BISKANEWIN ISHKODE (THE FIRE THAT IS BEGINNING TO STAND):
EXPLORING INDIGENOUS MENTAL HEALTH AND HEALING CONCEPTS AND
PRACTICES FOR ADDRESSING SEXUAL TRAUMAS

by

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Multiple traumas, including sexual vulnerabilities, sexual abuse, and sexualized violence, remain substantially higher among Indigenous peoples in Canada than among non-Indigenous peoples. These trends are rooted in a colonial history that includes systemic racism, a deprivation of lands and culture and other intergenerational traumas. Mental health sequelae following sexual vulnerabilities such as abuse and violence may include mood disorders, low self-worth, posttraumatic stress and a range of issues related to anxiety—yet Western mental health services are typically under-used by Indigenous peoples managing these issues. Indigenous mental health and healing services are explored as a more culturally appropriate and successful alternative for Indigenous clients experiencing multiple traumas.
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Dedication

For mum.
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Chapter 1: Introduction

Indigenous Peoples’ Sexual Health in Canada

Since colonization, systemic racism, dispossession, and threats to cultural identity in the Indigenous communities of Turtle Island\(^2\), has led to many social and health problems that were, prior to contact with Europeans, largely unknown (Gunn Allen, 1986; Moffitt, 2004; Paul, 2000; Steenbeek, 2004). The colonial legacy within Canada’s Indigenous history dates back to the first European settlers following Cabot’s landing on Canada’s eastern shores in 1497. Throughout our more recent history, federally imposed policies such as the Indian Act (relegating Native peoples to reserve lands, denying cultural rights and language, etc.), Bill C-31 (affecting Native women’s Indian Status), the residential schooling system, and forced adoption through the 60’s Scoop have resulted in a marginalization of Indigenous peoples within Canada (Moffitt, 2004).

Colonization has been referred to as a *soul wound* (Duran, 2006) to Indigenous peoples, as well as a physical and cultural genocide (Moffitt, 2004), and these social issues have resulted in high rates of alcohol abuse, family violence, under-employment and mental health issues in many Indigenous communities (Native Women’s Association of Canada [NWAC], 2007; Smye & Browne, 2002; Spitzer, 2005; Stewart, 2008, 2009).

A gender-based analysis reveals further that Indigenous women in Canada are at greater risk of facing health and social inequalities due to their being doubly disadvantaged (NWAC, 2007) as they face both racism and sexism in a Canadian mosaic rooted in a history of Euro-

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1. In this dissertation, the term indigenous with a lower case ‘i’ refers to global indigenous groups; a capital ‘I’ for Indigenous is used as a respectful way of referencing the First Peoples of North America.
2. Turtle Island is the ancient Indigenous name for North America (Bear Hawk Cohen, 2003).
Christian patriarchy (Spitzer, 2005). Within the Indigenous population, women experience significantly more disadvantages than men with respect to social determinants of health, including lower socioeconomic status\(^3\), lower educational levels, lower quality housing, poorer physical environment, fewer employment opportunities, and multiple forms of systemic discrimination (NWAC, 2007). With respect to specific health outcomes, Indigenous women face higher risks of alcohol and substance misuse, mental illness, suicide, diabetes, cervical cancer, and higher rates of violence and sexual victimization, among many others (McEvoy & Daniluk, 1995; NWAC, 2007). Despite the clear evidence and agreement among researchers and health experts of these health disparities, very little action has been taken in terms of health and social policy in an effort to close these gaps in social determinants for Indigenous peoples in Canada and Indigenous women in particular (NWAC, 2007).

Sexuality and sexual health represent contemporary areas of significant concern for Indigenous peoples, especially around the rates of sexually transmitted infections, including HIV, as well as cervical cancer, and sexual abuse and family violence, all of which remain significantly higher than in the non-Indigenous population (Clarke et al., 1998; Hoffman-Goetz, Friedman, & Clarke, 2005; Public Health Agency of Canada, 2007; Steenbeek, 2004). For instance, sexually transmitted infections (STIs) appear to be significantly higher amongst Indigenous peoples than in the non-Indigenous population. The reported rates of chlamydia and gonorrhea in Canada remain highest among First Nation and Inuit adolescents in many communities, ranging from four-to-ten times the rate in mainstream populations (Hoffman-Goetz

\(^3\) According to Statistics Canada (2001), Indigenous women’s average income was the lowest in Canada, a full five thousand dollars less per year than Indigenous men, over six thousand less per year than non-Native women and over twenty thousand less per year than non-Native men in Canada.
et al., 2005; Jolly, Moffatt, Fast, & Brunham, 2005; Steenbeek, 2004). First Nation women in Canada also have four-to-six times the mortality rate from cervical cancer than the mainstream population (Clarke et al., 1998). Additionally, while the cases of HIV/AIDS in the non-Indigenous population are decreasing, the numbers of cases in Indigenous populations in Canada are increasing. A report by the Public Health Agency of Canada (2007) states that, between 1996 and 1999, there was a 91% (1,340-2,740) increase in the number of Indigenous people living with HIV and a 19% increase in the number of newly infected Indigenous people (310-370). Of these cases, Indigenous women make up 44% of the AIDS cases and 44.6% of the HIV cases, as compared to 8.6% and 20% in the non-Indigenous female population, respectively (Benoit, Carroll & Chaudhry, 2003; Hoffman-Goetz et al., 2005). In addition, a study on HIV risk factors found homosexual Aboriginal men to be at higher risk for this disease due to life experiences of poverty, mental health vulnerabilities and childhood sexual abuse (Hoffman-Goetz et al., 2005).

Several studies have shown that Indigenous women also suffer from high rates of physical and sexual abuse (Brownridge, 2003; Culhane, 2003; NWAC, 2002, Pearce et al., 2008) and these trends have remained consistent over the years. For instance, a study by the Ontario Native Women’s Association found that 80% of the women in their Ontario sample had experienced family violence (1989). A 2006 Statistics Canada survey found that Indigenous women in Canada face substantially high rates of violence generally, including spousal and sexual abuse. Although findings from this survey indicated they face violence at a rate of three times their non-Indigenous counterparts, incidence levels are typically under-reported in these types of measures (Statistics Canada, 2006). This national survey indicated that Indigenous
women were also more likely than non-Indigenous women to report severe and life-threatening forms of violence, including having a weapon used against them, being choked or beaten, and being sexually assaulted. Indigenous women were also more likely to be assaulted on more than ten occasions by the same perpetrator, and were more likely to indicate they feared their lives were in danger. Some abuse survivors are also at a higher risk of contracting HIV and STIs due to lifestyle factors related to poverty, past abuse and post-traumatic stress (Young & Katz, 1998).

In fact, the association of gender-based violence to the risk of contracting HIV/AIDS has been well documented in the literature, sometimes referred to as the “twin epidemics” (Canadian Aboriginal AIDS Network [CAAN], 2009, p.16; Kathewera-Banda et al., 2005; Mamam, Campbell, Sweat, & Gielen 2000), illustrating their reinforcing relationship. One Vancouver-based study on men who have sex with men (MSM) also found Aboriginal men to be significantly more likely to have experienced sexual abuse as children, non-consensual sex as adults, and depression than non-Aboriginal MSM (Heath et al., 1999).

Mental health outcomes for survivors of sexual illnesses and traumas, including intimate partner violence, have been well outlined in the psychological literature. For instance, survivors of sexual trauma often face challenges in forming and maintaining intimate relationships and have relational difficulties generally (Baima & Feldhousen, 2007). They also often experience fear, anger, shame and guilt in the aftermath of their traumatic experiences and survivors are more likely to engage in self-destructive and suicidal behaviours (Baima & Feldhousen, 2007). Other common mental health outcomes for survivors of trauma and violence include posttraumatic stress disorder, mood disorders including depression and a range of anxiety
disorders, as well as somatization disorders (Beckerman, 2002). Finally, individuals who are conferred sexual health diagnoses, such as sexually transmitted infections (STIs) including HIV/AIDS, also experience stigma and resultant physical health complications (Balfe et al., 2010). Given the significantly higher rates of sexual health issues among the female Indigenous population in Canada, there are surprisingly few studies looking at mental health outcomes among this important population of women (McEvoy & Daniluk, 1995; Walters & Simoni, 2002). There are even fewer studies looking at relationships between sexual abuse and mental health outcomes among Aboriginal men in Canada and more research in this area has been called for (Devries, Free, Morison & Saewyc, 2009b). Of the available literature on mental health outcomes among abuse survivors and directions for mental health treatment, studies typically assume homogeneity in the abuse experience and do not differentiate experiences by ethnicity, class and personal context (McEvoy & Daniluk, 1995).

In order to address the mental health needs of Indigenous peoples facing challenges related to sexual violence, sexual trauma and sexual health issues, the political, historical and social contexts around these health outcomes must be considered within the framework of colonization. In addition, responses to the mental health needs of Indigenous peoples affected by sexual health issues and violence must be culturally appropriate and sustainable. This chapter introduces this research study, which investigates the use of traditional Indigenous healing among mental health staff at Anishnawbe Health Toronto to address these issues related to sexual health and wellness. It also offers a brief overview of the terms used in this study, as well as the conceptual framework for this study, detailing the purpose, research questions, design and
significance of this dissertation.

**Key Concepts: Sexuality, Sexual Vulnerabilities and Mental Health**

Sexual health is defined by the World Health Organization (WHO) as, a state of physical, mental and social wellbeing in relation to sexuality (2002a). It emphasizes respectful approaches to sexuality and sexual relationships and encourages pleasurable and safe sexual experiences free of violence, discrimination and coercion. Reproductive health refers to the same state of wellbeing (and not merely the absence of disease) in all matters relating to the reproductive system (WHO, 2011), including the right to a satisfying and safe sex life, the capacity to reproduce and the freedom to determine when and how frequently to do so, as well as access to information on methods of family planning, child birth and child care. The term ‘sexuality’ takes on a more broad definition by the World Health Organization in that it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (WHO, 2002a). Sexuality is multidimensional and can be expressed through various channels, such as one’s beliefs, attitudes, desires, behaviours, roles and relationships; additionally, sexuality is shaped throughout an individual’s life course through historical, economic, political, biological, social, psychological and spiritual factors (WHO, 2002a). Sexual rights include access to sexual health care services, access to education and information on sex, the right to choose one’s partner, the right to have consensual sexual relations and marriage, the right to be sexually active (or not), to have children (or not), and the right to bodily integrity (i.e. control over one’s own body) (WHO, 2002a).

The term “sexual vulnerabilities” has been used in other health promotion and health
policy literature looking at sexual health issues among Indigenous peoples (see for example, Pearce et al., 2008, p.2192). Specifically, among researchers who carried out the Cedar Project\(^4\), the term “sexual vulnerabilities” referred to various health issues relating to sexual abuse, sexual violence, survival sex work and sexually transmitted infections, including HIV (Pearce et al., 2008). The purpose in considering this array of sexual health issues in this present study (rather than considering sexual abuse or STIs independently) relates to the concept of the “twin epidemics” noted above where, for instance, the risk of contracting an STI, such as HIV, is increased by sexual violence and vice versa (Kathewera-Banda et al., 2005; Mamam et al., 2000). Consider this example in particular: Sexual violence may expose women to HIV or other STIs through forced intercourse, where wounds and cuts are more likely to occur and facilitate the transmission of the virus (WHO, 2002b). Alternatively, exposure to violence or childhood sexual abuse may result in poor mental health outcomes among women and can in turn result in the participation of high risk behaviours such illicit substance use or having multiple sexual partners (CAAN, 2009; Farley, Lynne, & Cotton, 2005; UNAIDS, 2003). Also, the experience of intimate partner violence may create difficulties for women in negotiating safer sexual practices (Mill, 1997). Finally, individuals who have been diagnosed with HIV may face increased violence from partners or within their communities due to stigma (CAAN, 2009). The overarching links between these sexual health vulnerabilities relate to social determinants of health, including colonization, which, for many Indigenous people in Canada leads to experiences of racism, poverty, social marginalization and multiple forms of trauma. Indigenous

\(^4\) The Cedar Project is a large multidisciplinary study which follows a cohort of young Indigenous peoples aged 14 to 30 in two urban centres in British Colombia who are injection and non-injection drug users to further understand health complications relating to intergenerational traumas, sexual abuse and HIV among this population.
women also carry the added burden of sexism. These factors in turn put many Indigenous people at greater risk of experiencing sexual vulnerabilities (CAAN, 2009). Therefore, when looking at mental health outcomes among these individuals, it is important to consider the intersection of these multiple sexual vulnerabilities, as they often co-occur and interrelate. This research study will use the same working definition of “sexual vulnerabilities” as in the Cedar Project outlined above.

With respect to specific sexual vulnerabilities, sexual abuse was defined in the Cedar Project as any sexual activity that is forced or coerced, including sexual abuse, molestation, rape and sexual assault (Pearce et al., 2008). Sexual violence is defined by the World Health Organization as any sexual act (or attempt to obtain a sexual act) against a person’s sexuality using coercion (2002b), where coercion covers a wide spectrum of degrees of force, including physical force, psychological intimidation, manipulation or verbal threats. Sexual violence also occurs when the victim is unable to give consent (i.e. when drugged, drunk, asleep, or mentally incapable of understanding the situation) and can be perpetrated by any person regardless of her or his relationship to the victim (WHO, 2002b). Sexual violence takes on many forms, including forced intercourse (within relationships or between strangers), forced prostitution and trafficking, sexual harassment, the denial of the right to use contraception, and forced abortion, among others (WHO, 2002b). The term survival sex is used to denote the sale of sex to meet subsistence needs, including the exchange of sex for shelter, food, drugs, or money (Shannon, Bright, Gibson & Tyndall, 2007). In a recent study of HIV risk among Indigenous women involved in survival sex work in Vancouver, women referred to sex work as a means of daily survival (Shannon et al.,
In the words of one participant, this type of work can often arise out of desperation: “Like I said, we put ourselves in shitty situations when we’re sick, or we’re hungry or we’re homeless” (p. 917). Increased rates of sexual abuse, violence and survival sex can result in sexual and reproductive health issues, including unwanted pregnancy, STI and HIV infection and mental health issues (WHO, 2002b).

Sexually transmitted infections are another form of sexual vulnerability and are primarily contracted through sexual contact, although some can also be transmitted from mother to child during pregnancy and childbirth, such as HIV and syphilis (WHO, 2007). There are over thirty different sexually transmitted viruses, parasites and bacteria, including more commonly known bacterial infections such as gonorrhoea, chlamydia and syphilis and commonly known viral infections including the Human Immunodeficiency Virus (HIV, which causes Acquired Immune Deficiency Syndrome (AIDS)), genital herpes, and the Human Papillomavirus (HPV). The World Health Organization’s global strategy to prevent and control STIs includes promoting safer sexual behaviours, securing affordable access to condoms, the inclusion of STI treatment in basic health services, the provision of information, education and advice around these infections, and screening for these illnesses (WHO, 2007).

The term mental health relates to the promotion of wellbeing, the prevention of mental health issues, and the treatment of people who are affected by mental illness (WHO, 2011). As described above, the incidence of sexual health vulnerabilities is associated with the development of mental health issues. The World Health Organization notes that mental health problems occur commonly among victims of sexual assault and can include depression, anxiety,
posttraumatic stress disorder, somatic complaints, low self-esteem, self-blame, sleep difficulties and aggressive behaviours, among others (WHO, 2002b). Psychological care and support is recommended in these cases in the form of counselling, therapy and support groups (WHO, 2002b); however, as these psychological services are often provided by the nongovernmental sector, the number of individuals who are able to access these services in most countries is limited (WHO, 2002b). The following section will explore the relationship of the concepts of sexuality and mental health to the present study.

The Biskanewin Ishkode Study

This dissertation study emerged from the voices of Indigenous community women who participated in a national, community based study looking at relationships around sexual violence and HIV among Indigenous women in Canada (Canadian Aboriginal AIDS Network [CAAN], 2009). This CAAN project explored ways in which Indigenous women living with HIV/AIDS coped with experiences of sexual violence in their lives, as well as their challenges in seeking appropriate health care services. It is well documented that negative sexual health outcomes and sexual vulnerabilities impact the physical, mental, emotional, social and spiritual health of Indigenous peoples, families and communities (Ship & Norton, 2002), as noted earlier in this chapter. Accordingly, the CAAN study found links between negative childhood experiences, disadvantages with respect to a variety of social determinants of health, gender inequalities, and poor self-concept as additional risk factors related to sexual violence and HIV. The study also revealed important findings related to mental health: for the twenty women in the study, negative sexual health outcomes contributed to damaged self-esteem, social isolation,
internalized blame, negative body image, suicidal thoughts and attempts, a lack of self-care, feelings of anger, resentment and betrayal, as well as addictions and involvement in the sex trade (CAAN, 2009). As coping tools, many women described seeking help at Indigenous health centres, seeking counselling (both Western and traditional Indigenous), participating in healing ceremonies (community gatherings, powwows, smudging, receiving guidance from Elders), employing faith-based approaches through church and prayer, and through personal wellbeing activities such as reading, writing and exercise (CAAN, 2009). Among the recommendations from the study, participants called for more research looking at emotional and spiritual health among affected women.

Within an Indigenous worldview of health, mental health is considered critical to healing and overall wellbeing rooted in a balance between the sacred aspects of the self (emotional, physical, spiritual, mental and social) (Blue & Darou, 2005; Mussell, 2005; Stewart 2008). This Indigenous paradigm of health had been successfully employed for thousands of years prior to the arrival of Europeans and colonialism (Stewart, 2008); however, colonial practices have, in many cases, interrupted community structure and inhibited the transmission of traditional healing knowledge (Kirmayer, Simpson & Cargo, 2003). Currently, many communities are working to re-build social support systems to improve mental wellbeing among individuals, families and communities, in order to promote cultural identity and healing (Stewart, 2008). Still, Indigenous health and healing practices remain largely absent from mainstream health care services and literature indicates that Indigenous peoples are less likely to use health services that are not adapted culturally to their understandings of healing (Blue, 1977; McCormick, 1996). Indeed,
among the recommendations that emerged from the CAAN study on sexual violence and HIV, participants asked that health service providers develop a greater understanding of Indigenous cultures generally, and traditional Indigenous healing and medicine in particular (CAAN, 2009).

In order to address the emotional, mental and spiritual health of Indigenous women affected by sexual violence and illness, this study sought to understand how traditional healing in mental health can help Indigenous women who have experienced sexualized violence, abuse and vulnerabilities. In exploring these topics, this study conducted important mental health research that has been identified by community women in the CAAN study (2009) who are impacted by these health outcomes. It also extended from a key question from CAAN’s study which asked women about how they use cultural tools (sweat lodges, smudging, etc.) to manage their health needs. Due to the increasingly high numbers of Indigenous women living with negative sexual health outcomes, studies have called for additional resources and supports around culturally appropriate mental health services in order to improve the quality of life for these women (Ship & Norton, 2002), often described as among the most vulnerable individuals in Canadian society (CAAN, 2009, p.55).

Specifically, the research question guiding this study was: how do traditional helpers conceptualize and address the mental health needs of Indigenous women experiencing sexual health vulnerabilities? In addressing the research question, this study was qualitative in nature and involved a narrative interview inquiry with traditional mental health workers (traditional counsellors, traditional healers and Elders) at Anishnawbe Health Toronto (AHT) who have worked with Indigenous clients who have experienced sexual health vulnerabilities. The research
question was chosen purposefully as it reflects a critical gap in the psychological literature around Indigenous healing in the area of sexual health from an Indigenous paradigm (CAAN, 2009; McEvoy & Daniluk, 1995; Stewart, 2008).

While the intention, design and proposed research question of this study sought to explore sexual trauma in the context of Indigenous women’s lives, the results from this study do not focus on the needs of one particular gender. The participants in this study inferred that while many female clients who use mental health services at this health clinic have experienced sexual abuse and violence (as well as many other traumas), the male clients who use these services experienced these types of abuse in almost equal numbers. The participants described further that within an Indigenous model of health, concepts of wellness, illness, balance and imbalance are not conceptualized differently by gender. Therefore, although this study’s research question and literature review focus on Indigenous women’s health, key findings in the Results and Discussion chapters reveal gender-neutral findings.

**Partnership**

This study was conducted through a partnership with Anishnawbe Health Toronto. AHT is a culture-based multi-service health centre that has been servicing Indigenous peoples in Toronto since 1989. In the urban city of Toronto, there exist numerous Indigenous individuals representing various Bands and Indigenous affiliations, varying in socioeconomic, linguistic and cultural backgrounds. AHT offers a variety of health and wellbeing services in various Indigenous languages and offers clients a sense of Indigenous identity as well as a place to engage in healing (physical, emotional, spiritual, mental, social). This facility offers traditional
teachings, ceremonies, access to Elders and traditional healers as well as mainstream Western services. The facility also exposes individuals to social justice issues facing Indigenous peoples through their teachings on the political, social and economic histories of Indigenous peoples in Canada and therefore serves an additional role in empowerment (Smye & Mussell, 2001). The mental health services offered at AHT place Indigenous culture and traditions centrally, while utilizing a client-centred, strength based approach to assist in healing (AHT, 2011).

The Anishnawbemoen (Ojibway language) name of this study is also significant and likewise emerged from this partnership with AHT. In April 2011 Jake Ago Neh, a traditional healer at AHT, was approached and asked to confer a traditional name for this study. Together with the Oshkabewis (healer’s helper) we underwent a traditional naming ceremony. Following this, the Anishnawbemoen name, *biskanewin iskode*, meaning “the fire that is beginning to stand” was given to me by the healer. The healer explained that the significance of this “new fire” had several layers of meaning: first, on our individual healing journeys, it is the fire that burns within our spirit that lights our way, propelling us to evolve as individuals and to move forward; second, fire is also symbolic of advancement and progress as we often burn fields to make way for new growth; and third, fire is central to healing in the Indigenous worldview as it is often a central focus in many ceremonies. In this respect, *biskanewin iskode* is symbolic of individuals on their healing journeys who are recovering from abuse, and honours them in their pursuit of wellness as their fires are beginning to stand again.

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5 This spelling was provided by an Ojibway language instructor in Toronto.
Ethical Considerations

Respectful protocols have historically been neglected when Western researchers have entered Indigenous communities (Tuhiwai Smith, 1999); for this reason, an overview of ethical considerations are included in this Introduction chapter to underscore their importance. This study was conceived and has progressed in the spirit of the OCAP Principles (Ownership, Control, Access and Possession; NAHO, 2007). Ownership refers to the right of the Indigenous community to own their own cultural knowledge and information collectively and therefore act as a stewards over the information. Control refers to the right of Indigenous communities to control all aspects of their lives, including academic research that is done with their collaboration from conception to completion. Access refers to the right of Indigenous communities to access data about themselves and to make decisions collectively about how to manage this information. Possession refers to right of the community to own and protect the data.

Specifically, this project involved community consultation and respected community protocol (Stewart, 2009) since its inception. This study was initially conceptualized in the fall of 2010 through the identification of needs around mental health research described by women in the Canadian Aboriginal AIDS Network (CAAN) study mentioned above (2009). Once a formal concept for the study was drafted, CAAN was approached in November of 2010 with this draft and this project was in turn given a letter of support from the lead Research and Policy Manager of CAAN. The community partnership with Anishnawbe Health Toronto was founded in January 2011 with the manager of the Babishkhan Mental Health Unit. A partnership agreement was drafted by each party and the Executive Director of the centre was given a research partnership
letter from OISE-University of Toronto while the researcher was given a partnership agreement letter from AHT. In addition, the Traditional Teachers (Elders) of the researcher were approached and were introduced to the study; they subsequently offered their approval of the study. In February 2011, a presentation was given to the mental health staff at AHT introducing the study and the team offered valuable feedback to the researcher. Community members and staff at AHT were also consulted throughout the analysis process. Through the life of this project, AHT continued to play a leading role in the development, execution and dissemination of the study. Finally, the project was funded through the Indigenous Health Research Development Programme which involves approval by a panel of community members and Elders. The Aboriginal Mental Health Working Group indicates that Indigenous communities must heal relationally with one another and that partnerships (both research and clinical) must therefore involve the community in a partnership of mutual respect, recognition, sharing and responsibility (Smye & Mussell, 2001). In keeping with the spirit of respectful relationship building, this project was conceptualized and formalized through a meaningful partnership with AHT, as well as with the approval of CAAN and community Elders.

