundred years or so of residential schools (p. 7).

This finding fits with my understanding of how an individual's overall psychological functioning and sense of identity are shaped by the interaction of

historical and personal trauma, and how they need to be addressed together as a prerequisite for healing. Further, if our understanding of historical trauma involves acknowledgement of the genocidal policies of colonialism, then it becomes clear that "healing" requires social and political solutions as much as therapeutic ones. Any approach to healing, regardless of whether it meets with the approval of EBP proponents must, then, serve the cause of empowerment of Aboriginal people whose cultural, economic, and political subjugation lies at the root of so many problems. Gone (2009) came to the recognition that:

> Native healing offered through distinctively Aboriginal therapeutic services is typically much more ambitious [than the objectives of the EBP movement]. More specifically, these services figure rather prominently in a comprehensive, community-based *decolonization* agenda. Decolonization is the intentional, collective, and reflective self-examination undertaken by formerly colonized peoples that results in shared remedial action. Such action traces continuity from traditional (pre-colonial) experiences even as it embarks on distinctive, purposeful, and self-determined (post-colonial) experiences. The key to decolonization is community emancipation from the hegemony of outside interests. (p. 9)

I included this lengthy quote because it speaks so clearly to the vital role social and political action could play in mitigating the impacts of multi-layered Aboriginal trauma.

Kirmayer, Simpson and Cargo (2003) arrived at a similar conclusion after reviewing the literature on Aboriginal mental health and its connection to colonialism. They concluded that the primary remedies must involve restoration of fractured relationships, focusing on "the family and community as the primary locus of injury and the source of restoration and renewal", a strengthening of cultural identity, and increased political empowerment (p. s21).

Kirmaya et al. (2003) cite a study by Chandler and Lalonde (1998) that looked at the impact of seven measures of what was termed "cultural continuity" (p. s18). These measures consisted of self-government, involvement with land claims, band control of education, health services, cultural facilities, and police and fire services (Chandler and Lalonde, p.14). The results showed a high correlation between these factors and the suicide rates across 80 bands in British Columbia. Those communities in which all measures were present had no incidents of suicide.

Kirmaya and colleagues (2003) considered these findings significant but did not agree with the use of the term *cultural continuity*. They suggested replacing it with the term *local control* as a more accurate way of characterizing these measures (p. s18). I agree with their conclusion that Chandler and Lalonde's choice of measures speaks more to autonomy and self-determination than *cultural continuity*. From this standpoint we can only conclude, then, that political empowerment is as important to individual and collective health as the provision of healing circles and treatment centres in Aboriginal communities. As Kirmayer and colleagues conclude, "The social origins of mental health problems in Aboriginal communities demand

social and political solutions" (p. s15), a conclusion that reinforces the social justice emphasis of so many of the previous authors.

**Aboriginal Treatment Approaches**

Other Aboriginal writers and healers speak of the broad overarching values and beliefs, common to most Aboriginal traditions, which must be understood, respected and incorporated into helping practices. I want to touch on the most commonly mentioned principles of effective treatment with Aboriginal people. We've already looked at the importance of transcending the purely individual focus in trauma work and situating personal pain and distress within the historical context of colonization and oppression. We have looked at the impacts of historical trauma and the need to adopt a "multi-dimensional trauma lens" when undertaking to assist Aboriginal people. The impacts of racism, combined with the devastating impacts of colonization on cultural autonomy and identity, have also been examined for the ways in which they contribute to personal and collective trauma. The need for collective consciousness raising, collective action and political empowerment, have also been discussed. Now I want to review the general principles of healing that are part of Aboriginal life, some of which have already informed the theory and approaches so far presented.

Baskin (2009) looks at the significant differences between Indigenous world views and Western ideas and values, drawing out the implications for practice with Aboriginal people. She identifies four primary characteristics of Indigenous world views that traditionally inform healing practices. They differ significantly from

Western ways of approaching therapy. The first is the idea of balance and harmony as indicators of health (p. 137). Problems arise when one is out of balance with self, family, and community. The medicine wheel is a widely shared cultural symbol of individual wholeness and balance as well as a symbol of the larger harmony of creation in which human kind play an intrinsic part. It is a potent symbol that works well in directing attention towards those areas of an individual's or group's mental, emotional, psychological and spiritual life that may require attention.

A related value that underlies Aboriginal healing is interconnectedness. It encompasses not only the various social groupings and communities people belong to, but the spiritual dimension of Indigenous connection to the earth and all of creation (Baskin, 2009, p. 137). This stands in sharp contrast to Western approaches that tend to be individualistic and which typically ignore or downplay the importance of the spiritual dimension which can be a source of strength for many Indigenous people (p. 136).

A third important concern for Baskin is positive cultural identity. Based on her helping work with adults over the years she concludes that "All the counselling, therapy and healing in the world are not going to truly help an Indigenous adult if they do not come to a place of being intensely proud of their identity" (Baskin, 2009, p. 138). The loss of pride in one's cultural identity is a harsh legacy of colonization and requires the kinds of consciousness raising and de-colonization we have already recognized as so important for countering the internalized oppression of Indigenous people. Baskin talks about the ways she helped people to replace

internalized negative stereotypes "with knowledge and understanding through discussion, questioning, challenging, research, spending time with other Indigenous people, attending events and ceremonies, learning about pre and post colonization, role modeling and mentoring" (p. 139). She also points out the effectiveness of "inherent markers" of identity such as clan symbols and traditional names in restoring a positive sense of identity (p. 139).

Finally, there's recognition of *help for the helper* as a necessary component of maintaining good health while providing counseling and other services. It is an understanding that goes beyond self care and encompasses the Indigenous value of collectivity (Baskin, 2009, p. 140). Helpers need support and inspiration through connection with other workers, but also through participation in ceremonial and other community activities that bring everyone together, regardless of status. The strict professional boundaries of Western social work practice are supplanted by the value and necessity of maintaining and fostering relationships.

These identified values are congruent with those of an earlier, and in some ways, foundational piece of work by McCormick (1997). He also underlines the importance of connectedness and collective values, and further stresses "the successful role which connecting plays in First Nations healing practices" (p. 171). He notes that traditional ways of healing, such as the sweat lodge and vision quest "reinforce adherence to cultural values and help to remind people of the importance of keeping family and community networks strong" (p. 173). McCormick was a

prominent critic of mainstream counseling services that operate from an individualistic orientation, putting them in conflict with Aboriginal values.

In a study conducted in British Columbia, McCormick asked 50 Indigenous adults to talk about times they had required help and to identify actions taken that had facilitated healing (1997, p. 174). He employed thematic analysis and utilized inter-rater triangulation to demonstrate reliability of the ten categories he came up with (p. 175). The three most prominent themes identified by the participants as most helpful were as follows: 1. *Establishing a social connection and obtaining help/support from others,* 2. *Establishing a spiritual connection and participation in ceremony,* and 3. *Establishing a connection with nature* (pp. 177-178). This study has several important implications for the provision of mental health services to Aboriginal people. First, it demonstrates the abundance of healing resources available to many First Nations people within their own communities. It also demonstrates that the Western focus on restoring personal autonomy conflicts with Aboriginal collectivism and should be subordinated to the values of relationship and reconnection. Spiritual sources of healing, including ceremony and connection with nature, also figure prominently in Aboriginal life and ways of helping - something seldom validated by Western approaches.

Eduardo Duran's book, *Healing the Soul Wound: Counselling with American Indians and Other Native Peoples* (2006), is unique for its detailed case presentations of his integrative, eclectic approach to working with Aboriginal people. Gone has asserted that "the book comprises as grounded and refined a study of the

subject as currently appears in the literature" (Gone, 2010, p. 189). Duran, himself a Doctor of Psychology, does not reject Western methods of practice, but radically recontexualizes them within the Aboriginal understanding of psyche as soul. He conceptualizes the impacts of colonization as "soul wound", and reframes the meaning of psychotherapy as "soul healing", returning to the original but misunderstood meaning of the Western root metaphor (p. 19). He thereby transforms the healing engagement from a secular to a spiritual kind of undertaking. He introduces a model which has worked well with his many Aboriginal clients over the years whereby they are invited to address the source of their pain or distress as living entities or spirits, with which they've formed a relationship - one that is subject to transformation through ceremony and ritual (p. 15). As Duran asserts, "one of the first tasks for the therapist working in Indian country is decolonizing the individual from the ideology of diagnosis and naming" (p. 31).

I want to end this section by turning, now, to a grass roots Aboriginal initiative to facilitate community healing from sexual abuse. Hollow Water is an Ojibway community in Manitoba which is now held up as a prime example of the kind of social transformation and cultural renewal that is possible, even in the face of overwhelming social problems. An estimate of the scope of child sexual abuse in the 60s and 70s was three out of four individuals (Sivell-Ferri, 1997, p. 117). It is here that Community Holistic Circle Healing (CHCH) was developed. "Part of what CHCH calls decolonization therapy ... is the restoration of balance through the healing of sexual abuse" (p. 118).

In keeping with traditional values, First Nation members resolved to deal with sexual offenses within the community. They utilized the dominant criminal justice system, and borrowed from Western approaches to sex offender treatment, but worked out agreements between all the players so that both victims and offenders would receive treatment within the community. Like dominant society, they shared a strong belief in the importance of accountability, but viewed it in very different, and traditional terms. For the Ojibway and most Aboriginal people, putting someone in jail does not constitute paying one's debt to society. "CHCH wants accountability to be shown to the community. Offenders enter the process of becoming accountable through healing - rebalancing" (Sivell-Ferri, 1997p. 120). The starting point is an admission of guilt and subsequent participation in offender treatment and healing circles that support the offender in taking responsibility and making amends to the victim, kinship group, and community. It can take years for the healing to progress through all the necessary stages. Meanwhile, the victim is receiving the counseling, support and validation s/he needs for personal recovery. If all goes well, a public apology will be received from the offender in the final circle of the healing journey for both.

Hollow Water exemplifies what can happen when traditional notions of healing and Western therapeutic approaches come together in the service of people who make the determination of how best to address their problems. Both individual and group treatment are carried out within the context of community, utilizing holistic Aboriginal concepts of healing (e.g., the medicine wheel, healing circles) along with

standard offender treatment approaches. Of greatest significance is the commitment to engage the entire community in the healing process and to work towards a restoration of community balance through the mending of fractured relationships. This would seem a prerequisite for the traditional values of sharing, cooperation and support to be fully realized so they can be brought to bear on the many other social manifestations of historical injustice.

## Methodology and Design

This is a qualitative study, thus "A gendered, historical self is brought to this process. This self, as a set of shifting identities, has its own history with the situated practices that define and shape the public issues and private troubles being studied" (Denzin, 2010, p. 27). It is important, then, that I position myself as an older white woman, middle-class, feminist, leftist, schooled in dominant trauma theory and practice, someone who has lived and worked within a First Nation community, and who is biased against imposition of purely Western paradigms of trauma treatment with Aboriginal and other oppressed groups.

This undertaking is influenced by structural social work theory, which views the structures of society as the primary focus for change (Mullaly, 1997, p. 104), is informed by a feminist and critical perspective, and takes a largely discovery-oriented approach (as laid out by Bernal and Scharron-del-Rio, 2001). This is a qualitative, naturalistic approach as opposed to hypothesis testing research.

