INDIGENOUS CHILD AND YOUTH MENTAL HEALTH: AN EXPLORATION OF INDIGENOUS CLINICIANS' EXPERIENCES OF CULTURALLY ADAPTING INTERVENTIONS

by

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Abstract

This thesis addresses a significant gap in the literature by exploring the professional experiences of Indigenous clinicians delivering mental health interventions to Indigenous children and youth. The study focuses on the clinicians' experiences of culturally adapting mental health interventions and seeks to understand the support they receive in achieving the delivery of these interventions. Six practicing, self-identified Indigenous child and youth mental health clinicians participated in the study. The Indigenous child and youth mental health clinicians shared their experiences through in-depth conversations, which were analyzed while employing a qualitative, exploratory approach within the framework of *The Dene Laws*. Data analysis revealed three central themes: 'Utilizing Culturally Adapted Mental Health Interventions,' 'Supportive Factors for Culturally Adapting Mental Health Interventions,' and 'Examining Barriers and Identifying Areas for Improvement.' The findings provide valuable insights into the clinicians' use of collaborative, intuitive, and client-centred approaches. The study further highlighted the necessity for systemic support to overcome challenges and improve the delivery of culturally adapted mental health care for Indigenous children and youth.

Keywords: clinicians, culturally adapted mental health intervention, Elders, Indigenous knowledge, Indigenous mental health, mental health, exploratory analysis, *The Dene Laws*

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máhsi ts'enidhê senóhtsî dii ndee, ndéh, k'ehk'ah gonezû, kõ, mek'eh ts'ê húle tu, ahsíi yágúndíh gogha.
(Thank you, Creator, I am grateful for the earth, land, fresh air, fire, clean water, and animals)

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~ehtl'ǫǫ dahtú~

Preface

"I didn't believe in the church. […] but I felt like I had a soul, and it felt like there was a God, and then I learned more about Creator, and I attached myself to that, and I pray when I smudge, […], and when we have sweats, I pray for all the people that I know […]. So, I feel that's where I learned my spirituality, and I share that."

-Participant Two

Chapter 1: Introduction

With this thesis research, I explored the professional experiences of Indigenous clinicians delivering mental health interventions to Indigenous children and youth; the focus was on discovering how they implement culturally adapted methods in therapeutic practice. I also aimed to understand how clinicians are being supported in their practice to achieve the delivery of culturally adapted interventions.

In Canada, the colonial process forced systems and policies that sought to suppress Indigenous identities and ways of life. Devastating measures included residential schools, the forced removal of children from their families, and the suppression of Indigenous languages and cultural practices. These actions further led to the widespread disruption of traditional knowledge systems, the fragmentation of families, and the enduring impact of intergenerational trauma (Nelson & Wilson, 2017). The colonialist legacy continues to affect Indigenous people, directly impacting their children's well-being. Indigenous children and youth (First Nations, Inuit, and Métis) are at greater risk than their non-Indigenous counterparts of mental health instability from exposure to various forms of trauma and violence (Drawson et al., 2016). When addressing the mental health inequities experienced by Indigenous children and youth, the focus must be placed on the historical and current disparities they face and on culturally appropriate means to remedy these disproportions (Greenwood & de Leeuw, 2012). The revitalization of culture and language promotes resiliency and a strong sense of identity; hence, clinicians who adapt relevant interventions focused on cultural and traditional healing practices, moving beyond the biomedical domains, are likely to lessen mental health disparities resulting from colonialism (Drawson et al., 2016; Greenwood & de Leeuw, 2012).

As an Indigenous researcher, I am responsible for continually maintaining a relational approach, which Wilson (2001) describes in these words:

> Indigenous people need to do Indigenous Research because we have the lifelong learning and relationship that goes into it. You are not just gaining information from people; you are sharing your information. You are analyzing and you are building ideas and relationships as well. Research is not just something that's out there: it's something that you're building for yourself and for your community. (p. 179)

As a fellow Indigenous clinician supporting Indigenous children and youth, my goal in co-constructing knowledge was to amplify the voices of the Indigenous clinician participants. This exploration highlights the significant work they do to address the mental health needs of Indigenous children and youth.

In this opening chapter, I provide the definitions and key concepts while presenting my primary research question and supporting sub-question. This is followed by a statement of my positionality and an overview of my educational and professional background that helped shape the direction and inquiry behind my research. Chapter Two reviews literature pertinent to the study and addresses historical implications, current determinants, and inequities related to Indigenous child and youth mental health. It further examines mental health ideologies, the experiences of mental health clinicians, and their use of culturally adapted interventions and supportive factors. The limitations of current research are also reviewed. Chapter Three outlines the research design and procedures, including the theoretical framework, methodology, and approach. Chapter Four presents the research findings under three main themes: Utilizing Culturally Adapted Mental Health Interventions, Supportive Factors for Culturally Adapting Interventions, and Examining Barriers and Identifying Areas for Improvement. Finally, Chapter

Five includes the final discussion, the implications of the findings, limitations of the research, recommendations for future research, and the conclusion.

1.1 Definition of Key Words and Concepts

a) Clinician: Within mental health services, the titles counsellor, practitioner, therapist, and clinician are often used interchangeably for these professionals (Moss et al., 2024). For the purpose of this paper, the term clinician will be used in reference to the related titles *counsellor, practitioner, and therapist.*

b) Culturally Adapted Mental Health Intervention: Wendt et al. (2022) divide these into structural and deep structural adaptations:

> Structural adaptations consist(ed) primarily of incorporating cultural practices, such as smudging, talking circles, and participation of Elders. Deep structural adaptations (pertain) to shifts in the "underlying values" of interventions. These (include) defining well-being in more holistic, strengths-based, and harmonious terms (e.g., the Medicine Wheel); incorporating cultural beliefs, traditions, spiritual values, and ceremonies; promoting cultural identity and Indigenous languages; and strengthening clients' connections with extended family members and community mentors. These adaptations generally (align) with the ceremonies, practices, and teachings of local communities. (p. 5)

c) Cultural Safety: Culturally safe client care begins with a safe environment in which to discuss presenting concerns, free of judgment from clinicians. The clinician should be aware that not all Indigenous clients will participate in cultural healing and may have differing beliefs, histories, and backgrounds. The safety element should then be placed on the strength building of the Indigenous client, following their comfort and direction (Maaagr et al., 2006).

d) Elders & Knowledge Keepers: Elders possess unique, distinct oral knowledge, encompassing perceptions, wisdom, advances, and practical skills connected with Indigenous communities that they pass along to individuals who, in time, may also be regarded as Knowledge Keepers (Agrawal, 1995).

e) Indigenous Knowledges: Kovach (2021) states, "The term *Indigenous knowledges* acknowledges the shared commonalities and the diversity of the many Indigenous ways of knowing" (p. 19).

f) Indigenous People: Indigenous people in Canada comprise three distinct groups: First Nations, Métis, and Inuit—the three Indigenous groups are recognized by Section 35(2) in The Constitution Act 1982 (Statistics Canada, 2022). On April 1, 2021, the term 'Aboriginal' was updated and replaced by the term 'Indigenous' (Government of Canada, 2021). In this thesis, I will use the term "Indigenous", though specific citations may include the terms "Indian," First Nations," or "Aboriginal" as originally used in the sources.

g) Indigenous World Views: For Indigenous peoples, these are "inclusive of spirit, blood memory, respect, interconnectedness, feelings, experiences, and guidance" (Baskin, 2016, p. 90).

h) Indigenous Mental Health: The term mental health is utilized in a broad sense among First Nations and Inuit communities (Government of Canada, 1991):

> It is the presence of a holistic, psychological wellness which is part of the full circle of mind, body, emotions and spirit, with respect for tradition, culture and language. This gives rise to creativity, imagination and growth, and enhances the capacity of the community, family group or individual identities to interact harmoniously and respond to illness and adversity in healing ways. (p. 6)

i) Indigenous Research: The SSHRC (2020) explains, "Whatever the methodologies or perspectives that apply in a given context, researchers who conduct Indigenous research, whether they are Indigenous or non-Indigenous themselves, commit to respectful relationships with all Indigenous peoples and communities" (para. 29). Kovach (2021) states, "If we think of research

as discovering new knowledge, Indigenous research, then, is about discovering new understandings as these relate to Indigenous people" (p.41).

j) *Mental Health:* Mental health refers to a condition of well-being where a person recognizes their abilities, manages everyday stresses, works efficiently and productively, and contributes positively to their community (World Health Organization, 2004). Throughout my study, I will use the term "mental health" explicitly to avoid any confusion with "mental illness."

k) Mental Illness: Mental illness refers to health conditions that affect a person's emotions, thinking, or behaviour (or a mix). These conditions are linked to distress and difficulties in functioning in social, work, or family settings. (Stewart et al., 2016). Throughout my study, I will use the term "mental illness" explicitly to avoid any confusion with "mental health."

1.2 Research Question

This study used a qualitative exploratory approach to explore the following question: *What are the experiences of Indigenous child and youth mental health clinicians in delivering culturally adapted mental health interventions for Indigenous children and youth?* One sub-question further enabled exploration of the topic: *What supportive factors contribute to the delivery of these interventions, and how can these supports be improved?* Enhancing our understanding of the development and delivery of culturally adapted interventions can influence the ability of Indigenous clinicians to generate well-informed practices when implementing culturally adapted interventions. In addition, understanding their needs for support to deliver these interventions could help organizations and policymakers improve the availability and quality of these valuable supports.

1.3 Researcher Positioning Statement

In congruence with my beliefs as an Indigenous researcher, positioning myself concerning the research is a significant element (Absolon, 2016; Kovach, 2021; Samms Hurley

& Jackson, 2020; Wilson, 2008). In the article *Mist No'kmaq: An Exploration of Positionality and Identity in Indigenous Research*, Samms Hurley and Jackson (2020) question the idea that researchers can be categorized as insiders or outsiders when working in Indigenous communities. They point out that this approach oversimplifies the complex relationships and identities researchers bring to their work. Instead, they suggest a reflective approach, encouraging researchers to consider how their personal, cultural, and social backgrounds shape their research. Upon reflection, researchers can move beyond these labels and build meaningful and respectful connections with Indigenous communities.

The theoretical orientation I have chosen for this research is *The Dene Laws*, which I will outline in Chapter 3; it emphasizes principles such as sharing, respect, and helping one another, aligning closely with the reflective approach to positionality discussed by Samms Hurley and Jackson (2020). These laws will remind me to honour the interconnectedness of all relationships and to approach this work with humility and reciprocity. As a researcher guided by *The Dene Laws*, I seek to listen deeply, share knowledge generously, and maintain respect for the community's history, wisdom and culture. These laws align with the Dene and honour and acknowledge Indigenous ways of knowledge and understanding, which connect our communities (Samms Hurley & Jackson, 2020).

Representing experience in Indigenous research requires understanding how a researcher's identity and intentions intersect with the process; reflecting on lived experience and integrating Indigenous ways of knowing enriches relationships and enhances the value of the research to Indigenous communities (Samms Hurley & Jackson, 2020). Margaret Kovach (2020) emphasizes this connection, stating,

> With Indigenous research writing, a prologue structures space for introductions. It is a precursory signal to the careful reader that weaved throughout the varied forms of our writing, analytical, reflective, there will be a story, our story, for story is who we are while clearly identifying research purpose and motivations. (p. 2)

As an Indigenous person, it is essential for me to interweave my personal connection to the topic, ensuring my work is both reflective of and grounded in the values and stories that shape my perspective.

My English name is Melissa Dexel, and my Dene yatié name, given to me by my beloved uncle Jeffery, is ehtl'ǫǫ dahtú, which means *Morning Dew*. I am South Slave Dene from Kátł'odeeche First Nation, Northwest Territories (NT), located on the southern shores of the vast Great Slave Lake. My husband, Andrew Dexel, is Nlaka'pamux from the Nooaitch Reserve in British Columbia (BC), where we currently reside. We have three beautiful children: a son, Anaru, who is 11, and two daughters, Naili, 10, and Sedea, 7. I identify as Dene, a heterosexual female, a mother, a wife, a sister, a daughter, an auntie, a friend, a survivor, a student, a mental health clinician, and a registered social worker.

As is unfortunately common among Indigenous people such as my family, we have endured the devastating impacts of intergenerational trauma inflicted by the religious-led institutions that stole our children, torturing our lives and spirits over the generations. This spiritual assault resulted in many years of immersing myself in substance addiction that almost took my life countless times. As an Indigenous female in Canadian society, I have experienced the immense intrusion of systemic gendered violence and oppression due to the stigmatization continually placed upon us. By the grace of the *Great Spirit* and my *Ancestors*, I am still here and have dedicated my life to my family, spirituality, sobriety, community, and education.

Both my mother and father were raised in the Hay River Dene Reserve, now called Kátł'odeeche First Nation, NT. My late father, Ernie, was from a large Métis family of 10 siblings called the Camsells, a name known well throughout the North. My great-grandfather, Sam Carter, was the guide of the infamous *Lost Patrol (1910)*, where a group of Mounties perished in the unforgiving North after they became lost. My grandmother, Polly Camsell, was born after her father Sam passed away; she was half Scottish and half Inuvialuit. Her Inuvialuit mother was from Hershal Island, Nunavut (NV) and died when she was four; then, she was placed in the loving care of her grandmother. A few years later, she and her older brother Sam were taken by missionaries and sent to St. Peter's mission school (a residential school) in the Hay River Dene Reserve, where she later met my grandfather, Harry Camsell, and married him at 23. I do not recall hearing much of my grandmother's time in residential school. Knowing my grandmother, she would not share the horrors she witnessed or possibly endured herself. The love she held for her family was immense; she was a community pillar, a devout Anglican, and I still dream about the glorious food she lovingly prepared for us all. She remains a true blessing in my life; she is loved and dearly missed by many.

My mother Sharon's biological mother, Marie Michel, was South Slavey Dene from Providence, NT, and passed away when my mother was one year old. My mother was left alone in the home with her mother's body for an unknown period until they were discovered. No one was ever charged with her death, although foul play was suspected. Her loss of life remains a historical case of a *Missing and Murdered Indigenous Woman,* a loss still heartfully felt by my mother. Following her mother's passing, my mother was scooped into the child welfare system during the infamous Sixties Scoop, a period from the 1960s to the 1980s when the Canadian Government took more than 20,000 Indigenous children from their families and communities

and placed them in adoptive care, foster care, and receiving homes (Sinclair, 2007). A nurse then contacted a community member, Mary Norn, asking her if she would foster my mother and another baby (my adoptive uncle Jeffery) for a short time, and she agreed. The family fell in love with them. Then, social services intervened and removed my mother from Mary's home, alleging that no father figure was present. My adoptive grandmother, Mary (I have never referred to her as my adoptive grandmother, although for clarity, I will use the term *adoptive* in this thesis), was a formidable force. She had many non-Indigenous allies through her hospital employment and involvement with the Pentecostal church. She went to court armed with the support of a doctor and a pastor, arguing that her brother Henry, who lived with her, would be the male figure in my mother's life. My granny Mary won my mother's adoption rights and saved her from being placed with a non-Indigenous family away from her homelands. For this, I am forever grateful.

My adoptive granny, Mary, was South Slavey Dene from Kátł‘odeeche First Nation, NT, and unlike my grandmother Polly, she spent a short time in a residential school. Although I have a blend of many Indigenous and European bloodlines, I identify as Dene because she truly influenced my life. She had a generous nature, and her personality was sweet, humorous, and feisty. She was fluent in her language, crafted beautiful traditional clothing, and harvested and ate traditional foods. I spent much of my childhood snuggled up safely in her bed, feeling loved within her home. Although she was traditional in many ways, she did not practice Dene spirituality. The church's presence was overpowering in the North, and my grandmother, like many, became dedicated to organized Western religion. Her prayerful ways and faith were instilled in my being. Today, my grandmother's prayers continue to guide me, máhsı cho ehtsų, neghǫhníetǫ (thank you very much, grandma, I love you).

My grandmothers had a tremendous impact on my life; they taught me the importance of love, family, and resilience. As loving and nurturing as they were, they could not protect their children from the effects of the intergenerational trauma surrounding them. My parents endured immense trauma throughout their childhoods, and I, in turn, was also impacted. My history includes struggles with identity, substance abuse, depression, suicidality, poverty, and domestic abuse. Although my past is riddled with misfortunes, I have persevered, living a life of sobriety. To show my gratitude, I aim to support Indigenous children and youth from a stable, well-informed, and healthy position. In my healing journey, connecting to culture and embracing ceremony ultimately saved my life, so I am well aware of the healing possibilities and positive outcomes that can come from these. I am also aware that although my history is much like many Indigenous people's, our spirits were impacted differently, and healing will be unique to each individual.

When contemplating how my locations, values, and beliefs may influence the research, there are many aspects to consider. As Berger (2013) exemplifies, "The degree of a researcher's personal familiarity with the experience of participants potentially impacts all phases of the research process, including recruitment of participants, collecting data via interviews and/or observations, analyzing and making meaning of the data, and drawing conclusions" (p. 229). With these instances in mind and given my close association with the research topic, I needed to be rigorous and avoid conducting this research through a lens of past traumas but rather through a lens of curiosity. Later in this document, I will describe how I stayed reflective in this area.

A deeply personal lens guided my study due to the reality that my family's experiences with colonization and intergenerational trauma heavily impacted my mental health during my

youth. This reality will be underscored later in this document when I discuss the literature on the historical implications of colonization on Indigenous children's mental health.