**Position of the Researcher**

I was born into a middle-class liberal family of mixed European and Caribbean descent in the Toronto area. Although both anti-war activists during the Vietnam era and left-wing (socialist), my parents did not greatly expose the family to social justice issues facing Indigenous peoples in Canada when my siblings and I were growing up. In fact, a climate of empathy for Canada’s First Peoples continues to be relatively non-existent among many in my social
environment. This is a telling fact about our lack of exposure to these types of issues in Canadian society at large. What I do credit to my father, however, are my recollections of an adolescent day when Aretha Franklin’s “Sisters Are Doing It For Themselves” was thundering from our new CD player and he shouted at me over the music (while dancing) about feminism and my right to pursue any career I chose, especially encouraging me to become an astronaut. Although my current passion is not space travel, I do recognize the fundamental lesson that I received from my father through his adoption of feminism: One need not have group membership to care about injustices facing that group. As penned from within the Birmingham Jail on April 16, 1963 by Martin Luther King Jr., the American Black civil rights leader, “Injustice anywhere is a threat to justice everywhere”.

I first became aware of social justice issues facing Indigenous communities during my undergraduate degree in health sciences and biology completely by chance: I happened to glance at the pamphlet for a play I was seeing (The Vagina Monologues) that revealed statistics on violence against Indigenous women, which I found to be alarmingly high. My own inflated ego told me I could not have possibly overlooked such a clear human rights violation in my own backyard and so I was prompted to seek out further knowledge in this area. I subsequently looked at violence against Indigenous women for my undergraduate thesis and sought out mentorship from community Elders who encouraged me to pursue graduate work in this area. I have been conducting research in the area of Indigenous women’s health since that time, first looking at neo-colonial social constructions of sexuality for young Indigenous women for my Master of Arts in the discipline of Health Promotion, and later in the field of Counselling
Psychology looking at topics related to education and employment among Indigenous youth. Through the many years and many relocations, I have maintained a relationship with my Elders.

In my years of study I have engaged in local Indigenous cultures in both Halifax and Toronto to varying degrees, as a participant in traditional ceremonies and gatherings, to Anishnawbe language classes and other retreats, to activism on campus, and in joining student organizations committed to Indigenous health. I have also worked for community organizations like Healing Our Nations in Halifax, an HIV health centre, as well as Anishnawbe Health Toronto, as a project coordinator for an Aboriginal Cultural Safety education programme. My learning journey throughout graduate school has also taken me to Geneva, Switzerland, where I worked briefly at an NGO in international health promotion, to Pune, India, where I worked with community members on HIV prevention and awareness as well as women’s empowerment strategies, and finally to The Gambia in Western Africa where I trained youth to be peer sexual health educators. These experiences have facilitated my mental and spiritual journey of understanding global indigenous cultures, including world histories of colonization, and my place within these complex histories. What has been most helpful in my struggle with the white guilt and shame that subsequently emerged along my journey have been my studies around cultural safety, wherein I have attempted to take on a bicultural thinking where socio-political, economic and power differences are brought into focus. I have become aware of my own power and privilege, social location and cultural history. In turn I can understand my impact on relationships (Smye & Mussel, 2001). This self-exploration has allowed me to begin to
decolonize⁶ my mind and spirit (however marginally), and to learn the humility and respect required to pursue this kind of work. I have been truly blessed through this passion as it has brought me into focus with my own disowned parts: my emotions and my Spirit, sacred aspects which had been neglected in my Western cognitive-based experience of the world. Interestingly, these experiences came full-circle when my participation in the National Geographic’s Human Genome Project revealed my maternal lineage to be Indigenous to North America.

This study in particular is of great significance to me as I have several Indigenous friends, both men and women, whose lives have been affected by sexual vulnerabilities as well as negative social determinants of health stemming from a history of colonialism and poverty. As a White middle class woman, I cannot relate directly to the racist and classist stigmas and oppressions that confront many of my Indigenous sisters and brothers; however, as with many women in general, I have not lived a life free from sexual vulnerabilities. In a small sense, I can relate to the impacts of these issues on wellbeing and I appreciate the need to seek out forms of mental, emotional and spiritual healing in the face of them.

Summary

In conclusion, this study asked, *how do traditional helpers conceptualize and address the mental health needs of Indigenous women experiencing sexual health vulnerabilities?* It looked at these mental health sequelae and therapeutic treatments from an Indigenous paradigm rooted in the knowledge and experience of traditional helpers at Anishnawbe Health Toronto. Results reflected gender-neutral understandings of sexual trauma and revealed culture-based mental

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⁶ Tufiwi Smith (1999) describes *decolonizing* not as a rejection of all things Western; rather it involves centering one’s world views from an “indigenist” stance.
health treatments. The significance of this study lay in its mandate to honour how Indigenous helpers and healers foster healing solutions that are culturally appropriate and sustainable for their clients. In doing so, it identifies how other clients with similar stories can most effectively be served by mental health practitioners. Also, this research informs academic literature and mainstream health practice on Indigenous mental health and healing interventions from an Indigenous paradigm. Findings will inform government policy around Indigenous healing interventions that are considered empirically successful at the community level (Stewart, 2008). The literature describes health promotion within this context as empowerment strategies to restore positive mental health, collective identity and self-esteem, and emphasizes that the recovery of tradition itself is healing (Kirmayer et al., 2003).

The following chapter reviews the literature related to Indigenous history, colonial impacts on health and wellbeing, and sexual and mental health outcomes among Indigenous women. Further chapters elaborate on the methodological underpinnings of this study, and findings from the narrative interviews which cover topics related to concepts of mental wellness, loss and recovery. Finally, the conclusions from the study are offered with a discussion on new directions for psychological theory and practice in the area of sexual trauma and recovery for Indigenous peoples in Canada.
Chapter 2: Literature Review

In order to understand mental health outcomes among Indigenous peoples with sexual vulnerabilities, it is important to first situate this discussion within the historical context of Indigenous health and wellbeing in Canada. This chapter will consider a brief overview of Indigenous cultures, the impacts of colonization on Indigenous women’s sexual health, as well as the relationship between sexual vulnerabilities and mental health outcomes. It will conclude by looking at traditional Indigenous healing as a direction for mental health treatment with individuals managing sexual vulnerabilities. This literature review focuses primarily on Indigenous women’s mental and sexual health, as per the research proposal; however, subsequent chapters of this dissertation will consider sexual traumas and mental health treatments for both genders, in keeping with the narrative interview results introduced in the findings chapter.

Indigenous Cultures in Canada

Canada’s Indigenous population currently numbers over one million (Adelson, 2005), and is composed of First Nation, Inuit, and Métis peoples. The term “Aboriginal” refers to the political status of the Indigenous peoples of Canada after colonialism. In the United States, the term “Native American” is also a construct of state governments (Hodge, Limb & Cross, 2009). What this pan-Indiansim (Hultkrantz, 1992) language overlooks is that over 500 Bands (or distinctive groups) exist in Canada, and over 500 Bands in the United States, each with their own unique cultural worldview (Hodge et al., 2009). Contemporary Indigenous communities of Turtle Island are multiracial, multicultural, multilingual, multiethnic, and can be found in a diversity of social classes and professions (Nelson, 2004). Other divisions exist in terms of rural versus urban individuals, traditional versus modern,
full-blood versus mixed ancestry, among others. A *traditional* person has been defined as one who lives culturally and spiritually as did the ancestors of her tribal tradition, modified somewhat by modern life; an *acculturated* person is one who is proud of her Indigenous heritage but who chooses to live the way of life in mainstream society (Coyhis & Simonelli, 2008, p.1929). Coyhis and Simonelli further explain that individuals live on this spectrum of these poles, and everywhere in between. Given this wide diversity, it is difficult to discuss common cultural characteristics between all Indigenous cultures of Turtle Island, especially given their keen ability to adapt and change in innovative ways in the face of a vast array of cultural disruptions (Bucko & Iron Cloud, 2008). Keeping these cultural nuances in mind, this section highlights some commonalities between these groups.

Traditional cultures typically see life in terms of a medicine wheel, or a “sacred hoop” (Bear Hawk Cohen, 2003; Gunn Allen, 1986, p.1) composed of four directions. The medicine wheel reveals an interconnected system, where life events are interdependent and joined (Coyhis & Simonelli, 2008). This sacred hoop teaches cultural values and knowledge, for instance, the four quadrants might signify the four seasons of nature and the four seasons of life (infancy, the state closest to the Spirit; childhood, a sacred time; adulthood, where men and women have equal power but different responsibilities; and old age, where Elders are the keepers of sacred knowledge) (Bad Hand, 2002; Bear Hawk Cohen, 2003). It can also refer to the elements (earth, sky, water and fire) or the ways in which we experience the world (emotionally, spiritually, physically and cognitively) (Bear Hawk Cohen, 2003; Moondance, 1997).

Deeply connected with the sacred hoop is the notion that *Indinawmaaganidag*

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7 Many do not have this teaching, however, such as certain Mohawk peoples. Other groups refer not to the sacred circle but to a medicine wheel in the shape of a turtle’s back.
(Anishnawbe language)/Um’Sit Nogama (Mi’kmaq)/Késsinnimek (Algonquin)/Mitakuye Oyasin (Lakota Sioux)/We Are All Related (Burkhardt, 2000). *All My Relations* refers to the prayer for health, harmony and balance of all natural and spiritual relations, including plants, stones, animals, earth, sky, sun, moon, ancestors, spirits and the Great Mystery (Cohen, 1998). Nature is seen as entirely alive, in both physical and spiritual dimensions (Bear Hawk Cohen, 2003). Most objects contain life energy and power and we gain tremendous wisdom from our environment, which teaches us about health, exercise and clean foods, while feeding us natural nutrients of clean air and plants (Bear Hawk Cohen, 2003). Through ceremony, song and ritual, individuals share reality communally, and bring the private self into harmony and balance with the larger reality; therefore, each creature is part of a living whole and through this relatedness, there is no distinction between the concepts of “worldly”, “supernatural”, “natural” and “unnatural” (Gunn Allen, 1986, p.61). Indeed, many Indigenous beliefs recognize the sacredness of all life and do not separate spirituality from it (Burkhardt, 2000).

In terms of gender differences, men are typically the caretakers of fire and women the caretakers of water (Bear Hawk Cohen, 2003). Typical feminine values are held in high regard, and may include, for instance, prioritizing relationship over control, offering patient wisdom over impulsivity and aggression, and using a gentle intuition rather than emotionless intellect when interacting with others (Bear Hawk Cohen, 2003; Gunn Allen, 1986). It is currently understood that few Indigenous societies in North America were patriarchal prior to 1600 (Dickason, 2002; Gunn Allen, 1986; Sacks, 1976). In fact, several groups were women-centred and shared myths of female creators, such as Thought Woman, the eldest God, whose thoughts preceded creation, and from whom all else was born (Gunn Allen, 1986).
Many Indigenous values were based on the principles of diversity, positive sexuality and equality and valued strong, decisive females and nurturing among males (Gunn Allen, 1986). By today’s Western standards, Indigenous cultures were quite forward thinking in terms of their treatment of women (who are not portrayed to be passive and helpless, as with many Western historical constructs) and acceptance of diversity (namely same-sex relationships, the partners of which were often respected members of Indigenous societies, as well as Two Spirit people\(^8\)) (Devries & Free, 2010; Dickason, 2002; Gunn Allen, 1986).

With respect to sexuality specifically, sex was often considered a gift from Creator (Kinnon & Swanson, 2002). Sexuality was not limited to the physical realm but involved the emotions, mind and spirit and was considered a strong contributor to pleasure, wellbeing and strong families (Gunn Allen, 1986; Kinnon & Swanson, 2002). Women’s sexual care included teachings on herbal medicines, pregnancy and birth control from the grandmothers, as well as coming of age ceremonies to celebrate transitions into adulthood (Fiske, 1996). Among most cultures, women were respected, rarely abused, and rape was typically rare or completely unheard of in certain communities (Bohn, 2003; Paul, 2000; Pearce et al., 2008). To mistreat a woman often incurred harsh punishments (Dickason, 2002) and strong social taboos against inappropriate behaviour, such as violence against women, helped to improve reproductive health and secure healthy relationships\(^9\) (Kinnon & Swanson, 2002).

**Impacts of Colonization**

When settlers first arrived to Turtle Island, an event foreseen by several visionaries

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8 The term *Two Spirit* refers to sexual and gender variance among Indigenous peoples, including: lesbian, gay, bisexual, transgender and/or queer (Ristock, Zoccole, & Potskin, 2011).

9 While these descriptions of traditional ways of life are clearly praiseworthy, some authors remind us not to romanticize these cultures, as all groups of people have strengths and innovations, as well as challenges; romanticizing risks losing the rich complexities of human behaviour (Hodge et al., 2009; Nelson, 2004).
amongst the tribes (Paul, 2006), it was the Indigenous people themselves who helped these new arrivals survive (Hill, 2009). Contact brought previously unknown diseases, however it also brought new ideas about how to treat illness; the two groups of medicine people, both traditional and settler, often sought the other’s council and learned from one another (Bucko & Iron Cloud, 2008). Unfortunately, the tide of new immigrants continuing to pour into the ‘New World’ disrupted many of these initial helping relationships, as the governing European authorities ultimately saw the “Indians” as an irritation to the new settlements (Hultkrantz, 1992). Since they believed Indigenous peoples were not using their enormous land mass in the most “efficient ways” agriculturally, authorities sought to push Indigenous communities onto reserve lands (Hultkrantz, 1992). These actions amounted to an involuntary relocation and displacement of many Indigenous communities (Nebelkoph & Phillips, 2004).

Additionally, the introduction of epidemics, which reduced the original population from what is currently approximated to be 15-18 million people living in North America pre-contact, to under half a million people at the turn of the last century (Aboriginal Healing Foundation, 2004; Hultkrantz, 1992), was also accompanied by military assaults, the introduction of alcohol, Christian missionary activities, the expansion of fur companies, the spread of White settlements, and the devastation of land and animals (Dickason, 2002).

The outcome of these policies has been that many Indigenous communities in North America are now living in a fourth world context ((Manuel & Posluns, 1974; Walters & Simoni, 2002), meaning that they exist as a minority population under the subordination of an institutionalized majority who enjoy privilege while exerting power over the Original Peoples. Colonizing forces sought to destroy language, traditional ways of life, and ancestral
spirituality (Hill, 2009), and sought to replace tribal spiritualism with a hierarchical authority wherein religion became an organizing force (Hultkrantz, 1992). Traditional spiritual practices became equated with pagan witchcraft, practices that were considered evil by the colonizer (Murillo, 2004); subsequently, many spiritual practices were pushed underground and communities were forbidden to discuss their secret spiritual traditions (Murillo, 2004). Traditional Indigenous spiritual activities remained illegal until 1978 in the United States and 1985 in Canada (Bad Hand, 2002; Struthers 2003); however many healing arts remained intact and continue to be practiced today (Murillo, 2004).

One of the more notorious colonial attempts at assimilation was the introduction of the residential school system, which sought to break down family structures, disrupt cultural teachings between generations (Hunter, Logal, Goulet & Barton, 2006) and essentially, “kill the Indian in the child” (Aboriginal Healing Foundation [AHF], 2006, p.11). It was later revealed by inspectors that these institutions were places of disease, hunger, overcrowding and disrepair and a 1950 census also demonstrated that as many as 40% of the teaching staff had no training (AHF, 2006). Survivors of residential schools later came forward to reveal various traumas they endured while in these schools, including sexual abuse, beatings, punishments for speaking traditional languages, bondage and confinement, electric shock, participation in medical experiments, forced labour and many others (AHF, 2006). Following the close of the last school in 1998, the Aboriginal Healing Foundation was established to address the intergenerational legacy of the sexual and physical abuse typical within the residential school system. The intention of establishing this foundation was to address unresolved trauma, to break the cycles of abuse, and to enhance the capacities of individuals and communities to sustain wellbeing (AHF, 2006). The residential schooling system
removed well over one hundred thousand Indigenous children from their families between the years 1874 and 1986 (Pearce et al., 2008) and there are approximately 86,000 survivors alive today (AFH, 2006).

The intention of the settler and European forces to quickly and fully assimilate Indigenous peoples to a Eurocentric way of life and Christian religion was not realized (Hultkrantz, 1992). Although some Indigenous peoples accepted Christianity, many continued to guard their spiritual beliefs and ways of life, and communities today are working to promote reconnection with cultural identity and healing (Stewart, 2008). The basic tenets of life on Turtle Island continue to support a politics of caring, harmony for the earth and social justice (Bear Hawk Cohen, 2003), while opposing an imperialist agenda. Ironically, these ancient politics of caring coincide with the values of most activist movements borne of Western cultures (Gunn Allen, 1986).

Indigenous populations in Canada and the United States are currently experiencing a greater per capita increase than any other ethnic group (Cesario, 2001; Human Resources and Skills Development Canada, 2010). However, the impacts of colonization have caused lasting health and mental health issues within numerous communities; many individuals suffer from intergenerational traumas, substance abuse and violence (Nebelkoph & Phillips, 2004). Increased mental health issues within these communities are likely related to chronic trauma, repetitive losses, chronic stress at the community level and higher rates of posttraumatic stress disorder due to violence, non-Native custodial care and racism (Clark & Stately, 2004; Walters & Simoni, 2004). Still, many cope with these stressors using cultural buffers, which help to create a strong Indigenous identity, enhance self-esteem and permit re-enculturation for those who were disconnected from their traditional communities.
Additionally, spiritual methods of coping also help with social, physical and emotional adjustments to life’s stressors for Indigenous peoples today (Walters & Simoni, 2004).

The following sections will examine these health outcomes in greater detail, focusing specifically on sexual health and mental health outcomes for Indigenous women today.

**Indigenous Women and Sexual Vulnerabilities**

Sexual vulnerabilities are more predominant among Indigenous women in Canada than among non-Indigenous women (Clarke et al., 1998; Hoffman-Goetz et al., 2005; Public Health Agency of Canada, 2007; Steenbeek, 2004). This section will review trends in sexual health outcomes; however these statistics vary by region, population, and group, and do not presume to tell the story of every Indigenous woman living in Canada. This discussion simply offers a broad picture of sexual vulnerabilities that affect many Indigenous women today.

Several research studies indicate that sexually transmitted infections (STIs) appear to be significantly higher in the Indigenous population than in the non-Indigenous population, especially with respect to rates of gonorrhea and chlamydia, two STIs that are dangerous if gone untreated as they can often be asymptomatic, and can lead to pelvic inflammatory disease, and chronic pelvic pain (Hoffman-Goetz et al., 2005; Jolly et al., 2005; Public Health Agency of Canada, 2008). Additionally, a Manitoba study found that Indigenous women had 3.6 times the age standardized rate of invasive cervical cancer as compared to non-Indigenous women, likely related to infrequent of Pap testing (Young, Kliewer, Blanchard & Mayer, 2000).

HIV/AIDS specifically represents an area of particular concern for Indigenous communities as the numbers of HIV/AIDS cases in Indigenous populations are increasing.
Currently, Indigenous peoples make up 3.8% of the Canadian population, and yet represented almost 24% of new HIV and 12% of new AIDS cases in 2002 (Devries & Free, 2010) and Indigenous women are almost three times as likely to contract AIDS than non-Indigenous women in Canada¹⁰ (NWAC, n.d.). Additionally, the Canadian Aboriginal AIDS Network indicates that Indigenous youth account for one in every four HIV positive tests among all Canadian youth, despite representing such a small proportion of Canadian’s young population¹¹ (NWAC, n.d.). Another risk factor in the transmission of HIV is participation in the sex trade (Pearce et al., 2008). A 2000 report by Save the Children found that Indigenous women accounted for as much as 70% of the visible street-based survival sex work in Canadian cities; also, young Indigenous female sex workers are far more vulnerable than other women in Canada to be pushed into working in isolated areas with high exposure to sexual and drug-related harms and into areas which lack health care support (as cited in Chettiar et al., 2010).

Physical and sexual abuse rates are also higher among Indigenous women than among non-Indigenous women¹² (Brownridge, 2003; Shannon et al., 2008). In addition, a 2006 Statistics Canada study found that the rate of spousal homicide for Indigenous women is eight times that of non-Indigenous women. It has been underscored that family violence for Indigenous women is linked to a number of factors, including systemic discrimination and racism against Indigenous peoples, breakdown of family life due to residential schooling, injection drug use is an important factor in the transmission of the virus, in addition to sexual intercourse (Wood et al., 2008).

¹⁰ Among HIV positive people in Canada, injection drug use is an important factor in the transmission of the virus, in addition to sexual intercourse (Wood et al., 2008).
¹¹ There are approximately half a million young Indigenous people under the age of 25 in Canada as compared to over ten million non-Indigenous people under the age of 25 (Canadian Council on Social Development, 2004; Steffle, 2008).
¹² Community research indicated a 70% rate of reported abuse among Indigenous women in a Nova Scotia study (Hoffman-Goetz et al., 2005), a 57.2% reported rate in a Prairies study (Cohen & MacLean, 2004) and a 75-90% response rate among women in various communities across Ontario (Ontario Native Women’s Association, 2007).
overcrowded and substandard housing, economic and social deprivation, alcohol and substance abuse, the intergenerational cycle of violence and the overall impact of colonization on traditional values and cultures (Statistics Canada, 2006).

Particularly chilling are the mortality rates among Indigenous women due to violence, which are substantially higher than among non-Indigenous women. Amnesty International’s 2006 report on violence against Indigenous women in Canada noted that young Indigenous women are five times more likely to die as a result of violence than non-Indigenous women, a trend rooted in racism and sexism, which deny dignity for women, as well as colonial policies, which have left women vulnerable to exploitation and attack. The Sisters in Spirit campaign spearheaded by the Native Women’s Association of Canada is an initiative designed to address “the disturbing numbers of missing and murdered Aboriginal women and girls in Canada...[It aims to] understand the root causes of this violence and identify measures to increase the safety of Aboriginal women and girls.” (NWAC, 2009, para. 1).

It is important to contextualize these alarmingly high trends as they indicate a fractured wellbeing around sexuality and sexual health and, in addition, differ substantially with what was presented with respect to a more positive social construction of sexuality prior to colonization. Indigenous authors and other academics in the field argue that the advent of colonization introduced cultural constructs of Euro-Christian patriarchy, which negatively affected the lives and wellbeing of Indigenous women (Carter, 1997; Gunn Allen, 1986). For instance, the introduction of the Indian Act by the Canadian Government in 1867 removed Indigenous women’s right to vote in Band elections, to hold political office or to speak publicly at meetings, among other injustices (Shepard, O’Neil, & Guenette, 2006). In addition, Carter (1997) writes that women’s positive sexuality was deconstructed and
reconstructed through the colonizer’s religious lens, resulting in a conceptualization of
Indigenous women as sexually wanton, immoral and “licentious”. Finally, findings from my
MA research in the field of Health Promotion\(^1\) indicated that the women in my study were
highly influenced by patriarchal and Christian messages related to the subjugation of women
and dominance of males, the notion of sex-as-taboo, compulsory heterosexuality, and guilt
related to their experiences of sex, among others. These findings coincide directly with
current Western literature on the subject of women’s sexuality, which theorizes that men are
characterized as active sexual subjects with a natural sexual desire, while women are the
objects of this desire (and also in need of protection from it) (Connell, 2005; Weekes, 2002).
Despite some similarities, the additional burdens of systemic poverty, abuse, a lack of
resources and other challenges stemming from a colonial legacy, results in Indigenous
women facing more barriers to wellness at a systemic level than non-Indigenous women.

Overall, this section briefly reviewed changes to the construction of sexuality and
sexual health outcomes for Indigenous women in Canada brought on by colonization. The
following section investigates mental health outcomes related to sexual vulnerabilities and
considers directions for mental health treatment.