I conducted interviews employing open-ended questions regarding the treatment approaches of non-Aboriginal counsellors working with Aboriginal trauma survivors. This allows for the emergence of a deeper and richer kind of information, informed by participants' personal learning, insights and experience, the full extent and flavour of which could never be captured by questionnaires. I aimed for *in-depth* interviews, the purpose of which "is to allow people to explain their experiences, attitudes, feelings, and definitions of the situation in their own terms and in ways that are meaningful to them" (van den Hoonaard, 2012, p. 78). These interviews were

completely flexible in terms of time and content, and took their form and direction from the interviewees. I recorded, transcribed, and subjected these interviews to thematic analysis, following Braun and Clarke's guidelines (2006), including their "15 point checklist for good thematic analysis" (p. 96). These guidelines were formulated to assist researchers through the necessary phases in thematic analysis, from coding and collecting of data right through to the final presentation of the study. In keeping with Guba's criteria for judging the trustworthiness of naturalistic research (1981), I enlisted co-raters from among my colleagues who were not otherwise involved with my thesis research, to evaluate the thematic analysis for purposes of "analyst triangulation" (Patton, p. 1193).

Starting with three contacts, seven non-Aboriginal women trauma counselors/social workers with Aboriginal clients were identified using a snow-ball recruitment approach. They received a letter outlining the purposes of the study and its compliance with ethical requirements under the UNBC Research Ethics Board. Personal contact followed, offering an opportunity for questions and to initiate personal connections with potential participants. They were all invited to review the transcript for accuracy but no one requested that revisions be made.

## Introduction to Thematic Analysis of Client Interviews

### Participant Demographics

I interviewed seven non-Aboriginal women counselors who provide trauma treatment to Aboriginal women. Two were interviewed in Prince George, B.C. and five were interviewed in and around Whitehorse, Yukon. All had extensive work histories in northern BC, Yukon or both. Six of the seven participants were women over fifty and all had worked in a variety of counseling and treatment contexts. Three were currently employed by First Nations. Two worked independently in private practice and/or on contract. One worked in an educational setting and another for a government mental health agency.

With the exception of the youngest participant, in her 30s, all had many years' experience working with Aboriginal people, having offered services through a number of different contexts ranging from government agencies and NGOs to First Nation treatment programs and private practice. All had attained at least a Bachelor level degree. Five of the seven participants' educational background was in social work. One was working towards her graduate degree and two were already in possession of MSW's. One held a masters degree in counseling education and one came from a psychiatric nursing background. All had pursued various trauma treatment and related workshops post degree. All had worked, or were currently working, with client populations which were either exclusively Aboriginal or in which Aboriginal people, and especially women, were well represented.

**Approach to Thematic Analysis**

It is not my intention to present a detailed description of the entire data set, but rather, in keeping with my areas of interest and inquiry, to focus on themes I perceive to offer something of importance with reference to my research aims and questions.

This is not to say that my questions served as strict determinants of the thematic categories to be presented and explored. Rather, they served to provide some sense of guidance when evaluating which themes might be considered of greatest relevance and value to this study. Because this is a qualitative study, the relative prevalence of a perceived theme, and the amount of focus it receives within each data item, are not the only, nor even the most important, considerations to be made. As Braun and Clarke (2006) assert, "... the 'keyness' of a theme is not necessarily dependent on quantifiable measures - but rather on whether it captures something important in relation to the overall research question" (p. 82).

I would characterize my approach as employing, in large part, an inductive analysis, i.e., the themes identified are strongly linked to the data themselves (Braun and Clarke, 2006, p. 83). Thus, they might not always bear direct relation to the interview questions, nor would they be strictly determined by my pre-existing interest in the topic. It's important to note, however, that while data driven, inductive analysis can never be completely free from a researcher's interests and biases. "Data are not coded in an epistemological vacuum" (p. 84).

On the other hand, I believe much of my work could also be considered theoretical thematic analysis - i.e., in significant measure "driven by the researcher's theoretical or analytical interest in the area" (Braun and Clarke, 2006, p. 84). This allows me the scope to see, for example, how a particular issue plays out across the whole data set and to focus on that particular feature when determining themes.

In keeping with this intended mix of inductive and theoretical thematic analysis, I also incorporated both semantic and latent levels of thematic identification, according to the aforementioned degree of theoretical interest evoked by a particular theme. That is to say, I began by identifying themes within the explicit or surface meaning of the data, the semantic level (Braun and Clarke, 2006, p. 84). In some instances I went further than just describing and elucidating the thematic patterns I've identified. I want looked at the implicit and underlying meanings of at least some of the themes, such that the development of the themes themselves involved a greater degree of interpretive work.

**Identifying underlying themes (rationale and process)**

Like many new to qualitative research (and perhaps especially to thematic analysis) I experienced growing frustration and increasing dissatisfaction with my results as I struggled to come up with meaningful and coherent ways of describing and organizing my data set. My initial efforts produced a number of different thematic groupings, but none seemed to capture or illuminate meanings and linkages in ways that really satisfied my interests and did justice to the ideas and insights of my participants. I came up with various (and rather lengthy) lists of

themes, some of which were suggestive of broader, underlying currents of meaning. Overall, however, I seemed to be coming up with material that lent itself to a more strictly descriptive process rather than to the kind of interpretive analysis I was aiming for. I was missing the structures of meaning below the surface that held the data together and formed the matrix of the themes I had identified.

As an example, one of my attempts at identifying themes produced the following;

1. The importance of transcending a purely individualized understanding of, and approach to, trauma and/or its context
2. The importance of understanding cultural values and beliefs, local histories and inherent limitations
3. The need to recognize and equalize power imbalances
4. The need to recognize and work on internalized racism
5. Awareness of non-clinical ways of healing, alternatives to "talk therapy"
6. Failure to help often due to system failures, structural barriers
7. Problem of impacts/effects of Christian religion
8. Things that are important/helpful in counseling (or providing help) to F/N women
9. The importance of relationship building/connection.
10. The importance of long-term involvement with client and/or community.
11. Some positives of being non-aboriginal
12. Some negatives of being non-aboriginal

Certainly most of my data fit easily within one or more of these themes, but the sheer length of the list and the vast differences in the relative size and importance of the identified themes (especially given my research questions), created an unwieldy collection of material to work with. What was needed to pull this data together in ways that would lend greater meaning to the concerns, understanding, knowledge

base and treatment practices of my participants? Eventually I began to understand the need to identify the more implicit assumptions underlying their thoughts and reflections as they talked about their work with Aboriginal women. What were the general threads that ran through all the accounts of their work?

Gradually it dawned on me that each and every woman I interviewed saw her trauma work with Aboriginal women as demanding far more care and attention to a wide array of issues and implications than her work with dominant culture clients. Despite significant levels of trauma training and, typically, many years of experience, not one expressed unwavering confidence in her ability to provide treatment of clear benefit to Aboriginal clients. All talked about various difficulties and limitations inherent in their work as white women practitioners offering treatment to Aboriginal women. These ranged from the barriers posed by the cultural and racial divide, to the historical and continuing impacts of colonization. All participants seemed to be continually questioning and re-evaluating their work, searching for better and more effective ways to counter the many obstacles to effective treatment they had experienced and identified. This line of thinking brought me to a distillation of quite a wide variety of themes into one larger underlying theme, namely: *1. The complexity and challenge of trauma work with Aboriginal women.*

Once I had formulated this simple generalized theme it struck me as both obvious and revelatory (a truth that had been hiding in plain sight), providing a fruitful ground for organizing and understanding the collected data. Its natural complement, the second broad theme in this approach, encompasses many of the very interesting

experiences (both positive and negative), perceptions and creative responses of the women interviewed, i.e. the ways they attempted to deal with these potential barriers to provision of helpful treatment, hence: *2. The importance of mitigating these difficulties and approaches that can help.* This was later shortened to *Themes of mitigation.*

Once I had settled on these two broad and inter-related themes, it was not difficult to arrive at a reduced number of sub themes which could capture the most important issues that dominant culture trauma counselors identify as posing significant challenges to their practice with Aboriginal women. Major components of the difficulties identified during interviews, can be broken down as follows:

a. The pervasiveness of trauma and trauma as multi-layered.

b. Recognizing how the power imbalance inherent in counseling relationships is exacerbated in work with Aboriginal women.

c. The greater significance and difficulty involved in helping Aboriginal women to establish safety and connection/relationship.

d. Being white and the great divide.

e. Individual focus of western culture and trauma counseling vs. collective nature of Aboriginal culture and healing.

f. Seriousness of consequences for First Nation women when trauma treatment falls short.

For all of these sub themes which fall under Major theme #1, there are natural counterparts subsumed under Major theme #2. Referred to as *Themes of*

*mitigation,* they are linked to the identified *Themes of challenge and complexity,* though they don't necessarily correlate on a one to one basis. That is to say, some *themes of challenge and complexity* may be addressed by more than one of the *themes of mitigation*, listed below:

a. Knowledge of history and culture of Aboriginal clients,

b. Owning your whiteness and its limitations,

c. Relationship building and long term involvement,

d. Thinking outside the box: Alternatives to TDWNA.

## Themes of Complexity and Challenge

### The Pervasiveness of Trauma and Trauma as Multi-Layered

This theme was present across the entire data set. It involves recognition of Aboriginal trauma as widespread, complex, and largely attributable to colonization. It informed the thinking and reflections of all the women interviewed, though there were various levels of familiarity with, and emphasis upon, the concept of historical trauma. It was interesting to see, however, the ubiquity of references to sources of trauma that transcend individual experience. One woman was explicit about the rarity of encountering what she termed "simple trauma" in her practice with Aboriginal women.

> Nearly everyone presents with complex, historical and current trauma, and you need to remember that. So you may think that you're dealing with sexual abuse, but you're dealing with all other kinds as well when you start unraveling the story.

Another woman, using particularly poignant imagery, commented:

> I think I've come to the point in my career where I visualize it (trauma) in every cell of their bodies. Whether they themselves have experienced direct trauma, they've been secondary partners in their experience in trauma.

This recognition of shared or collective trauma among their Aboriginal clients, whether explicit or not, was woven through the accounts of my research participants, sometimes when speaking about the steep learning curve they encountered in their work with Aboriginal women. One woman talked of her attendance at a ceremony where a history of mass death, concealed within a somewhat puzzling ritual, was finally revealed to her.

> So that was a real kind of *in-your-face* that they're living with that history, even though they don't talk about it most of the time, that we're walking on the ground where there's been tons of people killed, right? - that colonialism that non-aboriginal people are responsible for.

There were a number of other comments that speak to the pervasiveness of trauma, and trauma as cross generational, for example:

> I've worked now with women, seen their babies grow up, but I also see the trauma in their lives, just constantly, constantly, and it seems like just one thing after another ... It's just like going from one generation to another.

> I see more of the intergenerational trauma with Aboriginal women and so I'm bringing that more into the assessments and it's more a part of the work that we do together is exploring that to understand the impacts.

Reference to "inter-generational" trauma is found across all the interviews. Residential school trauma was regularly referenced as exemplifying cross generational trauma, for example:

> Well, there's all kinds of trauma but the first one that comes to mind is the residential school trauma which affects everyone on some level, pretty well, whether it's their grandparents or great grandparents or parents, or for some of them, themselves. Residential schools, of course, did a lot of destruction of culture. It took away the resiliency of many people, it destroyed parenting skills, and it had a legacy of all the impacts of abuse.

Another woman talked about the ways in which residential school trauma had created huge divisions within the Aboriginal community she worked for, fracturing relationships between one generation and another.

Residential school was typically positioned within the context of colonization and genocide, and often in quite an explicit manner. One woman was particularly adamant about the need to look beyond residential school abuses:

> ...usually we just think in terms of residential school and some of the abuse that was inherent in that and I think you have to look back further to the whole

> colonization process and the whole desire, an unexpressed desire, to cause total genocide to a population and I think that is inherent in anyone who has a First Nations identity.

Other typical comments follow:

> I don't want to say that trauma only relates to residential school because I think it's colonization in general and sometimes it can be hard to separate out the two."