1.4 Researcher Background

As mentioned in my positioning section, I am a registered social worker and employed as a mental health clinician supporting Indigenous children and youth. My educational background includes a Bachelor of Social Work (BSW) degree, and I am currently a candidate for a Master of Social Work (MSW) degree. I began my educational journey later in life, as I had only begun my sobriety road when I was 31. It took me five and a half years to obtain my BSW, and I had three children during that time. It was a heavy load, and I feel proud of my accomplishment. During my BSW degree, my specialization was child welfare. Initially, I was uncertain of my direction for my fourth-year practicum and had limited placement options within child welfare. However, an organization unexpectedly offered me a position in their mental health department. Although it was not an area I had previously considered, I felt a strong pull toward the opportunity and decided to accept.

I was offered a child and youth mental health position soon after my placement ended. I accepted and commenced my counselling role. I was extremely fortunate to have several clinicians (two Indigenous and one non-Indigenous) with extensive experience mentor me, guiding me through the unknown waters of Western mental health interventions and the ethics of counselling. I had little previous education in mental health and, at times, felt I was underqualified. Still, with their support and guidance, I slowly transitioned from previous group work in my practicum to seeing clients one-on-one. During my mentorship, I also took training, including sandplay therapy, which gave me a starting point for individual practice with children

and youth. Filled with self-doubt, I travelled to one of the surrounding First Nation communities to see my first clients, beginning my clinical journey.

As a novice clinician, I soon realized the circumstances of the children and youth that led to their need for support. Many had little or no connection to their culture, which left me uncertain for some time as I worked to understand how to incorporate cultural elements into therapy organically. I was unsettled regarding the Western approaches to mental health, witnessing how my clients needed much more. During that time, I was enrolled in a certificate program, Indigenous Focusing Orientated Therapy, and learned one intervention that included using traditional medicines and another that involved including grandfather rocks. I then made travel kits to utilize with my clients. The response was beautiful. I knew I had to keep going in this direction if I wanted to offer the support these children and youth truly deserved, and I sensed that they unknowingly longed for.

In my practice, I discuss the history of colonization with my clients and offer land-based healing practices such as collecting medicines, praying to the water, and sitting with the trees to connect them with nature. We drum, we sing, and we utilize medicines. Although I am of different Indigenous ancestry than the children and youth I support, my husband and his mother (an Elder and mental health clinician) are from the same Nation and offer me the support and guidance to integrate their culture into my practice respectfully. I am passionate about the topic I am exploring because I am on a continuum of learning how to implement culturally appropriate mental health therapies with clients due to having observed the benefits and positive outcomes within my practice.

Chapter 2: Literature Review

This section will give an overview of the literature related to Indigenous children and youth mental health, including historical implications, the social determinants of health, and existing inequities. I will further review ideologies of mental health, the roles and experiences of Indigenous mental health clinicians, and their implementation of culturally adapted mental health interventions. Finally, supportive factors will be discussed.

2.1 Indigenous Child and Youth Mental Health

Indigenous peoples comprise three diverse groups in Canada, including First Nations, Inuit, and Métis peoples (Statistics Canada, 2022). The Indigenous population remains the largest younger demographic in Canada: Indigenous people were 8.4% younger than the total Canadian non-Indigenous population in 2016 (Statistics Canada, 2022). Suicide rates among Indigenous youth are higher than the national average, with suicide occurring six times more often for Indigenous youth than their non-Indigenous counterparts (Roy et al., 2015). In addition, Indigenous youth experience poorer mental health outcomes than the non-Indigenous population, including anxiety and depression (Graham et al., 2021).

Many scholars attach poor mental health among the Indigenous populace to intergenerational trauma prompted by the colonial process, government involvement through policies and practices, social determinants of health, discrimination, and gaps in mental health services (Baskin, 2016; Isobel et al., 2021; Kirmayer et al., 2000; 2003; Menzies, 2008, 2010). Researchers contend that mental health interventions approached from a collective, culturally responsive, and historical perspective are imperative in supporting this client group (Baskin, 2016; Brady, 2015; Carriere & Richardson, 2013; Gone, 2013; Graham et al., 2021; Kirmayer et

al., 2003; Muir & Bohr, 2019; Roy et al., 2015). Therefore, investigating effective culturally adapted mental health interventions for Indigenous children and youth is crucial.

2.1.1 Colonization's Impacts on Indigenous Mental Health

Colonialism began with European settlers encroaching on the Indigenous people of Canada, aiming to rule their inhabited lands through genocidal and assimilatory tactics. Baskin (2016) explains, "The Indian Act of 1876 was the vehicle by which the goal of assimilating Indigenous Peoples was to be implemented, and it governed every facet of Indigenous life" (p. 9). Settlers aimed to weaken the identities and self-sufficiency of Indigenous people by forcing reliance on government programs and resources. Subsequently, the Federal Government's conduit of religious-led educational institutes established the most horrendous assimilation tactic, sending thousands of Indigenous children to residential schools between 1840 and 1996 (Menzies, 2008). The abuse endured in the government-funded schools operated by religious organizations significantly contributed to the intergenerational trauma still affecting the Indigenous population today (Boksa et al., 2015; Kirmayer et al., 2000, 2003; McCormick, 1995; Menzies, 2008, 2010; Nelson & Wilson, 2017).

The residential school system severely disrupted Indigenous identities by forcibly imposing Euro-Canadian culture on Indigenous children and stripping them of their traditional ways of life (Boska et al., 2015). Within these institutions, children were subject to physical, emotional, and sexual abuse, depriving them of nurturing environments necessary for healthy development and security (Truth and Reconciliation Commission of Canada, 2015). According to Graham et al. (2021), the schools were structured to dismantle Indigenous cultural ties by suppressing language, spiritual practices, and traditional practices. This forced disconnection

resulted in deep generational trauma, leaving survivors and their families to contend with the ongoing challenge of reclaiming their cultural heritage and identity.

In the 1960s, the ‘Sixties Scoop’ furthered the assimilation agenda through the child welfare system, where thousands of Indigenous children were removed from their communities and placed with non-Indigenous foster and adoptive families (Sinclair, 2007). Carriere and Richardson (2017) note that these placements in non-Indigenous homes isolated Indigenous children from their roots, language, and family structures, resulting in feelings of cultural disconnection and identity struggles. The wounds inflicted in these schools and the displacement from family continue to haunt Indigenous communities, contributing to the survivors' extreme loss as well as psychiatric disorders (Kirmayer et al., 2000). McQuaid et al. (2022) explain that these policy impacts are evident today in Indigenous communities, which experience elevated rates of poverty, mental health issues, and intergenerational trauma.

Currently, in Canada, Indigenous children are 17 times more likely than non-Indigenous children to be separated from their families and placed in the child welfare system (CWS). This high rate of separation is linked to systemic discrimination in public services and the enduring effects of the Indian Residential system, which has triggered a multi-generational cycle of family breakdown (McQuaid et al., 2022).

2.1.2 Intergenerational Trauma and Indigenous Mental Health

Studies confirm that intergenerational trauma is a consequence of exposure to frequent traumatizing events initiated by colonization as well as being a causal factor of poor mental health throughout Indigenous communities (Boksa et al., 2015; Kirmayer et al., 2000, 2003; McCormick, 2009; Menzies, 2008, 2010; Nelson & Wilson, 2017). Phillips (1999) explains the cycle of intergenerational trauma:

> If we do not deal with our trauma, we inadvertently hand it down to the next generation. We often take out our pain and hurt on those we love the most – which is ourselves and those closest to us – our family and friends. So, intergenerational trauma is trauma that is passed down behaviourally to the next generation: if we're angry and act angry all the time to others, our kids will think that's normal and do the same. If we ignore each other and deprive each other of love and affection in our relationships, our kids see and feel that deprivation of love and might think it's normal. (p. 6)

The impact on Indigenous children and youth is the unfortunate transmission of their families' difficult past experiences (Brady, 2015).

The impacts of residential schools in Canada have been well documented in reports such as the multi-volume Truth and Reconciliation Reports of Canada (2015) as a significant source of intergenerational trauma, contributing to adverse psychological effects on Indigenous communities and perpetually passing through generations of those who did not physically attend the schools (Boksa et al., 2015; Kirmayer et al., 2003). The Office of the Independent Special Interlocutor for Missing Children and Unmarked Graves and Burial Sites has recently highlighted the devastating legacy of residential schools in Canada through an intensive two-year engagement reported in the document titled "*Upholding Sacred Obligations: Reparations for Missing and Disappeared Indigenous Children and Unmarked Burials in Canada*" (Murray, 2024). This work seeks justice for affected families and highlights the resilience of Survivors while exposing systemic neglect, abuse, and loss of life tied to these institutions while reinforcing the urgent need for accountability, reconciliation and healing (Murray, 2024).

Researchers assert that it is vital to know these historical circumstances to offer informed care when supporting Indigenous children and youth with their mental health needs (Carriere &

Richardson, 2013; Kirmayer et al., 2003). This responsibility of helping professionals is aptly defined by Menzies (2008):

> As professionals, if we do not consider these mental illness and social issues data within the context of historical injustices then we will continue to collect and present the data in a vacuum, and perpetuating the myth that Aboriginal peoples are more susceptible to mental illness and other social issues then the general Canadian population. (p. 42)

Our duty as professionals is to maintain awareness and discourage the continual stigmatization that Indigenous people are at fault for mental health circumstances related to historical injustices.

2.1.3 Social Determinants of Health and Inequities Affecting Indigenous Mental Health

Not only has colonialism impacted the health and well-being of Indigenous people, socioeconomic conditions that contribute to poor mental health must also be considered. The *Integrated Life Course and Social Determinants Model of Aboriginal Health* conceptualized social determinants of health (SDH) into three categories: *proximal, intermediate*, and *distal* (Kolahdooz et al., 2015). Kolahdooz et al. (2015) further describe,

> *Proximal* SDH 'have a direct impact on physical, emotional, mental, or spiritual health' of Indigenous Canadians (e.g. employment and income, education, physical housing environments, individuals' health behaviors, and food security) and may be more easily targeted by policy changes compared to intermediate (e.g. resources, infrastructure, and opportunities) or distal (e.g. healthcare systems, educational systems, natural environment, cultural continuity, colonialism, and racial discrimination) SDH. (p. 2)

Studies suggest that oppression and disconnection from culture are associated with significant occurrences of depression, substance abuse, trauma, suicide, and violence impacting Indigenous youth (Stewart & Marshall, 2016). Additional restrictions are the limited resources

focused on the specific needs of Indigenous children and youth and the ability to employ mental health professionals in isolated Indigenous communities. Due to insufficient government funding allocated to education, especially on reserve, Indigenous children are disadvantaged and are often unprepared to enter postsecondary institutes (Ansloos et al., 2019). To conceptualize the mental health needs of Indigenous children and youth, clinicians must understand the current barriers and inequities while focusing on healing through culturally adapted interventions.

2.1.4 Ideologies of Indigenous and Western Mental Health

Numerous scholars maintain that Indigenous understanding of mental health and Western perspectives differ fundamentally (Brady, 2015; Carriere & Richardson, 2013; Kirmayer et al., 2003). Indigenous worldviews correlate mental health as encompassing all aspects of one's being, including the mental, emotional, physical, and spiritual elements (Carriere & Richardson, 2013); when one facet suffers, imbalance ensues, affecting a person in a variety of ways (Roy et al., 2015). Connection to the land, family, Elders, culture, language, and community is essential to Indigenous people's emotional well-being and healing (Kirmayer et al., 2003). Traditional Western approaches to mental illness often focus on the medical model and fail to include Indigenous history, community, culture, and beliefs, permitting repressive and unsuitable interventions that do not meet the distinct needs of Indigenous children and youth (Brady, 2015; Roy et al., 2015).

Although a plethora of literature separates Indigenous and Western views, Nelson and Wilson (2017) caution, "While differences in ways of knowing are important sources of misunderstanding in health and health care, overemphasizing such binary distinctions can collapse both Indigenous and Western worldviews into homogenous generalizations of what are in fact remarkably diverse perspectives" (p.100). Employing this understanding may contribute

to a collective, decolonized approach to mental health that moves away from the division of views and advances with respectful curiosity. When offered, culturally safe, respectful, and trauma-informed land-based interventions, medicine wheel teachings, drumming, singing, spirituality, traditional arts, and family participation allow for connection and unified healing (Carriere & Richardson, 2013). A firm sense of identity is held when one's roles, responsibilities, language, and culture are present and acknowledged, contributing to an overall positive sense of self (Wexler, 2009).

2.2 Culturally Adapted Interventions

Studies convey that mental health professionals who skillfully integrate Indigenous and Western helping modalities are essential. As stated in the definitions section, Wendt et al. (2022) describe culturally adapted mental health interventions by separating them into structural and deep structural adaptations:

> Structural adaptations consist(ed) primarily of incorporating cultural practices, such as smudging, talking circles, and participation of Elders. Deep structural adaptations (pertain) to shifts in the "underlying values" of interventions. These (include) defining well-being in more holistic, strengths-based, and harmonious terms (e.g., the Medicine Wheel); incorporating cultural beliefs, traditions, spiritual values, and ceremonies; promoting cultural identity and Indigenous languages; and strengthening clients' connections with extended family members and community mentors. These adaptations generally (align) with the ceremonies, practices, and teachings of local communities. (p. 5)

Studies relating to Indigenous clinicians' implementation of culturally adapted interventions are lacking. However, one study titled *Navigating Two Worlds: Experiences of*

Counsellors Who Integrate Aboriginal Traditional Healing Practices (Oulanova & Moodley, 2010) addressed the topic. The authors focused on the intersection of Western and Indigenous healing modalities and the barriers to integration and offered their recommendations. The Indigenous participants, who were clinicians, stated that their ancestors, Indigenous identity, personal and collaborative advocation, personal healing, and traditional healing practices encouraged them along their professional paths. Although their formal training was attained within postsecondary institutions, an understanding of traditional healing was passed orally from Elders, family, and community living. Participants relayed that they provide a cultural assessment before implementing traditional practices, ask about their clients' experiences, and follow their clients' needs. Cultural implementation included "smudging, using an Eagle feather, drumming, and taking the client out of office" (Oulanova & Moodley, 2010, p. 351). Holistic approaches included Medicine Wheel teachings, which consider the physical, mental, spiritual, and emotional elements and the inclusion of family and community. Participants noted that the history of the community must be acknowledged, and the integration of psychoeducation on the traumatic history of Indigenous people in Canada was stated as an essential provision (Oulanova & Moodley, 2010).

Moreover, research asserts that using Indigenous and Western healing modalities with Indigenous peoples is imperative and has been proven successful (Oulanova & Moodley, 2010, 2016). In addition, McCormick (2009) contends that Western interventions should support Indigenous practices in order to avoid further oppression. The prioritization of Western approaches over Indigenous methods risks the perpetuation of colonial dynamics, further silencing Indigenous voices and reinforcing cycles of inequity. Interventions such as play therapy, which encapsulates an abundance of methods, can be helpful when applied by

competent clinicians (Brady, 2015). Incorporating traditional art, music, and dance promotes healing, connection, and confidence while lessening stress during the creative process (Brady, 2015). Play therapy also promotes family inclusivity, an essential aspect of Indigenous healing.

Several Western healing modalities have been shown to work well with Indigenous peoples. Indigenous people's history includes the oral transmission of stories and Elders' knowledge to teach their communities' young (Stewart, 2008). Western narrative therapy allows clients to understand their circumstances by relaying their stories to their therapist; therefore, a narrative approach is considered a culturally appropriate therapy as the stories shared are utilized to gain information, creating a circular understanding of the client's experiences (Stewart, 2008). Poonwassie and Charter (2001) relate that sharing circles have also been considered valuable tools to promote healing, the transmission of values, and equality. Group sharing in a supportive environment fosters trust while leaving clients feeling witnessed and understood. Although not all Indigenous people participate in ceremony, having access is imperative. As Poonwassie and Charter (2001) relay, "Attendance and participation in traditional ceremonies provide opportunities to practice some of the most sacred values such as sharing, caring and honesty…" (p. 68). For children and youth, this participation can include making offerings, interacting with nature, and harvesting traditional food and medicines; Elder mentorship supports spiritual connection (Graham et al., 2021).

Research also affirms that cognitive behavioural therapy (CBT) is a suitable low-risk intervention to treat anxiety experienced by Indigenous children and youth (Nowrouzi et al., 2015). One commonality between CBT and Indigenous methods is the relation to health's physical, emotional, and mental aspects. With proper training, supervision, and agency

collaboration, Indigenous clinicians have relayed that CBT is a promising intervention when culturally adapted to meet the needs of Indigenous children and youth (Nowrouzi et al., 2015).

2.3 Indigenous Child and Youth Mental Health Clinicians

In Canada, Indigenous child and youth mental health clinicians may have training in disciplines such as counselling, social work, psychology, human service, and child and youth care (Stewart, 2008). The significant concerns commonly addressed in therapy are self-harm, suicidal ideation, negative behaviours, and mood difficulties (Government of British Columbia, 2022). Studies regarding the experiences of Indigenous child and youth mental health clinicians are limited. However, there is generalized literature on Indigenous counsellors.