**Sexual Vulnerabilities and Mental Health**

Indigenist scholarship emphasizes the need to situate sexual health issues for
Indigenous peoples in Canada within the context of historical trauma (Mehrabadi et al.,
2008). In order to appreciate the impact of sexual vulnerabilities on mental health among
Indigenous women it is therefore reasonable to begin with a consideration of the sexual

\(^1\) This study considered present-day social constructions of sexuality for young adult Indigenous women living
in Atlantic Canada. The women in this study identified as heterosexual or bisexual, were between 18-30 years
old, and were living, or had grown up, in a reserve community.
abuse that was systemic within the residential schooling system. Indigenous residential school survivors have authored numerous accounts of this emotional and physical torment (see for instance, Knockwood, 1992) within a religious institution that enforced a sexual ideology which suppressed sexual desire and instilled fears of sexual wrongdoing, while simultaneously being “opportunistic sites of abuse” for predatory staff (Million, 2000; Royal Commission on Aboriginal Peoples, 1996, p.367). Following years of sexual abuse, many survivors became emotionally reclusive and subsequently faced years of lasting issues with sexual intimacy (Shepard et al., 2006). Others have battled low self-concept and low self-esteem generally, rooted in the loss of family structure, degradation of culture and experiences of abuse (Barton, Thommasen, Tallio, Zhang, & Michalos, 2005). The Royal Commission on Aboriginal Peoples (1996) notes that issues stemming from residential school abuse involve social maladjustment, abuse of self and others, family breakdown, trauma related to growing up in an atmosphere of fear, hatred and loneliness, issues with identity and cultural acceptance, and lack of transference of parenting skills among subsequent generations. The report notes that children raised in this environment learned that one can exert control through abuse and many go on to use these tools with their own children. The pervasiveness of sexual abuse within residential schools, along with other traumas stemming from colonial policies, has led to “intergenerational trauma as a collective emotional and psychological injury over the lifespan and across generations” for many Indigenous peoples today (Pearce et al., 2008, p. 2186).

Psychological research supports the notion that individuals who experience childhood sexual abuse are at increased risk for developing depression, anxiety and substance abuse disorders later in life (Baima & Feldhousen, 2007; Devries, Free, Morison & Saewyc, 2009a;
Smith, Bryant-Davis, Tillman & Marks, 2010). In the Cedar Project involving Indigenous youth who use injection drugs, approximately half of participants reported having experienced sexual abuse in their lifetimes, the majority of whom were women (69%) (Pearce et al., 2008). The median age of first abuse among males and females in this study was six years old. Of those who experienced abuse, 65% had never received counselling to address the abuse. In the group of individuals who reported these childhood issues, 48% indicated they have since been abused by others. Indeed, sexual abuse early in life has been found to be a strong risk factor to being sexually victimized later in life (Brozowski & Hall, 2010).

Certain personal and relational dynamics have been observed among women who are survivors of childhood sexual abuse, including the development of dysfunctional sexual feelings and attitudes, feelings of betrayal toward the offender and other family members, a sense of powerlessness due to repeated violations and stigmatization of the self, and feelings of shame and guilt (Baima & Feldhousen, 2007). Other literature also identifies that childhood sexual abuse often leads to sexual risk taking later in life (possibly due to diminished self-efficacy and sexual negotiation skills as well as negative mental health sequelae) as well as vulnerability to STIs and HIV, an increased number of lifetime sexual partners and other mental health issues (Devries et al., 2009a; Pearce et al., 2008). Psychological research also suggests that those who are abused early in life risk developing more complex symptoms related to disturbances in identity and personality development, difficulties relating to others, a damaged sense of self, chronic depressed mood, dissociative symptoms, suicidal thoughts, self-injurious behaviour, and long term anger (Vandeusen & Carr, 2003). Conversely, when an individual is victimized later in life s/he may have a more
developed identity, sense of self and psychological resilience and s/he may have better support systems and access to treatment by that point in time (Vandeusen & Carr, 2003).

The psychological literature on mental health outcomes among adult women who have experienced sexual abuse and victimization is also fairly conclusive. However, as Phiri-Alleman and Alleman highlight in their paper on cross-cultural counselling around sexual violence (2008), much of the counselling and social psychology research regarding these topics typically reflects the views of White, middle-class women. Therefore, it should be noted that the following discussion offers an overview of Western literature on this subject, and there may be variances in these mental health outcomes for Indigenous women. With respect to diagnosable mental health disorders, women typically experience depression and anxiety spectrum disorders following an experience of sexual abuse (Baima & Feldhousen, 2007). They may also be more likely to engage in self-destructive and suicidal behaviours (Baima & Feldhousen, 2007). Notably, posttraumatic stress disorder (PTSD) is a common diagnosis among women who have experienced sexual violence (Barnes, 1995); some epidemiological studies indicate PTSD rates as high as 94% among this population of women (Ben-Ezra et al., 2010). These types of symptoms can include anxiety attacks, tension, recurring recollections and nightmares, phobic responses to reminders of the abuse, and interpersonal distress, among others (American Psychiatric Association, 2000; Ben-Ezra et al., 2010). Women have also met criteria for somatization disorders14, panic disorder, phobic disorders, substance abuse, suicidality, eating disorders, sleep disorders and chronic fatigue (Beckerman, 2002; Lehrer, Lehrer & Zhao, 2010).

14 Other physical symptoms, including pelvic pain, vaginal bleeding, bladder infections, and intense cramping, have also been reported (Phiri-Alleman & Alleman, 2008).
Other notable mental health outcomes among this group of women includes a disruption in positive personal identity. For instance, many women experience intense guilt, shame, low self-concept, fear and anger relating to these violations (Baima & Feldhousen, 2007; Barnes, 1995). Abuse can also result in negative schemas around exaggerated risk assessment and interpersonal mistrust; in turn, women may over-generalize their traumatic experiences to other life situations, feeling continuously on edge or in danger (Ben-Ezra et al., 2010). Women may dissociate from their memories (have an inability to recall the traumatic events), experience disordered thinking about the event or have fragmented recollections of the events (Orchowski, Uhlin, Probst, Edwards, & Anderson, 2009). They may also experience denial or repression of the traumatizing event and may have fears or phobias associated with sex (Barnes, 1995). Women have also reported emotional blunting and a loss of emotional and physical feeling stemming from abuse. This constellation of symptoms is also consistent with PTSD diagnoses. Finally, women have reported feelings of disgust and the need to seek revenge, feelings of being out of control in their lives, and a loss of security and sexual identity (Howard, Riger, Campbell & Wasco, 2003; Levine, 1994). For some women this victimization interrupts their sense of a just world and they subsequently struggle to come to terms with this perceived injustice (Baima & Feldhousen, 2007; Ben-Ezra et al., 2010).

In terms of relational outcomes, many survivors have difficulty forming and maintaining intimate relationships as they tend to be distrustful of others (Baima & Feldhousen, 2007). The self-blame that women often feel relating to the incident (i.e. “I was too intoxicated” or “too trusting” or “too provocative”) can lead to demoralization and sexual dissatisfaction in relationships and relational adjustment difficulties (Miller, Handley,
Markman & Miller, 2010; Roberts, Watlington, Nett & Batten, 2010). Additionally, women have reported extremes in sexual intimacy: some experience problems engaging sexually while others tend to have more sexual partners than women who do not experience this type of abuse (Baima & Feldhousen, 2007). Often survivors of sexual assault feel that their relationships are either empty and superficial or highly sexualized (Barnes, 1995). Although many women become estranged from others, a lack of social supports was found to be a predictor in the development and maintenance of PTSD following sexual assault (Ben-Ezra et al., 2010). Unfortunately, the disruption in emotional intimacy experienced by many survivors may limit the quality of support they receive (Ben-Ezra et al., 2010).

A paper by Howard et al. (2003) on sexual assault survivors notes that approximately 25-30% of all rape against women is committed by husbands or intimate partners; intimate partner sexual violence is therefore more common than sexual assault perpetrated by a stranger or an acquaintance (Phiri-Alleman & Alleman, 2008). This type of assault between intimate partners can interrupt a woman’s basic sense of trust and can result in feelings of powerlessness and isolation to a greater degree than if she were assaulted by a stranger (Howard et al., 2003). Women who experience intimate partner violence and abuse also may face additional security burdens, as she may depend on him15 for survival and she must interact with him more frequently; this often results in ongoing and persistent PTSD for women who suffer from symptoms of this type (Beckerman, 2002; Lehrer et al., 2010). Often when this abuse occurs between intimate partners, the experience of victimization can be so “schema incongruent” (p. 294) for the woman that she may not conceptualize the event as

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15 The masculine pronoun is used as studies show that sexual violence within heterosexual couples is male perpetrated in 99% of reported cases (Beckerman, 2002).
rape and instead turn to invalidating interpretations of the experience without naming it as sexual assault (Orchowski et al., 2009).

A few studies note mental health outcomes among Indigenous survivors of sexual assault in Canada and the United States. One study looking at sexual abuse among Indigenous women also found that the women had internalized feelings of shame and guilt, felt invalidated and reported a sense of internal fragmentation (Benoit et al., 2003). An American study of mental health outcomes among Navajo youth found past sexual abuse to be risk factors for suicide (Grossman, Miligan & Deyo, 1991) while another US-based study found that Native Americans who experienced sexual abuse as children were more likely to seek mental health treatment and to receive psychological diagnoses as adults (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). A 2003 study by Bohn looking at mental health outcomes among Native American women who faced sexual abuse and violence found that women who experience multiple traumatic events over the course of a lifetime were more likely to suffer from depression, suicidality and substance abuse. Bohn indicated that negative mental health outcomes tend to occur in a cumulative or dose-response fashion where, for instance, PTSD symptoms are exacerbated by ongoing experiences of trauma for these women. A Canadian-based study found similar findings when looking at the relationship of victimization to addictions among First Nation women (Herbert & McCannell, 1997). Finally, an Ontario-based study found that Indigenous women with a history of sexual abuse reported higher levels of mental health issues stemming from these experiences than Caucasian women, including more pronounced somatic symptoms, sleep disturbances, sexual difficulties and uncontrollable crying (Barker-Collo, 1999). Overall, these studies corroborate the findings of other psychological literature which emphasizes the
negative mental health impact of these violations on the life course of female survivors; indeed it clear that these can have lasting impacts on survivors through the lifespan. As described by a participant in Herbert and McCannell’s study with First Nation women, the impacts can be profound: “Sexual abuse was the pen that wrote the script of my life” (p.58).

With respect to mental health issues stemming from a diagnosis of a sexually transmitted infection, a study by East, Jackson, Peters and O’Brien (2010) indicates that STI diagnosis can represent an immense emotional burden in addition to physical health issues. This study found that many young women engaged in self-blame and shame following this type of diagnosis. Some women indicated feeling “spoiled” and believed others would judge them unfavourably for being sexually “irresponsible” (p.1998). Other women were in denial about their diagnosis and minimized the impact of the infection in their lives in order to avoid negative feelings of disappointment and shame. The perception of these participants to see their body as “diseased” and “unclean” contrasts with social expectations which dictate women’s bodies be attractive, pure and chaste, and led these women to experience a low sense of self as well as strained intimate relationships. Other psychological literature likewise points to social stigma and judgement as a source of concern for women who are diagnosed with an STI (Balfea et al., 2010; Rusch et al., 2008). East et al. (2010) explain that culturally, STIs are often associated with immoral, “deviant” sexual behaviours, which results in high levels of stigmatization towards women who have them. Again, this stigma, rooted in contemporary Western gender-based morals that subjugate women’s sexuality, is particularly strong toward women rather than men, as women are expected to carry higher sexual morals (East et al., 2010). A study on STIs and stigma in Vancouver’s Downtown Eastside found that Indigenous women with STIs also faced female-specific moral stigma (Rusch et al.,
This was in keeping with known discriminatory beliefs which posit minority women as the “vessels of STI transmission” (p.29); likewise, this sample of participants felt culturally targeted when describing this type of stigma (Rusch et al., 2008).

HIV specifically is stigmatized as a “sin of promiscuity” (Gostin et al., 1994, p.1436), homosexuality and a failure of moral impulse control (Gostin et al., 1994). Of course, HIV also has distressing mental health outcomes related to the fear, grief and pain of having contracted a virus that will certainly result in serious chronic health issues and could well result in loss of life, especially for HIV positive Indigenous people, as this group is typically diagnosed later in the disease progression (Mill et al., 2008; Mill, 1997). Mill’s paper on HIV risk behaviours examines lives of eight First Nation women in Alberta living with HIV (1997). The women in Mill’s study had in common several characteristics, including a personal history of abuse, turbulent childhoods, parents who had a history of substance misuse as well as a personal history of substance misuse. Of the eight women in the study, six had been sex workers and acknowledged they took a passive role in their relationships with male partners, and lacked power to negotiate and enforce safer sex practices. These findings mirror other trends discussed in this literature review related to Indigenous women’s sexual vulnerabilities and barriers to wellbeing rooted in discrimination.

This overview of mental health sequelae following sexual victimization and contraction of sexually related illnesses offers a clear picture of the damages caused by these sexual vulnerabilities. These represent grave outcomes, the impacts of which women often struggle with for years. The following section will outline Western counselling strategies for supporting women who are coping with these types of sexual health issues.
Western Counselling to Address Sexual Trauma

Western counselling services vary considerably in theoretical orientation, framework and technique (Howard et al., 2003); for instance, therapies may focus on cognitive restructuring, unearthing social oppressions, improving communication, solving problems, building self-esteem, managing trauma and grief, and gaining self-awareness of thoughts, feelings and the body, among others. In terms of counselling services for those who have experienced sexual vulnerabilities, various therapeutic modalities are used, depending on the needs of the individual. For instance, domestic violence agencies may offer psychoeducational and supportive counselling, crisis services (through a telephone hotline which individuals can access at any time), support groups for women, shelter, and/or legal services and advocacy (Macy, Giattina, Montijo & Ermentrout, 2010). Additionally, other complications may arise for these women, including needs related to child dependents, security and shelter, and in some cases, substance use treatment (Macy et al., 2010). Lastly, counselling needs are typically unique for women who have experienced abuse or violence of a sexual nature, due to the psychological complexity of the trauma (Howard et al., 2003).

This section outlines several approaches to psychotherapy when working with individuals who have experienced sexual trauma, including cognitive behavioural therapies which address cognitive schemas and encourage exposure to fearful stimuli, emotion focused approaches which restructure emotional schemas, feminist approaches which include psychoeducation around oppression and societal power structures, and group counselling. The intention is not to review all forms of Western-based therapy for this group of women, but to illustrate some techniques and demonstrate the diversity of approaches used.
Generally speaking, cognitive-based therapies for survivors of sexual assault involve identifying maladaptive thoughts, meanings and effects and replacing them with more adaptive ones (Orchowski et al., 2009). For instance, an assimilation model of cognitive work in therapy includes drawing the client from an avoidant state, or a vague or confused state about the traumatic experience, to a state where she can define her psychological issues and reach a place of understanding or insight (Orchowski et al., 2009). Once the client has accessed his or her problematic experiences, the client can work through the issues and integrate experience of abuse into his or her cognitive schema in a less fractured way (Orchowski et al., 2009). Cognitive based work can also look to exposure therapy for PTSD symptom reduction. For instance, exposure to traumatic memories in a safe environment can alter the feared memories and diminish threat cues (Foa, Rothbaum, Riggs, & Murdoch, 1991). This method emphasizes confronting maladaptive beliefs and rehearsing new coping skills while practicing emotional regulation and self-soothing (Resick & Schnicke, 1992). One study found this exposure method to be superior to supportive counselling in addressing PTSD symptoms (Foa et al., 1991). A study by Resick and Schnicke on cognitive processing therapy emphasized exposure as well as identifying and integrating “stuck points” (p.750) related to the trauma into healthy cognitive schemas that existed prior to the trauma (1992). This method was found to be statistically beneficial in minimizing PTSD symptoms among women who had experienced sexual assault. Imagery rehearsal therapy was also found to be beneficial when used in counselling to address chronic nightmares among sexual assault survivors with PTSD (Krakow et al., 2001). This method targeted nightmares as habits (or learned behaviours) and used waking imagery to influence nightmares. This resulted in decreases in PTSD symptoms, namely avoidance and physiological arousal. Other cognitive
therapies work with belief systems that negatively affect the client’s sense of self as well as disruptive interactional patterns that many women who are victimized experience (Barnes, 1995).

Emotion focused therapy (EFT) seeks to address not only maladaptive cognitive schemas but the complex issues stemming from sexual abuse, including affect regulation, self-esteem issues and interpersonal challenges (Paivio & Nieuwenhuis, 2001). The EFT model emphasizes the central functioning of emotions in therapeutic change and therefore the emotional content of traumatic feelings and memories needs to be accessed in order to be modified and adapted (Paivio & Nieuwenhuis, 2001). For individuals who react to abuse by minimizing or controlling their affective experience, accessing and feeling these emotions may prove therapeutic: for instance, anger helps with empowerment, setting personal boundaries and assertiveness; sadness permits grieving and acceptance of loss (Paivio & Nieuwenhuis, 2001). A preliminary study looking at using EFT techniques with adult survivors of sexual abuse found this method to produce statistically significant improvements for clients by reducing unfavourable symptomatology and interpersonal issues and by increasing self-esteem (Paivio & Nieuwenhuis, 2001). The two-chair technique used in EFT also allows individuals to externalize, differentiate and confront issues with the self or with an individual with whom the client has unfinished business (i.e. self-critic or an abuser) (Orchowski et al., 2009). Finally, EFT allows the opportunity for the therapist and client to model secure attachment within a safe environment that highlights unconditional positive regard for the client (Baima & Feldhousen, 2007).

Feminist therapy in particular seeks to recognize and problematize social justice issues and power imbalances within society as a whole, in order to make sense of the challenges
faced by clients on a sociological as well as psychological level (Orchowski et al., 2009). This type of therapy work would seem relevant when working with women who have experienced sexual victimization by men, as research highlights links between gender-based violence and patriarchal social structures (Baima & Feldhousen, 2007), as discussed previously. Work of this nature with women who have experienced sexual assault may involve challenging socio-cultural themes around gender as well as oppressive messages about social scripts or roles which give men the right to dominate and subordinate women and which imply that women are responsible for their victimization (Orchowski et al., 2009). In a (heterosexual) couple’s counselling context, this would involve working with both parties to identify and describe the harmful impacts of patriarchy and to foster a relationship with a more equitable distribution of power (Baima & Feldhousen, 2007). An interesting twist on feminist counselling appeared in a study on wilderness therapy for sexual assault survivors by Levine (1994). This type of therapy involved having women participate in rigorous outdoor activities which relate metaphorically to the original abuse scenario. The programme encouraged them to face their fears by carrying out physically demanding tasks that evoked the feelings of helplessness that they faced at the hands of their assailants. Confronting these fears assisted them to develop new coping strategies and gave women the opportunity to work as a team to build trust, self-esteem, and confidence.

Group therapy has also been described as a positive opportunity for individuals who have shared similar experiences to practice socializing techniques, act as witnesses to one another, promote collective empowerment and compassion, and to have the sense of not being alone in their grief (Yalom, 1995). Support groups as well as process-oriented psychotherapy groups exist for survivors of sexual assault and use various modalities,
including emotion focused therapy, solution focused therapy, feminist therapy, and others (Vandeusen & Carr, 2003). Group therapy has been reported to be successful in increasing adolescent girls’ as well as adult women’s self-esteem following sexual abuse, and improvements were seen in interpersonal relationships and coping strategies (Vandeusen & Carr, 2003). A group therapy study by Vandeusen and Carr (2003) with university-aged female survivors of sexual assault began with establishing safety within the group prior to taking on deeper, more emotionally vulnerable work; later the group explored the traumatic experience, and mourned the abuse. These phases of group work connected the participants to one another through the group process. Results from this study found that the participants felt less isolated, had expanded social supports, and had increased knowledge about common symptoms and symptom management following sexual assault. They were also able to validate their negative feelings of guilt, shame and anger. Finally, symptoms related to a fear of being alone, intrusive thoughts and emotional numbing decreased, while wellbeing, sense of personal safety and control, and trust in others increased.

Within the counselling literature on sexually transmitted infections, the research typically described approaches to counselling that focused on imparting information related to the illness, details on managing physical health symptoms, and interventions for minimizing transmission of the virus to others (Gostin et al., 1994). The majority of the public health and nursing literature available looks at counselling efforts to prevent STI transmission as well as pre-test counselling, rather than coping with diagnoses in a mental health context (Bucharski, Reuter & Ogilvie, 2006; Gostin et al., 1994).

Overall, no matter the specific modality used in therapy, efforts to counsel those managing sexual health vulnerabilities, particularly sexual violence and abuse, have certain
commonalities: first, they attempt to minimize negative psychological sequela associated with various psychological diagnoses (i.e., depression, anxiety, PTSD); second, they assist clients in making healthy decisions; third, they facilitate the rebuilding of client’s lives; fourth, they seek to decrease self-blame and increase self-esteem among clients; and finally, they assist in fostering appropriate coping skills (Howard et al., 2003). The following section will consider some gaps in these therapy modalities when counsellors work with Indigenous clients specifically.

**Gaps in Services for Indigenous Clients**

All counselling with those who have experienced sexual health issues must consider the specific value systems and unique culture of the client in order to assist in the healing work; the most appropriate ways of dealing with intimate partner violence in a European Canadian context, for instance, might not be entirely appropriate or ideal for members of other cultures (Phiri-Alleman & Alleman, 2008). Accordingly, Kirmayer, Brass and Tait (2000) note that most mental health services in urban areas have not been adapted to meet the needs of Indigenous clients; this lack of cultural appropriateness of services has resulted in lower rates of mental health service use as well as higher drop-out rates from counselling among Indigenous peoples (Harris, Edlund & Larson, 2005; Oetzel et al., 2006; Shah, 2005). Some authors have suggested that the reason mental health services are not meeting the needs of Indigenous clients rests on the fact that higher rates of mental illness within these populations are difficult to address with our current scarcity of public funding and personnel resources. However, what is more likely is that the issue lies in the inappropriateness of the services themselves (Hodge et al., 2009). Other Indigenous authors agree that the Western conception of health lacks an Indigenous worldview and therefore services are often
inappropriate or irrelevant to the Indigenous clients they seek to serve (Stewart, 2008; Vicary & Bishop, 2005), and individuals are less likely to use health services that are not adapted culturally to their understandings of healing (Blue, 1977; McCormick, 1996). For instance, the field of psychiatry, from which the Diagnostic and Statistical Manual of Mental Disorders (DSM) emanated, is rooted in implicit values of the dominant culture (Kirmayer et al., 2000) and therefore risks over-pathologizing Indigenous clients (Duran, 2006). The field of psychology also draws immensely from the DSM and therefore carries similar risks. Some authors argue that using Western therapy with Indigenous peoples is a continued form of colonization as some modalities, such as cognitive behaviour therapy, emphasize questioning values in a given framework (Hodge et al., 2009). The questioning of values, however, is rooted in the principle that certain values are correct and others are incorrect. What this theory overlooks is that these so-called “implicit” values are culture-bound. Even basic assumptions in the Western paradigm of individualism and self-efficacy may be inappropriate for Indigenous clients who may have more sociocentric values, where the self is defined relationally (Hodge et al., 2009). Finally, many Indigenous people have also noted that the health system remains culturally unsafe for them, as many people have experienced institutionalized discrimination and racism from their healthcare providers (Shah, 2005). Ironically, this system results in a cycle wherein Indigenous peoples report both the highest rates of mental health issues as well as the highest rate of unmet mental health needs (Harris et al., 2005).

Generally speaking, Western health practitioners in recent years have begun to recognize their lack of training and ability in addressing the needs of diverse patients and the movement toward developing cultural relevant psychological practices has expanded
dramatically (Gone, 2010). Despite the movement toward culturally competent practice, however, mainstream mental health services continue to lack in cultural safety due to inadequacies in the Western health care paradigm itself (Nelson, 2004). While, like all indigenous groups, Western medicine historically had a spiritual ancestry (in fact, Christ was originally considered a great shaman (Wolf, 1991)), it departed from a spirit-based understanding of the world with the advent of scientific advances such as Sir Isaac Newton’s laws of mechanics and Descartes’ notion of mind-body dualism. By the 19th and 20th centuries, a view of rigid materialism had developed throughout the West. In Western allopathic medicine the body came to be viewed as a machine and scientific reductionism moved spiritual and other wholistic16 practices out of the realm of medicine (Sulmasy, 1999).

While for many indigenous groups medicine and spirituality are two sides of the same coin (Hultkrantz, 1992), a Western view lacks a wholistic framework and overvalues the physical aspects of the self, while defining health as the absence of disease, confirmed through lab tests (Bear Hawk Cohen, 2003; Cohen, 2003). Other criticisms of this system suggest its scientific methods focus on theory and cures rather than on helping individuals find meaning in their suffering (Schneider & DeHaven, 2003). The Western practitioner is not trained to guide sufferers, to hear stories, and to understand wider contexts—in short, Western health care has no model of what it means to be a whole person and promotes no operational definition of healing (Egnew, 2005). Despite the technologically sophisticated medical practices and forward movements in health care, many patients have reported feeling alienated from their healthcare professionals, who now appear simply as technicians, rather than healers (Schneider & DeHaven, 2003). While many Western-trained healthcare

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16 A teaching offered to me by an Elder many years ago suggested this word be written with a ‘w’ to infer “wholeness” rather than with an ‘h’ for “holistic”, as the term “holy” carries Christian undertones.
practitioners accept the values of this larger scientific framework without question (Hodge et al., 2009), this type of helping lacks a fundamental consideration for the whole person and thus individuals often do not experience the wholism of traditional healing practices (Egnew, 2005). For this reason, many people turn elsewhere for healing (Schneider & DeHaven, 2003).