> much of the trauma, I believe, is related to colonization and residential school.

Though less frequent, I also encountered references to trauma originating in current manifestations of Aboriginal oppression and social disorder, further highlighting the participants' understanding of the multi-layered or multi-facetted nature of traumatic impacts in the lives of their clients.

> And again, another impact I would say, or conceptualization of trauma, is the trauma of poverty and the trauma of the reserve system because many reserves are corrupt. There's favouritism, money goes where it shouldn't go, or it disappears all together. There's rules I don't even understand, so you have people in substandard housing or actually condemned housing, and they live in it for years. All those kinds of things, I would say.

One woman talked about racism as part of the trauma Aboriginal people carry. She noted that " it can be unnamed, below the surface". She was touching on the reality of racism in Aboriginal experience which, though seldom addressed directly by either clients or practitioners, and typically left unexplored within treatment, persists as a significant factor in the overall trauma burden of Aboriginal people (Carter, p. 19).

Recognition of current traumatic conditions and events impacting women's lives, and whole communities, was also present. The high level of suicides, drug

overdoses, violence and addiction which plague many First Nation communities often lead to another level of grief and despair, overlaying the impacts of individual and historical trauma. Though not prevalent, some reference was made to the deleterious impacts of current social conditions and family tragedies, for example:

> ... and it's not just sexual abuse, it's psychological trauma, a lot of physical abuse, a lot of grief from, I think, a hard life dealing with family members who maybe are under the influence and freeze to death, are in car accidents - just multiple layers of different kinds of trauma.

One woman struggled to convey her sense of how Aboriginal women living in their First Nation communities are impacted by on-going contact with the trauma that others carry.

> I think there's almost like - I don't know how to put this into words - like an effect where people grow up in communities where they live along side other people who've had either trauma or similar trauma and I think there's something that happens with that - so I'm attentive to that.

In sum, perception of the very complex nature of Aboriginal trauma, with its multiple layers, sources and compounding effects, was certainly present throughout the interviews. Participants recognized trauma among Aboriginal people as far less straight forward in its origins and manifestations than is typical of the trauma presented by non-Aboriginal (and especially dominant culture) people, and far more attributable to socio/political forces which have created the racist and oppressive circumstances in which many Aboriginal people find themselves. The daunting difficulties posed by all this formed a major current running throughout the interviews.

**Recognizing How the Power Imbalance Inherent in the Counseling Relationship is Exacerbated In Work with Aboriginal Women.**

Attention to the power imbalance intrinsic to the counseling relationship, and efforts to address and minimize it, are characteristic of recent trauma literature, for example the emphasis placed on creating a "therapeutic alliance". (see Briere and Scott, 2006, and Haskell and Randall, 2009). As one would expect, this is a primary focus for feminist practitioners. As Herman states, "The first principle of recovery is the empowerment of the survivor. She must be the arbiter and author of her own recovery" (1992, p. 133). If the need to address and ameliorate destructive power imbalances is paramount in trauma treatment in general, it is especially critical when a white counselor undertakes to assist Aboriginal people in their trauma recovery.

Paralleling their awareness of the complex dimensions of Aboriginal trauma, I encountered broad recognition among research participants of the multiple ways in which First Nation women are subject to disempowerment and, consequently, the greater risk they face of perpetuating oppressive power imbalances when working with Aboriginal clients. One woman talked about a situation with a client that brought this into focus for her:

> ... I started to realize the dynamic in the counseling situation was actually a colonialist kind of thing going on. I was the expert counselor, white, kind of middle class (even though I come from working class, I am sort of middle class, being educated now) and here she is coming to me for advice as the expert on how she should feel coming from residential school. ... At first it kind of worked ...(But) there was a point we got to when I thought there was an unhealthy dynamic going on and there was a lot of transference happening...

Comments from other women also suggest a sensitivity to the ever-present issue of problematic power dynamics developing within their counseling relationships:

> Part of my role is to be constantly aware that I come from the dominating culture and so I have hidden biases, or blind spots, so I need to constantly reassess what it is I'm saying or suggesting. But I think that's the same for being a counselor for anyone. You have to be aware that you're in a powerful position with a vulnerable person...
>
> I think another important piece is always trying to equalize the playing field and being aware of power dynamics - and those power dynamics can be played out in really subtle ways, and obvious ways, such as language skills...

For white practitioners, then, professional status is only one of many factors contributing to the kinds of real and perceived power differentials that can, and often do, impede the therapeutic process. Working to recognize and address these factors which pertain to us as members of the dominant culture, (referred to by one participant as "perpetrators"), is a vital precondition for successful treatment. Numerous references to ways of approaching this challenge will follow in the *Themes of mitigation* section.

**The Greater Difficulty Involved in Helping Aboriginal Women to Establish Safety and Connection/Relationship.**

Beginning with Herman's *Trauma and Recovery* (1992), stage-oriented or phase-oriented approaches have become standard in the treatment of complex trauma (see Haskell & Randall, 2009 and Cloitre et al., 2006). They are grounded in a recognition that safety and stability need to be attended to before the actual trauma narrative and processing can be usefully undertaken. As Herman observes, "establishing safety begins with control of the body and moves outward toward self protection and the organization of a safe environment" (p. 160). Assisting clients to

secure the needed levels of safety and security in their lives, both in practical and psychological/relational spheres, is the first step in building readiness and capacity to handle the emotional activation that trauma disclosure typically entails. A majority of the research participants made reference to the often extreme challenges they faced in their attempts to work in meaningful ways with their clients to achieve the goals of this initial phase.

Safety from violence and abuse is a huge concern, especially in communities where victimization of various sorts has become normalized. One participant talked about her efforts to help a young woman who continued to live in a high risk situation:

> I was building resilience with her but I was well aware that she was in a very dangerous situation, but there was nothing that could be done. And we tried everything. She was in care for a while, but then she went back. ... when the murder happened people came out of the woodwork knowing what this youth was living with. And no one helped. No one helped the abusive parent, no one helped the brother, - no one helped.

The normalization of violence and victimization was flagged by most respondents as a big problem in many Aboriginal communities. When coupled with a lack of resources, this tacit acceptance of abusive and high risk situations makes the establishment of safe living conditions especially difficult.

> And that's what I found - this tolerance that blows me away. And even today I see this. I see the sexual predators hanging off the bodies of the young teenage women who are standing there rigid, in public, obviously not enjoying the touch, and no one tells these men to back off. And these young women don't have the power to say anything. They are terrified. And I see again, a community and public situation where we accept men touching young women. So those are the kinds of failures that I think about.

The legacy of residential schools, the overt as well as less obvious pain and suffering arising from broken attachments and other serious trauma, the loss of traditional parenting skills, the substance abuse, the missed developmental goals of emotional and social competency (Cloitre, 2006, p. 5) - all can result in stressful, chaotic and sometimes overtly unsafe family situations. These deficits can be at least partially compensated for if there is outside support and a positive sense of connection to the larger community. But, as more than one participant has pointed out, the prevalence of trauma throughout the community can make the finding of social support and healthy relationships a difficult undertaking.

> And what I see is the intergenerational impact of trauma in terms of addictions of all kinds, so you have children growing up where it's normal to have no food because somebody's spent the money on booze or bingo or any of that. Sexual abuse is quite standard. I had a group of young women who were all fourteen ... who told me everyone got sexually assaulted, that that was normal, that in fact, for them it was a rite of passage.

As another woman observes:

> even though I understand culturally that there's a real emphasis on family and community and it's important to look at it (trauma recovery) in that context, there's also been a lot of harm from their experience in their family or community ...

The role of a counselor working with trauma survivors is fraught with potential pitfalls, then, since she must help her client find empowerment and social connection under often adverse circumstances, and must also manage the therapeutic relationship in ways that foster a sense of both safety and autonomy. This is a difficult task for any trauma counselor, but especially for a white practitioner who is at even greater risk of recreating the oppressive power dynamics her Aboriginal

clients have experienced individually at the hands of their offenders and collectively through the imposition of colonialist policies. As we have learned over the years, it is through relationship that recovery occurs (Herman, 1992, p. 133), so creating a sense of safety and connection within the therapeutic context is vital. The obstacles are sometimes daunting, but all participants recognized the importance of working on the requisite conditions for that all-important sense of safety. Some of their approaches will be presented in *Themes of mitigation.*

**Being White and The Great Divide.**

As one woman noted:

> there were real barriers when I worked for the government. First of all, you work for the government and that's a barrier, you're white and that's a barrier, you're not born and raised here and that's a barrier ...

Whether we work for government or not, our whiteness immediately identifies us as belonging to the oppressor group. Our professional status and degrees, especially in the case of social workers, can prove more intimidating than reassuring, often triggering distrust and resentment. Despite our personal life struggles, despite our socio-economic class or political affiliations, as white women practitioners we carry with us the perception of unearned power and privilege and an inherent association with systems and structures of historical injustice and current forms of oppression.

Nearly all my participants spoke of the resistance that they encountered, at least initially, as white counselors offering treatment to Aboriginal clients. This they attribute to experiences of trauma understood as "related to colonization and

residential school and (us) as the perpetrators, as the non-aboriginals, as the whites who were doing that". Another of my research participants related:

> [In addition to residential schools] there's the sixties scoop thing where a lot of children vanished, and lost to the communities, are slowly returning - but that still exists in that a lot of First Nations people today are still afraid of the authorities. Like quite often I get asked if I work for "the welfare", and the little children, because I do work with children, that's a question that will come out of their mouths, like as young as kindergarten, "Do you work for the welfare?", so they've been trained not to talk to "the welfare" about anything.

This, as we know, is the sad legacy of a long history of oppressive government policies, implemented by social workers, aimed at eradicating Aboriginal cultures. It's little wonder, then, given the significant harm our Aboriginal clients have suffered at the hands of dominant culture people and systems, that we as white women are often met with suspicion or even hostility. Despite all our best intentions, we are typically faced with significant and largely justifiable barriers to acceptance by Aboriginal individuals and communities.

Some interviewees saw experiences of racism as a major factor holding people back from approaching white practitioners. As one woman stated:

> And I think there's still a lot of racism in Canada and that does taint some people choosing to act, even making a start through talking. And our understanding of racism and the ways in which oppression is experienced, is far more intellectual than experiential.
>
> I think there's a limit to my knowledge and it can be sort of head level understanding but it's not a lived understanding of what it's like for Aboriginal women living in Aboriginal communities, the history of trauma or, you know, moving through that, and what it's like to continue to live in those communities.

Along similar lines, another participant reflects:

> [Being non-aboriginal] can be a limitation in that sometimes I don't quite get it, I'm sure, even though I think I might sometimes, because I'm not Aboriginal and I can't imagine what that must be like.

Another woman also spoke to this perceived limitation:

> I try to be respectful of cultural differences ... but I don't know the deep cultural values on the same level as an Aboriginal person who's been raised with those does. So I only know what I've been taught, and I think that's limiting because I know I don't get taught everything because some things are still considered secret or sacred...

Given the huge divide between whites and Aboriginals in terms of life circumstances, and given an Aboriginal history of unrelenting struggle to survive and maintain some degree of cultural identity and autonomy in the face of almost unimaginable losses, it is not unexpected that Aboriginal people would question our ability to understand their lives and challenges in ways that could prove helpful. As one of my research participants put it:

> I think sometimes people might think that as a non-aboriginal woman I don't know, I couldn't possibly understand, how they feel or what they've gone through. And I think that might close some people up.
>
> So I do think that's one of the limitations [of being white] - maybe people think she doesn't really ... how could she know? I don't think I get that very often, but I know sometimes it happens and I just won't see people.