One study titled *Promoting Indigenous Mental Health: Cultural Perspectives on Healing from Native Counsellors in Canada* focuses on mental health and comprises two elements: mental health as a healing process and mental health as wellness (Stewart, 2008). The counsellors in this study brought up topics relating to community, cultural identity, holistic approaches, and interdependence. They noted that community-balanced healing specific to colonization was imperative, as they witnessed that healing proved successful as a collective journey. The participants relayed the importance of holding a firm cultural identity to support their healing journeys as they transitioned to their roles as helpers. As Stewart (2008) relays, "Thus cultural identity gives Native peoples the strength and wherewithal to consider healing possibilities through personal self-growth, connections with family, community, and Indigenous cultures" (p. 52). A significant point made in this study was that Indigenous approaches to healing are not deemed as an alternate measure but rather a "legitimate and unquestioned part of service to the broader community of peoples seeking mental health services..." (Stewart, 2008, p.

53). Ceremony, prayer, connection to Elders, and nature were also discussed as being significant to mental wellness.

Furthermore, Indigenous clinicians must understand that due to colonial history, there is a continuation of distrust toward service providers, including them, and the provision of client safety and rapport building is imperative (Baskin, 2016). Although Indigenous clinicians may have a deeper understanding of their client's experiences than non-Indigenous clinicians, staying mindful of the feelings evoked during disclosure is necessary to avoid vicarious transmission (Morrisette, 2003). Personal history must also be considered. As Baskin (2016) describes: "There is another layer to trauma that helpers may face-their own. It is not uncommon for those of us who have suffered past trauma to enter into a helping profession" (p. 41). There needs to be a shift from the stigmatization that helpers are ironclad toward viewing them as individuals who are likely to be enduring growth and healing (Santamaría-Dávila et al., 2019). Ryan-Schmidt (2020) further describes, "Indigenous helpers must feel safe in their organizations in order to safely work alongside trauma in their practices" (p. 16). There is a necessity for understanding within organizational settings, for open dialogue regarding the potential to be triggered in practice, and for an acknowledgement of what those triggers might be. Employees must voice boundaries regarding responsibilities and workload; having self-awareness of limitations is also essential in maintaining balance (Santamaría-Dávila et al., 2019).

Sinclair (2020) describes Indigenous students in helping professions as having attained knowledge prior to their educational journeys through personal post-colonial experiences of intergenerational trauma, suicide, substance abuse, lateral violence, depression, and sexual abuse. Research further suggests that a helper's personal voyage may enable a deepened understanding of traditional healing to support their clients (Oulanova & Moodley, 2010). As Baskin (2016)

states, "The expectation that helpers have not experienced trauma themselves and are somehow experts on the impacts of these experiences does not fit" (p. 41). However, Morrissette (2003) advises that Indigenous students should not assume their experiences alone will make them proficient counsellors. Therefore, a combination of educational attainment and individual healing is imperative to implement informed services safely and effectively.

2.3.1 Indigenous Clinician's Collaborative Supports

Throughout the literature, a theme regarding the need for support is also apparent. When incorporating traditional practice, the collaborations between Elders, Knowledge Keepers, the community, other helping professions, and Western mental health workers are seen as being imperative (Brady, 2015; Kirmayer et al., 2016; Nowrouzi et al., 2015; Oulanova & Moodley, 2010). Having the freedom and support of the employee's organization to follow cultural intuition and implement client-centred techniques has also been deemed essential (Oulanova & Moodley, 2010). As Stewart (2016) states, "Working collaboratively with individuals, families, organizations, communities, and nations allows both counsellors and clients to share their healing resources to address the erstwhile unmet needs of both the people and profession" (p. 86). It is also vital for youth to participate in developing and implementing interventions and programs suitable to their specific needs (Kirmayer et al., 2016).

The literature provides further recommendations regarding supportive factors. The need for Indigenous-specific counselling education not primarily rooted in Western theory was seen as fundamental to offering Indigenous clinicians the knowledge required to support their Indigenous clients adequately (McCormick, 2009). As Oulanova and Moodley (2016) convey, without traditional teachings and an understanding of Indigenous culture, researchers advise

mental health clinicians who employ Western intervention predominantly should not implement Indigenous practices, as it may cause more harm than support.

Through the lens of Indigenous worldviews, failure to incorporate Elders' knowledge is deemed disrespectful. With this in mind, I will end this section with the literature on Elders' perspectives on the topic. In an extensive study conducted with 19 traditional Indigenous Elders (Mehl-Madrona, 2009), they discussed their conceptions of collaboration regarding Indigenous approaches to mental health. They emphasized the importance of family and community participation throughout the healing process. They further shared that connection to spirituality is significant and that they often consulted the Creator and their Ancestors through ceremonies and dreams. These Knowledge Keepers also suggested that creating a safe alliance with clients was imperative in supporting their discovery of solutions and acknowledging their ability to heal themselves, just as "Nature heals herself and that we are a part of Nature" (Mehl-Madrona, 2009, p. 24). The Elders further mentioned that they must trust the mental health clinicians they are collaborating with; clinicians should have integrity and honest intentions from the heart. The following quote encapsulates their views of the importance of collectivity: "The Elders said that community contains the wisdom the individual lacks. Collective minds offer more wisdom than individual minds. This is why, some Elders said, ceremony is done with more than one person. Everyone's prayers and intents matter" (Mehl-Madrona, 2009, p. 26).

2.4 Summary of Literature

The limited research on the diverse experiences of Indigenous children and youth regarding their mental health highlights the urgent need for more inclusive and relevant studies in this area. Throughout the literature, many scholars attest to the success of Indigenous healing modalities and urge for a collaborative approach to focus on the unmet needs of the client group.

Finally, our Elders voiced the importance of spirituality, Indigenous identity, ceremonial embracement, community connection, and the innate ability to heal oneself (Graham et al., 2021).

Chapter 3: Research Design

This chapter outlines the research approach and theoretical framework that guided this study. I employed a qualitative, exploratory approach grounded in a Dene theoretical framework, which I will discuss first. Next, I will provide an overview of qualitative research, explain the research's exploratory analysis, and discuss methodological integrity.

3.1 Theoretical Framework

Initially, I struggled to understand the concept of a theoretical framework and how to incorporate it into my research. When I reviewed various Western methods, I realized that none resonated with my perspective or the lens I wanted to use for my study. I then turned to the books *Research is Ceremony* (Wilson, 2008) and *Indigenous Methodologies* (Kovach, 2021) to find a theoretical framework created by an Indigenous researcher. However, I quickly realized that their ideas were unique to them and could not be seamlessly integrated into my research.

I began reflecting on my values and Dene culture and thought of *The Dene Laws* as a potential guide for my research. At first, I was unsure if it would work, so I discussed my idea with my thesis supervisor. Her validation brought immense relief and a sense of honour to incorporate my people's values into my study. Smith (2012) accurately articulates the rationale for utilizing *The Dene Laws* as my framework:

> Indigenous theoretical frameworks in qualitative research emphasize the importance of community, the interconnectedness of all life, and the need for research to serve the interests of Indigenous peoples. These frameworks challenge Western notions of objectivity and highlight the significance of knowledge being rooted in relationships and context. (p. 123)

3.1.1 The Dene Laws

My Dene theoretical orientation will be grounded in *The Dene Laws.* The nine Dene Laws were created by Yamǫ́rıa, known throughout the Denendeh (The land of the people) as a great traveller and lawmaker (Andrews, 2011.). In my Dene yatié language, Yamǫ́rıa translates as *The One Who Travels*. The laws withhold teachings guiding the people of the Dene Nation based on our community, family, and cultural values (Blondin, 1997). I conducted my research while respecting the following Dene Laws:

1. *Share what you have*
2. *Help each other*
3. *Love each other as much as possible*
4. *Be respectful of Elders and everything around you*
5. *Pass on the teachings*
6. *Be happy at all times*
7. *Sleep at night and work during the day*
8. *Be polite and don't argue with anyone*
9. *Young girls and boys should behave respectfully* (Blondin, 1997).

The Dene Laws include respect, integrity, compassion, and reciprocity, all essential elements in maintaining harmony with my worldviews and values as a Dene woman while supporting the achievement of a balanced Dene approach. These principles shaped how the data was collected, interpreted, and presented, focusing on maintaining strong ethical relationships with the participants and the land. Furthermore, this framework acknowledges the importance of storytelling and oral traditions as vital means of knowledge transmission, and these were integral to the data collection and analysis process.

Examples of how *The Dene Laws* impacted my research include the following:

- Sharing my research with the Indigenous community to maintain the foundational reciprocity of my Dene approach by sending an email copy of my summary of findings and offering to provide a presentation to the communities and teams (Laws 1, 2, 5, 9).
- Expressing gratitude and positivity to the participants for their support through respectful communication and offering a gift for their involvement in the research (Laws 3, 6, 8).
- Involve an advising Elder and respectfully engage with them by honouring their time and schedules. I also expressed my appreciation for their shared knowledge by offering a gift upon completing the study (Law 4).
- Lastly, sustaining a balanced educational and personal life by setting a reasonable schedule for my research to allow time for my family and self-care (Law 7). I also committed to refer to *The Dene Laws* if any biases or ethical issues arose to ensure consistency and honesty throughout my research.

3.2 Qualitative Research

Kovach (2021) describes qualitative inquiry as "...an approach to research that tells a story through words not numbers. It is story interpreted from experience with an aim of offering further insight into human experience *from* human experience" (p. 24). The storytelling approach of a qualitative design and the implicit nature of understanding the human experience while hearing the voices of participants who may not otherwise be heard fits well with a relational and ethical study by an Indigenous researcher (Kovach, 2021). Reid-Searl and Happell (2012) state, "Qualitative exploratory research provides a framework for the participants to contribute their knowledge, expertise and opinions to contribute to the development of new knowledge in this field" (p. 2000). It is essential to speak directly to the clinicians to acquire an in-depth account of

their successful practices and supportive factors. In the words of Cresswell and Poth (2018), "This detail can only be established by talking directly with people, going to their homes or places of work, and allowing them to tell the stories unencumbered by what we expect to find or what we have read in the literature" (p. 45).

Within qualitative studies, the researcher's reflexivity informs how the information will be interpreted and how the investigation is meaningful to them (Creswell & Poth, 2018). It was necessary for me to weave my experience throughout the inquiry, maintaining an awareness of any biases I may hold, which is also referred to as bracketing in qualitative research (Creswell & Poth, 2018). To proceed with intention and in a good way (McCormick, 2008), I had to be honest, accountable, and open to learning throughout the entirety of my research. Kovach's (2021) account of research situatedness relays, "Our life story shapes our research interpretations. Past is prologue. Memory is preface. We know what we know from where we stand. We need to be honest about that" (p. 9).

Lastly, in alignment with my Dene worldviews, the qualitative, exploratory approach's interpersonal attributes allowed for a collective reflection of participant and researcher, offering respectful reciprocity. For example, after completing the initial thematic analysis, I contacted the participants and received feedback on whether or not themes arising from all the interviews resonated with them. This process, known as member reflections and also referred to as member checking, facilitates discussion with the participants and provides opportunities for questions, feedback, critique, and collaboration (Tracy, 2010). From an Indigenous research perspective, member reflections are more of a relational practice focusing on reciprocity, trust, and shared accountability between researcher and participant (Kovach, 2021). Smith (2012) relays that engaging participants in data review respects their lived experiences and affirms their roles as

custodians of their knowledge. Having the participants involved in the interpretation stages of the study was essential in capturing, respecting, and understanding their intentions. I had to ensure that my interpretations were relevant to the participants' views and my Dene worldviews. To accomplish this goal, I referred to *The Dene Laws* and had participants reflect and provide feedback on my initial thematic analyses.

3.3 Exploratory Analysis Approach

The English language defines *exploration* as investigating, studying, examining, or analyzing something (Stebbins, 2001). When applied to a thesis, an exploratory study's goal is "to research a topic informally so that the general design for a dissertation will be more likely to result in important findings" (Elman et al., 2020, p. 40). Exploratory research also focuses on the researcher's ability to gain a truthful impression of the group under study where scientific knowledge is scarce concerning their activities, processes, or situations (Stebbins, 2001). Still, the investigator believes there are essential elements to be discovered. In upholding answerability to the exploratory approach, my Dene worldviews helped guide my decision-making and ethical responsibilities during all phases of my study by encouraging accountability and respect. My Dene worldviews hold teachings rooted in sharing knowledge and relationships, which is vital when conducting Indigenous research and remaining truthful in relaying the participant's experiences as in exploratory analysis.

As described by Stebbins (2001), the key elements of exploratory research involve ongoing data collection and analysis to refine understanding, focusing on the problem’s context, including cultural and environmental factors. It uses inductive reasoning to generate hypotheses rather than test existing theories, providing a basis for research. The research design adapts based

on the initial findings, adjusting methods and focus areas as needed. These key elements were instrumental in shaping the research and interview design.

The previous literature review supports the idea that further exploration is required regarding Indigenous child and youth mental health clinicians' implementation of culturally adapted interventions. Two significant components of an exploratory study are flexibility and open-mindedness while engaging with the intimate personal insight of participants (Stebbins, 2001). As previously stated, and in keeping with an exploratory method, my goal in this research was to respectfully and collectively investigate the themes that arose with the participants and advising Elder.

3.3.1 Methodological Integrity

Kovach (2021) states, "Trustworthiness is about the legitimacy, dependability, and reliability of research findings" (p. 215). To sustain methodological integrity (trustworthiness) throughout my study, I have chosen to utilize Tracy's (2010) Eight "Big-Tent" Criteria for excellent qualitative research marked by a worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence. The universal qualities and adaptability to a researcher's preferred methods, skill level, and goals of the study drew me toward the criteria as I planned to employ a fusion of Indigenous and Western approaches. Examples of how I related each criterion to maintain methodological integrity throughout my investigation are as follows:

Worthy topic. The mental health needs of Indigenous children and youth encompassing colonial history, culture, and societal impacts is undoubtedly a valuable topic to explore. The literature on Indigenous clinicians' implementation of culturally adapted mental health interventions has proven to be insufficient, prompting further investigations.

Rich rigour. The participant recruitment for the study elicited rich rigour, as the sample criterion focused on the investigation's intent: recruiting Indigenous clinicians in direct practice with Indigenous children and youth and implementing culturally adapted interventions. The small sample size offered a purposeful richness to the study. As Tracy (2010) describes, "Researchers should evidence their due diligence, exercising appropriate time, effort, care, and thoroughness" (p. 841), which the small study sample allowed.

Sincerity. To maintain sincerity, I planned to meet with my supervisor if unsure how to proceed or if any ethical dilemmas arose. I also kept a self-reflexive journal to track any instances of bias or assumption post-interviews and throughout my research as needed. Meeting with my advising Elder was crucial in maintaining sincerity throughout the study. The Elder offered the knowledge and guidance to correct or confirm if I was relaying cultural information accurately. As an Indigenous researcher, it was important for me to focus on realizing my role in my research's relational aspects and obligations by retaining responsibility for all of my relations (Wilson, 2001).

Credibility. Offering thick descriptions is essential to attain credibility in qualitative research (Tracy, 2010). The semi-structured interview questions and conversational approach with the small sample were designed to encourage detailed responses, allowing participants to explore each topic in depth. Member reflections further ensured credibility, allowing for feedback, questions, and affirmation (Tracy, 2010). A vital facet of my Dene worldview is the element of reciprocity and collaboration, allowing "for more nuanced analyses with deeper meaning to members at hand" (Tracy, 2010, p. 844).

Resonance. This term refers to a researcher's ability to meaningfully resonate with and affect an audience (Tracy, 2010). Transferability is an element that leads to a study's resonance

and is reached when an investigator's experience intersects with the research subject (Tracy, 2010). As expressed throughout my introduction section, my experience directly relates to the study's purpose. I am an Indigenous child and youth mental health clinician who culturally adapts mental health interventions. This significant relationship allowed my story to weave through the study meaningfully, generating evocative storytelling and giving the reader a vivid experience of emotion (Tracy, 2010).

Significant Contribution. By extending the call for action and further investigations by researchers, policymakers, the Indigenous community, and the mental health field, I hope the research will significantly contribute to the unmet culturally inclusive mental health needs of Indigenous children and youth.

Ethics. To ensure procedural ethics, under the section titled Ethical Consideration, I provide an in-depth description of how I followed ethical responsibilities in my research with human participants and my moral duties as a registered social worker and social work student. The participants were advised on informed consent, confidentiality rights, and the right to withdraw. At the same time, continual self-reflection, abiding by *The Dene Laws*, and meeting with my supervisor and advising Elder helped me to maintain further ethical integrity.

Meaningful Coherence. Meaningful, coherent exploration fluently "intersects the researcher's research design, data collection, and analysis with their theoretical framework and situational goals" (Tracy, 2010, p. 848). To maintain meaningful coherence, I had to ensure all elements were connected and implicitly led to the study's goals. I also engaged in member reflections, "a practice that does not aim toward accuracy of a single truth, but rather provides space for additional data, reflection, and complexity" (Tracy, 2010, p. 848) - a suitable method for an explorative study and relating to Indigenous relational worldviews.

3.4 Research Procedures

This section describes the procedures involved in the research process. It provides an overview of participant eligibility along with the participant and advising Elder recruitment processes, the development of the conversation guide (Appendix A), transcription procedures, and member reflections. The chapter also addresses data analysis, data management, ethical considerations, and the dissemination of findings, including the provision of gifts to participants and advising Elder. Finally, it introduces the participants and advising Elder who took part in the study.