If Western practitioners working with Indigenous clients intend to move toward a more culturally competent practice in psychology, the acceptance of traditional Indigenous healing, as well as the integration of these traditional methods with contemporary Western practices, where appropriate (Gone, 2010), is necessary. Western practitioners should first accept the use of traditional helpers among their clients (Murillo, 2004) and allow the clients themselves to determine if and how they will engage in using these services (Bucko & Iron Cloud, 2008). Additionally, a movement within psychotherapy toward wholistic healing would involve working with life systems and social systems, as individuals do not live apart from the history, culture and geography of their communities (Nelson, 2004). In order to respond to Indigenous historical trauma specifically, socio-historical factors affecting Indigenous community members need to be addressed (Cesario, 2001; Kirmayer et al., 2000; Murillo, 2004). As more of the Indigenous population migrates into urban centres, the need for culturally appropriate care increases. All of these arguments lend support for an improvement in practitioner awareness of cultural variations and histories, and of the need for multiple approaches to healing. In this case, an obvious starting place for the provision of culturally appropriate care for Toronto-based Indigenous women facing sexual vulnerabilities is in an Indigenous healthcare setting. The following section introduces Indigenous healing conceptually, and highlights some modalities that are typically used.
**Indigenous Healing: Theory and Methods**

When discussing Native or Indigenous health, it is worth noting specific cultural and geographical groups (Bucko & Iron Cloud, 2008, p.596). There are likely some inherent misunderstandings in any discussion on Indigenous healing within North America, as this term implies uniformity in culture and healing practice (Cohen, 1998). Since healing practices have been ongoing for as many as 40,000 years on Turtle Island, during which hundreds of different cultural groups have evolved, diversity of culture and healing practices is the rule, rather than the exception (Bear Hawk Cohen, 2003). This diversity also makes it difficult to know the extent to which traditional healing is practiced today, although it is clear from many writings that it continues to be practiced widely (Murillo, 2004). Nevertheless, although there is no single “Bible” to draw on to uncover and understand traditional healing, there are commonly shared beliefs about the fundamental nature of the world, and how health and healing are a part of that world (Bear Hawk Cohen, 2003). Keeping in mind regional and ideological differences among Turtle Island Indigenous cultures, the following sections will review commonly shared beliefs, values and healing practices.

Traditionally, a spiritual interpretation of the human condition (Bear Hawk Cohen, 2003) included health and medicine. All things evolved through this cultural and spiritual way of life, rooted in the natural cosmic order; this concept of wholeness is fundamentally part of the consciousness of many—if not all—indigenous cultures (Begay & Maryboy, 2000). Six Nations Ontario author and healer, Wendy Hill, agrees that all indigenous peoples of the world share a particular commonality: the connection with the Earth and Spirits (2009). All peoples were spiritual beings, who respected life, nature and other animals, the ancestors, and our older relatives, such as the sun and moon (Hill, 2009). Shaman healers of
indigenous cultures focused on these natural and spiritual relationships in their work, which served not only to help those who were ill, but to connect spiritually with the sacredness of all things in the universe, fulfilling an existential need to make meaning of our existence here in the cosmos (Begay & Maryboy, 2000; Koss-Chioino, 2006).

It is estimated that the healing traditions of Native Americans have been practiced for at least 12,000 years and possibly as long as 40,000 years (Cohen, 1998). Hultkrantz (1992), a professor of comparative religions, lived among many Native American groups and wrote at length about Indigenous cultures in Canada. His writings speak of traditional Anishnawbe peoples as having lived in relative good health, keeping up high standards of hygiene, using sweats to prevent illness, calling on shamans and healers when required, and caring for the infirmed and elderly (even painstakingly carrying them on sleds during migratory periods) until the end of life. Anishnawbe peoples understood disease etiology as rooted in natural and supernatural causes; *Gitchi Manitou* (Lyon, 1996) was the “Great Mystery”, to whom they pledged ethical behaviour (including, for instance, solidarity, generosity, and helpfulness), respectful hunting and other rules of conduct (Hultkrantz, 1992). Cree peoples too, believed in manitous (spirits) everywhere in nature, and often interacted with animal spirits who acted as guardians and helped the hunt. The Cree too, were charged with following ethical ways of life in keeping with nature’s balance (Hultkrantz, 1992). Similar trends can be found in other Native American groups: for instance, the Kashaya peoples of northern California prayed to Coyote (the Creator), the Redwood trees (the Grandfathers), and believed all should live in balance with our natural world (Parrish, 2004). The Lakota peoples continue to practice the Sacred Pipe ceremony, which recognizes the spiritual phases of life and offers guidance for walking *the good road* (Bad Hand, 2002). Also, the Navajo
peoples healed by walking in balance and harmony with creation (Burkhardt, 2000). Finally, the Pueblo peoples enjoyed collectivist agricultural communities where egalitarian ideals prevailed. Among other traditions, they held ceremonies for rain and fertility, out of respect for nature’s power (Hultkrantz, 1992).

If we look outside of Turtle Island groups, to indigenous peoples in the wider global sphere, we see many interesting similarities between the belief structures of these communities, in terms of their relationship with the Earth and the sacredness of existence. For instance, shamanistic practices are common not only to Indigenous cultures in North America, but within South American Indigenous traditions, within Qabalah traditions, Anglo-Saxon traditions (Wolf, 1991), and traditional European faith healing (Hultkrantz, 1992), among others. For instance, Peruvian shamans use, as one component of their practice, the ayahuasca plant as a healing ritual that allows its followers the perspective of bringing the subconscious into awareness and experiencing a oneness with the earth (Wolf, 2004). The practice induces a timeless state that many spiritual traditions understand as being the key to our sense of harmony with all that is around us (Wolf, 2004). Other ancient spiritual traditions agree: for instance, the Bhagavad Gita, the sacred Hindu text, has as its philosophical core the notion that there exists an infinite, unchanging reality behind the illusions around us, and that our life’s goal is to connect to this infinite Source (Wolf, 2004). Many other similarities related to notions of time, the egoless self, the energetic and vibrational harmonies of the planet and universe, have been noted in Indian and Chinese societies, among the Aboriginal peoples of Australia, within Hindu, Sufism, Buddhist and Taoist practices and among Zoroastrians.

These are but a few similarities of the traditional peoples, who, in many corners of
the planet, are still seeking a life which is in balance with nature and Creation. That many of these groups still enjoy these traditions in the face of an ever-expanding technological globalization, speaks to the resilience of all indigenous peoples around the world. As Paula Gunn-Allen (1986) argues, the presence of survivors is a testament to indigenous resilience and the human will to survive. She writes, “Tribal systems have been operating in the ‘new world’ for several hundred thousand years. It is unlikely that a few hundred years of colonization will see their undoing” (p.2).

**Concepts in Indigenous Healing.** Healing can be conceptualized as the process of bring the sacred aspects of the self (physical, emotional, mental and spiritual) into focus, in order to integrate and balance these aspects, with each bearing an equal importance (Hodge et al., 2009; Hunter et al., 2006). Figure 1 (below) considers balance and harmony in the Indigenous concept of wellness, as noted by Hodge et al. (2009, p.215).

![Figure 1. Balance and harmony as the pathway to wellness](image)

Therefore, the task of the healer becomes to treat the balance, rather than treating the person (Hodge et al., 2009). While Western medicine reviews disease etiology to treat physical symptoms of illness, traditional healing takes a wholistic approach, looking at the four
quadrants above, as well as emotional and environmental contexts (Murillo, 2004).

The notion of ‘healing’—establishing harmony and wellbeing—is a lifelong commitment (Bear Hawk Cohen, 2003; Cohen, 1998). Healing connects people to nature and spirit and is not based solely on personal care (Bear Hawk Cohen, 2003). For this reason, healing might also involve ceremonies with the client, and can also include relatives and community members; for this reason, healing can also call on social networks and group practices (Murillo, 2004). For instance, if a community member is ill, relatives and friends may gather in prayerful support. Healing extends beyond physical illness, and practices might seek to heal social disruptions and the health of the entire ecosystem (Bucko & Iron Cloud, 2008).

Different healers and groups use a diverse range of formulations and practices for healing (Hultkrantz, 1992). Diversity in healing traditions was likely influenced by the migrations of communities over the years, and cultural exchanges along trade routes (Cohen, 1998). Within most healing traditions, diagnostic ability depends on the intuition, sensitivity and spiritual power of the healer, involves sensing disturbances in energy, and may include seeking information about the illness from spiritual forces (for instance, through dream interpretation, waking visions and other tools) (Bear Hawk Cohen, 2003; Wolf 2004). In terms of disease etiology, healers might perceive illness to be caused by spirits, or as a sort of disturbance with the supernatural (Bear Hawk Cohen, 2003; Hultkrantz, 1992). Etiologies also include other external causes, including pathogenic forces that come into the mind, body and/or spirit (including negative thoughts by others, environmental poisons, and physical or emotional trauma) (Bear Hawk Cohen, 2003; Hultkrantz, 1992).

The usage of the term “medicine man” (Lyon, 1996, p.168) dates back at least to
French Jesuit missionaries during the 17th century; however this term overlooks the fact that many healers were and are women. Although this term is often used interchangeably with shaman, they are not entirely the same (Lyon, 1996). Hultkrantz (1992) differentiates between groups of traditional healers in his writings. For instance, an herbalist is one who cures diseases using herbal medicines and works through natural means. A medicine person is a seer, who receives healing abilities during vision quests, and uses the power of guardian spirits in her practice, often including music in the healing experience. Finally, a shaman is an individual who is able to harness the power of spirits for healing, as with medicine people; however, a shaman is also a conjurer of sorts, able to take on new forms and transform. Cures in this latter case are typically of supernatural origin. From a general conceptual standpoint, Yeh, Hunter, Madan-Bahel, Chiang, Arora (2004) suggest that healers are individuals recognized by their communities as possessing special insight and helping skills. They are the keepers of traditional wisdom and use this knowledge and insight to address issues in the community. They also enter into the spirit realm and act as conduits of positive energy from this source (Yeh et al., 2004). As noted above, these helpers can be men, women or Two-Spirit people (Gunn Allen, 1986; Hultkrantz, 1992; Wolf, 2004).

Indigenous healers do not missionize their practices or coerce patients into accepting their services (Bear Hawk Cohen, 2003). In fact, some illnesses are not treated at all by healers if they are seen as a necessary aspect of the patient’s journey (Bear Hawk Cohen, 2003). Also, whereas a Western physician may prescribe medicine to anyone, traditional healing often depends on the time, the place, the healer and the patient, as all must be in harmony to achieve the desired outcome (Bear Hawk Cohen, 2003). The healer does not necessarily see herself as responsible for delivering a cure; rather, she is the healing
instrument through which healing power flows (Hammershlag, 2009); in this sense, she does not operate as a detached, clinical observer but is emotionally, intellectually and spiritually attached at all times (Hammershlag, 2009). Finally, healers themselves are expected to model healthy behaviour for the community (Bear Hawk Cohen, 2003).

Some comparisons between Indigenous healing and Western medical paradigms are highlighted by Bear Hawk Cohen (2003): Western medicine focuses on pathology and curing the disease, whereas Indigenous methods focus on health, healing, the person and the community; Western medicine sees illness as fundamentally biological in nature whereas Indigenous healing views diseases as complex without a simple explanation and therefore examine the larger picture (physical, emotional, social and environmental realms); Western treatment methods seek to produce measurable outcomes while Indigenous methods do not always have outcomes which are measurable; Western methods are adversarial, seeking principally to destroy the disease while Indigenous healing is teleological and asks, what are we to learn from this disease?; Western medicine values intellect and theory whereas Indigenous medicine values intuition and learning from Elders, nature and spiritual visions, etc.; Western methods focus on dependence on medication and technology and sees the practitioner as a central authority, whereas Indigenous helpers are counsellors and advisors who empower their clients through awareness and involvement of family and community; Western practices promote standards and uniformity, whereas Indigenous helping is diverse, situational and individualized; Western methods seek rapid cures or disease management where Indigenous healing denotes that patience is of the utmost importance and healing will occur when the time is right; and the legitimacy of Western practitioners is based on credentials while Indigenous helpers are accountable to their communities. This section
highlighted some general tenets of Indigenous healing. The following section will consider specific healing practices.

**Healing Modalities.** Traditional healing for many groups involves a combination of spiritual, pharmacological and physical treatments to aid the sick (Bucko & Iron Cloud, 2008). Healing typically begins with a prayer to help focus the mind on healing, and to affirm positive values such as love, thankfulness and acceptance (Bear Hawk Cohen, 2003). Among the multitude of healing practices, this section will touch briefly on herbal, ceremonial, physical, and counselling medicines.

Smudging is the practice of burning herbs to illicit smoke, in order to communicate with, and to honour, the Great Spirit. Its purpose is to cleanse and balance the self and brings about a feeling of being refreshed and rejuvenated (Moondance, 1997). Typically, tobacco, sage, cedar, sweet grass, white spruce, juniper, osha root and bitter root can be used, although typically only the first four in this list are commonly used (Bear Hawk Cohen, 2003; Moondance, 1997). Smudging can also purify a space with toxic energy, negative feelings or thoughts, and create a healing space (Bear Hawk Cohen, 2003).

Plants have also been used widely in herbal remedies, and plants are considered to have strong healing powers (Parrish, 2004). Animals and humans alike have always used plants for food and healing purposes; currently as much as 80% of the world’s population relies on herbs for their primary health needs (Burkhardt, 2000). Medicines can be found everywhere in nature and each healer who works with plants must learn to find, gather and prepare healing plants. Healers are known to have an astounding knowledge of hundreds of varieties of plant as well as precise methods of preparation (Lyon, 1996). They are taught to listen to the plants for healing instructions, not to pick plants unnecessarily, and to ask
permission of a plant to use it for medicine (Burkhardt, 2000). Cedar teas have been used for coughs and cedar twigs to warn off bad dreams; salmon is often baked on cedar wood planks (Bear Hawk Cohen, 2003). Essential oils found in nature are also used for their calming and rejuvenating properties, and natural crystals and stones (such as amber, amethyst and silver) are considered to have particular energies that bring the human body into balance (Bear Hawk Cohen, 2003; Burkhardt, 2000). Western scholars have often differentiated between plant-based healing (which they consider to be a rational treatment) and mystical shamanistic healing (which has been considered irrational) (Lyon, 1996). The following paragraphs will explore some facets of healing involving this second category.

Ceremonies are a natural part of life, and serve to bring communities of people together and to connect to the Great Mystery (Bad Hand, 2002). The circle offers the opportunity for people who share common views to join together for a common focus in harmony with one another, and affirms shared cultural identity and values (Bad Hand, 2002; Bear Hawk Cohen, 2003). In ceremony, the ego is laid aside and individuals become one with the larger group, receiving mutual support and disarming aggression and conflict (Bad Hand, 2002). Ceremonial experiences also allow mental quiet and focus, which has a secondary effect of decreasing blood pressure and stress hormones, and elevating endorphins to bring about positive feelings (Bear Hawk Cohen, 2003). Often during ceremony, the Spirit helpers are summoned to join, and participants may use music, drumming, dance and song to bring past, present and future into alignment (Bad Hand, 2002). Drumming and dancing can also heal, as noted earlier in this discussion, as they allow the mind, body and spirit to resonate at the same rhythmic frequency and results in relaxed brain waves (Bear Hawk Cohen, 2003). For instance, a sweat lodge ceremony is an opportunity to purify the self, to
commune with ancestors, animal spirits and the Great Spirit (Bear Hawk Cohen, 2003). A sweat lodge is a small, low and round dome shaped hut, with a door facing east, in the sacred direction (Hultkrantz, 1992). Stones are heated over a fire for many hours and are carried into the loge where water is poured onto them and they release large amounts of steam (Hultkrantz, 1992). During the ceremony, singing and chanting rituals are enacted in order to bring about spiritual and physical healing and may involve interactions with the spirit world (Smith, 2005). The ceremony itself may bring about stress and frustration, as it takes place in a cramped and extremely hot place. In this sense, the ritual also allows individuals to experience perseverance (Smith, 2005).

Practices to heal the sick body include curing ceremonies, bone-setting, massage, and the removal of the disease objects (Parrish, 2004). For instance, the sucking shamans typically use hollow bones or reeds to remove intruded objects by sucking. One particular account of this procedure was recorded in 1830 by a settler, Edwin Denig, who married an Assiniboin woman (Lyon, 1996). Sceptical of the practice, Denig searched the healer for hidden tools and objects but found nothing on him. The healer then continued his practice of drawing and spitting out large objects, clots of blood and hair from the body of the sick individual. These objects were too large to be easily secreted and the removal process left no marks on the patient’s body (Lyon, 1996, p.424). The practice of removing disease objects through sucking remains common today in many places on Turtle Island (Hultkrantz, 1992).

With respect to mental wellbeing, healers understand that all health problems affect the mind, emotions and spirit; therefore counselling is frequently a part of helping interventions (Cohen, 1998). Traditional counselling practices are grounded in Indigenous cosmology and focus on finding balance between the sacred aspects of the self (Nelson,
2004). Healers typically assist patients or clients by helping them to re-interpret their story, especially in terms of understanding life events through a symbolism which asks, Why did this issue develop? What am I to learn from this experience?, and so on (Bear Hawk Cohen, 2003). The purpose is to help the client to find meaning in her own life, to find her own gifts, and to commit to following a spiritual path, thereby helping to repair her spirit, which might otherwise be fragmented (Bear Hawk Cohen, 2003). Counselling techniques might also include prayer, visualization, special breathing, and may draw on dreams and visions (Bear Hawk Cohen, 2003; Cohen, 1998). Counselling tools also include offering support, clarification and interpretation, and spiritual advice. Within a group context, talking circles create an atmosphere of healing through storytelling and speaking from the heart, and group prayers can be sung or chanted (Murillo, 2004).

There no doubt exist countless diverse counselling approaches, however one model described by Hodge (2010) includes the use of narrative maps. For instance, he writes specifically about creating spiritual genograms with the client: these are modified family trees that help the client understand historically rooted spiritual patterns and understand intergenerational spiritual information. Other activities include creating a spiritual life-map, which is a pictorial representation of a client’s spiritual journey, symbolic of where the client has been and where she is going, as well as her relationship with the Creator. Finally, eco-maps indicate the client’s present existential relationship to spirituality in the here-and-now. What these examples indicate is the centrality of the role of Spirit in Indigenous-based counselling, which is often absent from Western models of counselling (Stewart, 2008; McCormick, 1997; Duran, 2006). The following section considers traditional healing techniques in mental health with Indigenous women who have experienced sexual
vulnerabilities.

**Traditional Mental Health Work with Women.** With respect to counselling and healing work with Indigenous women experiencing sexual vulnerabilities specifically, little is written in the academic literature on traditional helping. Yet it is clear from this literature review that mental health interventions rooted in an Indigenous worldview may be more successful with Indigenous women facing sexual vulnerabilities. One research study by Evans-Campbell, Lindhorst, Huang, and Walters (2006) does indicate that Native American women who experienced interpersonal violence were more likely to access traditional Indigenous helping than contemporary Western mental health services. The authors suggest that this study indicates clearly that Indigenous women are using traditional services and that Western-based mental health practitioners should promote culturally-appropriate therapies for women in similar situations.

Although little is written about Indigenous healing methods with women who have experienced sexual vulnerabilities, indigenist writings do suggest directions for healing from physical abuse. Of primary importance in the healing path is to situate the sexual abuse or negative sexual health outcomes within the context of intergenerational trauma rooted in the experience of colonization (Duran, 2006; Robinson, 1997). Struthers and Lowe (2003) explain that historical trauma can be conceptualized as the cumulative and collective emotional and psychological injury over the lifespan and across generations, resulting from a history of genocide (both physical and cultural). Robinson writes that not acknowledging the effects of trauma experienced by parents and grandparents carries unresolved grief into the next generation. If trauma remains unresolved it can manifest in various social issues, including domestic abuse and violence against women (Struthers & Lowe, 2003). Once
individuals have acknowledged the systemic impacts of colonization, they can then uncover feelings related to guilt, shame and hurt related to their trauma—not only in their own lives but in their families and communities as well (Robinson, 1997). From this point onwards, the healing journey will likely involve continued grief work, mourning and integrating the experience into a coherent narrative; however, other Indigenous healing methods aside from talk-therapy, such as traditional ceremonies, may also play an important role on the healing path. Seasonal ceremonies especially mark points along the healing journey and help to rebalance aspects of the self and tend ongoing wounds (Struthers & Lowe, 2003).

Sue and Sue (1990) argue that appropriate strategies for intervention in therapy must consider the social, cultural, historical and environmental contexts for Indigenous clients. For instance, a British Columbia study looking at the experiences of Indigenous women survivors of abuse by McEvoy and Daniluk (1995) found that participants shared common experiences around a sense of shame and guilt related to their womanhood, to their victimization and to their identity as Native women. This sense of deficiency for having an Indigenous heritage arises from stigma and racism, and is clearly a unique phenomenological experience for Indigenous clients. As Sue and Sue (1990) suggest, understanding the cultural, social and historical contexts of trauma allowed these participants to make sense of their abuse experiences. As one woman in this study noted, “I came to understand it wasn’t because of me that these things happened, [it had happened to] my grandfather and great-grandfather…all the way back…it was being collected from the point of European contact and being spilled out on the youngest generation each time” (McEvoy and Daniluk, 1995, p.299). The authors explain that the women in this study found a healing path through reconnecting to their identities as Native women and by overcoming cultural shame.
Differences in counselling philosophies between Western and Indigenous traditions may also affect women’s healing journeys. For instance, Western counselling contains particular procedures and assumptions around therapy, including individualistic approaches to counselling, emotional and verbal expressiveness, expectations of openness on the part of the client, clear distinctions between mind and body, investigations of cause-effect relationships, particular time boundaries and a focus on long term goals, whereas other counselling orientations may view the self as being relational and contextually bound rather than individualist, for instance (Yeh et al., 2004). Indigenous counselling also acknowledges healers as the keepers of wisdom, who therefore take a more active role in therapy (Yeh et al., 2004). Spirituality is also considered as a central focus in Indigenous therapy, which is relevant when considering healing for women who have experienced sexual traumas. For instance, the study by McEvoy and Daniluk mentioned above notes that the female participants conceptualized their experience of sexual abuse as a shattering of their psyches and souls (1995). They also reported that parts of the abuse experience became “split-off” (p.226), dissociated and kept out of their awareness. This type of dissociation was described not as a symptom of PTSD, but rather as a spiritual phenomenon wherein the spirit left the body for a time in order for the victim of abuse to survive the experience (McEvoy & Daniluk, 1995). Therefore, healing work with women that focuses on the central role of the spirit as well as the context of historical trauma utilizes an indigenist modality of healing that is likely more appropriate for many Indigenous women.

One working model of an indigenist approach to coping with trauma and stress for Indigenous women is described in a paper by Walters and Simoni (2002). The authors suggest that life stressors for women, including historical trauma, discrimination and
traumatic life events can be moderated by coping tools rooted in culture. They also suggest that wellness and health outcomes for women relate to social, psychological and cultural factors including discrimination and the colonial experience, as noted by other authors in this section. Walters and Simoni also offer that both specific trauma, as well as cumulative trauma, are significant factors in the higher rates of violence and abuse as well as PTSD for Indigenous women, but that these stressors can be moderated and reduced by healthy cultural practices. The authors argue that engaging clients in a process of enculturation, wherein individuals can learn about their identity and culture, can act as a protective buffer to decrease negative health outcomes. Finally, as with the above discussion on spirituality, Walters and Simoni note that spirituality continues to be a significant predictor of overall coping for Indigenous women.