Working to bridge this divide can be viewed as the white practitioner's greatest challenge and one that has no discernible end point. As we have already seen, trust, connection and the establishment of a healthy therapeutic alliance is essential to good trauma work and it's something that requires on-going learning, sensitivity and attention. The many ways in which my research participants undertake to help create positive working relationships with their Aboriginal clients,

in spite of the many barriers to doing so, will be another topic of discussion in the section on *Themes of mitigation.*

**Individual Focus of Western Culture and Trauma Counseling Versus Collective Nature of Aboriginal Culture and Healing.**

*In this section, which deals with issues I've been engaged with for many years, I interject some of my own questions and concerns into the discussion.*

"TDWNA (traditional dominant white North American) counseling is predicated on the importance of individuality. For the traditional Native, it is the community, not the individual, that is central" (Burstow, 1992, p. 72). This difference was widely acknowledged and sometimes discussed at length in the course of my interviews. There was recognition that even though community and collectivism are such strong traditional values for most Aboriginal people, the damaging impacts of colonialism, which gave rise to so much violence and addiction, have fractured many family and social relationships. Community based healing initiatives, then, as exemplified by the work undertaken in Hollow Water, would appear to be as vital, if not more so, than the individual trauma work which always runs the risk of individualizing problems that are socio-political and historical in origin.

Despite the fact that most of the participants' work was largely confined to one-on-one counseling, the limitations of a strictly individualistic approach were frequently raised. One woman felt particularly uncomfortable in her role as a drop-in therapist for two remote First Nation communities:

> And a lot of the problems were related to the unhealthiness of the two communities - and both were really unhealthy in different ways - and I felt like I was being paid by the band, and a very healthy sum, to go in and fix the problems, but the problems were community based - and I didn't have

> the where-with-all, I didn't have the knowledge or the power and the ability to do the kind of community development work that was really required to bring healthiness to the community - and it was a conflict that I experienced all the time. And I don't know the solution.

This brought to mind similar reactions of my own concerning a highly trained and skilled professional hired on contract to provide psychological counseling to a great number of the First Nation residents where I later worked. She was extremely well regarded and carried a formidable caseload, consisting in large measure of trauma survivors dealing with childhood maltreatment and abuse issues. People loved her and, no doubt, received valuable help and support. From the outside looking in, however, I could discern little change in the community as a whole when her contract ended after two years. Known sex offenders still roamed around the community plying the young women and girls with drugs and alcohol; the same level of violence, addictions, and sexual abuse appeared to be plaguing the community; women and girls, including staff, were still subject to harassment and triggering by predatory males, and little or no action was taken to change things on a collective, community level.

I underwent a gradual realization that there are severe limitations to a focus on individual counseling, at least in situations where community cohesion appears to be in such serious need of strengthening and restoration. This is especially true when it comes to transforming one's living conditions, her social circumstances, so that a level of safety conducive to personal recovery can be attained.

One of the participants, however, spoke at length about why she felt one-

on-one counseling was so important, even while acknowledging the importance of family and community when it comes to trauma work with Aboriginal people.

> So I think that the individual piece is important. [That] is, I guess, all that I'm saying. As a non-aboriginal therapist there's lots of pressure to look at [the wider social context]. I mean, maybe it goes again with the idea of making assumptions about what culturally would be helpful for this person, and there's lots of pressure around using family, community, to look at it in that context, yet I see an individual who has a difficult time to connect because there's too much going on with them and they need to do some work there. I guess this is validation for myself, for needing to feel okay about doing the individual piece. I think it's really important personally. And I think when that happens, it helps to grow the health of the family and community, particularly with the women because they have such an important role in their families. ... And when they can find ways within themselves to work with the trauma and find some healing around the trauma, then, I think, they can be less overwhelmed in the various roles that they've taken on or make clearer choices about how they want to be in those roles.

I have little doubt that this therapist's work is highly valued by her Aboriginal women clients. Most of us, as white practitioners, have little if any say in how Aboriginal communities define, prioritize and address their collective issues, and this is as it should be. Those of us who are well informed and care about the many injuries First Nation people have suffered under the forces of white colonialism, those of us dedicated to finding the best ways to help address these injuries through anti-oppressive measures, often question the efficacy and value of the roles we have undertaken. We do not want to become unwitting contributors to the maintenance of the status quo and certainly do not wish to perpetuate culturally bound ideas of healing linked to our western cult of individuality. On the other hand, it is neither our place nor our desire to be the initiators of social action in communities not our own. There are, however, things that we can do to make small, incremental differences.

A number of my interviewees talked about steps they take to move beyond the TDWNA approach to forms of treatment that offer greater flexibility and responsiveness to the needs of their Aboriginal clients and the communities where they work. Some of these many thoughtful and creative approaches will be presented in the section on *Themes of mitigation.*

**Seriousness of Consequences for First Nation Women When Trauma Treatment Falls Short**

As I have already pointed out, most of the research participants talked about taking particular care in their trauma work with Aboriginal women, and this appeared to be linked to their recognition of the depth of their clients' wounding and losses, both as individuals and as members of a group subjected to ongoing social injustice. Given the compounding effects of multiple traumas, both personal and collective, historical and current, it only follows that the triggering of trauma related experiences and reactions would be perceived to carry a far greater risk of serious harm to an Aboriginal person's emotional and psychological functioning.

Many of the women I interviewed indicated that all the things they were trained to watch for and look after in their trauma work generally (e.g., building trust, being fully present, attending to the critical issue of pacing, etc.) became even more critical in their work with Aboriginal clients. For example:

> ... we have to watch the pace we go at because many of the [Aboriginal women] are single parenting and they have to be functioning as single parents, and if we move too quickly ... we leave them so exposed, and what are we doing to their children when they go home and they're in their trauma brain and not able to function? And then they don't continue on but they carry the pain.

The dangers of re-traumatizing clients, especially through imposition of the counselor's agenda and/or by moving too quickly, were mentioned by several of the participants as posing particular concern in their work with Aboriginal women. I see this concern as connected to both the expectation of heightened sensitivity on the part of Aboriginal people to issues of power and control when working with white therapists, as well as to a fear of the serious consequences when severely traumatized clients are triggered into overwhelming emotional reactions.

> I'm very careful about continuing the colonization. Am I sitting there approaching it with some of the ways they've been traumatized as in "I know what's best for you, let's frame this as a problem and I'm going to help you fix it", all of those - "and you need me to help you fix it" - all of those approaches I feel like really continue the process of colonization and so I would say that's the number one way I'm different in how I approach it. I'm very conscientious of that. However, having said that, it kind of carries over anyways 'cause I still philosophically believe it's important that I'm not approaching any kind of counseling work from that perspective, as if I know what's best, and so I'm just more careful of that when I'm working with Aboriginal women.

What's more, the need to transcend the TDWNA style of counseling, a central tenant in the feminist approach, receives even greater emphasis when we're motivated by a commitment to anti-oppressive ways of assisting Aboriginal women. For example, when speaking of the ideal role for non-aboriginal counsellors one participant explained:

> I think it's the opposite of therapeutic in work with any women, but in particular with Aboriginal women, as a non-aboriginal woman to - I don't know - to sort of not engage with people at a very human level. I feel like there's a distancing there that's not therapeutic and that sort of reifies power and distance and difference and it's subtle.

Relationship building, I would assert, is both a far more difficult and complex undertaking, and ultimately a far more critical one, in our trauma work with Aboriginal women. In its absence, we're left at best with a top-down power dynamic that puts our clients at risk of re-traumatization and its damaging impacts. The various ways we "think outside the box", our departures from strictly TDWNA approaches to achieve this and related goals, will be explored in some detail in the section on *Themes of mitigation*

## Themes of Mitigation

This section presents some of the ways in which participants in this study have worked to minimize or mitigate the many challenges they face in their work with Aboriginal clients and communities. Each of the themes from the previous section will come under discussion, but not necessarily as a unique and separate counterpart to one of the themes of mitigation. Many of the reflections and approaches that were raised in the participants' interviews around ways to address identified difficulties pertain to more than one of the challenges and complexities we have reviewed so far.

### The Importance of Enhancing Good Trauma Training and Supervision With Knowledge of The History and Culture of Aboriginal Clients.

Along with a recognition of the daunting complexities of their clients' multiple traumas and often difficult personal circumstances, participants generally acknowledged the value of good trauma training and clinical supervision. The following comments were in response to questions about what we need to know to be helpful when working with Aboriginal women trauma survivors:

> I think when we're offering trauma treatment ... it's really important that the clinician or therapist has extensive training. You can really mess people up by having them retell the story and a lot of people want to retell the story - and then they get re-traumatized, all that kind of stuff ... Like you have to be very sensitive to dissociation. If someone's telling their story and dissociates, you have to stop. It's not helpful.

> I think they need to certainly have a background in trauma and understanding the brain and the new research and stuff, and how to calm a person quickly and actually be able to model those things in session.

Other participants agreed and also talked about the value of various approaches they had learned through their academic and post grad training, for example, drawing on some of Satir's work, or using aspects of Marsha Linehan's *motivational interviewing*. Formal training, then, was viewed as important, but not exclusively so.

Complex trauma work, especially within a context of ongoing oppression and struggle, is far more demanding than most of us could handle on our own. The required knowledge base is huge. We need to have training and experience in a variety of approaches, and need to keep up with changes and advancements in the field as new information and research become available. For example, the connection between addiction and trauma and the neuro-science that investigates the bio-chemistry involved, is becoming quite standard fare in the training of both addiction and trauma counselors. The significance of this connection was stressed by one participant who stated:

> I think the whole trauma informed piece is really important. And because lots of times Aboriginal clients ... they might be coming in because they want to do something about their drinking. As the counselor we need to understand the trauma under that. That might not be what they're wanting to do right now but we need to understand the connections. So the trauma informed piece is important.

With regard to clinical supervision, another woman asserted:

> I think you need really good supervision. That's key. I think you need **really**, **really** good supervision. It's such a range ... how people present, ... so I've got women who, in the mental health world, would be described as having sort of borderline-ish traits.

When we're faced with clients displaying extremely difficult and confusing behaviours, clinical supervision can become a life-line. It affords us the opportunity

to benefit from expert experience and insight well beyond our own, allowing for more valuable assessments of what's working, what's not, and why. It also provides us with a safe environment to examine our own reactions and emotional fall-out. Difficult issues like internalized racism can be raised and explored in ways that, ideally, increase our awareness of the culturally conditioned biases creeping into our work. One woman spoke at length about this need:

> One of the larger things for me is the lack of permission as therapists that we have to really explore racism as an issue, and the safety that's required to explore that issue so we can unpack our own racism ... In some ways it's like transference and counter-transference. It's finally become acceptable for therapists to talk about counter-transference that they may have going on with a client. I don't think we're anywhere near that point in terms of talking about counter-racism ... and essentially it's the same sort of thing. It's something that gets triggered in you because of something that you perceive in your client. And there's so little permission to really explore that, certainly in my formal work places. The only place that I've really had comfort exploring that is when I've had a very good [clinical] supervisor and they have been very few and far between.

Beyond the tools of current trauma training, and the ability to access helpful clinical supervision, there are all the things we need to understand about historical trauma, the socio-political forces that were at work, and the impacts on local cultures and communities. As we have seen, an understanding of residential school as a tool of colonization was evident throughout the interviews. Recognition of the inherent social injustice suffered by Aboriginal people and its intergenerational impacts was widely present:

> I think understanding intergenerational trauma is important. I think the whole trauma informed piece is important.