3.5 Eligible Participants: Indigenous Child and Youth Mental Health Clinicians

The criterion for participation was that they must be practicing child and youth mental health clinicians of Indigenous ancestry (First Nations, Métis, or Inuit); they must implement traditional Indigenous culture into their practice with Indigenous children and youth (aged 4-18), consistent with Wendt et al.'s (2022) definition of culturally adapted interventions; and they must have related education in counselling, social work, psychology, human services, or child and youth care (diploma, Bachelor's, or Master's degree). I attempted to recruit clinicians with varying years of practice experience to create depth and diversity in my sample.

3.5.1 Participant Recruitment

The initial study sample sought to involve four to seven participants. A mixed method of purposeful, relational, and snowball sampling strategies was employed. Purposeful sampling is "the primary sampling strategy used in qualitative research. It means the inquirer selects individuals and sites for study because they purposefully inform an understanding of the research problem and central phenomenon in the study" (Creswell & Poth, 2018, p. 326). I contacted specific agencies that employ Indigenous child and youth mental health clinicians for this

recruitment method, resulting in the recruitment of two participants. Relational recruitment is centred on the researcher's connections and mutuality (Kovach, 2021); in my instance, I utilized this method through my employment associations, reaching out specifically to known colleagues. One participant was recruited through relational sampling. Lastly, snowball sampling is often used to "locate information-rich key informants" (Shaheen et al., 2019, p. 34). To use snowball sampling, I asked the prospective participants to pass along the recruitment poster to anyone who fits the study criteria, hence creating a snowball effect. The snowball sampling recruited three participants for the study. The outcome was successful, with each method enlisting at least one participant.

The recruitment process began in August 2023 and focused on various agencies in the interior of BC, including several delegated agencies: Secwépemc Child and Family Services, Okanogan Nation Alliance, and Lii Michif Otipemisiwak Family and Community Services. I also contacted a few Friendship Centres and asked the BC Association of Social Workers to include my e-poster on their website. I spoke directly to several executive directors and team leads at the various agencies and organizations, explaining the research objectives and participant criteria in detail and providing them with my e-poster. I also proposed to attend agency team meetings to discuss my research study and recruitment and answer any questions they may have, although this offer was not accepted. Instead, the executives or team leads provided their team members who fit the criterion with the e-poster and offered me their contact information. The potential participants emailed me to discuss their future involvement in the study. Before each interview began, the participants received an Information Letter/ Consent form outlining confidentiality, the purpose of the study, risks, benefits of research, and the right to withdraw (Creswell & Poth, 2018).

The participant recruitment process flowed well. Despite my initial nervousness, I trusted that those meant to join this journey would do so in a good way, which is what transpired. Despite their demanding schedules, the clinicians kindly shared their time, support and knowledge. I was honoured to have six participants take part in my study.

3.5.2 Advising Elder Recruitment

I approached a well-respected Elder with whom I have a pre-existing relationship and requested her support as my advising Elder for my study (Kovach, 2021). I am aware of the ethical protocols in asking Elders for their support (as I have previously done so); offering a gift of tobacco is considered acceptable and respectful. She accepted the tobacco and agreed to take part in my study. I discussed my proposed research and her potential roles in the process, including providing me with cultural support, evaluating my research questions, participating in individual meetings to guide themes, and approving my final thesis draft. I further asked if she agreed or would like less responsibility or additional contributions; she agreed to take on the roles as outlined above. I also inquired where (by phone call or in person) she would like to meet and how often she would like to meet. Before the study commenced, the Elder received a Confidentiality Agreement to review and sign. My intention of including an Elder was to conduct ethical, valid research with Indigenous people, which was vital to the study because our Elders are the keepers of knowledge (Wilson, 2008). My research would not have felt respectful without her guidance and support.

3.6 Conversation Guide

I conducted interviews using a semi-structured conversation guide (Stebbins, 2001). I used 13 open-ended questions to elicit conversation, and participants were given the space to discuss what they felt was necessary regarding the research questions. Maintaining a respectful

Dene approach, I intended the interviews to be conversational and less rigorous than in a traditional interview setting. Kovach (2021) expresses my intention accurately when she writes: "Research conversations are more elastic and give research participants an opportunity to share their story on a specific topic without the periodic disruptions involved in adhering to a structured interview format" (p. 165).

The small sample size aimed to produce extensive in-depth details from the participants (Cresswell & Poth, 2018). I hoped to gain sufficient views and perspectives by engaging with clinicians to contribute to and inform the study's purpose. The conversations took from 40 minutes to 1 hour to complete. One interview took place in a natural and comfortable setting, which the participant selected, offering privacy for confidentiality reasons (Creswell & Poth, 2018). The other five interviews took place over password-protected Zoom video calls. The interviews were conducted from September 2023 and ended in November 2023, with each interview providing a wealth of information.

3.6.1 Transcription and Member Reflections

The discussions were securely recorded (with consent), enabling me to provide full attention to observe, engage with, and listen to participants' responses. I used the Zoom recording feature to record and download the transcript, providing a rough draft. I then listened to each participant's interview and corrected mistakes on the corresponding transcript.

In valuing good relational research, research participants should be provided opportunities to approve how their conversations will be transcribed and relayed (Kovach, 2021). The participants were given opportunities to take part in the analysis process through member reflections. This process included emailing participants the first copy of their transcript and the

prospective themes from the interviews. Three participants accepted the offer to review their transcripts and themes, with all offering approval.

3.7 Data Analysis

The meaning-making (data analysis) of the data entailed a thematic interpretation from an exploratory lens to locate themes and the composition of theory, the primary goal of exploration (Stebbins, 2001). Thematic analysis is the investigative method I chose to examine my data due to its overarching flexibility and specific steps to guide me as a novice researcher (Braun & Clarke, 2013). As Braun and Clarke (2006) describe, “Thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail” (p. 79). This method helped me explore the experiences of the Indigenous clinicians in my study, which added to the significant absence within the literature. As Braun and Clarke (2006) explain, “Thematic analysis can help in generating new insights and hypotheses that can be further explored in subsequent research, making it valuable for exploratory studies that aim to understand new or under-researched phenomena” (p. 84).

The thematic analysis process includes several stages: becoming acquainted with the data, creating initial codes, identifying themes, reviewing and refining these themes, defining and naming the themes, and ultimately compiling the final report (Braun & Clark, 2013). Following the steps, I read through each transcript and began inductively coding by highlighting and labelling insightful sentences and paragraphs related to the research question and sub-question. Inductive coding, described by Swain (2018), “involves generating codes from the data itself through a close iterative process of data examination, allowing for the themes to emerge organically” (p. 55). The initial themes that arose from the data were extensive and seemed too obvious, with five main themes and five to six subthemes developing. This outcome felt overwhelming and unfocused. As I engaged more deeply, I built a relationship with the shared

words (Wilson, 2008), reviewing them several times, narrowing them down, and combining the subthemes, and cohesion began to transpire naturally.

As I began compiling the data under the prospective themes, I struggled to limit the participants' quotes because I wanted to avoid losing the true meaning behind what they shared. Wilson (2008) accurately depicts my concern: “Separated from the rest of their relationships, the ideas may lose their life or become objectified and therefore less real” (p. 123). To avoid this, thick descriptions throughout all the transcripts were essential for preserving the depth and authenticity of the participants’ stories. As Ponterotto (2006) relays, “Thick description goes beyond mere surface-level reporting of events to include the context, emotions, and meanings that the participants attach to their experiences, thus enabling a deeper understanding of the phenomena being studied” (p. 543).

As an Indigenous researcher, I had to maintain truth and trust (Kovach, 2021) throughout my analysis, constantly reflecting on how my research would serve the community, connecting with my advising Elder and respecting *The Dene Laws*. Navigating both Western and Indigenous methods throughout my study was challenging. I often found myself wavering between these sometimes conflicting approaches, uncertain of which to follow. I then came across this passage by Kovach (2021),

> For Indigenous methodologists, there are a couple of pools, and double the number of ripples, because we research at the intersection of Indigenous and Western research thought. Clarifying the role of Indigenous theory in research analysis and interpretations will help us to wade through and say to the world, “This is what I believe to be true”. (p. 225)

By firmly placing my Dene theoretical framework at the forefront of my analysis and communicating with my advising Elder, I maintained my integrity while respectfully transmitting knowledge through an Indigenous lens.

Using a critically reflexive approach, I was mindful of my close association with the research topic and the risk of inserting too much of my personal opinions into the analysis. However, my connection to the spoken words fostered my relational accountability, reinforcing my commitment to respectful and truthful research. By honouring my views, I also honoured my participants and their knowledge. We have relational accountability to one another as Indigenous helpers serving our communities (Wilson, 2008).

3.7.1 Data Management

The data collected from my research was stored in my office at work in a locked filing cabinet and my home on my password-protected computer. In my absence, my office was only accessible by management (in case of emergency) and janitorial staff. I have the sole key for the cabinet. I also placed the electronic data on a password-protected encrypted USB device and kept it in the locked cabinet or at home when unused. After my thesis defence, the data will remain securely saved and stored for five years and then erased along with shredding the raw data.

3.8 Ethical Considerations

I identified my significant relation to the research topic in my personal positioning section. As an Indigenous child and youth mental health clinician who implements culture into therapy, I am aware of my commonalities with the participants. Therefore, I needed to incessantly respect their experiences, be vigilant when biases surfaced, and sustain self-awareness. Berger (2013) depicts one's duty within research, "It means turning of the researcher lens back onto oneself to recognize and take responsibility for one's situatedness within the

research and the effect that it may have on the setting and people being studied..."(p. 220). There was an instance where a participant was someone with whom I had a prior employment relationship, which I navigated professionally and ethically by ensuring confidentiality and informed consent. Finally, throughout my data collection and analysis process, I recognized the professional, cultural, and academic influences I hold and maintained my responsibility to preserve transparency and honesty.

My research received approval from the Research Ethics Board at the University of Northern British Columbia (Appendix B) in August 2023 and was assessed as low risk. As a registered social worker, I abided by the Canadian Association of Social Workers (CASW) and British Columbia College of Social Workers (BCCSW) codes of ethics and guiding principles; I was cognizant of my ethical responsibilities as a social work student and professional. While conducting this study, I also adhered to the TCPS 2 (Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans) in my research with people, including following the Research with Indigenous Peoples sections by conducting my research respectfully and reciprocally. As expressed by Kovach (2021), "If we think of research as discovering new knowledge, Indigenous research, then, is about discovering new understandings as these relate to Indigenous people" (p.41). Lastly, I am responsible for upholding my ethical beliefs as Dene and aligning them with my Dene worldviews and values. Following *The Dene Laws* gave me guidance and a sturdy foundation throughout my research.

My self-care throughout my research journey included continued prayer and involvement in ceremonies. We often utilize a family sweatlodge at our home to maintain spiritual connection and balance. I also took time to connect with my ceremonial sisters and we regularly got together for outings with our children and sometimes just the ladies. Maintaining my mental wellness has

been ongoing and crucial for me on my sobriety road; I continue to attend monthly sessions with my therapist and spend time in nature to nourish my well-being. Spending time with my husband and our children is ultimately the most important.

3.9 Dissemination and Participant and Elder Gifts

Gifts for the participants and Elders included individualized baskets of medicines I had respectfully harvested locally from the Nlaka'pamux Territory (sage, juniper, cedar), a print of my husband's artwork, and a smudge mix essential oil spray. Four participants agreed to receive the gift, which I mailed through the postal service. The Elder's gift was hand-delivered. As Dene, to ask for help without offering something in return would be considered disrespectful, so offering a gift illustrates my gratitude for their support.

The participants will also receive a digital email copy of my summary of findings, and the Elder will receive a physical copy. Dissemination will include my Kátł'odeeche First Nation band office, local Indigenous Human Service Agencies, Band Offices and Health Offices throughout the Nlaka'pamux and Secwépemc Nations, Nicola Valley Institute of Technology-Merritt, BC and Vancouver, BC, and First Nations Health Authority. Lastly, the final summary will be shared among my network of mental health clinicians and human service providers who service Indigenous clients by emailing their team leads. In honouring the practice of reciprocity, Kovach (2021) states, "A capacity-building ethos is a way to give back" (p. 251), which is my sole intent of dissemination.

3.10 The Advising Elder

The Elder who agreed to participate in my study is an Elder who is known to me personally and professionally. She is Nlaka'pamux from the Nooaitch Reserve in British Columbia, where her father was from. Her mother was also Nlaka'pamux from the Lower Nicola Indian band. She is a mother of three children and the proud grandmother of seven

grandchildren. She is a residential school survivor who has endured the impacts of colonization and overcome poverty. As a single parent, she strove to provide her children with a better life, turning to education as a means of empowerment. For 30 years, she has been in a helping profession supporting Indigenous children and families, with the last eight years specifically focused on mental health, specializing in somatic experience. She is passionate about utilizing an Indigenous lens in her practice and continually seeks new knowledge to support her clients. I admire her dedication and have the utmost respect for her.

My advising Elder has been an invaluable source of knowledge throughout this thesis journey and during my personal and professional journeys. I did not collect nor analyze data from the Elder during the study; instead, she offered guidance. She has thoughtfully guided me in the intimidating field of mental health and provided me with loving support through my struggles. She has graciously weaved her knowledge throughout my thesis, offering support with any ethical dilemmas or cultural queries while providing a secure sense of validity only an Elder can provide.

I asked her what advice she would offer clinicians who wanted to begin culturally adapting mental health interventions, and her response to this was:

> *So, like getting clinical supervision, get cultural exposure. Go to a pow wow, make some observations, stand by the drum, dance at Grand Entry, go to a sweatlodge, go to a friendship centre field trip to pick medicine to observe protocols. Go to a Sundance and inquire what's the purpose of a pipe ceremony. Seek out opportunities involving culture, demonstrating how to lean into land as a resource.* (Advising Elder, personal communication, July 3, 2024)

3.11 Sample: The Participants

As mentioned, the prospective participants emailed me to express their interest in the study. I followed up by sending them their information letter and consent form, which were

returned before the interviews commenced. My study generated six self-identified Indigenous child and youth mental health clinicians of varying ages as participants, with one male and five females. Among the six participants, one identified as Métis from British Columbia. The other participants included one from the Mikisew Cree First Nation in the Northwest Territories, one from the Stó:lō Nation in British Columbia, one Maškékowak from Northern Ontario, one participant from Lake Babine Nation in British Columbia, and one Anishinaabe participant from Ontario. The participants were located and currently practicing in Indigenous territories throughout British Columbia, with three located in urban areas and three in rural settings. These traditional territories included the Lheidli T'enneh lands of the Dakelh; the traditional, ancestral, and unceded territory of the Syilx; the Tk'emlúps te Secwẻpemc territory within the unceded ancestral lands of the Secwépemc Nation; and the traditional, ancestral, and unceded territory of the Nlaka'pamux people.

The participants' educational backgrounds included two Bachelor of Social Work degrees and two Master of Social Work degrees; one participant held a Master of Clinical Psychology degree, and two had Professional Counselling diplomas. They also possessed a wide range of certificates and specialized training in the mental health field, with many participants struggling to recall all their professional development activities. Most participants have been employed as helping professionals since the start of their careers, with their direct practice as child and youth mental health clinicians ranging from 3 to 22 years.

The participants' names have been omitted from the study to protect their privacy. In the findings section, the clinicians are identified as P1, P2, P3, P4, P5, and P6, corresponding to the order they were interviewed.

Chapter 4: Findings

As noted in Chapter One, my motivation for this research study stemmed from my practice as an Indigenous child and youth mental health clinician who culturally adapts mental health interventions. I wanted to learn about the practices of other clinicians like myself. Specifically, I was interested in details of their cultural adaptations, how their clients responded, whom they relied on for guidance and support, and any barriers they faced in the process. During my literature review, I struggled to find specific answers regarding the experiences of Indigenous clinicians because their perspectives were notably absent from the existing body of literature. These unanswered questions, prominent gaps in the literature, and discussions with my thesis supervisor helped shape the direction of my main research question and supporting sub-question.

Furthermore, in alignment with an exploratory lens, my supporting theoretical orientation of *The Dene Laws*, and Tracy's (2010) Eight "Big Tent" criteria, I thought it was crucial to include considerable quotes from the participants. Exploring and listening to their voices helped me to uncover deep meanings and understand their experiences related to the research questions, laying the groundwork for theme development and suggestions around areas for future research (Stebbins, 2001). In honouring *Dene Law (5)*, to *Pass on the Teachings,* I thought it was essential that the teachings shared by the participants came directly from them as their stories are theirs to tell. The participants' personal accounts are included to enhance resonance throughout the findings section as a way to ensure methodological integrity (Tracy, 2010). Although I provide a supportive narrative, the participants' voices are the primary focus.

The following three themes and sub-themes were derived through thematic analysis, as described in Chapter 4. The key themes were as follows: Utilizing Culturally Adapted Mental

Health Interventions, Supportive Factors for Culturally Adapting Interventions, and Barriers and Areas for Improvement. These three themes are broken into sub-themes, as outlined in Figure 1.

Themes	**Sub-themes**
Utilizing Culturally Adapted Mental Health Interventions	▪ *Establishing Trust and Respecting Individuality* ▪ *Integrating and Cultivating Cultural Knowledge in Therapy* ▪ *Leading the Way: Connecting to Land and Self* ▪ *Response to Culturally Adapted Interventions*
Supportive Factors for Culturally Adapting Interventions	▪ *Strengthening Familial and Community Ties* ▪ *Forming Collaborative Partnerships* ▪ *Building Relationships with Our Elders and Honouring Their Knowledge*
Examining Barriers and Identifying Areas for Improvement	▪ *Overcoming Resistance to Cultural Methods* ▪ *Increasing Cultural Competency and Sensitivity* ▪ *Promoting Systemic Equity and Supportive Policies*

Figure 1: Overview of three themes and corresponding sub-themes.