**Literature Gap**

From earliest times, all cultures developed their own explanations of abnormal and distressing behaviours as well as unique culture-specific ways of dealing with these types of issues (Yeh et al., 2004). It is presumed that this is the case for healing work for those with sexual vulnerabilities. Yet despite the fact that mental health sequelae for Indigenous women with these experiences is available in some psychological literature, there is little formal research on the mental health impact and treatment of sexual vulnerabilities specifically (Barker-Collo, 1999), especially with respect to Indigenous healing. Aside from writings on the adoption of culture, a focus on spirituality and an understanding of historical trauma noted above, very little is available in the psychological literature on Indigenous healing with this important population of individuals, both in terms of conceptualization of the distress and directions for treatment. This study seeks to address this significant gap in the mental
health literature by describing an Indigenous perspective on this phenomenon.

**Summary**

Duran and Walters posit that culture itself is intervention (2004); therefore, orienting counselling around a culturally relevant worldview about health and wellness might prove to be a stronger incentive for clients to remain in therapy, where they are more likely to receive appropriate care. As we have seen in this literature review, the mental health outcomes among those facing sexual vulnerabilities can be extremely distressing and interrupting of one’s sense of self and interconnectedness with others. Additionally, these burdens appear to be far more significant among Indigenous women than among non-Indigenous peoples, due to higher rates of abuse, violence and illness rooted in a landscape of oppression and systemic poverty. This study therefore sought to supplement the little academic literature that is currently available about Indigenous healing with clients facing these difficulties, by contributing to psychological theory in this area, while informing Western based practice about Indigenous philosophies of healing that are proven to be valid and beneficial for Indigenous clients. The following chapter outlines the methodology and methods utilized for this study.
Chapter 3: Methodology

This chapter describes the methodologies and methods that were adhered to in this study, and offers a rationale for this approach. Additionally, the sampling strategy, sample population, data collection, management, analysis and interpretation, and ethical considerations are described.

Paradigmatic Approach: Qualitative Research

This study is grounded in a qualitative or naturalistic paradigm. This refers to the study of events in their natural setting without researcher’s manipulation, as well as the intention to understand and interpret phenomenon according to the meanings people ascribe to them (Green-Powell, 1997; Pinnegar & Daynes, 2007). In this sense qualitative research maximizes contextual realism (McGrath & Johnson, 2003, p.44) as its results make claims and theories related to the specific natural system studied. In its divergence from quantitative research and the need to predict and control events, qualitative research focuses instead on understanding human and social actions (Pinnegar & Daynes, 2007). While quantitative research can lead to causal inferences, qualitative research does not focus on statistical modes (Marecek, 2003), but instead embraces a diversity of responses. Indeed, qualitative methodologies acknowledge the multiple nature of reality, see “truth” as subjective, and support the tenets that knowledge and understandings vary, and that growth and learning are part of the research process for both researcher and participant (Marecek, 2003; Pinnegar & Daynes, 2007).

The nuances of experience and relationship in people’s lives are kept intact throughout a qualitative inquiry, and systems are studied in context. Therefore, knowledge is considered to be value-laden, subjective and situated in particular cultural, social and historical contexts
In contrast to quantitative methods where the researcher intentionally establishes herself as an independent observer within the research process, qualitative methods involve a relationship between the researcher and participant (Guba & Lincoln, 1994) which in turn influences the unfolding of the research process and development of research findings. The naturalistic paradigm assumes a flow in social and cultural life that changes over time; during the research process both research and participant interact within this ‘flow’ and thus the results are co-created as the two influence each other through this interdependent interaction (Guba & Lincoln, 1994; Marecek, 2003).

**Conceptual Framework**

The framework of this study reflects Constructivism, Indigenous Ways of Knowing, and Cultural Safety. These philosophical underpinnings reflect the understanding that individuals experience the world subjectively and that there exist multiple ways of knowing (Clandinin & Rosiek, 2007). Additionally, the voices of Indigenous research participants are prized and historical realities of colonialism are acknowledged.

**Constructivism.** Constructivism adheres to qualitative assumptions as it posits that reality is subjective and multiple: reality is the product of human consciousness and experience and each individual’s understanding of reality evolves over time and through space (Guba & Lincoln, 1998, 1994). In this sense, ‘knowledge’ and ‘truth’ undergo constant revisions and therefore it is accepted that there are multiple ways of knowing (Clandinin & Rosiek, 2007). As noted in the section above, these qualitative inquiries are considered to be value-laden, and include the personal assumptions and biases of the researcher and participant (LaBoskey & Lyons, 2002). Therefore, who the participant and researcher are as individuals cannot be separated from the research process. For instance, during an interview
the researcher asks questions that she feels are important and the participant shares responses and details that she feels are important (Walcott-McQuigg, 1997). The researcher cannot neutralize her influence on the participant’s contributions during their interactions, and in fact, she ought not to (Xu & Connelly, 2010); the emergence of multiple ideas, perspectives and views of reality is a strength within the framework of constructivism as it recognizes and validates a wider variety of human experiences (Pinnegar & Daynes, 2007). Indeed, individuals are complex. To decontextualize “knowledge”, “experience” and “truth” as atemporal and static overlooks the essence of the lived experience (Pinnegar & Daynes, 2007). Constructivism does not encourage the researcher to search behind a “superficial” reality to uncover a deeper, unchanging transcendent truth, but rather sees naturalistic research as, “an act within a stream of experience that generates new relations that then become a part of future experience” (Clandinin & Rosiek, 2007, p.41). As such, constructivist theory and the qualitative paradigm of research go hand-in-hand.

Constructivist theory is relevant to this study as it acknowledges the individual perspectives of each of the participants as being valid and legitimate. It recognizes that “truth” is different for each participant and that values are central to the conceptualization of healing, mental wellness and sexual health.

**Indigenous Ways of Knowing.** Culturally appropriate research with Indigenous communities involves first and foremost respecting Indigenous Ways of Knowing or Indigenous epistemologies (Benham, 2007; Kovach, 2005; Stewart, 2008). Indigenous Ways of Knowing represents a framework for privileging the voices of Indigenous research participants within a constructivist view that acknowledges historical realities. In her paper on culturally relevant story-making from an indigenous perspective, Benham (2007) argues
that research with indigenous peoples must address sovereignty, social justice and equity issues stemming from a colonial legacy of racism and oppression. Further, community “issues” must not be framed as belonging to a particular individual or group of individuals, but rather to larger structural issues within society (Tuhiwai Smith, 1999). Research must emerge from an indigenous ontology (what is known about the world) that involves a recognition of historical pain, that validates those who have been made silent and invisible by dominant cultures, and that promotes community healing (Benham, 2007; Grande, 2008).

Throughout the lifespan of Western research, the complexities of socio-political histories of indigenous communities have not typically been acknowledged. In her ground-breaking text, Decolonizing Methodologies, Linda Tuhiwai Smith (1999) reminds us that the term research, for Indigenous peoples, is synonymous with European imperialism and colonialism. Aside from the “casual taking” of sacred indigenous knowledges and the writing of decisive academic work and policy by Westerners on the validity of indigenous peoples’ claim to land, language, culture and self-determination, Tuhiwai Smith points out that by and large, research efforts in indigenous communities have proven to be worthless to the community itself while being entirely beneficial to those academics who earned accolades and careers from it. She goes on to deconstruct Western research systems, especially those who privilege positivism, as being cultural institutions that seeks to define what is “truth” and “reality”; however, while positivism posits that truth is objective, Tuhiwai Smith reminds us that “truth” and “reality” are rooted in historical systems of knowledge, cultural ways of being and relations of power (p.48). As research emerged historically as a Western enterprise, Western cultural conventions came to be considered superior while others were deemed primitive, a notion that Western research supported (Tuhiwai Smith, 1999). Tuhiwai
Smith writes, “The globalization of knowledge and Western culture constantly reaffirms the West’s view of itself as the centre of legitimate knowledge, the arbiter of what counts as knowledge and the source of ‘civilized’ knowledge” (p.63). Within the Canadian context, Martin (2001, as cited in Dunbar, 2008) argues that research about Indigenous Canadians has typically been carried out by outsiders who have dissected, labelled and dehumanized Indigenous peoples, further exacerbating colonial disruptions in Indigenous communities.

Tenets of Indigenous Ways of Knowing align with the principles of constructivism and therefore contradict the notion that one cultural viewpoint is the centre of legitimate knowledge. Kovach (2005) explains that from an Indigenous standpoint, experience is a legitimate way of knowing, Indigenous methods (such as storytelling) are valid forms of knowledge sharing, the formation of relationships between researcher and participant is a natural part of the research process, and knowledge itself is fluid, non-linear, experiential and relational. This relational piece is noteworthy as Western participants typically account for themselves individually during a qualitative interview, whereas other cultural groups often orient personal identity around the social fabric that frames their lives (Andrews, 2007). In this respect it may be important to acknowledge the impact of social communities on the lives of participants when conceptualizing personal identity. Just as Indigenous individuals have complex intersecting identities (with respect to social location, degree of acculturation, mixed heritage, etc.), so do their communities, who are likely caught in their own “collision of political change, racial tensions and spiritual controversy” (Benham, 2007, p.513).

As noted previously, a model of research rooted in Indigenous Ways of Knowing includes a focus on decolonizing, healing, transforming and mobilizing (Tuhiwai Smith, 1999). Focus should also be made on survival (of physical selves, cultural practices, and
languages), recovery (of traditional knowledges, indigenous rights) and development (of an indigenous research agenda that benefits the community) (Tuhiwai Smith, 1999, p.116-117). Specifically, narrative methods of storytelling give participants the opportunity to participate in resistance and cultural resurgence as it validates historical and socio-political stories of being (Benham, 2007). Further, several stories gathered around a phenomenon of interest contribute to a collective story which connects past to future for a given community of people (Barton, 2004; Benham, 2007; Tuhiwai Smith, 1999), in this case narratives around Indigenous peoples’ issues within a community focused on healing. These collective stories represent “diversities of truth” (Tuhiwai Smith, p.145) as there is not just one Indigenous worldview but multiple experiences, each rooted in a particular time and space (Benham, 2007).

These concepts around Indigenous Ways of Knowing related to this particular study in several ways. First, the study honoured the stories of Indigenous research participants and allowed their narratives on historical realities, social justice issues and the colonial legacy to emerge. Second, their narratives did not pathologize clients but rather contextualized mental health issues, as well as other community issues, within a larger backdrop of historical pain. Third, this methodology offered a relational approach to data collection in that relationships were established between myself and the participants and topics related to mental health provision and career training, personal career aspirations, and family story telling were shared reciprocally. Finally, the findings suggest directions for the promotion of community healing within the organization itself as well as among clients.

Cultural Safety. Finally, the lens of Cultural Safety also underlies the conceptual framework of this study and relates strongly to the values and personal approach taken by the
researcher. Cultural safety has been defined many times but for the purposes of this conceptual framework, it is described in the following way: cultural safety was first introduced by Irihapeti Ramsden, a Maori nurse in Aotearoa (New Zealand), in 1990. Her description of the term explained that cultural safety moves beyond cultural sensitivity and cultural competence (i.e. having knowledge about the culture of “the other”) in that it analyzes power imbalances in society, as well as political ideals of self-determination and decolonization. In terms of Indigenous values, cultural safety also includes respect for traditional ways of life, as well as knowledge and values, including spiritual values (Smye & Mussel, 2001). It emphasizes respect for the participant’s value system, life experience and expectation of the research process, “even if the participant is not fully aware of these factors” (Smye & Mussel, 2001, p.38). Importantly, it also asks the “student” (a Western researcher, in this case) to engage in self-exploration in order to truly begin to understand and respect difference (NAHO, 2006). Indeed, culturally safe research involves the Western researcher adapting into a bicultural thinking, or a “seeing of difference” (Andrews, 2003) across cultural boundaries. We are not isolated as humans but exist within particular historical, social and political contexts; we must learn to analyze and understand stories which are sometimes distant from our own experiences (Andrews, 2003). In addition, identities are complex and we must appreciate the nuances of mixed heritage, evolving cultures and other collisions of identity dimensions (Benham, 2007). Once the researcher recognizes her own social location and privilege, her behaviour within relationships becomes increasingly more mindful (Smye & Mussel, 2001). This intuitively changes the social dynamic in the meeting of individuals from two cultures and results in the ability of the

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researcher to engage relationally with the participant at a deeper level and establish trust. Each identity is changed when two individuals share a meaningful cross-cultural encounter as “each person gives up a little of the self to the other” (Barton, 2004, p.521). Barton suggests further that relationality is central to this meeting: “Is experience ever outside relationship? I think not; being in relation provides a continuous unfolding texture to human experience” (p.521).

The experience of first knowing the self, specifically with respect to social location, of then respecting the unique socio-political history of those from different social locations, and of engaging empathically with these individuals, inherently changes the “researcher-as-expert” dynamic and facilitates the beginnings of a decolonization process in the mind of the Western researcher. Although I identify as non-Indigenous, it was entirely respectful for me to adopt an “Indigenist” approach in my personal and professional life, which Churchill defines as focusing the rights of indigenous peoples as a political priority and respecting sacred traditions and values of Native peoples that are thousands of years old (1993, as cited in Tuhiwai Smith, 1999).

Cultural safety was included as the conceptual framework for this study as it is described by Smye and Brown (2002): not something we “look at” but as something to “look through”: an interpretive lens. As suggested here, this lens also prompts the Western researcher to engage in a personal change process through the research experience. Using a cultural safety lens was relevant to this research project as I do not personally identify as Indigenous. Having grown up as a White woman, I must acknowledge that my perspective

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18 The concept of cultural safety can also be applied to the health care setting, where service providers adhere to the same respectful tenets with clients/patients as I describe above for researchers. The concept of cultural safety in healthcare will be considered in chapters four and five of this dissertation.
may be unique from my participants in certain ways (due to age, culture, gender, education, urban vs. rural upbringing, etc.), perhaps some more than others. Using a cultural safety lens allowed me to remain self-aware throughout the data collection and analysis process and to be more mindful of my assumptions and biases. This included a respect for aspects of traditional ways that were not part of my upbringing (i.e., consultation with Spirits during a healing ceremony). I also used this lens to engage with participants at a deeper level. For instance, I may have verbalized my biases as a Western-trained therapist with clients, stating: “I understand this phenomenon as posttraumatic stress disorder. How do you understand it?”, or “That idea is new to me. Will you explain it again?” In this sense, I acknowledged that I was not an expert in these topics and asked for help from the participants, revealing a certain degree of vulnerability on my end and helping to establish trust.

Culturally safe research also includes the meaningful participation of Indigenous peoples in important decision-making processes throughout the research process. Research that is culturally safe and respects the healing path of Indigenous peoples in turn empowers individuals and communities to continue bringing about social change (Smye & Mussel, 2001). These ethical considerations for Indigenous research are discussed further in this chapter, beginning with an exploration of the culturally respectful research protocols that are shaped by the OCAP principles defined in the Introduction chapter and their relationship to Participatory Research.

**Methods: OCAP/Participatory Research & Narrative Inquiry**

**OCAP/Participatory Research.** The mandate of Participatory Research (PR) is to engage individuals and communities as collaborators in the research process, especially those who have historically been passive research participants (Fine et al., 2003; Grande, 2008;
Travers, 1997). The goal is to empower and raise awareness among vulnerable groups, in the hopes that consciousness raising encourages participants to unite, reflect, and ultimately break a culture of silence around a given injustice or health issue (Grande, 2008; Travers, 1997). This facilitates a process of recognizing a common source of individual problems and naming the systemic oppressor, thus breaking free of self-blame and feelings of personal inadequacies (Cornwall & Jewkes, 1995; Travers, 1997). PR has typically been rooted in community-based social action projects that document or evaluate the impact of social or health programmes (Fine et al., 2003), the intention of which is to improve social conditions as well as health and wellbeing (Cornwall & Jewkes, 1995). This results in research work that takes on a social-justice lens in order to promote equity among people; as a starting point, this process adopts a research agenda that includes the community as a stakeholder in every stage of the research process. In the case of research with Indigenous communities, the OCAP principles described by NAHO and discussed in the Introduction chapter are especially relevant to PR and are summarized below.

The OCAP principles (Ownership, Control, Access and Possession; NAHO, 2007) were discussed in the Introduction chapter and refer to the right of the community to own their own cultural knowledge and information, to collaborate in and have some control over the research process, to have access to the findings from the study, and to protect these findings. Due to the historical legacy of damage to indigenous communities by Western researchers, it is essential that these principles are highlighted in this discussion on research methods. As noted earlier, this project has adhered to OCAP principles and community protocols in the following ways: The topic was identified by community women in a national study on violence against Indigenous women affected by HIV/AIDS; this project received
support from the Canadian Aboriginal AIDS Network prior to commencing; a community partnership with Anishnawbe Health Toronto (AHT) was developed and the mental health staff were included in procedural discussions; AHT’s research agreement protocols were adhered to; traditional healers and managers were included respectfully and were approached with tobacco; and finally, the project was funded through the Indigenous Health Research Development Programme which involves approval by a panel of community members and Elders. This partnership with AHT involved mutual respect and developed gradually over time, as with all relationship building efforts. I also indicated my willingness to engage in a longer-term partnership with AHT in the future, should they desire to continue this research relationship.

**Narrative Methods.** Storytelling is an integral part of indigenous research (Tuhiwai Smith, 1999). Stories are considered sacred within an indigenous ontology and offer a meeting place between Indigenous Ways of Knowing and academic research (Barton, 2004; Benham, 2007). Narrative methods within a qualitative inquiry are considered a “relational methodology” (p.525) when used in an Indigenous context (Barton, 2004); since many Indigenous peoples describe themselves as coming from an oral-based storytelling tradition (Medicine-Eagle, 1989), this method is considered culturally appropriate in this context (Stewart, 2008). In addition, storytelling for peoples who have been historically marginalized provides powerful “counterstories” (p.93) which challenge the status quo upheld by the dominant group (Dunbar, 2008).

Connecting through story and narrative constitute a human practice that has been used since language was first shared (Clandinin & Rosiek, 2007). It has been suggested that human beings have a natural tendency to think in narratives (Clandinin & Rosiek, 2007;
Pinnegar & Daynes, 2007; Shenhav, 2005); the field of psychology likewise supports the notion that people understand, imagine and make moral decisions according to narrative-based cognitions and as such narrative inquiry is an important method in qualitative psychological research (Shenhav, 2005). Although in decades past narrative inquiry was mostly confined to literary scholars, it is now pervasive in many social sciences disciplines, humanities and even physical sciences and is a considered cross-disciplinary methodology (Murray, 2003; Xu & Connelly, 2010). Some researchers have turned away from positivist and objective perspectives that sought to understand the ‘universal’ and instead turned inward toward understanding diverse meanings in the local and specific (Pinnegar & Daynes, 2007). Narrative psychology in particular looks at the content, structure and function of stories we share, acknowledging that we live in a “storied world” (p.95) which is shaped through narrative (Murray, 2003). In this sense, narrative imitates life and that life imitates narrative (Bruner, 2004).

Narrative inquiry in the form of long interviews offered participants the opportunity to tell their own stories around particular phenomena of interest. Narrative inquiry reveals not only responses to questions and accounts of events and actions, but delves into meaning and significance in people’s lives, offering a rich and complex context of historical, social and political meanings as they unfold through time (Pinnegar & Daynes, 2007; Xu & Connelly, 2010). Narratives have been noted as being therapeutic as the telling of one’s story facilitates self-discovery, especially around memory, reassessment, resilience, justification and embracing the self (Riessman & Speedy, 2007). In this sense, narrative inquiry can be transformative for the participant, especially those who have not historically been given a voice, as they can uncover the complexities of their stories, their hopes, dreams and
intentions (Clandinin & Rosiek, 2007; Barton, 2004; Vaz, 1997). In their paper on narrative inquiry with individuals coping with trauma, Burnell, Hunt and Coleman (2009) argue that their methods were therapeutic for their participants. Trauma can disrupt the creation of story as it often undermines one’s assumptions and hopes of a just world and can result in a fragmented narrative (Burnell et al., 2009). The authors explain that the narrative approach they used in their research study facilitated the transformation of threatening stories into coherent stories, allowing participants to reconcile traumatic experiences through integration of difficult memories into the life story, and in doing so harmonize past, present and future.

Psychologists have become increasingly more interested in narrative inquiry in recent years (Smith & Sparks, 2006). Researchers have recognized that “life is itself storied” (p.169) and that people understand the self, identity, ways of being, and their world through narrative (Smith & Sparks, 2006). For instance, Harvey, Mishler, Koenen and Harney (2000) at Harvard Medical School offered another example of using narrative research in psychology. In this study, the authors applied a narrative inquiry to understanding psychological trauma and the process of recovery by examining the stories of three survivors of sexual abuse. The intent of the project was to consider how survivors make meaning of their experiences, particularly around concepts related to “victimization” and “survivorship” (p.292) within cultural, ecological and developmental contexts. In particular, the study focused on survivors’ relationship to trauma recovery and on how survivors constructed coherent life stories. Analyses considered “illness narratives”, “narratives of hope” and “narratives of suffering” (p.293), as well as how stories change over time. Their paper concludes by acknowledging that cultural constructs, including cultural folk-tales and myths, family sagas and scientific models, offer us a “map” (p.307) for storytelling. These cultural
frames offer a starting point for new and emerging narratives that take on personal meaning. This example of narrative research in the area of psychological trauma reflects the significance of applying narrative methods to this project. It acknowledges that life narratives are a legitimate way of knowing and that these stories change over time. It also values the cultural contexts through which stories emerge, and that knowledge is co-constructed between researcher and participant (Murray, 2003).

Given that knowledge is co-created in narrative methods, research itself can be considered to be rooted in the principle of relationship (Riessman & Speedy, 2007; Stewart, 2009), which also reflects Indigenous Ways of Knowing, as discussed earlier. The narrative structure offers the participant control over the interview: what matters to people is told and re-told through their stories about themselves and their lives (Barton, 2004). This is in keeping with Participatory Research where the participants not only produce ‘data’ but shape it through identification of major themes (Murray, 2003). Therefore both parties have power in the creation of knowledge through narrative inquiry; the participant knows the full story of her life and attends to what she deems to be important. Likewise, the researcher exerts influence in her questions, probes and responses, and these tools also steer the interview (Conle, 1999). For this reason, it is essential that the researcher make her biases and assumptions known to herself throughout the research process and especially during data analysis. These concerns around protocols for creating qualitative research that is rooted in standards of quality and rigour will be discussed in the next section, along with the specifics of carrying out this study.
Study Design

This section will review the study design, specifically the rationale for the study, sampling and recruitment procedures, the sample size, honoraria, data collection, data management, data analysis, standards of quality and rigour, knowledge translation and ethical considerations.

**Rationale.** The rational for undertaking this study lies in the fact that it addresses a critical gap in the psychological literature around attending to the mental health needs of Indigenous women struggling with past and current sexual trauma and abuse. Literature shows that Indigenous women do not access Western mental health services at a rate proportional to their mental health challenges and needs (Harris et al., 2005; Oetzel et al., 2006; Shah, 2005); therefore, traditional healing was investigated as an alternative model of mental health treatment for these women. Additionally, traditional healing in mental health is not well understood. Interviewing traditional healers, counsellors and Elders at AHT allowed them to explain concepts of mental wellbeing, wounds to the mind, body, spirit and emotions following sexual trauma, as well as traditional methods of healing. The intention was to uncover tools for healing that may prove to be more culturally appropriate for women struggling with these mental health issues.

**Study Sampling.** Purposeful sampling was used for this study, wherein specific individuals were chosen because they were likely to offer the most rich, detailed information around the research questions (Cresswell, 1998; Green-Powell, 1997). In this case, this study sought to recruit traditional helpers (counsellors, Elders and healers) at AHT who work in the field of mental health and who have worked with female Indigenous clients who have experienced sexual health issues and vulnerabilities. Specifically, *traditional counsellors* are
individuals who do not necessarily have formalized Western training as counsellors but who operate in that capacity, given their knowledge of, and connection to, traditional cultures and teachings. Some traditional counsellors at AHT also have counselling training from a Western institution. In his MA thesis on traditional healers and counsellors at Anishnawbe Health Toronto, Skye (2006) defines traditional counsellors as those who: “offer a dual approach to the spiritual, mental and emotional health of the clientele. The traditional counsellors utilize a combination of traditional and Western counselling approaches. […] Counsellors are unique in that they have individualistic styles and approaches” (p.62). Of traditional healers, he explains:

At Anishnawbe Health Toronto, practitioners of traditional medicine are generally referred to as healers, medicine people or Elders although these are not clearly bounded categories. […] They may use a variety of techniques to do their healing. Within the context of Anishnawbe Health Toronto the term healer is used to refer to someone who has a “gift” or ability to heal someone either physically, emotionally, spiritually or have the ability to heal all of these individual aspects. (p.54)

Finally, in her MA thesis, Beaulieu (2011) offers a definition of Elder which was also taken from AHT literature: “An Elder is an individual who is recognized by their community as someone who holds the knowledge and teachings of the ancestors. While they may practice or facilitate various healing ceremonies (such as the sweat lodge or use of plant medicines), the sharing of their wisdom is often considered a healing act in and of itself.” (p.8)

The ten participants who participated in this study were English speaking, over 18
years old, and self-identified as having an Indigenous heritage. This study sought to recruit between 8-10 participants. Of the ten individuals who were included in this study, five participants were women and five were men. Three individuals identified as traditional healers, or medicine people. Five identified as traditional counsellors. One identified as a traditional counsellor and traditional teacher, who also conducts traditional healing work, such as ceremonies. One participant identified as an Elder. Participants also ranged in age, from early thirties to late sixties. This number of participants allowed diverse and unique perspectives to emerge from the data, as well as the identification of common themes across the research findings. The sample size is typical for qualitative studies (Guba & Lincoln, 1989), and is reflective of the resource and time limitations inherent in completing a doctoral thesis as well as the personnel limitations related to the number of AHT staff who qualified as potential participants.