> I think it is crucial to have the knowledge of what has happened as a result of colonization ... how through the Indian Act and through various ways, so much of their own personal power was taken away.
>
> I think having a historic context to understand the trauma of what First Nations people have been exposed to is absolutely essential and I don't think that is ever explored thoroughly or completely enough.
>
> With Aboriginal [clients], I am probably taking into account more of the context they're coming from. I think I have somewhat of an understanding, working here for 20 years, an understanding of how damaging the settling of this country by Europeans has been on First Nations culture...

In addition to a general understanding of the many forms of oppression that Aboriginal people have been subjected to, the importance of knowing and understanding local impacts was also raised. Without the relevant knowledge of how colonization played out in a particular First Nation or region, we lack the context for a full understanding of the multitude of traumatic events that have impacted our clients' lives. Further, as we shall see, local histories also provide a potential window into the strengths and resiliency of our clients and their communities. Many of my research participants raised the importance of knowing this local cultural and historical information:

> And I think it's different for every community and if you're working with a particular community, you need to know the specifics. For example, I'm working in [community X] right now, and because of their whole history of land claims, the scenario is very different from the scenario in [community Y] where they settled their rights, well, supposedly, ten years ago. So I think you have to be familiar specifically with each community.
>
> But I think before they [white counselors] meet their first Aboriginal client, they need to look at the history of the area that they're working in - whether it's the Yukon or British Columbia. They have to look at the colonization process, they have to look at the Indian Act and some of the land claim agreements and what the impacts are on communities and what that truly means to be an Aboriginal person.

> I would say that the non-Aboriginal person needs to be aware of the Aboriginal cultures in the area in which they work, so that is not the pan-Indian approach. It is knowing the local culture. I think you need to have Aboriginal informants, cultural informants. That's very helpful ... you need to have people you can talk with to find out, because every nation has its own taboos and ideas of what their culture is and culture is not a dead thing. It's a living thing, and it's always changing ...so again, you need to know what's going on in your community and the level that the systemic trauma has had, like in terms of what has been lost.

I was struck by the linkage of cultural awareness to the understanding of colonization and its impacts. My participants displayed an implicit grasp of the limitations of cross-cultural awareness when it is pursued to the exclusion of education around all the harms attributable to racism and colonialism (see St. Denis, 2011, p. 185).

There were several stories told about how local and sometimes hidden histories came to light and how they informed my participants' practice. One woman learned of the real meaning of a current ritual practice where a gun is fired during reconsecration ceremonies at a graveyard. The local priest is in attendance during these times and the story is always told about how "traditionally" the gun was fired off to let people know that the priest was coming so they could gather for mass. It was a way to honor him.

> But, the story that's underneath that story is, they did fire the gun, but the reason was to tell the people that the priest was coming and they would hide their ceremonial objects and drums because at those times they were seized and burned.

This becomes, then, a story of resilience and resistance which was certainly not apparent on the surface. Stories of this kind can prove very useful when we're

undertaking a more strength-based approach with our clients. As another participant related:

> And if you understand that historical context, [for example] the Alaska Highway, the gold rush, when you think of Dawson going from 300 people to 10,000 in one summer- oh my god! - And what the First Nations did to try to protect themselves - you can use those resiliency stories in current day because the story telling is such an important part of Aboriginal culture and healing. So you need to know where you're working and you need to connect with people who have those stories and learn them, listen, and be open to it.

**The Importance of Owning Your Whiteness and its Limitations**

> I think there's limitations in not being Aboriginal. I think therapeutically what I can offer people would be probably more substantial for them if I were Aboriginal. (research participant)

In *Healing the Soul Wound* (2006), Duran talks about advice he gave to a blue-eyed intern who was having difficulty connecting with her Aboriginal client. He suggested she ask the client what he saw when he looked into her eyes, if perhaps her blue eyes made him think about Custer's blue eyes. She followed his advice with very positive results. "This acknowledgement propelled the therapy into a process that I could not have imagined. From that point on, the patient was able to disclose even the most well-guarded secrets to the therapist" (p. 54).

Research participants generally shared this understanding of how important it is to be up front about who we are, acknowledging our whiteness and, when appropriate, our power, our privilege and the limits to our understanding. For example:

> When I start working with an Aboriginal person for therapy, I put it on the table and I say, "Look. I know I'm white and I'm of the culture that has oppressed your people. Do you feel that that's going to be difficult for you

> to relate to me?" and if they say "yes" then I say, "If it's a problem I'll help you find someone you're comfortable with".

Other participants reflected:

> I think it's interesting, because one of the things that I identify as being most helpful is not identified by Aboriginal women as being particularly helpful, and that is always acknowledging the differences in terms of my being white and their being Aboriginal. Lots of times, when that issue's brought up, I'll have someone say, "Oh, that makes no difference whatsoever". And I think as the work goes on it becomes more and more clear how much of a difference it does make because their assumptions on how the world works is based on an Aboriginal orientation, regardless of whether they've been raised in an Aboriginal context or not. ... If they (quote, unquote) **look** Aboriginal then their experience in the world is coloured by that because of how people relate to them.

> I think as a therapist I really work to own that I'm not Aboriginal - so just trying to own and have that be in the room. I have one client in particular where we sort of got to that about a month ago And just to name it, that there might be pieces that I miss, there might be pieces that I don't completely understand, you know, just because those are all possibilities ... and I probably mess up some times, but for whatever reason it works better and we talk about those pieces, about what it's like to work with a non-aboriginal therapist and the limits of that.

This same woman also puts out to her clients that she recognizes how working with a First Nations counselor would likely be the preferred choice and how it's okay to have feelings around that, to talk about that, and when appropriate for referrals to be made. Similarly, another woman spoke about having made referrals for residential school trauma:

> So understanding, in a sense, we're witnesses of the impacts of trauma, and as non-native counsellors we can assist with some of it, but depending on long-term work, I think sometimes, at least in my experience, there's got to be a shift at some point to someone who can better reflect their culture, 'cause I can't reflect First Nations culture, not in a way that's probably necessary for some women, especially women who have been to residential school.

The reality, however, is that we are often faced with a severe shortage of available options for Aboriginal clients wishing to access services provided by First Nation practitioners. Often we represent the only resource available to Aboriginal people. It is our responsibility, then, to explore all the various ways we can bridge the divide with our Aboriginal clients and facilitate the kinds of healing connections so necessary for trauma treatment and recovery. Knowing and communicating who we are, attending to the power imbalances inherent in the counselling relationship, acknowledging our limited grasp of Aboriginal experience and culture while trying to learn as much as we can - all of these things and more can help us mitigate the barriers imposed by our whiteness.

Regarding the important things we need to keep in mind as white women working with Aboriginal women, one participant offered:

> I would really say the importance of knowing your own biases and how you continue to perpetuate colonization is number one. So what are you bringing to the plate, and is it aligned with their values ... ?
>
> ... do you have a consciousness of what your biases are and how those might be presenting and creating problems or being harmful in some way?

While getting to know ourselves is a prerequisite to effective work, learning to know who's sitting across from us is the next vital step. Most of the research participants spoke about the importance of avoiding assumptions about who it is we're working with, and this is especially true when it comes to cultural values and practices. Not only must we avoid the "pan-Indian trap", we need to recognize the many differences between people, often within the same community, when it comes to the value and

importance they place on their traditional Aboriginal culture. One woman related a lesson she learned early on with regard to making assumptions about Aboriginal cultural beliefs:

> I was doing a group and trying to be so Aboriginal sensitive. I ended up calling it a healing circle and I didn't want to call it a support group. I really wanted to offer a service for Aboriginal women, and I brought in ... an eagle's feather and the Aboriginal women would not touch it but the non-aboriginal women had no problem with it. And when I asked the Aboriginal women what the issue was, they said it was black magic - and I realized they're all Catholic, right, so that was a really big learning, not to automatically assume that because they're Aboriginal they're going to believe in the Creator.

Some of the research participants talked about the lessons they had learned from their First Nation clients. There were the "hidden" stories we have already referred to, but also very deep and fundamentally different ways of viewing the world and relating to people that were shared when the requisite trust was established. One participant, who had worked in the addictions field, related her learning process around what she'd always perceived as a lot of enabling behaviour in First Nations culture, something that had troubled and confused her. At some point it was explained to her that:

> rather than it being about enabling, it's about the commitment to be there for one another, for family members, and that often gets interpreted ... [in] a white person's view, as enabling - but it's a different cultural framework, and you have to consider that, and draw it to their attention and give credit for what it's about and look and see if there's another way that you can facilitate helping and meeting their cultural value without shooting yourself in the foot.

She went on to say:

> I remember when I learned that from a client that a whole piece of my understanding came into place, and I think clients deserve credit for teaching us...

Another participant also saw the importance of maintaining an openness to learning from clients:

> I'd say everyday I learn something, you know what I mean? I think that's important particularly when working with Aboriginal women, and Aboriginal clients in general, because it's so complex, it's really complex I find. For me, I feel that openness to understanding and making sense of that is so important in terms of being helpful.

Avoiding assumptions, being open, being curious, and owning the limits of our knowledge and understanding are all ways of minimizing the distance between client and therapist. As one participant pointed out, however, this needs to be done with care and sensitivity:

> I think it's also important to not feel guilty or feel somehow wrong for being non-aboriginal. ...I don't think you have to apologize for who you are, but I think it's also important to acknowledge limitations and there's this sort of subtle balancing in that.

We need to take responsibility for educating ourselves while all the while learning from our clients, not necessarily asking for information, but by being receptive to what they wish to share:

> So being really sensitive and open, and without having our clients educate us, because that's not really good either. So, getting it where we can, in places that are healthy, and lots of times women share stuff with you, and over the years it's huge. So learning from women, but not because you're asking, but because they're telling, because they want you to know.

Another participant had a somewhat similar view but also stressed the importance of having informants she could go to when needed.

> Well, I believe in working with Aboriginal women, first of all, a therapist's job is to become a good ally, which means that I am responsible for my education and I'm also responsible for staying current with some of the research and literature which is evolving from Aboriginal peoples. I'm also responsible for ensuring I don't fall into the pan-Indian trap, because Aboriginal people are many cultures, they're not one culture ... and so there's a real difference, and what works is having local cultural informants. I need to have people I can ask questions of who won't be offended by my ignorance and who can help me understand things that perhaps my European mind doesn't perceive ...

**The Importance of Relationship Building and Long-Term Involvement With Client and Community.**

> I think that if you're going to work with the Aboriginal community you better want to stay somewhere for a long time because people are tired of the revolving door of white professionals who are there to then go down south to some nicer place. (research participant)

This theme is about trust building and the therapeutic relationship, vital components of all effective trauma work, but perhaps especially so in our work with Aboriginal clients. Establishment of a trusting connection cannot be easily accomplished without long-term involvement with our clients and community. As we have seen, this can be particularly challenging when we take into account all the barriers to authentic connection which exist between Aboriginal clients and non-Aboriginal counselors. Here we encounter participants' thoughts about the importance of long term relationships with Aboriginal clients and ways to foster connection.

Recognition of relationship building as vital to the therapeutic process was widespread. The importance of connection and relationship building was often raised by research participants, as well as the barriers they have dealt with along the way. The following are some of the many comments related to this theme:

> one of the most important roles [for a therapist] is earning the person's trust first of all, because if you haven't got their trust you're not going to be able to really help them move forward.
>
> just carefully and slowly build the relationship, and I think through relationship change happens.
>
> if we make a good connection I think there's just some bridges that are built that maybe lays things down for future interactions with them and with other people.