4.1 Utilizing Culturally Adapted Mental Health Interventions

Our life experiences often direct and shape many aspects of our journeys, so I thought it was essential to illustrate how the clinicians' life journeys helped them to cultivate their current practice of culturally adapting mental health interventions. During their interviews, the participants shared accounts of their unique paths; their stories offered insights into the motivating factors leading to culturally adapted methods. The significant influence of their Indigenous heritages, coupled with the healing that came from reclaiming and preserving their culture and identities, was also brought to light. As Baskin (2016) notes, "Many Indigenous counsellors are driven by a sense of responsibility to their communities, stemming from their

own histories of trauma and resilience. This drives their commitment to providing culturally relevant care" (p. 237).

4.1.1 Establishing Trust and Respecting Individuality

This subtheme demonstrates the complex nature of clinicians building trusting therapeutic relationships with their Indigenous child and youth clients and the careful considerations they must put into that work. They provided numerous examples of how they navigate this process.

Having a flexible approach in therapy is essential, as Participant One expressed: *"Starting where they are culturally within the therapy is very important. Yeah, it's really dependent how quickly you can bring it in and what you can use"* (P1).

Another participant spoke of the necessity of patience and creating space for trust to develop:

> *most times, they don't want to talk about anything, and it takes them a long time to trust you, and you know, giving them space for that even that is an Indigenous way of knowing, […] creating space and not saying anything and trying to fill up that space with words you just sit there.* (P2)

Participant Six explained how she meets clients where they are:

> *What I mean by meeting them where they're at is, say, if I have a client that comes in and says I feel like I want to learn how to make a drum […], so I follow through with it, trying to find a place where there's drum making and try to get her involved in that.* (P6)

She further described the importance of walking beside her clients, "*It's being hands-on and trying to walk with them and experiencing it together and seeking it out. So, it's […] not just told to them, it's helping them walk with them and experiencing it together.* (P6)

Participant One acknowledged the individuality of each client and the importance of an individualized approach:

> *every client that walks in your office is their own unique person, so I can't just say, come in and let's figure out your troubles by looking at a medicine wheel. Thinking that […] like this is the tool because they're Indigenous, this is the direction we're going… I guess there's a softer approach.* (P1)

The relationship between counsellor and client can sometimes extend beyond traditional therapeutic goals, which provides a sense of security and stable reassurance for the client. As one participant shared:

> *I have a few youth that […] don't want me to close their file. Even though they're maintaining their goals and they're doing very well they just need that. They know that they got that hand that's always there, and I know I can't keep them forever, but you know, you can hold on to them for a while, and you'll come to a time where they'll let go.* (P2)

Participant Four shared how demonstrating respect for the youth's cultural and familial practices without imposing beliefs promotes open and respectful dialogue. This approach not only validates the youth's cultural identity but also builds trust and rapport:

> *for youth, I mean, I just asked them sometimes what do you know? What do you believe? What does your family believe? What's your traditions in your family? […] never pushing, […], do you guys pray at your house? Do you guys smudge, do you go to powwows?* (P4)

In further relation to trust, some of the clinicians articulated the unique impact of being an Indigenous insider, with the heritage they share with their clients reducing defences, allowing therapeutic relations to form. As one clinician described, "...*being Indigenous myself, it helps take down one of the barriers that youth feel when working with a clinician […] being able to*

speak to the youth from a common ground" (P3). Participant Three also stated, *"I just feel as an Indigenous person, you know, understanding Indigenous ways. Just puts it in the language that the youth understand"* (P3). Two more participants additionally shared about the commonality, "*Oh, this is not just like, another white counsellor. She actually knows what my mom and dad talked about. She actually knows, […], she went to pow wow too…"* (P4), "*They know that […] I am Indigenous, and I have a knowledge of that, and also a deep knowledge of trauma. Not just from maybe studies […] I feel like they feel more comfortable in my work with them"* (P5).

One participant explained how their words may carry altered meanings compared to those of non-Indigenous clinicians, highlighting the importance of cultural relatability in therapy:

> *I swear, like a Western-based psychologist, […], maybe a Caucasian person could say the exact same words that I'm saying or that we're saying as Indigenous practitioners, but they will hear it different when it comes from us. As there's less of a guard, I feel to what we're saying whether or not taking it as we're trying to take something from them or give them something that they have to use in their life*. (P3)

Another participant described how her deep awareness of the historical context of colonization enhances her ability to connect with the youth she supports:

> *just from my own family, history and background, I'm able to understand more deeply about intergenerational trauma or addiction in families and how, you know, the 60's scoop impacted families as well. Just not [..]residential schools. And I think that it helps me really connect with the youth as well.* (P5)

Furthermore, Participant Two revealed how she navigates when her clients are from a different culture, "*[…] no child is […], left out, because he's from a different culture. […] we just integrate them and make sure that they're honoured for who they are, where they come from, and make sure there's connections"* (P2). Participant One shared a similar view, *"I would be*

really excited if someone was from somewhere else, and I didn't know stuff. I'd be really keen to find out with their guidance and what a good chance for that person to feel and own and be proud" (P1). Participant Five also said, "*I would just maybe inquire more about, like, where they're from in the Nation. Yeah, just maybe do my own research of like, how they do things"* (P5).

The clinicians' reflections emphasized how their culturally-attuned and empathetic approaches enhance their therapeutic alliance and empower clients to reconnect with their heritage. This process helps clients to navigate their personal healing with enhanced confidence and resilience.

4.1.2 Integrating and Cultivating Cultural Knowledge and Teachings in Therapy

Refining this specific sub-section proved challenging due to the depth and richness of the knowledge shared. The insights provided were profoundly inspiring, offering a genuine understanding of how the clinicians intuitively support their clients through culturally inclusive interventions. In alignment with the definitions of Wendt et al. (2022) provided in the Literature Review, the participants provided examples of both structural adaptations and deep structural adaptations. The following participant quote accurately establishes the tone of the following section, "*I don't have […], some book that I've learned my ways of knowing from, […] some of it is even just like I would say, epigenetics, like you just know"* (P2).

The clinicians shared many concrete ways in which they culturally adapt their mental health interventions. Their approaches encompassed a range of practices that integrate Indigenous culture and values into therapeutic settings. For example, one clinician described how she carefully employs the use of traditional, nature-based tools and storytelling in her approach:

> *I find most of my tools are earth-based, land-based, drawing on legends, and that the original knowledge sharing comes through storytelling and usually those characters or animals or transformers, so I would only go there if they're okay and…they're not gonna have a deer in headlights in your chair.* (P1)

The importance of smudging was heavily echoed throughout the participants' reflections. The following two participants describe how they introduce the practice to their clients:

> *Smudging is really important. We do that a lot. […], I teach my youth different medicines and when to smudge with them, and when not to smudge with them, and how to smudge. There's no wrong way but you know, just make sure you cover everything.* (P2)

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> *I […] make sure I'm upfront and honest with where I was taught how to use this (smudging) and what it looks like. So, the description part is always important. Trying to deliver that to make them either see in describing it or walking them through it by having my own shell and mixing it up and showing them how I was taught to smudge right…I even provide my own packages of giving them a smudge kit if they need that.* (P6)

Another participant communicated the healing capabilities of smudging, stating, *"smudging practices help cleanse the negative energy that may be surrounding them or the heaviness they feel from losing someone. It just really helps them feel refreshed"* (P5).

Participant Five also mentioned another cleansing cultural practice used with clients, spirit baths. She noted: "*We do spirit baths sometimes, and I know that gives them a lot of good energy afterwards"* (P5).

Furthermore, Participant Three focused on his practice of creating overt links between cultural teachings and recovery goals. This perspective is illustrated in the following quote:

> *I try to find like a commonality with what the cultural teaching is trying to bring into it to what they want in their recovery, or what they want in their life. So if they're looking for*

> *peace and serenity to get away from abusive households or abusive relationships, it's, you know, while calming the central nervous system or that connection to self for you can feel safe in your own skin, and how, you know, smudging is meant to be cleansing, or how standing by a river, not looking at your cell phone, or worrying about pictures but the peace and serenity of like that doesn't have to be found in a unhealthy coping mechanism like drugs and alcohol.* (P3)

Another participant spoke about the practice of incorporating traditional arts and crafts in therapy:

> *Even when we do anything […] with art, it's always like Indigenized as well. So, you know, they learn, we bead, we bead together. That's like a therapy right there. Spend time just the stitch after stitch, bead after bead, following a pattern. […] I get them to make these little medicine bags. Flowers, like they're super easy to make, and maybe have a drumming session after our group sessions are over at the end. We'll celebrate by making drums […].* (P2)

Participants also described the practice of blending both Indigenous and Western methods in practice to support the unique needs of Indigenous children and youth. For example, Participant One noted:

> *And because we see we don't just see clients in the Nation, it's open to the urban Indigenous person. You do have to appreciate that there might be gaps. So, you really kind of need the blend. The blend is most effective if that makes sense*. (P1)

Participant Five provided an overview of training she received and now incorporates into her practice on Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) adapted through an Indigenous lens. CBT is a type of psychotherapy that supports individuals to change negative thoughts and behaviours contributing to mental distress (Beck, 2011). This method of delivering TF-CBT through an Indigenous lens integrates Indigenous cultural beliefs, practices, and traditions into the therapeutic model. She explained:

> *trauma-focused cognitive behavioural therapy, but with the Indigenous lens, […], a lot of incorporations of Indigenous cultural beliefs, practices, traditions, like in the model… […] there's a section talking about relaxation and coping strategies. So instead of […] the usual […] learning breathing […] kind of clinical stuff, they would incorporate any cultural things that the youth or child might find calming, so like drumming or smudging or beadwork, or maybe doing art with them…. braiding sweetgrass as like a relaxation activity, like anything that connects them with their culture as well. […] It's all about talking about feelings, expanding their feelings vocabulary, talking about where you feel feelings in the body. And […] really exploring that, and another piece […] they incorporated was like whatever Nation they're from, kind of getting words from their language, like their native language and like feeling words […] so that they can learn feeling words in their native language. We made a talking stick as well. […] making a talking stick with them and using that in conjoint therapy sessions with the parents or caregivers (*P5)

Another participant outlined how her organization has adapted the Signs of Safety framework to include Indigenous perspectives and practices. This framework is utilized as a strength-based and safety-focused approach to child protection intervention (Turnell & Murphy, 2017). She described how she incorporates the framework into her therapeutic practice:

> *We have a framework, […] it's called Signs of Safety. […] even that's Indigenized, like I honour the youth right at the beginning. I talk about the worries, like what the worries were, what the worries are and what our future worry is. And then I create [..]that big worry statement, but I say it in such a way that they feel honoured. You're such a beautiful, strong Michif woman, you know, those things, and […] it's in your blood, your ancestors walk this way […] they love it. I mean, they feel connected, and then they're like,' I don't know what to say I want to cry', […] they really appreciate that you see them through this lens, and I guess with love. I think that's so important. They don't have that; most of our youth have been in the system for so long. They're just so jaded and so hard, and they won't let anybody in. But when you tell them all these good things about themselves, they're like blown away.* (P2)

Indigenous clinicians do not always work with clients from their community, requiring them to engage in respectful cross-cultural practice. Participant Six discussed the respectful adoption and integration of various Indigenous cultural practices, emphasizing her sincere intention to support her clients effectively:

> *So, it's whatever that cause*(s) *any positive outcome that comes out of it. The teachings may not be mine, but I adopted into our family… I know cedar headbands may not be all ours, and it's probably only practiced up in Prince Rupert area, and ribbon skirts are mostly worn through Cree cultures, but still, […] the background is Indigenous, right? […]. So, I adopt those. I'm taking a little at a time* (P6).

Finally, when discussing how they culturally adapt mental health interventions, the clinicians shared their ongoing journeys of learning, adapting, and building confidence:

> *I'm learning, I'm stumbling, […] so it's okay to, for you to learn and stumble, it's not something even if you're a 98-year-old Elder who's done ceremony for 60 years, there's still stuff to learn, there's still stuff to adapt… I say I'm far from successful. It's just stumbling along the best I can.* (P3)

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> *every time we like set up something for the youth or children to be learning. I'm learning, […] right alongside them. […] different things about, […] types of materials we use for smudging, what they are used for, you know, what's the difference if you use them in a sweat lodge, or if you're using them to smudge? How, like Coastal Salish people, […] use like the water brushing or with cedar branches, instead of, say, with smoke…*(P3)

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> *Just from I guess, experience and listening to Elders and going places, and coming with a humble attitude, you know, and not be like, this is the way you do it. Like this is how I was taught, so and so taught me this, this is not mine, you know? And that everybody's learning.* (P4)

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> *I guess […] everyone has their own, like, unique way of doing things. I just kind of used my intuition and practice on my own until I felt comfortable with leading and just like trusted myself in the process of learning and […] being kind to myself too. Because obviously, I'm not gonna be perfect the first time, but yeah, […] a lot of just practice being kind with myself.* (P5)

This sub-theme offers numerous suggestions for concrete ways in which Indigenous clinicians can adapt mental health interventions. Having humility, a willingness to make mistakes, following one's intuition, and continual growth were significant topics that arose in the conversations.

4.1.3 Leading the Way: Connections to Land and Self

The participants often described the transformative power of engaging with the natural environment in therapy; they shared about the unexpected and profound experiences that can occur by immersing clients in the land and how these experiences can facilitate healing and learning. As Participant Three shared, establishing lost connections is integral to the healing process:

> *Just the generalization of our teachings of connection, you know, to connection to land connection, to people connection to animals, you know, and learning how to […] connect to yourself, because that's the biggest thing. I feel a lot of youth with mental health and addiction concerns. They've lost that, you know, that connection to themselves.* (P3)

Participant One spoke about the power of being open to lessons from the environment, *"Let's go out and engage and just be there, and what happens is what happens because the magic happens, just if you're there…the land and the environment shows up to teach or help in some way. Very powerful"* (P1). Another participant emphasized experiential learning and engaging emotionally with nature: *"I teach a lot about medicines and healing on the land and*

how it makes you feel, what does that make you feel like and really immersed in it, like take your shoes off step and then feel that with your toes" (P2). This participant went on to speak about the innate nature of Indigenous ways of knowing and healing, focusing on the felt sense:

> *it's like somatic as well. […] immersing the youth or the children right in what we're doing, like touch it, wash your hands, feel how cold that is, look in there, what do you see? You know, those are all your relations, see little fish, […] so I just incorporate all that, and it's so spiritual, and I think that's important.* (P2)

She went on to share how she gently plants seeds of cultural knowledge during her sessions:

> *So, we'll get out walk a little bit, and there'll be water or even a big field, and I would just point out plants and tell them what they're good for, and say, hey, you know, if you ever got cut, you pick this plant, and you just break the leaf and just put it right on your cut, that'll heal it faster, and you won't have a scar, and you know little things like that. Yeah, and then they'll start, 'oh, that's interesting' or 'oh, I'll never do that.' But then they'll be sharing those little thoughts, and then they'll start asking for more. And then all of a sudden, they're eager, eager to come out in groups and they never did before.* (P2)

The narratives shared by the participants illuminate the impact of reconnecting with the land as a therapeutic intervention. This transformative engagement with nature encourages emotional healing, self-discovery, and a rekindling of cultural knowledge to support the well-being of Indigenous children and youth.

4.1.4 Responses to Culturally Adapted Interventions

Most clinicians observed that their clients had varied responses to incorporating cultural elements in therapy. They noted a significant contrast between urban clients and those who grew up in their communities or were exposed to culture through community or family. Participant Three discussed how urban Indigenous children and youth often experience feelings of shame due to the disconnection from family and culture, stating:

> *talking about culture in a way that would, […] get rid of that shame because you could see that from many in the inner city and like urban-based Indigenous people where they kind of still carry that shame and guilt of being brown, where you can teach them…there's a lot more to it, that pride and that connection to others and land.* (P3)

Another participant highlighted the distinction, noting that urban Indigenous clients appear more apprehensive, "*I notice, […], I'm gonna be honest, […] a lot of the urban First Nations people. I don't seem to affect them in a way that I do affect the people that come from the community that live here"* (P6). Participant Three shared the experience of supporting clients previously exposed to culture*, "If they come from a community where they live on the reserve, it's more accepted because they kind of grow up seeing or hearing about it, or that's what Kookum talked about..."* (P3).