**Recruitment.** A voluntary recruitment strategy was used to recruit helpers and healers at AHT. The staff had already been made aware of the study through my ongoing partnership with AHT. Once ethical approval was secured I distributed an email to the appropriate staff members to invite them to volunteer to participate in this study (Appendix A). Potential participants were instructed to contact me via telephone or e-mail. Most participants contacted me by email to set up a meeting time. Participants were given the option to review interview questions prior to the interview. Three individuals indicated a willingness to do so.

**Honoraria.** An honorarium was offered to participants in the amount of 20 dollars and in the form of a gift card to a bookstore. Participants were also given a traditional gift. This

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19 Tuhiwai Smith (1999) self-identifies as Indigenous Maori, based on her specific genealogy, as well as particular cultural and political experiences (p.12).
honorarium was intended to compensate participants for their time, not as an incentive to participate. The honorarium was given at the outset of participation and the individuals were informed they could keep this should they choose to withdraw from the study at any time.

**Interviews.** Interviews are a commonly-used technique to guide qualitative inquiry (Pope & Mays, 2000). As noted above, interviews took on a narrative inquiry, rooted in the principle that individuals make sense of their world through storytelling (Stewart, 2008). In a qualitative research context, narrative interviews ask participants to share personal stories about relevant features of their lives. In this case, episodic interviews (rather than life-course interviews), which focus on narrative accounts of specific experiences around healing topics (Murray, 2003), were used to capture the stories of helpers. Interviews explored these stories through metaphor, understandings and daily experiences. The interview guide is presented in Appendix B.

Data collection consisted of two long interviews. The first interview spanned approximately 1.5 hours in length and participants were able to see the interview guide questions ahead of time. They were also invited to have an initial meeting with the researcher in order to build a relationship prior to the interview, if they so chose. This occurred with four of the participants. The first interview was semi-structured, with open-ended questions, and in almost all cases took place in confidential office spaces on site at AHT. One interview was conducted over Skype as the participant was out of town and one interview took place in a private and confidential location at OISE. The participants were given consent forms to sign prior to the interview (see Appendix C).

The interviews were audio-taped, with the permission of the participants. After the first interviews were completed, they were transcribed verbatim. Field notes were journaled
directly following the interviews in order to capture non-verbal cues, feelings, body
language, facial expressions and an overall impression of the meetings (Vaz, 1997). This
type of memoing captured theoretical ideas that emerged during the data collection process
and lead to the generation of new interview prompts and relationships between categories
(Vaz, 1997). Collecting multiple sources of data (interviews, field notes and theoretical
literature, including, for instance, the “Aboriginal Mental Health Strategy” published by
Anishnawbe Health Toronto) allowed for the triangulation of data and more thorough results
(Walcott-McQuigg, 1997). A second, follow up interview, was conducted to review findings
from the initial interview. These findings were presented in a story map format (Stewart,
2008), which is a visual representation of emerging key words or themes from the interview.
This story map is discussed in the analysis section.

**Data Management.** Data management was assisted with the use of the TAMS
Analyzer computer software program. TAMS Analyzer assists in data management by
allowing the researcher to organize codes and themes identified from each transcript. Each
interview was transcribed verbatim and the TAMS Analyzer program was used to store the
interviews on my computer. The electronic data was also encrypted and password protected
on my computer. Hard copy data, including consent forms, my notes, and copies of
transcriptions, were stored in the locked cabinet in my research office at the university. After
participants verified their story maps following the second interview, the tape recordings
were destroyed.

**Data Analysis.** Interviews were transcribed verbatim and identifiers were removed.
Analysis of transcripts proceeded using the use of the TAMS Analyzer software.
Transcriptions as well as field notes were also used as sources of data. Analysis was
hermeneutical in nature, which refers to a pattern of iteration, analysis, critique, re-iteration, re-analysis, and re-critique (Pope & Mays, 2000). Analysis involved the research supervisor in this process of iteration, analysis and critique by offering her draft reports of themes and codes and their relationships to one another for her to comment on.

The methods for analysis were adapted from grounded theory (Glaser & Strauss, 1967). Grounded theory offers a systematic approach to qualitative analysis which seeks to generate or discover a new theory or model, in order to explain a psychological phenomenon of interest (Cresswell, 1998). Thematic analysis was carried out with the assistance of the TAMS Analyzer software program. Open coding captured the detail, variation, and complexity of the content, and allowed the information to be categorized (Burnell et al., 2009; Henwood & Pidgeon, 2003; Peterson, 1997). Codes were derived from the data inductively, where codes emerged through the interpretation of the raw data by the researcher (rather than being derived using pre-existing theory, as with deductive analysis) (Thomas, 2003). A total of 145 codes emerged through the open coding process across all transcripts. The open coding process using the TAMS Analyzer software can be found in Appendix D.

Open coding was then followed by axial coding, where connections between categories were made for conceptual similarities and differences. Selective coding was also carried out, whereby the data were searched for instances that either support or contradict the themes developed (also referred to as negative case analysis). In a nutshell, this software program allowed me to search relationships between categories of codes using the “and”, “or” and “not” buttons in order to examine connections between categories and verify negative case analyses, specifically on topics where participants indicated divergent opinions (i.e. around topics such as “whether trauma affects men and women differently”, and “the degree to
which it is helpful for clients to revisit details of traumatic experiences”). An image of the
tool used to carry out axial and selective coding is in Appendix D. Tables of relationships
between codes were also constructed during this process, as shown in Table 1. The term
“overlap” in Table 1 refers to my questioning of whether these codes are found to overlap on
sections of transcripts.

Table 1.
*Code clusters and relationships to themes*

<table>
<thead>
<tr>
<th>Theme(s)</th>
<th>Codes</th>
<th>Overlap?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential schools &amp; Silence around sexuality</td>
<td>Taboo&gt;sexuality</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Residential&gt;school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexism</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unhealthy&gt;sexuality</td>
<td></td>
</tr>
<tr>
<td>Colonization, Colonial Policies, resultant effect on Social Det’s Health</td>
<td>Social&gt;determinants</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Colonization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential&gt;school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cultural&gt;interruption</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stigma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Politics</td>
<td></td>
</tr>
</tbody>
</table>

Relationships between categories were further explored using conceptual models, such as
with the Venn diagram (Figure 4) in the Results chapter. Throughout this analysis process,
my position as the researcher (including my biases, questions, etc.) were critiqued by my
research advisor, some colleagues at AHT, and myself (Murray, 2003).

Salient themes that were identified in the analysis were then placed into a story map so
that the themes became integrated and the pieces of the narrative brought into a meaningful
whole (Stewart, 2008). The story map consists of a chart displaying major emerging themes
across all interviews on one axis and the narrative story timeline (past, present & future) on
the second axis. This is considered the narrative “life space” (Barton, 2004; Xu & Connelly, 2010, p.361).

Based on the preliminary analysis of the findings, I organized participant narratives by the meta-themes that emerged from the data: Wellness, Loss and Recovery. These headings were plotted along the top axis of the story map as indicated in Figure 2 below:

<table>
<thead>
<tr>
<th>Story Map</th>
<th>Wellness</th>
<th>Loss</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future</td>
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</tr>
</tbody>
</table>

*Figure 2. Sketch of story map for this project*

Relevant themes from each interview were then entered into this story map. In the case of this project, relevant quotes were also placed into boxes for the benefit of the participants. This story map was shared each participant following data analysis. Participants were asked to comment on its accuracy and completeness and were given an opportunity to lend more information to the study if desired. Second interviews typically asked participants: “From your narrative I have identified the following themes…does this reflect your thoughts and feelings about this topic? Is anything missing?” Participants were also asked to comment on their story maps. Several participants offered additional information or explanation in their second interviews and offered suggestions for improvement to the story maps. Figure 3 below offers an example of one participant’s story map:

<table>
<thead>
<tr>
<th>Quotes</th>
<th>Wellness</th>
<th>Loss</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>Spirituality in Healing: “My Elders taught me I’m a hollow bone. My job is to be a hollow bone for the Creator to work through. I’ll often have a little agenda [but sometimes] I get this instinct—the spirit comes to me and I need to</td>
<td>Colonial History: “I think a lot of my clients, and me included, have spent a lot of time—due to wounding, colonization, marginalization, oppression—have spent inordinate amounts of time from a CBT standpoint in our heads, locked in our heads […] Creator gave us this mind for a</td>
<td>Healing through Reconnection with Culture: -“culture is treatment” -“What does it mean to be Anishnawbe? Or Anishnawbe Kwe? Or what does it mean to be Two Spirited? […]And culture and identity: If so much of that is the wounding process is a result of colonization, residential school syndrome, etc.,</td>
</tr>
</tbody>
</table>
address this. […] [It is] alive, vibrant, not mechanical! […] The reason why I’m at AHT is ‘cause spirit is so important and that has made my practice come alive.”

**Health Promotion**

“If you’re not given the teachings or the tools to live your life effectively and address all four sides of your medicine wheel, then life is going to be excruciatingly painful. And that lack of skilfulness in a dominant culture—or any culture that is not generous with teachings—is going to be excruciating. […] Good living, mental health, well-being, whole being…requires focus, attention and work—it just doesn’t fall into our lives.”

**Sexual Abuse:**
-clients as individuals who have, for the most part, experienced severe and complex traumas

**Complex Traumas:**
“If the same leg is broken every time in the same place, imagine how your walking is going to be as an adult!”

**Present**

<table>
<thead>
<tr>
<th>Balance as Central to Wellness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>“clarity, wholeness of mind, and connection to reality”</td>
</tr>
</tbody>
</table>

**Balance**

-“medicine wheel” approach to health

**Caring Culture**

**Philosophy**

“Some of my clients are so generous of spirit, it’s beyond understanding. It’s actually beyond my comprehension…their generosity, spiritually and culturally and just emotionally. […] [One of the first people I met when I came to AHT greeted me] “Welcome!! Aani!!” And he was the guy who eventually gave me my first spirit name.

**Sexual Abuse & Trauma:**
-incest and abuse common in the community & “silence is part of the trauma”

**Wounds from Abuse & Trauma: Relationship Issues**

“I know a lot of my clients who are sexual abuse survivors struggle in partnership, struggle to find clear boundaries around healthy sexuality, struggling with what healthy sexuality is, and either tend to go towards hyper-sexuality that’s not in line with their values…cause if someone has a lot of sex and that’s in line with who they are and their values then there’s nothing wrong with that. But if it’s out of line with their values or puts them at risk or danger, then we question it. Or they fly into the other, the hypo…then sex becomes evil or surely giving that back would be part of the simple healing. This is not rocket science! My god! I went to school for how long to get this?! Like, if you take something away…if I steal an apple for you then perhaps the amends to rectify it is to give back a nice shiny apple. Like, if you rip someone’s culture and language away and that’s so much a part of the wounding process, then maybe giving it baaaack is—sometimes I feel like we’re all so clever! Then sometimes I feel like we have single digit IQs!”

**The Talking Cure: Narratives & Traditional Knowledges:**
-recommend clients engage in “storytelling”
-tell “their story in a good way”

“Using trauma theory and empowering the client with […] grounding techniques and the emotional containment side. Then be mindful: “When are you telling your story, to put it back into the memory, so it’s processed and done.” And “How do you know when you’re going into your story and you’re back there again and you’re reliving it and actually retraumatizing yourself and setting yourself up for any number of consequences?”

**Using a Medicine Wheel to engage all aspects of the self in healing:**
“They’re laughing and they’re talking, and sometimes they play music. Often she just asks them to express through a visual medium where they want to be
Figure 3. Sample story map

Based on the emergent story maps, clusters of themes, and negative case analysis, this narrative analysis seeks to contribute to a model of healing (Cresswell, 1998). For instance, findings point to a model around the cultural appropriateness of Indigenous healing for women (and men) in this study, as well as principles of cultural safety rooted in Indigenous healing and helping practices at AHT. It also offers differing conceptualizations of Indigenous healing and Western counselling from the point of view of traditional helpers, as well as some similarities across the two fields of helping, which I term “universal healing” in the Results chapter. Finally, direct quotes from transcripts served to root the findings in the voices of the participants so that conclusions drawn are validated by participant language (Green-Powell, 1997).
Standards of Quality and Rigour. Assuring standards of quality and rigour in qualitative research involves a process of establishing credibility, transferability, dependability and confirmability of findings (Cresswell, 1998; Green-Powell, 1997; Pinnegar & Daynes, 2007). These features together ensure the study meets standards of trustworthiness, which reflects the worth of information in a given scientific study (McGrath & Johnson, 2003). With respect to credibility (how well the findings match reality (Green-Powell, 1997)), member checking was used, wherein participants had the opportunity to verify emergent themes from their interviews in a story map format. This process ensured that themes derived were consistent with participant meanings and experiences (Cresswell, 1998). Credibility was also maintained by engaging in peer review and peer debriefing. This was an external check where a reviewer, in this case the research supervisor, as well as another PhD student in the research group, reviewed the data analysis to ensure that the methods of analysis were sound. These individuals also had the opportunity to question aspects of the study’s analysis and findings (Cresswell, 1998).

Transferability is considered to be the qualitative equivalent to quantitative research’s external validity. Transferability determines whether the research findings can be transferred to other populations or situations based on shared characteristics (Green-Powell, 1997). In order to establish transferability, the findings from this study offer detailed descriptions of the participants’ experiences in order to identify for the reader if other contexts or settings are similar to that of this study. In addition, within this Methodology chapter a detailed overview of the methods and procedures for this study are outlined, which will also assist readers in determining similarities between contexts.

Dependability and confirmability can be addressed in several ways. With the
understanding that personal values and biases of both the researcher and participant play a role in qualitative research (Cresswell, 1998), it is important that the biases of the researcher be made explicit throughout the research process through the maintenance of a journal containing personal thoughts, assumptions and feelings (Green-Powell, 1997). This personal ‘audit’ throughout this process has allowed me to maintain dependability and confirmability.

**Dissemination.** Anishnawbe Health Toronto requested an official report outlining the procedures and findings of this study as well as its relevance to their work at the centre. They also requested an information package stemming from this study which can be posted to the website. In addition, study participants were given a community newsletter outlining the findings from the study. In keeping with the approval of Anishnawbe Health Toronto, these community newsletters can be shared with relevant Indigenous and non-Indigenous agencies and communities. Anishnawbe Health Toronto has also given approval for these findings to be presented at academic conferences and in academic journals.

**Ethics.** Privacy, confidentiality and anonymity was considered to be a challenge when conducting research within Anishnawbe Health Toronto, as the community is relatively small and staff are known to each other. To ensure privacy for the participants, the interviews were conducted in a private setting, typically in a private office at AHT. Privacy also extended beyond the physical to include privacy in storytelling. For instance, one participant requested that a quote on the story map be altered to protect anonymity, and this decision was fully respected (Guba & Lincoln, 1994; Pope & Mays, 2000).

With respect to confidentiality, all communications between the participants and myself remained confidential and private between us. Information was stored in a locked cabinet in the research office at OISE. Journal notes and transcripts were securely stored and
will be destroyed five years post publication. These measures ensured confidentiality of the participant as well as the data.

I ensured the anonymity of the participants by using a coding system for data collection; the names of participants are therefore not connected to their interview notes, nor to their transcriptions. The transcripts were also cleaned of any names or identifiers. This includes the names of participants, as well as the names of their friends, family members, acquaintances, or home communities mentioned during the interviews. No direct quotes that may identify a participant were used in the results of this study. Due to ethical protocols around confidentiality and anonymity, no information disclosed in the interviews was used against employees in the workplace. Information reported in the findings reflected attitudes and beliefs toward healing and helping clients specifically.

Participants were informed of their rights during our initial contact as well as during the first interview. They were informed that their participation in this study was completely voluntary and that they had the right to discontinue the interview at any time, without explanation and with no professional repercussions. No participants chose to excuse themselves from the research process.

In terms of other risks of participation, I was aware that a social risk could potentially arise if I were to wrongfully analyze the findings and thus misinterpret and misuse the data. For example, negative stereotypes surrounding the sexual health of Indigenous women could be perpetuated, including victim blaming. To protect the community from this error, story maps were used to ensure that the themes were true to the feelings and experiences of the helpers and did not reflect any outside bias I might bring. The Executive Director of AHT also offered mentorship and support throughout the course of the study, particularly on my
reporting of culturally sensitive issues, such as using spirit guides in traditional healing. Additionally, my research supervisor reviewed the analysis of the findings. In order to minimize power imbalances between myself, a member of ‘the university’ and my participants, I presented myself as a peer and colleague and maintained a friendly manner, practicing empathy to maintain a safe, non-threatening environment. Lastly, there was a risk of coercion for participation among mental health workers due to the fact that I have partnered with Anishnawbe Health Toronto for this study. For this reason, I indicated to the management of the centre that participation is voluntary and that the identity of staff participants who had come forward will not be discussed during the data collection process. Several employees who were aware of the study chose not to participate for personal reasons, with no professional repercussion.

Ethical approval was sought from the University of Toronto Social Sciences, Humanities and Education Research Ethics Board in July of 2011 following the approval of this research proposal, and was approved by the ethics board in August of 2011.

**Summary**

Chapter three presented the methodology and methods that were used in this study. Theoretical approaches to qualitative research, including constructivism and Indigenous ways of knowing, as well as narrative methods and cultural safety principles were described. The study design was outlined, including recruitment procedures, a description of the participants, interview and data analysis procedures, as well as ethical considerations. The following chapter presents the findings from these interviews.
Chapter 4: Results

Organization of the Results Chapter

The results presented in this chapter are organized by theme and relate to the research question: *how do traditional helpers conceptualize and address the mental health needs of Indigenous women experiencing sexual health vulnerabilities?* The Results chapter is divided into three parts to reflect the three overarching meta-themes that emerged from the interviews with the traditional mental health workers (traditional counsellors, traditional healers) at Anishnawbe Health Toronto (AHT). The three meta-themes, *Wellness, Loss* and *Recovery*, represent the results from the qualitative thematic analysis described in the Methodology chapter and relate directly to the research questions, which asked traditional helpers to relate their conceptualizations of mental health, the wounds incurred from sexual traumas, and the nature of their work as healers/helpers with clients who experienced sexual vulnerabilities. These meta-themes can be conceptualized with the following diagram in Figure 4 below:

*Figure 4. Wellness, Loss and Recovery as interrelated meta-themes.*

This figure indicates how these three large thematic areas relate to mental health around
sexual wellbeing for the participants in this study. These areas of Wellness, Loss and Recovery represent the dynamic flow between states of being related to enjoying sound health, experiencing ill health, and the process of recovering back to a healthy place. These narratives also relate directly to the research question as they offer a traditional conceptualization of mental health as well as mental health needs for those who are suffering, and methods of addressing these needs in the counselling setting. Specifically, narratives on Wellness referred to the tools at one’s disposal that allow him or her to enjoy mental health. Themes within the area of Wellness relate to traditional Indigenous cultures as well as to concepts such as cultural identity, a sense of balance in one’s life, a connection to spirituality, and access to culturally safe healthcare services. On the other hand, narratives of Loss related to events that lead to mental ill-health, specifically around themes of sexual abuse and intergenerational traumas, spiritual and relational wounding due to complex traumas, a disconnection from one’s culture and history, and accessing healthcare services which may be culturally unsafe. Finally, narratives of Recovery referred to the tools and supports that helpers at AHT employ in their daily work with individuals who have experienced sexual health issues to address clients’ resultant mental health issues or sequelae. Tools to promote recovery and mental wellbeing among Indigenous clients who use AHT services include: reconnection with culture, identity, and spirituality, accessing traditional healing services, attending client-centered and strengths-based counselling sessions, taking action to regain control and balance in one’s life, and benefitting from the integration of traditional and Western services offered at AHT. Table 2 presents the organization of this chapter by meta-theme, theme and, where appropriate, category, as per Bogdan and Bilken’s organizational method for qualitative research findings (2006).
Table 2.

Meta-themes, themes and sub-themes presented in this Results chapter

<table>
<thead>
<tr>
<th>Meta-theme</th>
<th>Theme</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness</strong></td>
<td><strong>Connection to Traditional Knowledge and Teachings</strong></td>
<td>Spirituality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Balance</td>
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<tr>
<td></td>
<td></td>
<td>Healthy Sexuality</td>
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<tr>
<td></td>
<td></td>
<td>“Caring Culture” Philosophy</td>
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<tr>
<td></td>
<td></td>
<td>Organic Health Promotion</td>
</tr>
<tr>
<td><strong>Culturally Safe Health Care Services</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Loss</strong></td>
<td><strong>Colonization</strong></td>
<td>Intergenerational Trauma</td>
</tr>
<tr>
<td></td>
<td><strong>Complex Traumas</strong></td>
<td>Sexual Abuse</td>
</tr>
<tr>
<td></td>
<td><strong>Wounds</strong></td>
<td>Broken Spirit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relationship Issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Addictions</td>
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It is noteworthy that few participants made clear distinctions between male and female clients\(^\text{20}\) in this type of helping work, despite the focus on women’s health in the interview guide. This “inclusive gender” approach will be reviewed in the sections on Culturally Safe Healthcare Services. Another important finding relates to the fact that for many participants, sexual trauma was not considered unique from other traumas faced by their clients, such as

\(^{20}\) Two-Spirit clients were only discussed in the context of sexual identity/orientation (i.e. homosexual, in Western terms); there was no discussion raised on Two-Spirit peoples in terms of a third gender category.
physical assault, the experience of neglect, managing addictions and poverty, etc. This finding, indicating that sexual trauma is conceptualized as being part of a larger constellation of traumas, will be considered in further detail in the section on Complex Trauma. The first section of the chapter contains an exploration of conceptualizations of mental health through the meta-theme of Wellness, according to the helpers at AHT interviewed for this study.

**Wellness**

Conceptions of mental health, or *Wellness*, as relayed by these participants, reflect notions of Indigenous mental wellbeing introduced in the Literature Review. These include concepts of connection with spirit and balance between the four sacred aspects of self: the mind, the emotions, the spirit and the body. While this section will not go to great lengths to explain these concepts again, it will present themes related to Wellness that emerged from the analysis, as well as quotes to support these concepts.

**Traditional Culture & Knowledge.** Wellness was found to be strongly linked to understandings of, and engagement with, traditional Indigenous cultures and traditional knowledge and teachings, including notions of spirituality, balance, healthy sexuality and health promotion. These themes all relate to the internalization of traditional identities, and will be considered below.