Time is a huge factor for achieving successful connection, given the depth of wounding that many Aboriginal clients have suffered. One woman described her experience with a girl who did not actually talk for 3 years:

> So we'd just colour, sit, play - and I knew there was something severely wrong, but I didn't know what it was. Now what's happening is the mandates have really tightened up and there's this view of therapy that it's got some sort of twelve session scenario which is totally unrealistic ... Well, it took three years to build that relationship and the current system would never tolerate that. They would say I was wasting my time and hers. But I wasn't, because at one point the fountain turned on and it was non-stop talking.

Another woman talked about the time involved in building trust and positive relationships with her clients in a Yukon First Nation community:

> I was there long enough to have time to build some of those relationships and with some people it took a really long time. Like I bet you I was there at least two years before I started to notice a change in the level of resistance. Yeah, it took that long and longer for some others. And even seven years later when I was leaving, there was one person who had been particularly resistant the whole time, and it was just at the very end before I was leaving that there was actually a change. It takes a long time.

Connecting and forming alliances through trust-building was viewed not only as a precondition for trauma work but, in some cases, as almost an end in itself. One woman talked about a client who had suffered so much trauma and tragedy,

had such severe mental health issues, that relationship building and attending to her safety was as far as they went in their work together.

> She was very childlike. She'd come in and she'd draw pictures and she'd talk about the most horrific things while she was drawing pictures of flowers and butterflies and little children and a mom playing in a house ... she, in a way, was a success really, in the sense of connecting. We got her into good housing and stuff like that.

Another research participant talked about a woman who, for a number of years, had accessed services at the transition house where she worked. She led a street and drug involved life from which, sadly, she was unable to extricate herself. Still, her connection with the staff and residents at the transition house clearly enhanced her quality of life.

> we provided this client with a place to be where she felt respected and cared for - and she maintained that relationship with [the transition house] for a good four to five years prior to her murder. And she would go in and out of living on the street to support her habit, but when she wasn't living on the street - and even when she was living on the street - there was a quality in the relationship that she had with the various staff people at [the transition house] that was really enjoyable, that was really respectful ... So it was a success story and yet her life would be considered a tragedy because she was murdered in the end. So I think ... that causes questions about how does one evaluate, because, quite bluntly, that would be a negative statistic in the end. The quality of the relationship she had with the staff people was really, really positive and that could never be dismissed.

There was a great deal of reflection on the ways in which relationship can be fostered, above and beyond the necessary time commitment. We have already looked at the value of acknowledging our whiteness, the differences that mark our respective life experiences, and the limits of our cultural knowledge. Doing so would appear to have a profound impact on the power dynamic within the counseling relationship. We are not the experts on our clients lives and healing. Research

participants talked about the importance of communicating this, both directly and implicitly through the way we work:

> I think there's this interesting balance ... in working with Aboriginal women where trauma's involved ... of being willing to be tentative and say "I don't know", sort of not needing to draw firm conclusions about something and to really own my own shit internally in an experience with somebody ...

This same woman talked about where she places herself in relationship with her clients, how important it is to "engage with people at a very human level", how "there's a distancing that's not therapeutic":

> So I try to be really conscious of that and think about who I'm being when I'm with someone and I'm not just this distant sort of clinical mind looking down on a situation. So I'm pretty big on that, like sort of being side by side with people and I usually conceptualize with people, like they're in the driver's seat and I'm in the passenger's seat of the car, and I might have some ideas about (where we go) but kinda like, we don't have to go down any roads you don't want to. I'm not here to tell you how to do this kind of thing.

Tending to the power dynamic by eschewing an authoritarian stance was a thread that ran through many participants' accounts of their efforts to build trust and relationship. Some further examples are:

> whenever I shift into a linear way of working, problem-solving, "I want to help you fix this", I find that not only invalidating but also not helpful. There's all kinds of resistance and other problems. It's what "what's his name" [Duran?] calls Euro-western.

> I think with any women with trauma I'm really attentive to the notion of control and permission ... asking when I'm working with people ... "I'm having a thought about this. Would that be all right if I shared that with you?".

**Thinking Outside the Box: The Importance of Finding Alternatives to TDWNA.**

Many of the research participants talked about their efforts to assist their Aboriginal clients through non-traditional and often creative alternatives to the more

standard one-on-one talk therapy. One woman spoke about her commitment to work collaboratively, outside the individual counseling model, whenever possible:

> there's not a lot of Aboriginal counselors but there's a lot of very good lay people who provide good support and we can work together and they can be the front line person with the individual.

She expands on this line of thinking and where it's led:

> What I've found, personally, the most rewarding, is when ... I do a lot of workshops, like healing workshops, and it's co-facilitating with an Aboriginal person. And we share and they'll talk about something and I'll put it in a western context and sort of look at, from a trauma perspective, how the brain works ... but whether you use energy medicine or whether you smudge, whether you pray, you have to find something that calms your amygdala. So I think working really collaboratively and presenting as equals going in, and sharing the teaching, is a way of opening those doors up.

Along similar lines, one of the participants talked about the importance of "thinking outside the box" and "making counseling and therapy a safe environment". This is accomplished through application of a variety of tools, including the visual and sensory-based, as opposed to more cognitive approaches such as CBT (cognitive behavourial therapy).

> Okay, my recent experience has been, because I've been working directly with a band, ... that a lot of people don't want counseling,... so I've done a variety of workshops that include art, so we've been doing collages or necklaces or bracelets. I've been doing visualizations that help people stay grounded and calm and can be very therapeutic.

She explained how she provided the necessary materials and encouragement for women to fashion "strength bracelets" which then carried special meaning for them in their efforts to better manage the difficulties in their lives. This same woman talked about keeping a collection of rocks in her office:

> so I often give someone a rock or have them pick a rock they can hold when they need to feel grounded. It's like having tactile tools, not just intellectual tools, physical things that can be done.

Likewise, use of art work, genograms, and guided imagery were all identified as not only valuable adjuncts to talk therapy, but often as effective therapeutic approaches in and of themselves, i.e., viable and valuable alternatives to counseling.

Many of these attempts to reach beyond typical western counseling approaches echo something of the holistic and culturally informed approaches of Aboriginal healers who tend to utilize ceremony, art, story-telling and ritual in their work to alleviate the suffering of those who seek their help. In her work Healing Wounded Hearts (2004) Fyre Jean Graveline epitomizes this understanding of healing work with Aboriginal people:

> Ceremony teaches.heals. us.
> Be. in Touch. with our Human Powers. our Senses.
> our Gifts to See. Hear. Smell. Taste. Touch.
> We Heal. With our entire Bodies.
> Not only with our Minds. Or Hearts.
> Ceremony. Meditation. Dreaming.
> Smudge. Circle. Feasting.
> Crystals. Feathers. Herbs.
> Drumming. Singing. Dancing.
> Art. Drama. Poetry. Story. (p. 221)

All participants, then, in varying degrees, recognized the value in approaches that lay outside the conventional realm of TDWNA counseling, and in particular, Aboriginal healing techniques. The importance of cultural elements where often referenced. This was true of one woman who talked about the need to create "containers for pain":

> ... and that may include some cultural elements such as smudging or offering tobacco, or for those who do it, going to the sweat, talking to the creator.

The need for Aboriginal clients to pursue some healing activities outside their scheduled sessions was not only acknowledged, but sometimes encouraged by my research participants.

> I think we need to keep in mind exposure to other Aboriginal techniques that I would encourage but don't have the knowledge. I'm thinking if there are any spiritual components that people should be pursuing, the whole notion of community which needs to get stronger. And I think those things need to be identified and encouraged while the woman is doing therapy - and they may become more valuable to the woman than actual therapy.

Encouraging attention to one's spiritual side as an important element in healing, is certainly a departure from a strictly TDWNA focus. This is in keeping with recognition of the value, especially when working with Aboriginal women, of following a more holistic approach. One woman reflected on her sense that her work with First Nation clients needed to be expanded beyond the counseling she'd been providing:

> I keep using the (western) therapeutic framework just because that's the one I'm familiar with, but I think there are other ways of doing healing, ... I'm thinking of, I don't know, canoe trips with a group of women. I'm thinking of a variety of exposures to healing situations which would allow people to re-frame how they view themselves in the world.

We have already noted a tendency on the part of research participants to place special emphasis on certain standard trauma treatment components which they view as especially important in their work with Aboriginal women, e.g., attention to the power dynamic in the therapeutic relationship, the importance of building trust and connection, and the need to take great care in the pacing of client exposure to

traumatic material. Another very prominent concern that, I believe, runs counter to the TDWNA approach, is the identified need for a strength-based orientation. Virtually all the participants stressed the added importance of this perspective when working with Aboriginal women clients. One woman reflected on how, in our trauma training and practice, we can "forget about the more positive elements of being a First Nation woman".

> Some of the women I work with get a lot of self esteem and pride from, say, doing hides or doing fish or being able to go out and shoot a moose. ... So, not forgetting those pieces is something that I'm trying to become a little more aware of, that I can get so trauma focused that I forget that actually in that trauma for some of these women are those amazing skills and sense of pride for who they are. ... And those are important things to remember, sort of coming from a strength-based place instead of just a trauma-bound place ... There's a need for looking at the strength in all that too, the resiliency, because of all the people I've worked with, I think the women up here - I don't know how they live sometimes - their resiliency, their strength...

The importance of identifying clients' strengths and building resiliency were commonly cited as elements in participants' overall approach in working with Aboriginal women:

> You know, sometimes people come in and they wonder what's wrong with them, and I say, "I don't wonder that, I wonder what happened and how that makes you feel". So it's not coming from the point of ... what's wrong with somebody, but trying to do my best to find the strengths in people and trying to build on that, you know, and helping them to sort of see their own strengths.

Another participant talked about her efforts to help Aboriginal clients to recognize the acts of strength and resistance inherent in their survival of so many spirit-crushing circumstances, for example living through the multiple abuses of residential school.

And while pursuing strength-based approaches is common in her work with most clients, she noted that:

> I just find that those approaches that focus on their strengths and resiliencies and resources is so important with an Aboriginal client.

One woman, recognizing the importance and power of story-telling in Aboriginal culture, would look there for examples of personal strengths and resiliency:

> Sometimes I'd ask about stories, whether ... their family stories or stories they heard growing up, and I might weave that back into what that brought to them, like where they found strength in that story or something like that, so it's not just straight behavioural therapy. It's a very different kind of thing.

It was heartening to find that all the participants worked in ways that demonstrated, to one degree or another, a marked departure from what Duran (2006) calls "Western trained therapists [who] are trained to think within a prescribed paradigm that targets pathology". (p. 19)

# Conclusion

## How Typical was my Research Group?

When considering the make-up of my interview group, it is fairly clear that some factors might distinguish my participants from other women in similar positions. One thing, however, is clearly evident: we are all northern women who have lived and worked in Yukon or northern BC for much, if not all, of our adult lives. That alone affords us a greater opportunity to interact socially and professionally with Aboriginal people, given the prominence of their numbers and cultural presence. For example, the largest First Nation in Yukon, Kwanlin Dunn, is centered within the municipality of the capital, Whitehorse, with settlement lands and traditional territory extending well beyond city limits. First Nation issues, activities, and politics are as prominent in the news as national and world affairs. Everyday we are reminded, in numerous ways, that we occupy traditional Aboriginal territory. We tend to be far more informed about residential schools and their impacts, given the prominent coverage of the issue by northern media. Many of us also have social connections with people who were directly affected, and we are witness, close up, to their protests, community healing initiatives, and celebrations. Unlike those who live further south, then, we experience far more exposure to the harmful impacts of colonization as well as the on-going efforts at recovery. It seems to be almost part of the air we breathe. Likewise, we also participate in numerous shared activities that afford us greater familiarity with local Aboriginal life and experience. I believe all of this accounts for a more developed sensitivity to the collective struggles of

Aboriginal people, which might not be the case for those practicing in other areas of Canada.