Participant Six described the response from her urban Indigenous clients, reflecting on their resistance to learning about culture:

> *So, what is it that makes you like hold you back from wanting to learn? And they often come back with, well, we weren't raised with it. We were raised in a group home, (culture) wasn't presented to us. We didn't grow up with it. There's that disconnection. They're not with family. Our children are lacking that knowledge because they're disconnecting with family members. Sad.* (P6)

Participant Three further noted the difficulties faced by urban clients:

> *If they come from urban areas, it's a lot harder. They're a lot more standoffish from it. They're just like, oh, this is something else that you're trying to give me or teach me like, why, you know, I don't know how to explain it, but from like, community, Indigenous children and youth to urban, especially like, the bigger the urban area, the more resistant they are.* (P3)

Participant Six also observed that people from remote communities are more responsive to learning about culture and seek support to do so, and explained:

> *I notice a lot of people from communities, remote communities that are residing in Prince George are the ones that are very open to that. They're wanting to continue to learn. They're wanting to, they're just starving for that.* (P6)

Participants also described ways to gently introduce resistant clients to culture in therapy. Participant Two shared the following:

> *Ah, when I first started here, I had some youth that are very resistant. Yeah, […] so I'll probably go for a drive, and they're not realizing that they're out on the land. In a car, but they're out on the land, and […] I would just like introduce it gently. We'd maybe get a Starbucks, and it's so nice about this community. You can drive in any direction, you'll be out of town in 10 minutes.* (P2)

Participant One voiced how she changes her cultural approach based on her clients' comfort:

> *I'd say 75% appreciate (cultural interventions) […], and their takeaway seems really deep. But there's some that it's, new, newer. There's something new about it. It's not landing the same way. It's not connecting the same way. And I just […] shift gears […] because everybody's a little bit different.* (P1)

Participant One added:

> *…anxiety is such a big issue that even being outside is uncomfortable even though I know their family likes to gather food and make medicines and, you know, different things, even just canning and what have you and […] I know […] I have an idea of where they are within their culture, but still, there's reluctance due to what's presenting.* (P1)

Participant Two shared the importance of planting the seeds of culture in the youth she supports. She recounted the story of a client who was initially resistant to cultural practices but later returned to her services after some time away, eager to continue engaging in cultural activities. She shared:

> *And then he came onto my caseload, and we're talking about like, you know what we used to do, I said, would you like to continue with that? And he says, yeah, actually, I like to*

> *learn more about my culture. And I'm like, wow, I remember when we first started, he says, yeah, this is yeah, but now like, I'm usually the one that knows more than other people. And I said, well, good for you, good for you, and you've retained all that.* (P2)

Often, what appears to be minuscule outcomes are, in fact, profound, indicating the therapist has made an impact, as the following participant described:

> *When things sink in, you know, […] we don't know what's going to impact people sometimes whether it's going to stick with them […]. I guess if someone asks more questions, sometimes I think that's a success. If they asked me if I can smudge or pray for them.* (P4)

The varied responses to culturally adapted interventions depict the value of personalized and culturally sensitive practices. The clinicians' approaches validated and respected the clients' cultural backgrounds and strengthened the therapeutic alliance, paving the way for deeper and more meaningful healing experiences than they might otherwise have had.

4.2 Supportive Factors for Culturally Adapting Interventions

This section addresses the first part of the supporting sub-question: "What supportive factors contribute to the delivery of these interventions?". The clinicians conveyed that the following factors collectively contribute to the effective delivery of culturally adapted mental health interventions for Indigenous children and youth.

4.2.1 Strengthening Familial and Community Ties

A recurring theme among the participating clinicians is their commitment to valuing the cultural knowledge of the communities and families they support and respectfully integrating this knowledge into their practice. Participant Two reflected on the collective nature of her identity and stressed the importance of honouring individuality, all relations, and community as familial connections in her practice:

> *my way of knowing, I've always been more of a collective and not a standalone individual person. I felt I belonged to a community of family members that we may not be related, but we're related in my way of knowing, and I think that's really important honouring the person for who they are and where they come from and, and their ancestors, how they're connected. And we could be related, maybe not by blood, but we're related in many ways. And so, sharing that knowledge I think it's really important for utilizing all of your experiences and using those as tools. And I think that's what I incorporate in my work.* (P2)

Participant Two further discussed the pivotal role family plays in preserving and sharing culture and how their knowledge provides direction to support their clients thoughtfully:

> *Family, family is very important. They're the ones that, you know, are the first ones that would bring their culture to the forefront and say, well, we don't do it that way. We do it this way. And we honour them. Honour them for sharing their knowledge and allowing us to participate in it.* (P2)

The participants shared about mindfully respecting the communities their clients are from when implementing cultural methods, with one stating, "*I don't want you practicing in a way that's going to be disrespectful to your community. Because […] I learned to smudge from Okanagan, Indigenous people, which is completely different from here, and completely different from where I'm from"* (P3). Another clinician added,

> *Some of the youth are from different communities; we talk about their culture, and we try to bring that in. […] ensuring that they have those connections. […] a lot of times like we would reach out to Elders from their communities and have them support us and that youth.* (P2)

Participant Three also related the importance of seeking advice from the clients' community when questions regarding ceremony arise:

> *Say I'm working with Jane Doe, and this comes up, and they have a question regarding, you know, their ceremony. I swear the answers always is like, what community are they from, and who could they ask for permission for that, but for my own practice, it was like, is it okay if I talk about this practice?* (P3)

These clinicians honour their clients' individual and collective identities by valuing and integrating cultural knowledge from families and communities. They provided numerous examples of how they go about this process.

4.2.2 Forming Collaborative Partnerships

In further discussing the supportive factors contributing to delivering culturally adapted mental health interventions, the importance of collaborative partnerships appeared as a substantial sub-theme. Clinicians highlighted various aspects of collaboration, including support from colleagues and supervisors and the integration of community practices. Collaborations with Elders rose predominantly in this section; therefore, this will be discussed separately in the following sub-section.

Participants described the importance of receiving support within your employing organization. Participant One also discussed how she feels supported in her practice by her supervisor:

> *pulling on the community of work colleagues, having really solid supervision […] from an Indigenous woman who has a similar approach…we really connect… and partaking in things that the community puts on and staying engaged that way also helps."* (P1)

Another participant relayed how she receives support within her organization from internal and external sources:

> *my team leader supports me, my advisor, a clinical advisor; she supports us for our practice and also with the world life promotion project that we were creating. We had an*

> *amazing advisor from there that supported us in many many ways, and understanding with a different lens and then applying it in Indigenous ways. So that was awesome.* (P2)

Participant Five reflected on her previous and current work environments, revealing how the presence of Indigenous colleagues in her current role enhanced their sense of community and engagement in cultural practices:

> *Beforehand, I did connect with some Elders and smudged and things like that, but I didn't really feel like I was around Indigenous people or clinicians. It was actually like, mainly at my job, it was mainly […] white people, it was like hard to like, feel like I was surrounded, but now that I'm working at […] I feel like I am surrounded with Indigenous clinicians and also just […] other Indigenous support staff, which is really nice. And also, because of that, it's much more immersed in cultural activities and spirituality.* (P5)

Participant Five further shared the initiatives to foster connections and support among Indigenous clinicians with regular meetings, explaining:

> *we actually created a table for Indigenous clinicians to connect with ICYMH (Indigenous Child and Youth Mental Health) to […] just connect about our practices and touch base about things. Yeah, just like kind of feel more connected and supported. […] I'm also part of another table too; it's Indigenous. It's like Indigenous clinicians' support group that my supervisor started, and so we would meet once a month just to talk about our practice, how things are going and what we're noticing with our youth because […] we work with Indigenous youth primarily. So yeah, just another way of, like, connecting and feeling supported […] in the community to connect with community members and other professionals.* (P5)

Participant Three also spoke of the importance of building a network of culturally knowledgeable individuals who can offer support and guidance to his practice:

> *You meet people along the way where, you know, I can text friends that, […], practice and teach our culture. […].* (And ask them) *Hey, can you come out and help me, or what would you do in this situation?* (P3)

The factors in this section collectively enhance the delivery of culturally adapted interventions. They essentially foster deeper connections and meaningful therapeutic outcomes for Indigenous children and youth.

4.2.3 Building Relationships with Our Elders and Honoring Their Knowledge

The participants emphasized the significance of engaging with Elders, whose wisdom, experience and cultural knowledge provide invaluable support to both the clients and clinicians. This subtheme emphasized the importance of Elders' presence in therapeutic settings, emphasizing their contributions to the healing process.

The following quotation illustrates the lighthearted nature that Elders often bring to their supportive roles, as an Elder humorously tried to persuade the participant that her office décor needed improvement: "*One Elder was trying to convince me to buy […] beaver pelts from him.* He stated, "*I need to hang some animal skin in your office to make people see that […] they just see rocks, they need to see wood, they need to see an animal hide"* (P4).

Several participants discussed the resourceful roles of Elders within their mental health practices. Participant Five highlighted the cultural support provided by Elders within her organization, *"…we have access to Elders regularly. We see them all the time. Talk to them. We do circles, healing circles. […] we've been able to attend spirit baths and offered to go to sweat lodges…"* (P5). Another participant shared the importance of collaborating with Elders, *"We collaborate with a lot of Elders with experience, especially the ones that carry pipes, and they have a whole knowledge of certain ways of healing, especially when you're having a letting go ceremony"* (P6). Participant Four explained why she seeks the wisdom of Elders: *"I wanted to*

get, you know, Elders' opinion and wisdom and to get sensitivity and what I should be doing and not doing, you know" (P4). Another participant poignantly shared how Elder knowledge enriches and informs her practice: *"I connect with Elders, and I gather information from them, and you know, the old ways of connecting with a child or youth […] and wrapping our services around our children or youth"* (P2).

Participant Five shared insights into the frequent and meaningful interactions with Elders and the benefits of collaborative efforts among staff. Participant Five highlighted how these interactions and practices contribute to the support system within their work environment, stating:

> *We have access to Elders regularly. We see them all the time. Talk to them. We do circles healing circles. We just did one recently. And yeah, like we've been able to attend spirit baths and offered to go to sweat lodges, …staff collaboration and building really positive relationships with each other.* (P5)

Elder can provide gentle teachings related to nature's innate ability to heal and rejuvenate us, as this participant revealed:

> *We went for a walk, and there's this beautiful place. It's a few kilometres out of town. But there's a beautiful little walk right around the little lake, and we went for a little hike there. And every time she got tired; she says I need a hug. And not from me, but from a tree. So, she would lean against the tree, and she'd hold it in, she'd take a break, and she felt rejuvenated just by holding it, and we talked about that. Like she's […], such a blessing to know and what a great resource.* (P2)

Participant One reflected on the impactful influence of Métis Elders in her work, emphasizing the strength derived from community and relationships. She shared:

> *I immediately think of some of the Métis Elders that I got to work with who come from a place of […] the philosophy of we're stronger when we're united, and we're stronger*

> *when we're together in a community and […] the circle is strongest when there's connection and just learning from them and hearing how they would work and be with us when they were approached to help with say, a troubled teen, and just, them sharing like, the experience not even like debriefing but just sharing the story of how that was and what they did. It was so much about the relationship, and the relation that you created with the person has been inspiring and informative and just reaching back and helping those that need it.* (P1)

Lastly, Participant Six shared the importance of seeking Elders who embody humble wisdom:

> *elderly ladies that have background experience, the ones that I find that's more powerful are the ones that we seek out, not the ones that advertise. […]. So, the powerful ones are the ones that are very humble and that just try to support and are there for the […] people, not so much for themselves.* (P6)

This section suggests that Elders provide essential cultural support and traditional healing practices and enrich the therapeutic process with their gentle teachings and lived experience. Their knowledge strengthens mental health practices by ensuring that services offered are rooted in cultural sensitivity and respect.

4.3 Examining Barriers and Identifying Areas for Improvement

The following section examines the challenges and barriers faced by Indigenous Child and Youth Mental Health Clinicians in their efforts to provide culturally adapted mental health interventions. Through the participants' voices, this section provides an overview of the intricate dynamics of integrating traditional cultural practices within the confines of Western mental health frameworks.

4.3.1 Overcoming Resistance to Cultural Methods

Participants discussed instances of resistance from their clients that they relate to the lingering impacts of colonization, as Participant Four shared:

> *I'm taking clients medicine picking, and we pray and do our own offering in our own way, and some people get angry. No, you can't do that. You're not Okanagan […] you shouldn't be picking medicine. Just like Creator knows our hearts and minds like if you have good intentions […], that's what I think a lot of it. It's good to respect the people and where you are, you know, on the land for sure. But I don't know […] in some ways, I think Christianity historically has been rigid and too many rules, and then there's a lot of Indigenous people that are too rigid and too many rules. Also, it's kind of doing the same thing in some ways.* (P4)

The following participant also experienced rigidity from clients regarding her methods:

> *For example, like smudging, a lot of people are taught different ways of smudging. And I got cornered a few months back by a lady that kind of like was sizing me up and questioning me about how do you […] smudge and is that the right way that you're doing it? And I looked at her and said I don't know how you were taught, but I said many of us were taught different ways of smudging…* (P6)

Participant Three shared how clients are sometimes overwhelmed with the cultural adaptations in therapy:

> *even like smudging, they're like, well, what kind of feather do I need? Where do I get this feather? Where he can't just go pick up a feather, […] there's so many different steps to it, where they get, they stumble over the complexity of it, where you have to simplify it, […] just meeting people that use culture and healing helps them, you know, take down those barriers.* (P3)

Participant Four also described some misconceptions and beliefs that prove to be barriers for her clients and how she gently navigates this:

> *I can't go to Creator, you know; I need to be a better person before I pray, you know, […] being sober, I understand that […] I need to do this first, and […] Creator will just listen and accept you as you are, right? Other people won't. But Creator already knows what's on your heart and what's on your mind, and it's okay, and just trying to […] show*

> *how Creator can be another support and just to be relaxed and accepting, […] kind of puts people to ease it's like, you don't need to go through an Elder to pray for you. Maybe for certain things. Yeah, but I mean, you can just talk to a Creator by yourself…* (P4)

Lastly, one participant relayed her observation regarding barriers to culturally adapting mental health interventions, *"We're not quite there yet. There's some more forward-thinking places in the world. So, there's taking smaller steps"* (P1).

The clinicians experienced some levels of resistance in delivering culturally adapted interventions. Despite that reality, they demonstrated resilience and adaptability, navigating misconceptions with patience and understanding.

4.3.2 Increasing Cultural Competency and Sensitivity

In this subtheme, participants discussed the importance of increasing cultural competency within mental health practices with Indigenous children and youth. They also described the challenges of integrating cultural practices within the constraints of institutional guidelines and the need for a broader understanding of cultural and spiritual perspectives in mental health.

Participant Three addressed the limitations of institutional guidelines that often fail to accommodate Indigenous cultural practices and kinship structures:

> *we try to do things in a culturally sensitive manner, but you still have to fall within certain guidelines. And those certain guidelines don't take into consideration things like kinship care, things like community care, community wholeness of it doesn't matter if it's an aunt, uncle, brother, you know, third cousin removed. If they're part of the community and trusted, you know, the child is going to be trusted with them, no matter what. But if you don't have those people on a set little checklist for the ministry to accept, you can't practice culture* (P3)

Participant Five shared an instance where a youth felt that her experiences were more spiritual than clinical and emphasized the need for mental health practices that recognize and incorporate spiritual perspectives:

> *one youth was telling me yesterday that she thinks […] what she's experiencing is more spiritual rather than clinical. What I mean is like the psychologist or psychiatrist sorry, […] was saying that she might think that she was experiencing maybe early onset of schizophrenia. So, however, my youth was saying, well, I don't know […] she said yesterday, I don't believe that […] psychiatrist is right because, like, I feel like it's more of a spiritual thing that's happening to me. And she and I suggested we go see the Elder because she hasn't seen one in a while, and it kind of gave her hope. Because she's like, well psychiatry doesn't understand, […] they don't recognize that* (spiritual component) *like in the mental health, which is fair, […] they're very clinical. And they diagnose and give meds and things like that. […] I feel like having that other option is really helpful for the youth.* (P5)

Participant Five also highlighted the barriers she faces when working with other organizations that may lack a trauma-informed approach or an understanding of intergenerational trauma:

> *I think the only time I've had like pushback on anything is from other organizations like MCFD* (the Ministry of Children and Family Development – the provincial arm of child welfare in BC)*. Which […] I don't know how […] they learn about things, but I don't think it's very evident that they're trauma-informed […]. Or […] they've actually done the work and learned about intergenerational trauma […]. I don't know if they're considerate when it comes to that, so I think maybe that's […] something I've experienced barrier-wise.* (P5)

The participants' statements captured the ongoing challenges they face. Their words highlighted the need for greater cultural competency and sensitivity within institutional frameworks to better support the mental health needs of Indigenous children and youth.

4.3.3 Promoting Systemic Equity and Supportive Policies

The sub-theme explored barriers and challenges faced by Indigenous mental health clinicians as they strive to provide culturally adapted mental health interventions. When the

question was posed regarding what barriers the clinicians faced in their current practice, many noted that they feel well supported in their efforts to adapt mental health interventions culturally. However, some discussed issues related to discrimination, bureaucratic influences, funding constraints, and the difficulties in aligning Indigenous practices with Western organizational requirements.