**Spirituality.** According to these interviews, many traditional teachings centre around spirituality. As one male Elder notes, “If you want to understand a people, know their spirituality” (P.172). This Elder went on to explain that understanding Indigenous peoples’ spirituality may be difficult for outsiders, as many concepts “only exist in the Anishnawbe language”; however this participant felt that Anishnawbe people should be proud of who they are and celebrate their strong sense of spirituality and the fact that in many respects,
wellbeing is the product of “Spirit working through us” (P.172). Another male traditional counsellor reflected on this notion of the presence of spirit in wellness and healing:

My Elders taught me I’m a hollow bone. My job is to be a hollow bone for the Creator to work through. I’ll often have a little agenda [but sometimes] I get this instinct—the spirit comes to me and I need to address this. […] [It is] alive, vibrant… not mechanical! […] The reason why I’m at AHT is ‘cause spirit is so important and that has made my practice come alive. (P.119)

This passage underscores the active nature of healing with spirit and the fact that spirituality is a prominent force in overall healing and wellness. Other participants reflected on the link between spirituality and healing, as with this female healer:

If society had a heart and spirit, and started helping each other as human people, as raising our children as family, and as raising the child to be the best they can be, with absolutely no violence, no abuse, no nothing—but to raise that child to be the best that that child could be, we’re going to have a better world. (P.194)

This quote refers to traditional teachings around the notion that society, too, has a spirit and that our larger connection to spirituality can promote an overall sense of wellness among all peoples. This female traditional teacher and counsellor also spoke about the role of spirit in a person’s sense of balance:

Every one of us has a spirit and when you ignore that or don’t nourish that, you become really unbalanced in your life and you become ill. And that can come out in many different ways—physical illness, mental illness, emotional unwellness. (P.130)

This notion of balance as being grounded in spirit was a trend that emerged throughout several interviews. The following section reviews this concept of balance as another central
aspect of overall wellness.

**Balance.** Participants referred to walking in balance between the four aspects of self as being central to overall wellbeing. They also described mental “clarity, wholeness of mind, and connection to reality” (P.119) as being part of mental wellness specifically. Mental wellbeing was also described by one female counsellor as: “How you perceive the world, your feelings about yourself, your general well-being and the mental aspect of your whole person” (P.130). The Indigenous approach to wellbeing was also described as being circular and integrative, rather than being rooted in any hierarchy of needs; this approach was referred to many times by participants as the “medicine wheel” approach to health (P.119, P.141) where all aspects of the self are examined to determine where an imbalance lies, or where “one or more needs haven’t been met” (P.165), as noted with this male healer:

> We’ll look at it and say, “Okay, there’s something not in balance here”. We would try to pin point where that imbalance is coming from. That way we can address that mental health problem. We understand it as something not being in balance, within the mind, body, spirit and emotion. (P.127)

One female traditional counsellor related these imbalances to spirituality:

> Well, from some of the teachings that I’ve received, if someone has no spirit or their spirit is unhealthy, they develop the illnesses and they can be physical, they can be emotional and mental. It’s because that large part of their wellbeing is missing, or it’s not well. (P.130)

These findings suggest that even within the field of mental health, all aspects of personal health are valued as important contributors to overall wellbeing; also, spirituality is regarded as central to the delicate balance among the sacred aspects of the self.
**Healthy Sexuality.** Another area of traditional teachings pertinent to Wellness in this study related to the topic of healthy sexuality. Few participants spoke of sexuality in terms of its relationship to wellness; conversations around sexual health focused mainly on ill-health. However, this female healer did expand on the traditional teachings that she received in her community on healthy sexuality:

As First Nations people we used to have a teaching on traditional womanhood. We also had the traditional manhood. So that is when you’re a girl and turning into a woman. And we have teachings on it. And that teaching taught us that we used to look after our sexuality in the most powerful and most sacred way. (P.194)

She went on to recount receiving care from Elders during her moontime, where she was given teachings on how to look after herself for that period of time, as well as counsel around making plans for her future. This traditional healer also described traditional teachings that young men and women received from community members about their roles and responsibilities throughout the life course:

They’ll also talk about his manhood. If he’s gone out to become a man already. All these teachings from the women will also be taught to him. So that he has to learn to respect you. [...] And then they say you go through the next stage. [Describes phases of life and responsibilities in each] What is your role and responsibility, not only to your family, but to the community. [...] How you work with the community and how you make sure that you always help the young girls coming into womanhood. (P194)

This passage represents a clear overview of the transmission of traditional culture from generation to generation in a positive way. This also reflects the principles of a “caring culture”, where multiple generations assist with child rearing and individuals have important
roles in caring for the community. The philosophy of a “caring culture” will be reviewed next.

“Caring Culture” Philosophy. Caring culture is defined by participants as an integral part of Indigenous cultures, where compassion for others is a valued and sacred practice. Participants spoke about the nature of the Anishnawbe culture as being a culture of kindness and respect that is deeply rooted in principles of community, as described by this male counsellor: “We have caring workers. Just our culture in general is a caring culture. So when [clients] finally get to see what their culture is like, they just grab onto it” (P.183).

Participants spoke of the care they themselves have received at the hands of their colleagues in AHT; one female counsellor noted that sitting with a healer often feels like being at the kitchen table, sharing “a cup of tea” with a family member (P.156). An example of caring culture offered by a male healer is simple kindness and sharing between individuals that fosters a connection to wellbeing:

One of the biggest healers there is, is them being able to talk and people being able to listen, without any judgment. And it seems to take a lot of the weight off sometimes.

And to understand them, to understand what you’re saying…“I feel you. I’m so sorry that happened to you”. As a human being, you have that connection. (P.127)

Another female healer spoke about the importance of offering one another natural expressions of caring, especially with clients:

A lot of times these people have never been given any love. And so I give them love.

And I always tell them, you know, every time they do something good, I say, “Wow! I’m just so proud of you! Because you’ve gone through the next stage of life.”

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21 This study was conducted on Anishnawbe (Ojibway) territory and thus the majority—though not all—of the participants identified as Anishnawbe.
Another female counsellor also shared an example of the importance of showing caring through listening: “Sometimes all you can do for people is be kind and listen” (P.165). This male counsellor expressed being moved by the nature of his interactions with clients through their expressions of kindness:

Some of my clients are so generous of spirit, it’s beyond understanding. It’s actually beyond my comprehension…their generosity, spiritually and culturally and just emotionally. […] [One of the first people I met when I came to AHT greeted me]

“Welcome! Aani!” And he was the guy who eventually gave me my first spirit name.

And welcomed me and gave me kindness. (P.119)

These passages reflect the nature of the 7 Grandfather Teachings among the Anishnawbe people, which include practicing wisdom, love, respect, bravery, honesty, humility and truth. Several participants referred to these teachings in the interviews, which offer a foundation for building mental wellbeing through daily reflection and practice. Other results that captured these teachings are discussed in the sections on the Talking Cure and Wellness as a Lifestyle in later sections. The following section considers other daily practices that promote wellbeing, which reflect other Indigenous traditional teachings.

**Organic Health Promotion.** Health promotion, defined by Health Canada as the action of enabling people to take control over their health through behaviours of daily living (1986), is also expressed by participants as part of traditional Indigenous cultures and teachings. While Western healthcare services currently operate a specific department of health promotion, this notion is organic, or natural, to many Indigenous peoples and is built into traditional culture and teachings, as described by this male Elder:
Health promotion, it’s inherent in our approach. […] And if you’re a believer in health promotion, in terms of how it reverberates in the community, then you can appreciate that if you have one person who happens to be a member of a family, and is well on their path to healing and identifying themselves, that will spill over to other members of the community and hopefully particularly with family. (P.172)

This participant sees health promotion as being natural to the culture and sees the potential for positive healing to reverberate through families and communities through role modeling. Other participants noted supporting mental health promotion and wellness as actions of daily living through traditions such as smudging, prayer, and through following traditional teachings. This female counsellor explained:

So by doing more and more ceremonies and nourishing that everyday…and it’s not just doing ceremonies, it might be everything that you do, how you think, how you act. […] And these are the little things you can do every day that can help your spirit grow so that you’re a healthier person and you make better choices. (P.130)

This passage emphasizes the “everyday” efforts individuals can make to maintain wellness. Finally, this male counsellor described the risks inherent in going without the tools of health promotion:

If you’re not given the teachings or the tools to live your life effectively and address all four sides of your medicine wheel, then life is going to be excruciatingly painful. And that lack of skillfulness in a dominant culture—or any culture that is not generous with teachings—is going to be excruciating. […] Good living, mental health, well-being, whole being…requires focus, attention and work—it just doesn’t fall into our lives. (P.119)
Therefore, wellness depends on utilizing traditional teachings around balance, spirituality and community, and operationalizing them as tools for daily living. Additionally, all of these areas of traditional knowledge and culture contribute to building strong cultural identities that promote wellness at a population level. This female counsellor summarized this concept of cultural connectedness as something that resonates with individuals at a deep level through cultural traditions:

When you hear some of these stories of when people go into the ceremony and they smell that smudge and they hear that drum and it hits you in here [points to heart] and it’s just like, vibrating right? And even just sitting in a circle and that feeling of security and knowing, belonging, and “What is this feeling and what does it mean?” I think that, you know, it definitely awakens—gives people that awareness. (P.156)

The final area that will be considered in this section on wellness is the promotion of wellbeing through access to culturally safe healthcare services.

**Culturally Safe Healthcare Services.** Cultural safety in healthcare requires the service provider to practice culturally sensitive and competent care, to engage in self-exploration of their own cultural biases, and to recognize power imbalances within society and how these may affect clients’ overall health and wellbeing. With respect to Indigenous clients, cultural safety also includes respect for traditional ways of life, as well as knowledge and values, and the opportunity for clients to help design their own treatment plans (Smye & Mussel, 2001).

Participants offered descriptions of care at AHT that reflect these principles of cultural safety. For instance, mental health services and care at AHT take on a person-centered approach, and helpers described being transparent with clients and discussing treatment plans openly. As described in the above section of this chapter, the notion of health promotion
practices as being built into the culture (P.172) encourages the transmission of traditional
culture into practices of daily living, and clients who use services at AHT also exchange
cultural teachings around wellbeing with staff. One male counsellor described his personal
involvement in traditional Indigenous cultures as “a way of life I’m totally committed to”
(p.119) and a male Elder stated that his connection to this work has encouraged his own
personal growth and wellness: “I found a place here, not only in terms of the work that
needed to be done. But it was also the process of discovering my identity as an Aboriginal
person; it was that kind of journey.” (P.172)

According to these participants, this facility is a safe space for clients and helpers to connect,
as described by this female counsellor:

> You know, this is my community. And it’s—you know, this is like my family. You
> know, my family members have walked through—doors, places like this. And I have
> very strong beliefs in our traditional knowledge. And we have our own ways of
> helping people. (P.156)

Participants also described cultural safety in their alliance with clients, stating that AHT is a
place where clients could feel safe and, as described by this female counsellor, “[admit]
things that they never told anyone else” (P.165). Another female counsellor agreed:

> I think it is important for them to build some kind of therapeutic relationship with
> someone they trust…while encouraging them that there’s this other way of looking at
> their issues, which is the traditional route. And that the services are here if they really
> want to explore that. […] And it’s getting that relationship so that eventually they
> trust enough so that they’re able to open up about those issues. (P.130)

This passage indicates the gentle guidance that helpers take with clients on their healing
journey. Another male counsellor supported this notion of gentle guidance and support: “[We] see what they need and then help them to walk down the path that they need and get the supports that they need” (P.119). This quotation depicts strong therapeutic relationships, where helpers walk the healing path alongside clients, offering support along the way.

Another important aspect of cultural safety raised in these interviews was the fact that healers and counsellors practiced in a gender-inclusive way, meaning that they did not approach cases differently depending on the gender of the client. This approach was consistent with other feedback about this project from community members who asked why this study focused on trauma among Aboriginal women, rather than among both genders. This is included as another example of culturally safe practice at AHT, as this approach with clients is consistent with traditional cultural norms that emphasize gender inclusiveness. As described by one male healer about helping work, “The spirits don’t say […] are you a man or a woman?” (P.127), suggesting that aspects of healing are universal. Two female counsellors explained that while their female clients have experienced high rates of sexual abuse, their male clients have as well—and at only slightly lower rates (P.165, P.130). When specific questions from the interview guide related to women’s health were asked, participants responded in a gender-neutral way. For instance, one female counsellor offered a story about a female client struggling with being in dark spaces due to traumatic flashbacks of abuse, and directly after this shared a story of a male client who healed from sexual trauma through his connection with the earth (P.156). When asked about healing work with female clients, another female counsellor immediately offered two healing stories with male clients (P.130). In both instances, no feedback was given by participants regarding the

22 This vignette is described in the Recovery section of this chapter.
gendered nature of the questions; they simply offered their stories of men and women in therapy, seemingly unaware that I had queried about women specifically. This is a significant finding for this study, especially in light of the fact that this project set out as an exploration of women’s health issues and needs specifically. Findings suggest that this gender dichotomy is not observed by this staff and that participants responded in gender-inclusive terms to the interview guide questions.

To summarize this section, an overview of the meta-theme of Wellness was presented, which emerged from the analysis of these ten interviews. What is particularly salient about this meta-theme is the focus on traditional understandings of mental wellbeing and healing, and the notion of spirituality and balance as being central to Wellness. With respect to social supports, the caring culture philosophy was noted prominently throughout the interviews and suggested that the larger spirit of caring for a wider cultural family is intact at AHT. The following section will consider the meta-theme of Loss, and its relationship to the wounds incurred from sexual health issues and traumas among this population.

**Loss**

Loss was the second meta-theme to emerge from the data and refers to the factors in clients’ lives which propel them to seek out mental health services at AHT. *Loss* is defined by participants as a spiritual injury or pain, resulting from the experience of oppression, abuse, trauma, violence, and other sources of harm. From the data, similarities in loss for clients emerged across all participant interviews, relating to the impacts of *Colonization* on the mental health of clients, a shared history of *Abuse* among clients, an emergence of particular personal and interpersonal *Wounds* due to past traumas, and challenges to
Indigenous Cultural Safety in the Western healthcare model. This analysis of the nature of the emotional, psychological, physical and spiritual wounds created by sexual health issues, traumas, and abuse in clients, revealed that participants typically consider the larger socio-political contexts in their clients’ overall health.

Colonization. Colonization was understood among participants as the invasion of outsiders into traditional territories and the attempted assimilation of Indigenous cultures into the dominant Western culture. Colonization is the fundamental cause of various forms of oppression facing contemporary Indigenous peoples was a consistent theme throughout the interviews. Colonial policies and systemic injustices served as a vehicle for explaining much of the mental health issues and symptoms in the population of clients who access mental health services at AHT. This male healer related clients’ current struggles to the overarching cultural losses set into motion by the process of colonization: “[Colonization] is a spiritual wound. Because like I said, the assimilation, colonization, has taken our teachings from us” (P.127). A female counsellor likewise related present-day issues among clients to historical issues:

I’d say 90% of the people we see come into the agency—either they were in the residential school system or they were in the adoption system or foster system, um, or even if they grew up on the reserve, it was an unhealthy environment, with no culture or tradition. […] These relate to larger political issues. With marginalization and oppression and all of those other big factors. (P.130)

These quotes denote that an interruption in the transmission of culture due to “historical traumas” (P.118) has led to larger societal-level issues, including the loss of traditional teachings, an interruption in the transmission of culture, and historically oppressive policies
such through the residential schooling and adoption systems. This male Elder also discussed the relationship between colonization and resultant health outcomes:

[Clients] can begin to understand their personal health. Sometimes that’s a difficult journey. ‘Cause you go back to colonization, residential schools, and all of those things. And how it disrupted Aboriginal life and why that may be causing some health challenges for you today. (P.172)

A male counsellor also made connections between mental health issues and oppression:

I think a lot of my clients, and me included, have spent a lot of time—due to wounding, colonization, marginalization, oppression—have spent inordinate amounts of time from a CBT standpoint in our heads, locked in our heads. […] Creator gave us this mind for a reason, but if it’s not in balance with the other three sides, which it often isn’t as a result of all of the experiences, then we tend to get locked in there and what is a very valuable gift from the creator becomes a prison. (P.119)

This quotes indicate that colonial policies relating to residential schooling for instance, as well as oppression at a societal level, have led to mental health issues and wounding, where the mind becomes focused on pain. Participants discussed the ongoing issues faced by their clients due to colonial structures: That having children “scooped up” by the foster care system (P.130) continues to present date and that clients continue to face oppression by members of the dominant culture in their daily lives. One female counsellor noted that many Western people may have a biased view of what it means to be Indigenous: “A lot of people’s experiences are seeing the homeless guy on the corner who is drunk, getting into a fight. And they’re just like, [shrugs] that’s an Aboriginal person!” (P.130). Overall, participants had a keen awareness of the historical context in which their Indigenous clients
live and continue to struggle. For helpers, this understanding represented the root issue among their peoples, from which other negative social determinants of health and mental health outcomes originate, including complex trauma, intergenerational trauma and sexual abuse.

**Complex Trauma.** Participants referred to their clients as individuals who have, for the most part, experienced severe and complex traumas (P.119). Complex trauma is a term which refers to the physical, emotional and psychological outcomes related to chronic or ongoing traumas (Haskell & Randall, 2009). One female healer used terms such as *lost souls* or *lost spirits* (P.194) to indicate that many individuals are spiritually lost or disconnected from their spiritual identity and wellbeing due to the ongoing experience of trauma in their lives. Complex traumas include sexual abuse, intergenerational traumas, domestic violence, and other losses that are unrelated to sexual vulnerabilities. For instance, helpers at AHT noted that their clients typically experience an entire constellation of traumas in their lives, of which sexual vulnerabilities are just one. They named cycles of poverty, loss of culture, forced adoption, addictions, isolation, neglect, and many others. They stated that any one of their clients may have faced a multitude of these issues in their lives, and that at times it is difficult to address histories of sexual abuse, for instance, when clients are currently facing housing instability, are risking losing their children to the child welfare system, and are struggling with significant economic difficulties. In terms of this broader concept of complex trauma, including but not limited to sexual traumas, one female counsellor offered an example of a client’s story which highlights the complexity of these challenges:

You’re looking at unresolved childhood abuse, neglect maybe, abandonment. Being put into a foster system where that stuff may be repeated. They grow up, they have no
idea how to have healthy relationships, and they usually get involved in some sort of abusive relationship in some aspect. Um, have lots of children, you know. ‘Cause psychologically it’s someone that loves them. […] It’s just so complicated. The relationship ends and then they struggle with their own addiction and mental health issues, and are living in poverty a lot of times, and their kids are taken. And then so they drink more, or they use drugs more. […] Because it re-traumatizes the moms because they themselves may have been through that system. And now they’re losing their own children to the same system. And it’s really difficult for them to actually try and work on their own issues, which are complex already. It’s a lot of trauma. (P.130)

This participant offered an overview of the cycles of trauma within a single woman’s life, including dealing with childhood abuse and foster care as a young person, and later cycling through the same social service system with her own children. This participant also identifies negative outcomes related to these lifelong issues, including poverty and addictions:

‘Cause you can’t address healing when the bigger issues are: there’s no jobs and people are living on very little welfare cheques every month that are gone when they get them, and they’re all unhealthy and they buy alcohol to forget their—what’s going on in their life. Or they leave and never come back. The families are broken up. So it’s a really complex…It’s so deep. So it’s really sad actually. (P.130)

This participant later stated that this cycle is typical for the clients seen at AHT. Another female counsellor offered a description of some of the complex traumas she has observed among her clients, identifying sexual assault, violence and abandonment as part of the web of complex traumas:

And it’s not necessarily just based on a specific event of what the trauma was, so um,
being raped, being jumped, being left. It’s the compound of it all, right? Many of the clients that I’ve seen don’t just have one event of trauma; it’s years—it’s countless events of trauma. (P.141)

This male counsellor offered an analogy between these compound traumas and a physical health issue, suggesting that ongoing psychological injuries over the lifespan can result in stunted growth: “If the same leg is broken every time in the same place, imagine how your walking is going to be as an adult!” (P.119).

These descriptions suggest that clients are experiencing complex traumas within their own lives, and that families are experiencing intergenerational traumas across multiple lifespans. What is also noteworthy about this theme relating to complex traumas, is the fact that helpers at AHT do not necessarily differentiate sexual traumas from other traumas in client’s lives. In other words, sexual traumas are contextualized within the larger constellation of traumas for individuals and are not necessarily prioritized above other client concerns. Given the narratives shared by helpers, it seems that client cases are overwhelmingly clouded with multiple and intersecting traumas and that the process of counselling and healing is a slow journey given the compound nature of these challenges. While this interview guide focused on asking helpers about managing sexual vulnerabilities, these traumas were not discussed outside of the larger context of other intersecting traumas.

**Intergenerational Trauma.** The topic of intergenerational trauma was raised by many of the participants. One female counsellor noted that she found counselling work with Indigenous clients and non-Indigenous clients to differ principally in the fact that her Indigenous clients “all have a shared history of trauma” (P.165). Another participant noted that the complexity of the healing work carried out at AHT is rooted in the fact that most of
the clients’ trauma is intergenerational (P.130). This male counsellor explained:

You think about residential schools, I mean, I can show you four generations of residential school issues, where, you know, the kid hasn’t gone, his parents haven’t gone, his grandparents never went, but his great-grandparents did. But the kid has all the same symptoms that the great-grandparent had. […] His parenting skills are the same as the great-grandparent’s was. Because no cycle was broken. […] If you look at the abuser, if you really look close, they are the way they are because it happened to them. It’s a learned behaviour. (P.183)

This quotation offers a clear description of the cyclical nature of abuse when patterns go unchallenged: Individuals grow up in an environment where abusive patterns are normalized, and they later repeat these behaviours as adults. Another female counsellor agreed that abuse experienced earlier in life can later affect parenting (P.156), creating cyclical patterns of abuse. This female counsellor stated that these issues can be cyclical within generations:

They don’t actually grow mentally and emotionally, and spiritually they shut down because it’s a way to cope and survive with things that are going on in your family.
And if you carry that on into adulthood. […] It’s just such a—it’s such a complicated spiral. (P.130)

Within discussions on sexual traumas specifically, participants noted that this topic continues to be a taboo subject, likely related in part to the shame of sexuality introduced in residential schools, as described by this female counsellor:

An elderly person sitting in front of you that went through the residential school system, and you’re going to ask them about their sex life?! They’re not—they’re going to leave! […] It’s still something that’s not really talked about. […] So that to
even admit that or open up that door is like a huge deal and it just won’t happen. And for elderly people who went to residential school and were raised very Catholic, they won’t talk about it. (P.130)

This quote indicates that it may be difficult for individuals who grew up in an atmosphere where sexuality was silenced to discuss their experiences of sexuality. Another female healer agreed that residential schooling affected cultural constructions of sexuality, as it interrupted the natural flow of passing on healthy sexuality teachings from one generation to the next: “I looked at where the biggest problem begun: When residential school came into our life. It took away all that responsibility for us to be the greatest Elders, to be the teachers of manhood and womanhood” (P.194). The taboo nature of sexuality continues to pose a barrier to working through these issues in the counselling setting, as this female counsellor describes:

Looking at childhood, trauma, sexual abuse–very much still taboo and still very scary. […] Because there’s been so much trauma I think it’s been hard for Aboriginal people to turn around and look at it. […] If you say sexual assault or sexual abuse, you can clear the room really quickly. […] We all need training. (P.165)

This participant notes that even discussing this topic outside of the counselling session can illicit strong avoidance reactions. This counsellor goes on to explain that despite the high rates of abuse in the community, many clients are reluctant to discuss such painful topics:

No one is talking about this. […] These women need more education around it too.

To normalize–like I said, “This is not your fault. You were a child.” A lot of that stuff they’ve never heard–cause they’ve never been able to talk about it with anyone. Or if they did, no one believed them. (P.165)
Another male counsellor agreed that “silence is part of the trauma” (P.119), meaning that the fear of shame and rejection in coming forward to acknowledge the abuse present an additional source of pain for affected individuals. These findings suggest that sexual health issues and sexual traumas are still topic areas that are taboo in the lives of many clients. Despite the higher rates of sexual vulnerabilities among Aboriginal peoples, according to these healers and counsellors, it remains a subject that is not openly discussed by clients and within their families.

A consideration of intergenerational traumas and silence around sexual abuse within families and communities relates to the concept of Sexual Abuse itself, another category related the theme of Complex Trauma. The inclusion of this concept as an individual category serves to highlight the high rates of abuse within the community, as expressed by the participants in this study.

**Sexual Abuse.** As with the statistics relayed in the review of the literature, participants in this study also commented on the high rates of sexual traumas among their clients, noting that incest and sexual abuse is “rife” (P.119) within the Indigenous community, as described by this female counsellor:

I would say that probably 95% of my female clients—and I’ve generally worked with women—they were either sexually assaulted or sexually abused. Or they’re in a relationship now where there’s sexual abuse. [...] Probably 70-80% of the men.