This leads me to conclude that the women who participated in my study could, indeed, be considered broadly representative of *northern* women practitioners who identify as non-aboriginal/dominant culture counselors, with at least one major proviso: they come from a predominantly social work background and also tend to see feminism as an important influence in their work. These two factors would help account for the structural orientation to client problems that appeared across the board, and for the shared recognition that trauma among Aboriginal people cannot be sufficiently dealt with utilizing a solely individualistic approach. Had these women been trained in counseling psychology, the findings here might have been somewhat different, though living and working in the North might still have provided corrective insight into the social/historical context for trauma among Aboriginal people.

Another factor that may have influenced the outcome of my study was the average age of my participants and their many years of experience. As indicated, they were of an older demographic with most in their 50s, one in her 60s and only one much younger woman in her early 30s. It is uncertain if a wider range of ages would have resulted in a noticeable difference in the discernible themes, but we need to remain open to that possibility.

**Reflections on the Primary Findings**

I was rather surprised by a striking consistency among the research participants, especially with regard to their reflections on the complexity of trauma work with Aboriginal women and the impacts of historical injustice. I am not sure if my expectations were really very well defined, but given the lengthy process of learning and reflection that I had engaged in over the years, I think I suffered from the illusion that my perspective would generally prove more informed, enlightened, and progressive than that of most of the women counselors I interviewed. In fact, I found that participants often exhibited an exceptional knowledge and sensitivity when it came to the impacts of colonization on Aboriginal people. And they had been grappling with the same sorts of questions I had been struggling with. They were very much aware of the limitations inherent in the standard TDWNA approach when working with Aboriginal women, and all seemed engaged in continual self examination when it came to the adequacy of their understanding of Aboriginal experience and their own limitations and biases as members of the dominant (perpetrator) culture. What were the best ways to counter those limitations and barriers, and what kinds of approaches proved most helpful? As we have seen, all the interviewees had been deeply engaged with these concerns and were often creative in their responses to the challenges they faced in their work. Though in varying degrees, we all recognized and were sensitive to the contradictions involved in our situation as dominant culture women undertaking to assist Aboriginal women

in their healing. And to some extent we all explored ideas and approaches that transcended typical western academic training.

In short, research participants were far more knowledgeable about the kinds of trauma Aboriginal people struggle with, and the sources of that trauma, than I had expected. Likewise, they were far more cognizant of the difficulties posed by their non-Aboriginal status, the limitations of "talk therapy", and the relative value of their counseling role, than I would have anticipated. All expressed uncertainty about the ways they might reshape their practice to better assist Aboriginal clients. And, most importantly, all had thought about, and most had explored, alternatives to standard trauma treatment. These included non-counseling approaches, recognition of traditional Aboriginal healing methods, and collaborative healing circles and workshops.

The following discussion stems from my central research question(s): *"Do non-aboriginal women counselors provide trauma treatment to Aboriginal trauma survivors which references the broader historical and inter-generational trauma of Aboriginal people in general?" And if so, "How is this aspect of treatment conceptualized and delivered, and what is its perceived value in facilitating recovery from trauma related difficulties?"*

*And: "How much (or how little) does the historical reality of oppression, as well as the struggle of Aboriginal people to survive current adverse social conditions and pervasive racism, help shape the ways in which trauma and addiction are treated by non-Aboriginal women counselors?*

As we have seen, participants were all aware of the harsh legacy of colonization on Aboriginal people, and though not everyone employed the term *historical trauma*, all recognized the importance of knowing and appreciating the social and historical context of their clients' trauma related symptoms. When it came to recognition of *current adverse social conditions and pervasive racism* as important traumagenic factors, the picture was less clear. Only two participants identified racism per se as a significant factor implicated in the overall trauma of Aboriginal women, though there were common references made to oppression, discrimination and social injustice. Reference to current social conditions, attributable to continuing colonialist policies, was more frequent. As noted, an appreciation of the complexity and multi-layered or multi-dimensional nature of trauma among Aboriginal people ran through all the interviews. While not everyone used this terminology, all made reference to inter-generational or cross-generational trauma. And, as previously discussed, all conceptualized trauma among their Aboriginal clients as far more complicated, and more attributable to factors that lay outside the direct control, or even personal experience, of the individual.

While it was clear that participants brought considerable thought and attention to this perceived challenge, there was relatively little detailed discussion of how this understanding of trauma was translated into practical approaches. When, how or even if the counselors would address connections between individual difficulties and the historical traumas with their clients was not always clear. I now find myself wondering if they had developed helpful techniques or could recommend effective

guidelines for introducing or eliciting such linkages and I wish I had asked for specifics. Certainly, the need to avoid pathologizing the individual would seem to require that this expanded trauma framework, and its potent political implications, be woven into the counseling sessions in some fashion at some point.

This being the case, recognition of the need for social and political remedies would seem the next logical step, but I found little to suggest that participants had given this the consideration I believe it deserves. It is true that most expressed a desire to operate in an anti-oppressive manner and to serve as allies to Aboriginal people in their attempts to overcome structures and systems of oppression and discrimination. No one, however, directly identified political struggle for autonomy and self-government as critical to the process of recovery from the collective trauma of displacement, cultural annihilation, occupation, and all the other dehumanizing impacts of colonization. This could well be due to my interview format and style, which failed to elicit deeper levels of participants' thinking on these matters. Likewise, though it seems clear that all the participants would see themselves as supporters of Aboriginal solutions to Aboriginal problems, there was no direct reference to the politics inherent in the role of a structural/feminist counselor, and its implication for commitment to transformational change. Are there particular forms of involvement with individuals, families and communities that could prove most helpful in our efforts to support such change?

**Suggestions For Future Research**

I believe this research could be usefully followed up by more broad-based exploration into best roles and practices for white counselors working with Aboriginal clients. I would like to see a next phase which employs focus groups, rather than interviews, in hopes of stimulating fruitful discussion of practical ideas and approaches for trauma work which transcends typical one-on-one counseling. How do we best incorporate our understanding of the social and political ramifications of historical and multi-dimensional trauma into our practice? We encountered some ideas along these lines but a fuller picture is needed. What techniques and tools have we developed and used to advantage in response to this search for a better way to assist Aboriginal people in recovery from trauma? How might we integrate them into the often restrictive expectations and conditions of hire that tend to limit our practice?

I think it would be especially meaningful to look at ways that academic training could incorporate the valuable insights and experience of effective and well respected counselors working with Aboriginal people. Certainly the theories of historical trauma (including all the various elaborations such as post colonial trauma response), could serve as valuable foundational information on which to build up a practical store of diverse, problem-solving approaches. Students and practitioners alike could draw on this body of experience and ideas while contributing to a growing archive of all the factors we need to take into account, and many of the techniques that have been tried and developed, so that we have the tools and information at our

disposal to better meet the needs of Aboriginal trauma survivors.

**Final Remarks**

Though it seems rather obvious, it may bear mentioning that the ideas presented by research participants are their own, and do not necessarily reflect the ideas or understanding of the clients with whom they work. As we have seen, it takes work and commitment to subject our dominant culture conditioning and training to an even modest degree of critical scrutiny, and we have a lot further to go in our understanding of what is truly helpful to our Aboriginal clients. In some critical areas, however, a case could be made for a fairly high degree of congruency between aspects of our practice and traditional Aboriginal approaches, for example the shared recognition of the critical importance of community and spirituality to First Nations people, something that clearly needs to inform our approach to trauma treatment.

The participants' age, experience, and commitment generally afforded them a long process of learning, primarily acquired through their working relationships with Aboriginal clients and through on-going reflection on the value of various approaches. None, of course, could claim to share the lived experiences of their clients, though they had set themselves the task of learning as much as possible about both their clients' lives and the various social and political forces that shaped their collective reality. In some ways they could be said to have one foot in the world of western academic theory and training, and one in the far less clear or easily definable world of Aboriginal struggle to manage the impacts of multiple traumas,

almost entirely attributable to a long history of survival under colonization. The women I interviewed are all well positioned to act as potentially valuable allies to Aboriginal people and, as we have previously observed, they face a kind of moral imperative to act as advocates and supporters of transformative change. May we all rise up to meet this challenge to the very best of our abilities.

We would do well to remind ourselves that our presence and active participation in protests and demonstrations, our support of community based initiatives and political action of all kinds, are critical as visible demonstrations of our commitment to Aboriginal rights and empowerment. This is one way we can actualize our recognition that the collective challenges of aboriginal people are not reducible to individual pathologies, but rather to the impacts of colonization that need to be remedied through social and political means.

## References

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.)Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd.ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Baskin, C. (2009). Evolution and revolution: Healing approaches with Aboriginal adults. In Sinclair, R., Hart, M.A., & Bruyere, G. (eds.) *Wicihitowin* (p.133-151). Winnipeg, Manitoba: Fernwood Publishing.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3, 77-101.

Brave Heart, M.Y.H. (1998). The American Indian Holocaust: Healing Historical Unresolved Grief. *American Indian and Alaska Native Mental Health Research/The Journal of the National Center,* 8(2), 60-82.

Brave Heart, M.Y.H. (1999). Oyate Ptayela: Rebuilding the Lakota nation through addressing historical trauma among Lakota parents. In Weaver, H.N. (Ed.), *Voices of First Nations people: Human services considerations* (pp. 109 -126). New York: Haworth Press.

Brave Heart, M.Y.H. (2000). Carrying the historical trauma of the Lakota. In *Studies in Social Welfare*, Tulane University, School of Social Work, 245 - 266.

Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment.* Thousand Oaks, California: Sage Publications.

Brown, L. (2004). Feminist paradigms of trauma treatment. *Psychotherapy: Theory, Research, Practice, Training.* 41(4), 464-471.

Brown, L. (2005). Not outside the range. In C. Caruth (Ed.), *Trauma: Explorations in Memory* (pp. 100-112). Baltimore: John Hopkins University Press.

Bryant-Davis, T. (2007). Healing requires recognition: the case for race-based traumatic stress. *The Counselling Psychologist*, 35(1), 135-143.

Bryant-Davis, T. & Ocampo, C. (2005) The trauma of racism. *The Counselling Psychologist,* 33 (4), 574-578.

Burstow, B. (1992). *Radical Feminist Therapy: Working in the Context of Violence.* Newbury Park: Sage Publications.

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. . *Violence Against Women,* 9 (11), 1293-1317.

CBC News (Nov. 29, 2011). *Attawapiskat First Nation's call for help prompts action.* http://www.cbc.ca/news/health/story/2011/11/29/attawapiskat-tuesday.html

Carter, R. (2007). Racism and psychological and emotional injury: recognizing and assessing race-based traumatic stress. *The Counselling Psychologist*, 35(1).

Chandler, M. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry*, 35, 191-219.

Cloitre, M., Cohen, L., & Koenen, K. (2006). *Treating survivors of childhood abuse: psychotherapy for the interrupted life.* New York, London: Guilford Press.

Comaz-Diaz, L. (2000). An ethnopolitical approach to working with people of color. *American Psychologist,* 55(11), 1317-1325.

Cvetkovich, A. (2003). *An Archive of Feelings: Trauma, sexuality, and Lesbian Public Cultures.* Durham & London: Duke University Press

Cvetkovich, A. (2012). *Depression: A Public Feeling.* Durham & London: Duke University Press.

Denzin, N. (2010). *The qualitative manifesto: A call to arms.* Walnut Creek, California: Left Coast Press, Inc.

Duran, E. (2009). *Healing the soul wound: counselling with American Indians and other Native peoples.* Teachers College Press: New York, New York.