Participant Three shared his frustration on delayed progress and action: "*Let's get a committee together to talk about maybe planning it so they can get a committee to talk to the committee about doing it. Yeah. It'll happen in seven to 32 years"* (P3). He also expressed barriers to receiving funding, *"So grassroots-wise, it's a great concept, and we know it works. But how do you argue that to funders, and what's reportable? What do you have to report to the funders to keep, you know, the doors open?*" (P3)

Participant Six expressed the pervasive discrimination faced when trying to advocate for Indigenous people through various processes encountered in legal and healthcare settings:

> *Barriers, if anything, it's more the barriers that I face […] trying to support our people in anything, whether it's mediation, going to court.* (When) *making sure they have adequate health check in Psych. […] I'm just gonna bluntly say it, there's a lot of discrimination when you bring our people up to emergency.* (P6)

Participant Three discussed the challenges of integrating cultural practices within the constraints of Western organizational requirements and the difficulty of securing funding and approval for culturally appropriate methods:

> *Everything else is we're trying to be culturally informed or provide cultural teachings. But you still have to follow […] this Western organizational checklist. So, it's hard to find places where if you want to do things in a cultural manner, 100% of the time, you could never find funding to get staff to do that. Or, you know, allow your board to be like, yep, that's our way of practicing. […] the board would be like, well, no, we have this grant*

> *from so and so, which needs this big Western Eurocentric checklist done. You know, Western medical model practices. […] but try to fit your culture in there somewhere.* (P3)

Participant Three further added that complicated bureaucratic hurdles and legislative constraints complicate the implementation of cultural practices, mainly when supporting youth in care and involving community members:

> *if you want to practice in a cultural way, you know, okay, great, but still make sure you're within these parameters. Yeah, because even working with youth, like try to get permissions for youth that are in the care of the ministry, to even take them out to like a trap line. You got to do like safety protocols and safety checklists. And this, that and the other, criminal record checks for anybody that you want to get involved. Where you have Uncle Tom, per se, that's been doing it for 57 years and is the most practiced, culturally sensitive, humble human you'd ever meet, but his license expired in 1987. He hasn't went to go get a new one. So, how are you going to get him a criminal record check? To oh, yeah, so the bureaucracy and legislations and limitations of funding and allowances. It's a nightmare.* (P3)

Addressing these issues is essential to supporting the implementation of culturally adapted mental health interventions, which enhances their accessibility and effectiveness. The interviews provided much rich information to reflect on and in the next chapter I will offer my interpretation of the findings and how I made sense of them.

Chapter 5: Discussion of Findings

The primary aim of this research was to address a significant gap in the literature regarding the experiences of Indigenous clinicians who culturally adapt mental health interventions for Indigenous children and youth and explore how they are being supported in these efforts. The research question and sub-questions were, *'What are the experiences of Indigenous child and youth mental health clinicians in delivering culturally adapted mental health interventions for Indigenous children and youth? What supportive factors contribute to the delivery of these interventions, and how can these supports be improved?'.* The six clinicians who participated in the study shared genuine, in-depth accounts of their journeys, offering rich information and valuable insights. The interviews revealed how the clinicians intuitively and gently introduce cultural elements to their Indigenous child and youth clients as a means of healing. The participants shared numerous examples of how and from whom to seek support, highlighting the importance of community and collaboration with Elders, youth, and work associates. Additionally, the clinicians conveyed a generally positive experience of being supported in their practices and facing minimal barriers.

In this final chapter, I will provide an overview of the three themes: 'Utilizing Culturally Adapted Interventions,' 'Supportive Factors for Culturally Adapting Interventions,' and 'Barriers and Areas for Improvement.' I will also relate the key findings to the current literature and share my reflections. Following this, I will explore the implications of these findings, with a particular focus on 'Examining Barriers and Identifying Areas for Improvement.' Lastly, I will discuss how non-Indigenous clinicians can contribute to this work. I will also address the limitations of the research and offer recommendations for future studies.

5.1 Utilizing Culturally Adapted Mental Health Interventions

The clinicians in this study shared several examples of culturally adapted interventions they use in their practice. In this section, I will offer insights into these approaches, highlighting the specific cultural practices mentioned and their impacts on enhancing therapeutic outcomes. These practices will be explored in relation to existing literature and through consultation with my advising Elder to ensure a deeper understanding of their significance.

Many clinicians discussed incorporating arts and crafts, such as making drums, cedar headbands, ribbon skirts and beading, as a therapeutic intervention. These practices align with the *Dene Law* 'Pass on the teachings' because they enable youth to learn cultural knowledge through creative expression. One can relate these practices to the Western modality of Art Therapy, a psychotherapeutic approach utilizing the creative process to improve mental health and well-being, which the clinicians in this study have adapted to include Indigenous arts (Martin & Ross, 2018). Indigenous arts and crafts serve as a powerful therapeutic tool, enabling clients to express their emotions and reconnect with their culture; this creative process also aids in healing trauma and building resilience (Kaimal & Arslanbek, 2020).

The practice of smudging was also shared as a healing method. McCabe (2007) explains smudging as the burning of Indigenous medicinal herbs such as sage, sweetgrass, cedar or juniper individually or ground together. After the flame has gone out, the cleansing smoke is fanned over the body with your hands or a feather. This practice helps calm the central nervous system and cleanses the mind, body, and spirit while connecting to one's ancestors (Marsh et al., 2015). Participant Five explained that "*smudging practices help[ing] cleanse the negative energy surrounding them or the heaviness they feel from losing someone. It just really helps them feel refreshed"* (P5). She also provided insight into the healing properties of smudging, which is cleansing and beneficial during the grieving process.

Participant Five also mentioned spirit bathing, which she states provides her clients "*with good energy"* (P5). I asked my advising Elder to explain this practice and the benefits related to mental health. She shared:

> *You are connecting to that spirit of water, leaning into the element of water. Speaking with that spirit, what is it that you want to let go of? Also, recognize that spirit of water in your body and honour that connection.* (Advising Elder, personal communication, August 12, 2024)

This practice strongly reflects *The Dene Laws*, especially the principles of "Help each other" and "Love each other as much as possible," as it supports emotional release and self-compassion through nature's healing properties.

Participant One explained how she incorporates Indigenous legends and storytelling into therapy. As discussed in Chapter 3, oral traditions have been a fundamental aspect of Indigenous history and, in therapy, result in a culturally adapted narrative method (Baskin, 2016). Friskie (2020) describes the positive impacts of storytelling on Indigenous youth:

> Storytelling can help us learn about the tragic and comedic nature of life and make us feel less alone, confused, and anxious. The stories we share impact our life choices, emotional state, and relationships. The practices of mutual communication and harmonious storytelling are comprised of activities that use our interpersonal skills and build upon our resilience in the face of adversity. (p. 24)

In the subsection '*Leading the Way: Connections to Land and Self,''* the clinicians revealed the unwavering power of the land and the gentle therapeutic effects on their clients. Participant One encapsulated this sentiment, stating, '*…the land and the environment shows up to teach or help in some way'* (P1). Several participants also emphasized the connections

between Indigenous identity, emotional awareness and the healing benefits of connecting with the land. Land-based healing practices are intrinsically tied to Indigenous peoples' mental health and identity, highlighting the land's role in nurturing and sustaining well-being (Redvers, 2020). Again, I will share this quote as it deeply encapsulates Indigenous peoples' relationship with the land: "Nature heals herself and that we are a part of Nature" (Mehl-Madrona, 2009, p. 24). I hope that by providing the details above, the reader will better understand the culturally adapted mental health interventions shared by the participants.

The participants heavily relayed the importance of trust-building and mutuality in their work. Due to their shared lineage, Indigenous clinicians are more likely to be viewed as insiders. In the helping professions, an insider shares a cultural, social, or experiential background with clients, enhancing empathy, trust, and therapeutic efficacy (Baskin, 2016). These findings suggest that building trust with Indigenous children and youth in mental health care requires a deep understanding of their cultural context and the historical trauma they may carry. It is suggested that clinicians approach with humility, patience, and a willingness to learn from their clients to create a safe and trusting therapeutic environment (Baskin, 2016; Brady, 2015; Kirmayer et al., 2019). The participants all relayed an innate awareness of the continual learning involved in supporting their clients while gently acknowledging they, too, are learning as they go. This patient therapeutic relationship building can be coupled to The Dene Law, ‘Be polite and don’t argue with anyone,’ emphasizing respectful communication and empathy in clinical practice.

Additionally, the participants reflected on how their personal experiences with trauma have shaped and influenced their professional practice. This personal history has instilled in them the importance of continual self-reflection and healing in their roles as helping professionals.

This process is crucial for clinicians, as it deepens their understanding of personal biases and values, thereby improving the authenticity and quality of their work (Wilson, 2008). There was a clear connection between their personal experiences and their current use of culturally adapted interventions. The findings highlight that having sought culture to heal themselves in some capacity, they possess firsthand knowledge of its positive impacts. This relationship enriches their therapeutic practices and informs their approaches. As Duran (2017) notes, the therapeutic practices of Indigenous counsellors are profoundly influenced by their personal healing journeys, utilizing their lived experiences to shape and inform their approaches.

Many participants noted a significant difference between their urban clients and those raised in their communities, and they discussed how they navigate these differences in their practice. Urban clients appeared more apprehensive about culturally adapted methods, while those connected to their communities were more accepting and comfortable with these approaches. These observations highlight the importance of gentle introductions, with the clinicians navigating any resistance to cultural methods with client-centred approaches. The findings suggest it is crucial to recognize that resistance often stems from historical trauma and loss of culture due to colonization (Duran, 2017). Having this awareness emphasized the requirement for culturally safe, trauma-informed practice that acknowledges both colonialism and the Indigenous identity of our clients and the reality that this may impact the counselling methods we use to effectively address the mental health needs of Indigenous children and youth (Clark, 2016).

The discoveries in this section underscore the importance of culturally adapted mental health interventions for Indigenous children and youth. It was a reflective journey, highlighting the profound influence of the clinicians' life experiences and cultural heritage on their therapeutic

practices. The findings suggest that by integrating traditional practices, respecting individual and cultural backgrounds, and engaging with the land, these interventions contribute to meaningful and effective mental health care. The journey of learning and adapting interventions remains ongoing, demonstrating the dynamic and evolving nature of culturally inclusive mental health.

5.2 Supportive Factors for Culturally Adapting Interventions

The findings from the section 'Supportive Factors for Culturally Adapting Interventions' are heavily focused on how the clinicians experienced support. These supports are presented in the subthemes, which provide the clinicians with the cultural grounding, resources, and support necessary for effective practice. *The Dene Laws* emphasize principles such as sharing, helping, love and respect for Elders; these teachings resonated deeply within the clinicians' narratives, particularly their emphasis on respecting Elders and drawing upon their wisdom as a fundamental resource in culturally adapting interventions.

The role of Elders in mental health practices, particularly in mainstream settings, remains underexplored and insufficiently understood (Constantine et al., 2004). A scoping study by Viscogliosi et al. (2020) found that, although the role of Indigenous Elders in promoting mental wellness is recognized, findings suggest there is not yet a comprehensive understanding of how their participation contributes explicitly to the mental health of individuals and communities. By sharing detailed insights on how Elders' humble wisdom informs their practice of culturally adapting interventions, the participants are helping to address the significant literary gap. As clinicians continue to navigate these complex relationships, the involvement of Elders remains an indispensable resource, bridging the current disruption between culture and modern therapeutic practices (Wilson, 2008).

The clinician's reflections further highlighted the fundamental role of integrating cultural knowledge and relationships into their therapeutic practices. Gaining knowledge from Elders,

youth, community, and family offers respect for individual and collective identities. The clinicians stressed the importance of these relationships. The findings suggest that effective interventions require a collective approach that respects Indigenous peoples' relational nature and cultural practices. From an Indigenous lens, O'Keefe et al. (2022) capture the importance of interconnection, stating,

> When children are perceived as unique beings that are part of a collective, it expands our awareness of well-being to include the wellness of everyone and everything to which they are connected. In this light, when we serve individual children, we are also serving their family, community, the environment, culture/spirit, and ancestors and future generations because who they are is embedded in those interconnected relationships. (p. 8)

The findings imply that the clinician's perspectives support the idea of focusing on interventions and fostering connectivity. O'Keefe et al. (2022) reinforce this by stating, "…future research will benefit from understanding how Indigenous-led programs promote the collective health and well-being of youth beyond narrow targets of intervention" (p. 12). This broader perspective echoes *The Dene Law* to "Share what you have," as the clinicians' work underlines the reciprocal relationships in the communities they serve.

The formation of collaborative partnerships is a pivotal element in the delivery of culturally adapted mental health interventions for Indigenous children and youth. The narratives shared by the clinicians highlight the significance of regular interactions with Elders, the support from colleagues and supervisors, and the integration of community practices. Duran et al. (1998) explain the benefits of creating partnerships, asserting, "Building a community of practice among Indigenous clinicians fosters mutual support, professional development and a shared

commitment to culturally appropriate care" (p. 69). The findings of this section further demonstrate the participants' collaboration experiences and how they are partnering with others to implement culturally inclusive practices. These efforts enhance the clinician's engagement with the community's cultural practices and provide essential support systems contributing to professional growth and effectiveness. The research findings recommend that to improve the well-being and mental health of Indigenous children and youth, it is necessary to have coordinated efforts from relevant service sectors alongside comprehensive community and government initiatives (Jongen et al., 2023) to make the right relationships that honour truth and reconciliatory practices (Brown, 2013).

5.3 Examining Barriers and Identifying Areas for Improvement

The findings related to 'Examining Barriers and Identifying Areas for Improvement' brought about themes relating to the multifaceted barriers that Indigenous Child and Youth Mental Health Clinicians encounter while attempting to integrate culturally adapted mental health interventions. The narratives highlight obstacles stemming from cultural resistance, institutional limitations, systemic inequities, and bureaucratic constraints. Discussing these key findings reveals the complexity of the clinicians' work and areas where improvement is necessary.

Resistance to cultural methods came about from participants mentioning rigidities from community members and resistance from clients regarding cultural protocols. Participant Four's experience shows how the effects of colonization create resistance not just from non-Indigenous people but also within Indigenous communities themselves. Her story about being questioned for picking medicine as a non-Okanagan reveals internal conflicts over who has the right to practice certain traditions. This finding highlights the reality that some Indigenous people may choose to withhold or scrutinize the use of cultural practices, further reflecting how colonization has

impacted Indigenous identities and traditions (Hartman & Gone, 2012). Similarly, Participant Six's experience with being questioned about her smudging methods reveals another layer of resistance based on how cultural practices are taught and practiced in Indigenous communities. The Participant's response was an acknowledgment that people are taught various ways of smudging (Participant Six, 2023), demonstrating a need for flexibility and openness in handling these cultural nuances and stressing respect for diversity within cultural practices.

As Participant Three noted, the complexities of cultural practices can also be an ongoing barrier to clients' engagement in therapy. He described how clients could become discouraged when faced with cultural protocols or using appropriate ceremonial items, causing them to disengage due to the perceived complexities of the practices (Participant Three, 2023). To address this, *The Dene Law* of helping each other can be applied by meeting clients where they are, simplifying cultural practices, and showing them how these methods can support healing in accessible ways (Gone, 2013).

Although most participants felt supported in their practices, some relayed that systemic barriers to providing culturally informed care within existing frameworks include discrimination, bureaucratic delays, restrictive funding requirements, and fixed Western organizational practices that pose challenges. Despite these obstacles, the findings reveal the resilience and adaptability of the clinicians in overcoming resistance. They navigate these barriers with patience and understanding, finding gentle ways to challenge misconceptions and adapt cultural methods to meet clients where they are while educating their clients on the diverse and flexible nature of cultural healing. This sharing of knowledge reinforces the importance of reciprocity and storytelling, which are essential to the Dene worldview and contribute to building stronger community relationships.

Lastly, Participant One's comment that *"we're not quite there yet"* highlights the systemic and societal barriers to fully integrating cultural methods into mental health care. Despite efforts to include Indigenous practices, resistance persists at individual and institutional levels, with progress varying across settings, requiring continued advocacy and education. There is a highlighted need for more adaptable structures in mental health care, prioritizing integrating Indigenous cultural practices across all aspects of care to effectively support Indigenous communities (Kirmayer & Jarvis, 2019).

5.4 Implications of Findings

The findings from this study highlight fundamental implications for the delivery of mental health services to Indigenous children and youth, emphasizing the need for culturally adapted interventions. One significant implication is the necessity for mental health services to actively integrate Indigenous cultural practices and acknowledge historical traumas that continue to affect Indigenous communities. As discussed in Chapter 3, Indigenous children and youth have specific mental health needs that often are not fully met by mainstream mental health services, mainly because many of these services are built on colonial foundations (Ineese-Nash et al., 2022). Due to this reality, Indigenous communities continue to encounter significant difficulties in obtaining suitable mental health interventions that consider culture, lived experience, and mental health objectives, resulting in perpetual mental health disparities among Indigenous youth (Nelson & Smith, 2017).

5.4.1 Implications for Organizations that Employ Indigenous Clinicians

For organizations that employ Indigenous clinicians, recognizing and addressing cultural biases within mental health care systems is essential for fostering more inclusive and equitable environments. As Nelson and Smith (2017) point out, cultural recognition in mental health care

is often selective, showing how predominant attitudes can marginalize some groups while favouring others. A suggestion is that organizations actively examine and address such biases, ensuring that the contributions of Indigenous clinicians are recognized and that the care they provide reflects the cultural contexts of their clients (Baskin, 2016; Nelson & Smith, 2017).

All participants noted aligning their practices with a client-centred approach, honouring and recognizing each client's unique experiences, cultural backgrounds, and overall autonomy. However, it is essential to acknowledge that the client-centred approach originates from Western models, particularly the work of Carl Rogers (1951). While it contrasts with more directive approaches that position the clinician as the expert guiding the therapeutic process (McCabe, 2007), the distinction should not imply that all Western models are inherently directive or expert-led. Indigenous clinicians are uniquely positioned to contribute to this model by integrating Indigenous knowledge and practices into mental health care. Kirmayer and Jarvis (2019) emphasize the significance of person-centred and equitable mental health services. They state,

> Culturally safe and responsive services and systems are essential to achieve equity in mental healthcare. Integrating culture in mental health services and systems is not just an issue for groups that face specific inequities related to their identity and social position but is central to person-centred healthcare for all. (p. 18)

Organizations have the potential to make significant steps toward achieving this goal by employing Indigenous clinicians who adopt person-centred approaches rooted in sustained engagement with Indigenous communities, which is essential for delivering equitable care (Kirmayer & Jarvis, 2019).