Duran, E., Firehammer, J., & Gonzalez, J. (2008). Liberation psychology as the path toward healing cultural soul wounds. *Journal of Counseling & Development*, 86, 288-295.

Evans-Campbell, T. (2011). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*, 23(3), 316 - 338.

Fournier, S. & Crey, E. (2011). Killing the Indian in the child: Four centuries of church run schools. In M. Cannon & L. Sunseri, (Eds.), *Racism, colonialism, and Indigeneity in Canada* (pp. 173 - 177). Don Mills, Ontario: Oxford University Press.

Fogelman, E. (1988). Therapeutic alternatives for Holocaust survivors and the second generation. In R.L. Braham (Ed.), *the psychological perspectives of the Holocaust and of its aftermath* (pp. 79-108). New York: Columbia University Press.

Fogelman, E. (1991). Mourning without graves. In Medvene, A. (Ed.), *Storms and rainbows: The many faces of death* (pp. 25-43). Washington, D.C.: Lewis Press.

Gone, J. (2007). Identifying effective mental health interventions for American Indians and Alaska Natives: A review of the literature. *Cultural Diversity and Ethnic Minority Psychology*, 13(4), 356-363.

Gone, J. (2009). A community-based treatment program for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting and Clinical Psychology*, 77 (4), 751-762.

Graveline, F. J. (2004). *Healing wounded hearts.* Winnipeg, Manitoba: Fernwood Publishing.

Guba, E. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *ECTJ*, 29 (2), 75-91.

Hart, M. (2009). Anti-colonial Indigenous social work: Reflections on an Aboriginal approach. In Sinclair, Hart, & Bruyere (Eds.), *Wicihitowin* (pp. 26-28). Winnipeg, Manitoba: Fernwood Publishing.

Haskell, L. & Randall, M. (2009). A social context trauma framework and the lives of Aboriginal peoples in Canada. *Journal of Aboriginal Health*, 11, 48-99.

Health Canada. (2009). *A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999 to 2003.* Ottawa: Health Canada.

Herman, J. (1992). *Trauma and recovery.* New York: Basic Books.

Herman, J. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress,* 5(3), 377-391.

Kestenberg, J. (1990). A metapsychological assessment based on an analysis of a survivor's child. In M. Bergmann and M. Jucovy, (Eds.), *Generations of the Holocaust* (pp. 137-158). New York: Columbia University Press.

Kimayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, 11, s15-s22.

McCormick, R. (1997). Healing through interdependence: The role of connecting in First Nations healing practices. *Canadian Journal of Counselling,* 31(3), 172-184.

Mullaly, B. (1997). Structural social work theory. In Mullaly, B., *Structural social work: Ideology, theory, and practice.* Toronto, Ontario: Oxford University Press.

Niederland, W. (1968). Clinical observations on the "Survivor Syndrome": Symposium on psychic traumatization through social catastrophe. *International Journal of Psychoanalysis,* 49, 313-315.

Patton, M. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research,* 34 (5 Pt 2), 1189-1208.

Pearlman, L. (2001). Treatment of persons with complex PTSD and other trauma related disruptions of the self, In *Treating psychological trauma & PTSD.* Wilson, Friedman, & Lindy, (Eds.), New York, London: Guilford Press.

Roth, S., Newman, E., Pelcovitz, D., van der Kolk, B., & Mandel, F. (1997). Complex PTSD in victims exposed to sexual and physical abuse: results from the DSM-IV field trial for posttraumatic stress disorder. *Journal of Traumatic Stress*, 10(4), 539-555.

Sinclair, R. (2009). Bridging the past and the future: An introduction to Indigenous social work issues. In Sinclair, R., Hart, M., & Bruyere, G. (Eds.), *Wichitowin* (pp.19-23). Winnipeg, Manitoba: Fernwood Publishing.

Silver, J., Ghorayshi, P., Hay, J. & Klyne, D. (2011). Sharing, community and decolonization; Urban Aboriginal community development. In M. Cannon & L. Sunseri, (Eds.), *Racism, Colonialism, and Indigeneity in Canada* (pp. 213-228). Don Mills, Ontario: Oxford University Press.

Sivell-Ferri, C. & others (1997) The four circles of Hollow Water. *Aboriginal peoples collection.* (Report # APC-15-CA) retrieved from Supply & Services Canada web site http://www.publicsafety.gc.ca/res/cor/apc/apc-15-eng.aspx.

Smith, A. (2011) Sexual violence as a tool of genocide. In M. Cannon & L. Sunseri, Eds.), *Racism, Colonialism, and Indigeneity in Canada* (pp. 252-262). Don Mills, Ontario: Oxford University Press.

Smith, L. (1999). *Decolonizing methodologies: Research and Indigenous peoples.* London & New York: Zed Books Ltd.

Solkoff, N. (1981). Children of survivors of the Nazi Holocaust: A critical review of the literature. *American Journal of Orthopsychiatry,* 51(1), 29-42.

Speight, S. (2007). Internalized racism: One more piece of the puzzle. *The Counselling Psychologist*, 35(1), 126-134.

St. Denis, V. (2011). Rethinking culture theory in Aboriginal education. In M. Cannon L. Sunseri, (Eds.), *Racism, colonialism, and indigeneity in Canada* (pp. 177-187). Don Mills, Ontario: Oxford University Press.

Stevenson, Winona (2011). Colonialism and First Nations women in Canada. In M. Cannon & L. Sunseri, (Eds.), *Racism, colonialism, and indigeneity in Canada* (pp. 44-54). Don Mills, Ontario: Oxford University Press.

van den Hoonaard, D. (2012). *Qualitative research in action: A Canadian primer.* Don Mills, Ontario: Oxford University Press.

van der Kolk, B. (1996). The complexity of adaptation to trauma. From *Traumatic Stress: The effects of overwhelming experience on mind, body, and society* (pp.182-214). New York, London: Guilford Press.

Varas-Diaz, N. & Serrano-Garcia, I. (2003). The challenge of a positive self image in a colonial context: a psychology of liberation for the Puerto Rican Experience. *American Journal of Community Psychology*, 31(1-2), 103-115.

Wesley-Esquimaux, C. & Smolewski, M. (2004) *Historic trauma and Aboriginal healing.* Aboriginal Healing Foundation: Ottawa, Ontario
*Aboriginal healing.* Aboriginal Healing Foundation: Ottawa, Ontario

Willox, A. (2013, October 8). *CBU Research - Ashlee Cunsolo Willox* [Information Morning Cape Breton audio podcast]. Retrieved from http://www.cbc.ca/informationmorningcb/2013/10/08/cbu-research---ashlee-cunsolo-willox/

Appendix 1

***Definition of PTSD**

**Criterion A** - The person was exposed to a traumatic event in which both of the following were present:

1. the person experienced, witnessed, or was confronted with an event... that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

2. the person's response involved intense fear, helplessness, or horror

**Criterion B** - The traumatic event is persistently re-experienced in one of the following ways:

1. recurrent and intrusive distressing recollections of the event

2. recurrent distressing dreams of the event

3. acting or feeling as if the traumatic event were recurring (e.g. flashbacks)

4. intense psychological distress at exposure to internal or external cues that symbolize or resemble the traumatic event

5. physiological reactivity on exposure to internal or external cues that symbolize or resemble the traumatic event.

**Criterion C** - Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness...as indicated by three or more of the following:

1. efforts to avoid thoughts, feelings or conversations associated with the trauma

2. efforts to avoid activities, places or people that arouse recollections of the trauma

3. inability to recall important aspects of the trauma

4. markedly diminished interest or participation in significant activities

5. feelings of detachment or estrangement of others

6. restricted range of affect

7. sense of foreshortened future

**Criterion D** - Persistent symptoms of increased arousal...as indicated by two (or more) of the following:

1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hyper-vigilance
5. exaggerated startle response

**Criterion E** - Symptoms in Criteria B, C, and D persist for at least one month

**Criterion F** - Symptoms have significantly altered one's ability to function socially, vocationally, or in other important areas of life

*Adapted from the DSM-IV-TR (American Psychiatric Association, 2000)

Appendix 2

## Information Letter

**Aboriginal trauma & non-aboriginal counselors: What is the prognosis for healing?**

I am a non-aboriginal graduate student and former trauma counselor, undertaking an investigation into the kinds of counseling approaches used by non-aboriginal women counselors/therapists/caregivers in their work with Aboriginal women struggling with trauma and addictions. I am sending you information about this intended study in hopes you may consider becoming a participant.

The purpose of this research is to learn more about the ways in which non-aboriginal counselors approach issues of trauma and addiction among their Aboriginal clients, and their understanding of how best to assist clients along their journey of healing and recovery. While people of all ethno-cultural backgrounds may seek help for addictions and trauma in their lives, it is nonetheless important that we understand which approaches might prove the most relevant and beneficial for different ethno-cultural groups. Your willingness to participate in an interview (approximately one hour) would help increase the current level of knowledge around what works best for Aboriginal women, and specifically those in treatment with non-Aboriginal counselor/care givers.

Interviews will be open-ended, allowing for a deeper and richer kind of information to be collected, informed by participants' personal learning, insights and experience. These interviews can be as long or short as participants wish. They will be recorded, transcribed, and made available for participants to review for accuracy prior to being analyzed for whatever themes may emerge. At any point in time, participants may decide to withdraw from the interview or the study, and any information already collected will be safely disposed of in accordance with participants' wishes.

No names, nor identifying information, will be attached to any of the interview material used in this study. The raw data and recordings collected from interviewees will be destroyed upon completion of this research project. A summary of the completed study will be made available to each participant who may wish to receive a copy.

This study will be fully compliant with the guidelines of the UNBC Ethics Board to which all research by university students and faculty is accountable. Any complaints about the project should be directed to the Office of Research (reb@unbc.ca) or 250 960-6735.

It's hoped that you will join us in this research study and lend your valuable perspective to the work at hand. I'll be contacting you for your thoughts or any questions you may have concerning the purpose, value or methodology of this investigatory project. I look forward to speaking with you soon.

Jan Forde, BSW (phone # was provided)

Appendix 3

## Interview Guide

How do you conceptualize the impacts of trauma among your First Nation clients?

How would you compare your trauma work with Aboriginal and non-Aboriginal women?

In your estimation, what aspects of your work have proved most helpful/least helpful to Aboriginal women?

Are there particular successes or failures you'd care to talk about?

What do you think might be the potential strengths and limitations in your role as a non-Aboriginal woman offering trauma treatment to Aboriginal women?

What would you see as the ideal role for non-Aboriginal counselors when it comes to Aboriginal women's healing?

Based on your experience, are there particular things you feel we need to keep in mind when offering trauma treatment to Aboriginal women?

What kinds of special knowledge or training, if any, should non-Aboriginal counselors have when working with Aboriginal women trauma survivors?

Are there any other thoughts you'd like to share regarding these themes and concerns?

Appendix 4

**Consent Form**

Having read the information provided by Jan Forde, MSW student at UNBC, concerning her thesis research, and having had the opportunity to meet with her to discuss the purpose of this project, the potential benefits, as well as what my participation would entail, I hereby agree to be interviewed for the purposes explained to me.

I understand that my participation is voluntary and that I may decide to withdraw from this research study at any time, in which case any data collected as a result of my interview will be returned to me and/or safely disposed of in accordance with my wishes.

I further understand that all efforts will be made to ensure confidentiality of the interview material, and that no identifying information will be included in the final report or thesis that results from this work. I further understand that I will have the opportunity to review the final draft to ensure both accuracy and an adequate level of confidentiality.

I have been informed about the ethical obligations of this researcher and my right to register a complaint with the Office of Research should any concerns arise.

Name _____ Date _____
print

_____
signature

Researcher _____ Date_____
print

_____
signature