However, to truly benefit from the cultural knowledge of Indigenous clinicians, the findings suggest organizations must engage meaningfully with Indigenous communities,

involving them in the development and delivery of mental health care. The research further suggests that organizations must embed historical and cultural contexts into their mental health policies, research, training, and care systems to address long-standing inequities (Kirmayer & Jarvis, 2019). As Ineese-Nash et al. (2022) note, “Honouring context entails meaningful engagement with Indigenous communities who hold valuable understandings, approaches and resources to support the healing of Indigenous youth” (p. 50).

For organizations, this suggestion means fostering an environment where Indigenous clinicians can apply their cultural knowledge to provide care and influence broader systemic changes. This can improve mental health outcomes for Indigenous children and youth, promote a culturally sensitive workplace, and encourage policies that ensure person-centred, culturally safe services. Organizations can also improve access to culturally adapted care by offering more flexible funding options and removing strict bureaucratic rules that hinder the use of Indigenous healing practices.

5.4.2 Implications for Indigenous Clinicians

Indigenous clinicians play a critical role in advancing Indigenous people’s rights to self-determination within mental health services by integrating culturally relevant approaches into their practice. This process is essential in challenging colonial attitudes that dominate mainstream mental health systems (Nelson & Wilson, 2017). By embedding Indigenous cultural methods into clinical work, Indigenous clinicians actively reject the narrative that asserts “The dominant cultural values and orientation of society also determine which aspects of culture and identity are recognized and deemed worthy of explicit attention in healthcare policy and practice” (Kirmayer & Jarvis, 2019, p. 12). Several participants mentioned rigidities from community members regarding cultural protocols and related it to a lingering symptom of

colonization. Clinicians should recognize that these instances may reflect deeper relations to historical traumas. The findings suggest that future training and educational programs for mental health professionals should incorporate this historical and trauma-informed context to foster more informed and sensitive approaches to address the complexities of these issues (Gone, 2013).

The research implies that future training and education for mental health professionals include a deeper understanding of colonization and trauma to help professionals address these issues in a more thoughtful and informed way. Additionally, policymakers should work to ensure that mental health policies actively support Indigenous healing practices by incorporating Indigenous clinicians' voices in the development of health policies, which is also essential for creating inclusive and culturally appropriate mental health systems.

5.4.3 Implications for Non-Indigenous Clinicians

This study is written specifically for Indigenous mental health clinicians who engage in the cultural adaptation of interventions. It is important to note that it is not considered best practice for non-Indigenous clinicians to implement culturally adapted mental health interventions without appropriate guidance and training from an Elder or Knowledge Keeper. While the focus is not intended to exclude non-Indigenous clinicians who support Indigenous children and youth, this study aims to amplify the voices of those who have been underrepresented in this critical area of work. At the same time, there are ways that non-Indigenous clinicians can be supportive of this work.

In my practice, I have the honour of working alongside two non-Indigenous clinicians whose unwavering support and genuine allyship have profoundly influenced me. Their humility and sincere dedication to supporting Indigenous children and youth have inspired my practice

and helped me challenge and soften any biases I previously held. Much of what I will share is drawn from observing their actions and approaches while providing meaningful contributions.

Regarding best practices for non-Indigenous clinicians, supporting this work starts with actively engaging with Indigenous communities and learning about the local Nations, languages, and cultural practices on the lands where they live and work (Wendt et al., 2022). Having a firm knowledge of the history of colonization in Canada and the current social determinants of Indigenous child and youth mental health supports cultural safety (Kirmayer & Jarvis, 2019). It also offers awareness of the injustices faced and magnifies the resiliency of Indigenous people (Bowden et al., 2017). Just as the Indigenous clinicians in this study, non-Indigenous clinicians are encouraged to practice self-reflection to develop an awareness of their cultural identities. Achieving this involves recognizing their attitudes, beliefs, and values related to race, ethnicity, and culture and how these relate to privilege, discrimination, and oppression (Bowden et al., 2017).

Non-Indigenous clinicians must continually endeavour to engage in cultural humility, which stresses the need for clinicians to acknowledge the limits of their knowledge and remain open-minded toward others (Kirmayer & Jarvis, 2019). When incorporating culturally adapted interventions, non-Indigenous clinicians must seek guidance and permission from Elders or Knowledge Keepers who are associated with their organizations for proper training and permission before proceeding. Non-Indigenous clinicians can play a vital role in collaborating with their Indigenous colleagues in supporting Indigenous children and youth's mental health by engaging in ongoing learning and partnerships while building genuine connections with Indigenous communities and honouring their client's traditions, strengths, and resilience.

5.4.4 Implications for the Field of Social Work

The findings from this study have significant implications for social work, particularly in addressing systemic inequities and promoting culturally inclusive and safe practices. The conversations shared in this study highlight opportunities for the transformation of social work practice in Canada, which has historically been complicit in settler colonialism and the marginalization of Indigenous people (Frontier & Wong, 2018). By centring Indigenous perspectives and experiences, social work can address historical injustices and foster culturally responsive interventions that support Indigenous children, youth, and families (Sinclair, 2020). Serving as a bridge to Indigenous healing practices, social work has the potential to promote mental health and well-being while embodying cultural humility, partnership, and inclusivity. By challenging colonial attitudes and embracing Indigenous approaches, the field can evolve to meet the unique needs of Indigenous communities, driving systemic change and offering a path toward healing and hope for future generations (Nelson & Wilson, 2017).

5.5 Limitations of Research

Offering the limitations of research is essential for maintaining transparency and credibility while allowing the reader to understand the scope and boundaries of the research (Creswell & Poth, 2018). In exploratory research, acknowledging these limitations emphasizes areas for future research, fostering ongoing inquiry and improvement (Stebbins, 2001). The study's small sample size and parameters may be limitations because the cultural aspects may only be relative to individuals with the Nlaka'pamux, Syilx, and Secwẻpemc Nations and may not apply to Canada's vast array of Indigenous cultures. For instance, each Indigenous community has its language and ceremonial and cultural traditions, such as songs and protocols specific to their Nation. The plethora of diverse healing practices among Indigenous Nations

poses a challenge in articulating culturally adapted interventions, as there is no particular resource to follow (Reeves & Stewart, 2016). Although Indigenous peoples share fundamental values and beliefs, each group's practices are unique to their communities and should be respectfully acknowledged and recognized. At the same time, the study focuses less on the nuances of the cultural interventions and more on how practitioners implement them and how they are supported; I did want to include diversity among Indigenous cultures, as I feel it would add richness to the findings.

Another potential limitation to the research that I observed is the hesitation, and emotional burden participants may feel when discussing the lack of support in their practice, which could hinder their willingness to share their experiences and challenges fully. This was evident as several participants paused and carefully chose their words, with Participant One explicitly stating, *"I'm trying to be really choosy with my words"* (P1), when asked how she felt she was not being supported in her work. As an Indigenous child and youth mental health clinician, I have experienced the barriers to implementing culturally appropriate mental health services and witnessed the significant unmet needs of Indigenous clients throughout my career. Our society provides services to rural Indigenous communities to fill in the gaps for mental health support, although, at times, we are essentially the only service available. I realize that, as clinicians, we do our best with considerable wait lists and heavy caseloads while trying to understand each client's unique needs, which can be tremendously overwhelming. I hoped that my commonalities with the participants in the study would ensure a compassionate space in expressing the barriers they may be facing. I noticed that some participants were apprehensive about the question regarding how they felt unsupported in their practice. To ensure a safe environment, I reassured a participant who seemed concerned by saying, "…you only share what

you’re comfortable sharing”. This statement appeared to ease their apprehension, and they continued their conversation. I considered the potential stressors the participants might experience within their practice and ensured I did not add any additional pressure on them.

The participants in this study were practicing in both rural and urban areas; research that focuses exclusively on participants’ experiences in either urban or rural settings may have different results. The study was also limited to clinicians who were employed at Indigenous organizations, and the data did not address the specific challenges faced by Indigenous clinicians within non-Indigenous organizations. Such research could offer a deeper understanding of systemic barriers, cultural misalignments, and the emotional labour Indigenous clinicians might face when working in predominantly non-Indigenous settings.

Lastly, exploratory, qualitative research focuses on gaining a basic understanding of a problem or situation. Instead of delivering final answers, as previously mentioned, it lays the groundwork for further, more detailed research efforts (Stebbins, 2001). The findings from this study are not generalizable to a larger population (Stebbins, 2001); however, the study's goal was to identify notable issues to explore further, which I feel was the result.

5.6 Recommendations for Future Research

Although the study produced an insightful view of the Indigenous clinicians' experiences, it also revealed that further exploration is needed to gain a more comprehensive understanding of details related to their adaptations and positive outcomes of culturally adapted mental health interventions for Indigenous children and youth. As previously mentioned, the literature highlights the benefits of culturally adapted mental health interventions but lacks detailed accounts of clinicians’ experiences and the complexities of implementation. Gaining these insights would enrich knowledge, support Indigenous clinicians, and inform organizations, policymakers, partnerships, and future research. Further in-depth longitudinal studies on

understanding the contextual nature of their adaptations and the mental health outcomes for Indigenous children and youth would be beneficial (Lund et al., 2022). Additional evaluation of methodologies and identifying the components of the adaptations can help guide future efforts in modifying existing mental health programs (Lund et al., 2022).

In practice, the clinicians spoke of utilizing client-centred approaches by following the lead of their clients when it came to implementing culture. The youth, in turn, are the directors of their healing journeys, empowering youth to reclaim their culture and identities. However, in research, their voices are predominantly overlooked, leading to gaps and misalignment of mainstream service provision (McGregor et al., 2024). To ensure lasting change, the perspectives of Indigenous youth must be woven into the fabric of policymaking and community health initiatives. The data suggests that increasing the involvement of urban and non-urban youth in the design and delivery of mental health services in collaboration with Elders, community, and service providers is essential and ensures these services are culturally secure, relevant and accessible (McGregor et al., 2024).

In their 2024 study, Brown et al. highlight the proactive efforts of Indigenous youth, emphasizing their involvement in activism and advocacy for inclusion in critical decision-making processes regarding their future well-being. They argue that:

> Indigenous youth are speaking out (i.e., school strikes and political activism) to be included in the discussions and decisions being made by community and political leaders, where doing so would shift the praxis of research and health care development and delivery to empower and support Indigenous communities and youth. Without this praxis shift, Indigenous communities and youth will continue to be marginalized by the health, social and political systems that operate around and for them. (p. 2018)

Future studies can enhance our understanding of implementing and sustaining culturally adapted mental health interventions for Indigenous children and youth.

Further reflections revealed that I did not explore intrinsic links between the cultural methods used and the specific mental health concerns they aimed to address. This omission stemmed, in part, from my recognition of how the clinicians intuitively aligned their interventions with their clients' needs. As an Indigenous clinician who also culturally adapts interventions, I share a reciprocal understanding that may have influenced my decision not to investigate these details further. However, this important topic warrants further research to examine these connections more explicitly, ensuring a deeper understanding of how certain cultural practices support specific mental health concerns.

Lastly, there is a need (or opportunity) to address and examine the systemic disparities that Indigenous mental health professionals and their clients encounter. The research should identify institutional policies and practices that do not include Indigenous knowledge, obstruct culturally adapted care, and suggest solutions to advance equity and inclusion within mental health services (Montesanti et al., 2022). This also includes understanding the challenges of securing funding and navigating bureaucratic constraints, which can help develop strategies to advocate for more supportive policies and resources (McGregor et al., 2024).

5.7 Conclusion

The experiences shared by the participants revealed multifaceted processes involved in culturally adapting mental health interventions that support Indigenous child and youth clients. The study uncovered how Indigenous clinicians humbly realized their culturally adapted interventions through lived and work experience, collaboration, gentle client-centred approaches, and intuition. As I referred to *The Dene Laws* throughout my study, respect, integrity,

compassion, and reciprocity remained tangibly present; I hope I have honoured the participants, the readers, the field of social work, and the Indigenous community respectfully.

Indigenous healing modalities remain theoretical within mainstream counselling and psychotherapy and are not substantively published in the literature, implemented in practice, or described within research (Stewart et al., 2016). Due to the lack of research, I am hopeful the result of my exploration will produce sound evidence regarding the benefits of thoughtful and adequate culturally-inclusive mental health service delivery to Indigenous children and youth. Further, I hope my results will offer acknowledgment and support for Indigenous clinicians in understanding how they navigate their roles and the support they require to ensure effective delivery.

Due to historical colonial interference, Indigenous people were separated from the inherent knowledge needed to engage in the healing practices of their ancestors. The reclamation of these healing practices is essential for the future and well-being of our Indigenous children and youth. This reclamation is also integral to cultural preservation, fostering resilience in the face of historical trauma caused by colonization, residential schools, and systemic marginalization. By sharing these healing traditions across communities, Indigenous people not only resist cultural erasure but strengthen collective identity and foster intergenerational healing (Gone, 2013). As Waterfall et al. (2016) articulate, "Organized through kinship systems of relationship, the locus of Indigenous healing strategies for helping and healing were ones that focused on people connecting their own personal connection and power" (p. 13).

As stated previously, there is a crucial opportunity for social work to address its historical role in perpetuating settler colonialism and to take meaningful steps toward systemic transformation. By centring Indigenous knowledge, perspectives, and healing practices (Gone,

2013), social work can move away from colonial frameworks and create culturally-rooted, inclusive approaches that genuinely respond to the mental health needs of Indigenous children, youth, and their families. Achieving this goal requires a commitment to cultural humility, authentic partnerships, and advocacy for systemic change that confronts and dismantles inequities (Sinclair, 2020). The future of social work lies in its ability to challenge colonial structures, support Indigenous leadership, and redefine mental health care through the lens of reconciliation and justice (Fortier et al., 2019). In doing so, the field can build equity, foster healing, and empower Indigenous communities for their future generations.

Throughout my research journey, I was impacted in numerous ways, namely through the reciprocal camaraderie, mutuality, and respect experienced when speaking with all the clinicians. Despite our diverse Indigenous backgrounds, I understood that we hold collective similarities related to our work and our intent behind incorporating culture into our practices. Like the participants, despite the many hardships I have faced as an Indigenous person due to intergenerational trauma, I transformed those trying experiences into a source of strength and positivity, allowing me to support my clients with a deep understanding and compassion from my heart. I also heavily identified with the participants' experiences of self-doubt while navigating the complexities of their professional roles. I sensed we all share an innate awareness that land heals us, and our culture heals us, a knowledge passed down through the generations; this is our blood memory of how to care for our children, just as our ancestors before us. By collectively working to revitalize Indigenous healing practices, we can provide Indigenous children and youth with opportunities for meaningful cultural inclusivity as they embark on their healing journeys; this is my hope.

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Appendix A - Conversation Guide

Study: "Indigenous Child and Youth Mental Health: An Exploration of Indigenous Clinicians' Experiences of Culturally Adapting Interventions"

An Interview Guide is simply a basic structure to guide our conversation.

Below is a list of some of the topic areas that this thesis research is curious about.

1. I would like to start with some general questions to help me learn more about you and your background. Can you please share with me what community you are from and how you would describe your Indigenous ancestry?
2. What Indigenous Territory are you providing services to?
3. Can you please tell me about your educational background, including training?
4. How long have you been in mental health practice with Indigenous children and youth, and what led you to work with this specific population?
5. What are your personal experiences with culture and involvement in Indigenous ceremonies?
6. How does your Indigenous culture and history inform your work as a mental health clinician?
7. How are the children and youth responding to the cultural elements of therapy?
8. How do you describe your successful adaptation of therapeutic interventions using culture?
9. How did you learn those cultural interventions, and how did you develop your methods for using them?

10. How are you implementing these practices in a culturally safe manner with your Indigenous clients? Is anyone advising you?

11. Who has supported you during the process of culturally adapted mental health interventions? With whom have you collaborated?

12. If relevant, how are you navigating the implementation of culture when the child/youth is from a different culture?

13. How do you feel you are not supported in implementing culture into practice, and what barriers have you encountered?

Appendix B – Research Ethics Board Approval

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

August 18, 2023

Dr. Susan Burke (Principal Investigator) Mrs.
Melissa Dexel (Principal Applicant) c/o
University of Northern British Columbia
Faculty of Human and Health Sciences\Social Work Dear

Dr. Burke and Mrs. Dexel,

File No: 6009196
Project Title: Indigenous Child and Youth Mental Health: An Exploration of Indigenous Clinicians' Experiences of Culturally Adapting Interventions
Approval Date: August 18, 2023
Expiry Date: August 17, 2024

Thank you for submitting revisions to the above-noted proposal to the Research Ethics Board ("REB"). Your project has been approved.

We are pleased to issue approval for a period of twelve months from the date of this letter. To continue your proposed research beyond August 17, 2024, you must submit a Renewal Form prior to that date. If your research has been completed before a Renewal Form is due, please submit a Final Report Form in order to close the REB file.

Throughout the duration of this REB approval, all requests for modifications, renewals and serious adverse event reports must be submitted to the REB via the Romeo Research Portal. If you encounter any issues when working in the Research Portal, please contact our system administrator by email to researchportal@unbc.ca.

Please refer to the Chair Bulletins found on the REB webpage for updates on in-person interactions with participants during the COVID-19 pandemic. If questions remain, please do not hesitate to email reb@unbc.ca.

Good luck with your research.

Sincerely,

Dr. Neil Hanlon, Chair, Research
Ethics Board