(P.165)

Another female counsellor agreed that rates of sexual abuse are significantly elevated among both female and male clients at AHT. However, this participant did differentiate between genders in terms of the ease around which clients share their abuse experiences in therapy:
Even a lot of our male clients have had a lot of sexual abuse. And it takes—it takes a significant amount of time for them where they can be in a place where they can open up about that. And for men I think the impact is a little bit different. I think for men because they have this perception that boys are raised to be macho and they’re not supposed to talk about those things and somehow it affects their perception of themselves as men if they admit that they were sexually abused as children. (P.130)

This participant explained that the social construction of masculinity in our contemporary society may serve to silence male clients about their experiences of abuse. Another female healer reflected on a cultural loss related to positive sexuality teachings: “In our culture as First Nations people we never ever experienced so much sexual abuse. […] We used to have a teaching on traditional womanhood. […] Today our culture has lost that” (P.194).

While many participants agreed that histories of sexual abuse and trauma are common place among their clients, participants did not readily describe instances of working through other sexual health issues with clients, such as diagnoses of sexually transmitted infections. When queried about the types of sexual health issues that present in a typical counselling session, clients referred overwhelmingly to the alarmingly high rates of sexual abuse and trauma. The lack of discussion on sexually transmitted infections in these interviews is an important finding in this study, indicating that this is not a focus for these participants in their provision of mental health services. However, perhaps the most significant finding for this project around the topic of sexual abuse relates to the fact that, despite the interview guide questions which probe directly around sexual trauma, sexuality itself was not extensively examined by participants. Discussions around the nature of mental health issues, oppression, and trauma in general, were rich and expressive; however,
questions which asked directly about sexual health traumas and therapeutic skills for working through sexual vulnerabilities did not illicit responses that were as descriptive. While a few participants noted that staff require more training around sexual traumas, others suggested that past traumas among staff could be affecting their work as helpers, limiting their openness to pursuing these topics with clients (and perhaps during our interview as well). One female counsellor noted, “Even with the helpers I think there’s so much trauma” (P.165). Two other counsellors suggested that helpers should be encouraged to work through their own issues in order to provide better care for clients who have experienced sexual abuse. Overall, the trend of sexuality as “taboo” may not only exist among clients and communities, but also among staff.

The next section will present the theme of Wounds, reviewing how participants conceptualized the mental health outcomes of sexual assault and trauma.

**Wounds.** Wounds refer to the harms associated with the traumas described above. One of the questions posed in the interview asked participants to describe the types of mental health issues, or wounds, observed in clients who had experienced sexual abuse and traumas, or any other sexual health issues. Thematic analysis revealed three major areas where these impacts of sexual traumas manifest: as issues in relationships, in struggles with addiction, and as what one female healer referred to as broken spirits (P.194), meaning an interruption or feeling of loss within the realm of spiritual health. The concept of having a broken spirit will first be explored below.

**Broken Spirit.** Within the context of wholistic health rooted in spirituality, participants referred to the spiritual wounding that is incurred following experiences of abuse, naming spiritual health as the primary area of the medicine wheel that is damaged, as
described by this female counsellor:

I think our spirit gets affected first. That’s the first one, that’s the foundation. It affects the physical, the mental and the emotional. [Spirit is] the core. And I think when that spirit is wounded, it affects the other ones. (P. 156)

Another female counsellor likewise understood these wounds as being rooted in spirit, explaining that once individuals become spiritually lost, they struggle to feel connected in their lives and struggle to find direction:

I just look at them as someone who is wounded. And really it’s—they’re lost. They’re lost spiritually. […] And I think that’s what people feel, is that general sense of loss and not feeling connected to anything around them. And people can get stuck there for years and years—their whole lives! And never really know what it is that they’re looking for. And I think a lot of it comes from fear. (P.130)

Participants stated that clients sometimes feel that they cannot trust others or feel safe (P.156) due to a violation of their safety and the need to protect themselves. One female counsellor also explained the phenomenon of losing trust in one’s spiritual compass: “If you’ve gone through a lot of abuse and trauma, it’s hard to believe that your spirit is a guide for you. […] There’s a disconnect, a lack of trust in the Creator or higher power, and um, there’s a loss” (P.141). This quotation suggests that these negative experiences can also lead to a breach with spirituality itself. Although participants agreed that Western mental health constructs, such as posttraumatic stress disorder, do apply to their clients (P.130, P.141, P.119), the root cause of these symptoms relates to a wounded spirit, and a sense of the spirit “going dim”, as described by one male healer (P.127), or by a female healer as being “pushed away” (P.194), meaning that one’s spiritual connectedness weakens. This female
counsellor conceptualizes having a *wounded spirit* as the experience of trying to outrun one’s pain using tools such as denial and emotional numbing:

I found that most of my clients, a lot of resistance, a lot of walls—they were really good at protecting themselves. […] I think that what was happening, because of the trauma, the sexual trauma, is they were constantly running…emotionally and spiritually, they were always trying to outrun that—whatever happened in the past. […] Denial, blame, just shutting down. (P.165)

Overall, participants did relate that clients had difficulties with denial, blame, trust and pain; however at the root of these issues was a fundamental sense of spiritual loss through a strong disconnection with that aspect of their medicine wheel.

**Relationship Issues.** Participants also noted that many of their female clients who had experienced sexual abuse or trauma seemed to continually engage in unhealthy relationships. For instance, one female counsellor described a client who had been physically and sexually abused as a child, and later by her partner as an adult. This participant stated, “This happened to [her] as a child and now [she’s] putting it back in [her] life. It consistently carried through” (P.165). Other participants agreed that individuals who experience difficulties in childhood often go on to participate in damaging relationships as adults, as they lack experience of healthy relationships and thus have no model of healthy boundaries or healthy sexuality to follow, as described by this male counsellor:

I know a lot of my clients who are sexual abuse survivors struggle in partnership, struggle to find clear boundaries around healthy sexuality, struggling with what healthy sexuality is, and either tend to go towards hyper-sexuality that’s not in line with their values. […] Or they fly into the other, the hypo…then sex becomes evil or
Another female counsellor noted that unhealthy relationships are commonplace among individuals who experienced childhood traumas, as they lacked positive examples of love and relationships:

Serial relationships in the Aboriginal community is like, epidemic. But I think it all comes from historical issues and personal traumas as a child and not having parents that were role models on what is a healthy relationship, what is love, what is sex. You know? What does that mean for you? What are boundaries? You have the right to say no. Men shouldn’t abuse women. […] Why do women go out and place themselves at risk from getting HIV or STIs? Um, why they allow men to abuse them? Well, it’s like, you can’t look at that without looking at their history really. Cause that’s where it all comes from. (P.130)

These participants agreed that women often grow up “not knowing how to have healthy relationships” (P.130) and often have “a constant addiction to relationships” (P. 165), believing perhaps that “this guy is going to save me” (P.165), as described by these female counsellors. They often lack an understanding of positive boundaries in relationships, continually and impulsively seek out relationships and perhaps do not understand or respect their own sexual desires. Participants suggested that these issues are, again, rooted in a history of abuse and a lack of experience in healthy relationships.

**Addictions.** Finally, participants noted that many of their clients struggle with substance abuse or other addictions. This was not stated as being directly caused by early life traumas, however a male counsellor did discuss a connection between “trauma and substance abuse” (P.119). A female healer also described her belief that there exists a link between
having a “broken spirit” and addiction (P.194). Another female counsellor explained this trend among some of her female clients, suggesting that there is a connection to both relationship and substance abuse among those who experienced sexual trauma: “I found that [abuse] was connected to addiction for the majority of them…so either they had an addiction to alcohol or drugs or relationship addiction” (P.165). This participant went on to describe an example of this trend with one particular client:

Her partner beat her up. […] And when her partner went to jail, she started using cocaine—like, hardcore. […] And I think that’s where all the addiction stuff is coming from. Not being able to talk about it or anything. (P.165)

Again, the notion of silence around traumas emerged from this data. One female counsellor suggested that self-silencing can lead to the manifestation of this pain in other areas, such as through substance abuse:

I actually have an example of a client who, probably had the most trauma-packed life that I’ve ever heard. […] He didn’t relate all of this life experience to why he was an alcoholic, why he couldn’t maintain a relationship—there was no correlation. He had kinda wiped his hands of all that trauma. (P.141)

Participants noted the high rates of addiction as well as trauma in the population who uses services at AHT, and saw the two as being linked. With respect to the meta-theme of Loss, this male healer explained that abuse and substances can both affect the spirit: “Alcohol is a spirit as well. Drugs are a spirit. […] Our spirit is like a light. And when we’re taken from that, whether it’s because of abuse or alcohol, it’s like it takes us to a dark place” (P.118).

Overall, the description of wounds suffered as a result of sexual abuse and trauma include difficulties in relationships, with trust, in denial and self-silencing, and turning to
substance abuse as a means of coping, among others. What is noteworthy is the participants’ understanding of these issues as being rooted in issues related to the wounding of spirit. The final theme in this meta-theme of loss that emerged from these data considers helpers’ notions of Western healthcare services that continue to be culturally unsafe for Indigenous clients, adding to their overall challenge to maintaining wellness and balance in their lives.

**Culturally Unsafe Healthcare Services.** What these themes of Loss share in common is their fundamental connection to colonial structures, such as the legacy of residential schools, the foster care system, and intergenerational traumas, among others. This theme around culturally unsafe care is no different, as it looks at fundamental differences in paradigms of care between Western and traditional models, and how these differences may undermine a traditional view of care that emphasizes wholistic approaches to achieving wellness.

I notice [Western models] are looking more at emotional health and physical health now. But they’ve only kind of really adopted a kind of three-pronged … they don’t really use the whole circle, and don’t see spiritually where people are at […] They’re not addressing spiritual need. […] They don’t actually look at the fourth part that makes it truly wholistic, is the spiritual. (P. 130)

This quote from a female counsellor highlights that some Western models of health may not focus adequately on spirituality and thus lack a central aspect of wholistic health. A male counsellor agreed that Western approaches to mental health care may lack an appreciation of all four sides of the medicine wheel and thus may undermine the provision of culturally competent care with Indigenous clients:

The medicine wheel of those disciplines is not round and balanced. There may be a
cursory mention of spirit, and the term “wholistic” is being tossed around a lot. But where is the focus on the spirituality? Where are the teachings around the heart? […] And how specifically are you being culturally safe, competent, and aware with Aboriginal clients? (P. 119)

Another difference in healing between Western and Indigenous paradigms lies in beliefs around using medication to address mental health issues, which is considered to be something that should be used cautiously among the participants in this study. This male Elder voiced his concerns with what he considers to be the widespread administration of medications in some Western mental health approaches:

The difference between Western and Traditional? […] One is dispensation and the other is more…you have to be involved in it much more. It’s less doctor-centered kind of thing. And more client-centered. […] But the Western health care—you know, psychiatrists largely, or psychologists largely, have the beginnings of talk therapy…but now they all want to dispense. […] And talk about going overboard, when we’re now prescribing these things to children! (P.172)

A male healer agreed with these concerns about pharmacotherapy by stating that medication can sometimes interfere with traditional healing work: “Medication is not the solution. It doesn’t work. If there’s somebody that has the medication that has stabilized them, sometimes I can’t work with them” (P.183). Another female counsellor noted that she disapproves of the dispensation of medication as a “quick fix”, especially for treating children (P.156) and suggested that more wholistic approaches to care offer the most long-term benefits.

Participants also noted being concerned about mis-diagnosis among Indigenous
clients, especially in cases where individuals may have “gifts” and “perceive things that other people don’t see”, as described by one female counsellor (P.130). For instance, a shake tent ceremony revealed one client to be possessed by a negative spirit, undermining his earlier mental health diagnosis of schizophrenia. Healers later “did a ceremony for him and he got better” (P.130). Another male healer worried that because the Western medical system uses “five senses to make something concrete and real”, individuals with gifts will be misunderstood, as “spirit can’t be examined like that” (P.127). Any “proof” that healers or helpers have of spirit is “purely anecdotal”, as a male Elder describes, and therefore not “evidence-based” (P.172). These differences in philosophical paradigms of practice illustrate some of the barriers between Western and traditional approaches.

When considering the provision of mental health care for women who have experienced abuse, one female counsellor was concerned about some Western approaches to therapy that risk causing additional pain to clients through their insistence on clients disclosing details of traumatic experiences:

But it was the approach to psychotherapy, which was to actually really talk about the details of [her] past, that [she] didn’t find helpful. That actually re-traumatized [her]…I think [she] had even more PTSD symptoms after [she] did that than [she] had before! (P.130)

The same participant goes on to describe her observations of stereotypical and damaging views on Indigenous peoples by mainstream healthcare workers who do not understand the historical context associated with various health behaviours within the Indigenous community, and who offer directions for helping that do not include community-based solutions:
They’re like, “Why can’t you just like, get with the program and do what you need to do?! I don’t get why you can’t stop drinking or you can’t stop doing drugs! Why do you keep having babies?!” Or it’s […] very much this paternalistic, “This is what you’ve got to do now go do it.” […] Cause it doesn’t help. And it’s taking away power from communities. Cause there is still—“White people are going to save the ‘Nish.” […] And that’s not empowering anybody to make any changes. Uh, it’s not giving people what they need, the tools and the resources to do their own work. So you’re just perpetuating the colonization thing over and over. (P.130)

This passage offers a rather grim example of the power imbalances and false beliefs that this participant feels continue to cause rifts between Indigenous and non-Indigenous communities, rooted in ignorance and paternalistic behaviour. A female healer described her feelings about the Western model of care and its use of diagnosis, offering her ideas for improvement involving the incorporation of health promotion strategies:

And how we diagnose them is the wrong. […] But sometimes life never gives them that chance. So we need to open our minds and spirits to make sure we give them that chance to be healthy and stop giving them pills as a way for them to heal themselves. (P.194)

This passage offers some suggestions for healing in what this participant considers to be a more positive direction, including personal healing, an area that will be considered in the following section.

Overall the meta-theme of Loss focused on particular trends relating to ill-health on the topic of sexual traumas and abuse. In particular, analysis revealed themes on wounds related to the history of colonization, including high rates of sexual abuse, intergenerational
and complex traumas, as well as relationship issues and addiction. This discussion also reviewed some differences in the Western health care model that participants found to be troubling. As with the meta-theme of Wellness, central to the meta-theme of Loss is central role of spirit; however, this section focused on the wounding of spirit as being the foundation of mental ill-health or imbalance. The following section will discuss the meta-theme of Recovery, and will outline positive modalities of helping work that these individuals at AHT employ in their daily therapy work with clients.

**Recovery**

Results from these interviews revealed a multitude of healing strategies that helpers employ when working in therapeutic settings with clients who have experienced sexual health issues, especially around abuse and trauma. Again, the participants made few distinctions between their helping approaches with men and women in this type of work, suggesting that fundamentally, all peoples are alike in their wounds and in their abilities to heal. As one male healer described, “When people come in to see you, the spirits don’t say, where is your status card? Are you a man or a woman?” (P.127), suggesting that certain aspects of healing are universal. This section will expand on these healing approaches and will supplement the discussion with four case vignettes as detailed examples of this work.

**Cultural Identity & (Re)Connection.** Themes related to connecting, or in most cases, reconnecting, to cultural identity and traditional teachings, emerged as a primary focus of helping work. Significant discussions centered on this area, highlighting the importance of bringing culture and traditional healing into helping work. Given that many clients grew up away from their traditional cultures, helpers immediately sought to re-connect them with their traditional identities. For instance, this female counsellor described the importance of
leading clients back to their roots, where they can re-engage with their culture and

probably the first thing that’s most important to help someone with is to really look at
their identity, who they are as a person. And that can be someone who is raised in an
urban centre, no culture or traditions, who has some Aboriginal heritage that they do
know about, don’t know about—who knows! That person can really—once they
come to a ceremony or a sweat lodge or get a teaching, suddenly feel like their spirit
has come alive! […] It’s like re-educating people all over again: this is what it is
traditionally what it means to get healthy. (P.130)

This quote emphasizes the centrality of cultural identity in wellbeing. Other participants
likewise focused on spirit and identity in healing work, noting the importance of regaining
cultural traditions that may have been lost, especially around spirituality and healing. One
male Elder asked:

So how do you re-Aboriginalize ourselves? In terms of utilization of spirit? Which is
probably the weakest part of ourselves that we didn’t grow with and nurture. […]
Healing has to reflect the cultural paradigm. But it relates to our health and a lot of it
has to do with identity. Whether it’s the restoring of that or having it in my life.
(P.172)

Another male healer agreed that addressing traumas must begin with culture, and that
understanding spirituality is central to this learning: “The only time we mend it is when we
learn our spirituality. We learn about our way, our culture” (P.127). Indeed, a large focus of
helping work at AHT is on connecting clients with traditional culture, especially through
prizing spirituality. This male counsellor agreed that “culture is treatment” (P.119) and uses
humour to illustrate the “obvious” nature of this helping approach:

What does it mean to be Anishnawbe? Or Anishnawbe Kwe? Or what does it mean to be Two Spirited? …And culture and identity: if so much of that is the wounding process is a result of colonization, residential school syndrome, etc., surely giving that back would be part of the simple healing. This is not rocket science! […] Like, if you rip someone’s culture and language away and that’s so much a part of the wounding process, then maybe giving it baaaack is—…sometimes I feel like we’re all so clever! Then sometimes I feel like we have single digit IQs! (P.119)

This tongue-in-cheek statement reveals that healing need not be complex: If wounds are caused by the loss of culture, then reconnecting an individual with her traditions and knowledge of history is a clear starting point in therapy.

Two participants, one female counsellor and one male healer, also described the importance of helping clients reconnect to their culture through the receiving of a traditional name, suggesting that this can offer a strong sense of cultural pride for clients and a positive way to restore identity:

A really key thing is people getting their name and their clan. Seems to really help with their identity. […] Every time a client goes and gets their name, they just walk around so proud. Like, I’ve got my name! …Can you tell me how to say this?! (P.130)

Giving them a name. Giving them a name is a step forward that they can take and be proud of the name and what it means to them. And after a while you see them back and more and more people are coming back for names and identity and in taking those small steps towards, I guess, to the identity of who they are and those small
steps by smudging, praying, going to powwows and things of that nature. (P.118)

This last quote reveals that receiving a traditional name may be a first step in encouraging clients to engage further in other cultural experiences.

The following passage offers the first case vignette in this Recovery section. It is a healing narrative recounted by a male counsellor that centers around the power of reconnecting to traditional culture as a significant aspect of the healing journey for individuals and communities.

Vignette 1. I had for a year asked what’s the drum’s name. Because our teaching is that drums are spirits, whether they’re grandfather or grandmother spirits. And nobody knew if it was a grandfather or grandmother spirit. Because the base was so wrong I couldn’t…I couldn’t get it to communicate with me. So the only place I figured it would work was the shake tent. So I took it to the shake tent to find out what the spirit was, what its name was, because it did—it was given a name years earlier. Just nobody could remember it. And then asked what we needed to do to activate it. And so we brought it to the shake tent and we found out it was a grandfather. I was told what its Anishnawbe name was and it’s funny—I had asked what its name was to the staff and not one of them could remember. And I thought, “This is why you are all struggling” […] The thing we had to do was change the base, bring it to a sweat lodge, feast it, and then bring it to a function and set up the drum. And we needed to get four community Elders to sit at that drum and sing at it. And I thought, you know, “I can do everything except the last” […] The few times I tried to bring out my drum the Elders would get upset. They called it “taboo”. A lot of them wouldn’t let their grandsons come and drum with me because they said it was
“taboo”. So anyway, we ended up having a drum social. […] And then before that

drum started, they said the next drum up was [ours]. “Were there any people that

would come out and help support and sing on the drum?” So this one Elder that did

help us with powwows, he went and sat at the drum first. And I just watched and I

seen him call his brother over and his brother went and sat with him. And then

another Elder was going by and the brother called him and said, come on over! And

he finally convinced him to come over so there was the third one. And I was waiting
to see...and low and behold this Elder just got up out of his chair, walked over to the

drum, asked if he could sit down and they said, “Yeah!” And they started to sing!

They started to sing one of the songs from their community. And then from that day

on I could talk to the drum. The drum was activated, the spirit was strong, it was

alive. (P. 183)

This narrative emphasizes the role of cultural understandings of spirituality and tradition in

one community’s healing journey, as well as the power of a spiritual and cultural symbol—

the drum—in bringing communities together. This counsellor describes the drum as

something that is spiritually alive, and something that he can communicate with once it is

“activated”, or given life, through ceremony. He notes that once the community lost their

traditional knowledge of this drum, including its gender and name, it became obsolete. He

inferred that it is no wonder the community is struggling (with addiction and other issues, he

goes on to tell), as they have lost their connection to their traditional ways. An example of

this is seen when the older generation, perhaps residential school survivors, prohibit the

younger generation to sit at the drum; they perceive drumming to be “taboo”, likely through

their internalization of the dominant culture’s oppressive views from that time period. This
counsellor goes on to share that once the community was able to re-connect with the drum during a social gathering, it became alive again. This of course, required courage by those who chose to sit at the drum, as they were consciously reversing a colonial trend that separated them from their traditional culture. This narrative highlights the importance of re-engaging with lost teachings in order to heal a wounded community.

**Understanding Historical Contexts.** In order to encourage clients to reconnect with culture, healers emphasized the need to educate them about the history of colonization and its impacts on their communities and families. This male Elder drew clear links between historical impacts on mental health issues and recovery, suggesting that only through a clear understanding of one’s cultural history can an individual appreciate the impact it may have on her personally:

> When a person goes through mental health issues, what we say is that there are historical contributors to that, and that continues even today. Perhaps on a less pronounced level, but they reverberate still. […] If you can understand and accept that history and come to terms with it to some degree, then you can begin to address and understand how it’s affecting you personally. So it might need a re-dressing or a revisiting of all kinds of things and being to restore balance. (P.172)

This passage highlights the importance of understanding of one’s place in history in the restoration of balance for wounded individuals.

In terms of sexual traumas specifically, helpers noted that healing can also be facilitated by understanding that victimizers were likely once victims themselves, and had traumas in their own childhood “that they haven’t dealt with” (P.130), according to this female counsellor. Another female counsellor stated:
Those wounds form the sexual trauma that they’ve experienced…one of the things that I often go to is the intergenerational effects, from the residential schools and the 60’s scoop. That’s one area that we talk about, and an understanding that something happened long before. […] That one person who was in residential school who had hurt you, and then that person was in school and somebody hurt them. (P.156)

Helping clients see the complex cycles of abuse rooted in historical factors can facilitate healing following experiences of trauma, and also relates to self-awareness. One female counsellor described the healing effects that breaking the silence around historical and intergenerational traumas can have on families, as it creates new understandings between individuals and allows relationships to grow closer:

[Many] Elders who may have been in residential school never talked about their own stuff. Cause in their generation it was something that you just don’t talk about…[Then] they started talking to their kids about, “These are some of the things that I’ve experienced.” They weren’t able to do that before. So it doesn’t have a huge impact. Yeah, that, “I went through this stuff and I don’t want to be this way anymore. I want to be healthier and I want to try to make a difference in my family. At least my family, if not the community.” And it does make a difference. (P.130)

Participants agreed that understanding historical and intergenerational cycles of abuse and violence can have a lasting and positive impact on individuals, families and communities; clients are able to see that these negative patterns were in place long before their time, and that these issues are not unique to them.

**Spirituality.** A focus on connecting to spirit and spirituality was another main theme to emerge from these interviews. Although not unique from the theme of cultural identity
engagement outlined in the previous section, the notion of spirituality as central to healing merits its own discussion. The general area of spirituality was described in the section on Wellness; however, how spirituality is applied as a tool in Recovery will be expanded on here. Spirituality, considered a cornerstone of wellness, offers several important healing directions for recovery, such as balance, groundedness, and feelings of overall meaning and purpose. One female counsellor described how healthy spirituality permeates everyday living and changes an individual’s experience of living: “This is like, every day. Your perspective on how you live your life, how you see yourself, how you see everybody else. It’s spirituality” (P.130). Another male healer described the relationships between spirit and balance, suggesting that healing work involves grounding a client in cultural values around spirituality, which is often difficult to describe in words:

- Cause we’re talking about spirit and there’s no way to explain-
  
  Interviewer: with words.

  To use words, yeah. [It’s] maybe four or five sessions before they get to that, that understanding of what it is, what it is I’m talking about. And all I’m talking about is life, and about an individual […] Healing] is kind of like putting them back on the path, in the centre. Where everything is kind of balanced. Where there’s an imbalance on one side and this side is a balance, right? (P.118)

Another male healer described spirit as being central to our human identities, and that it is this spirit that guides us in learning:

- We are spiritual beings having a human experience. We all have to go through the same kind of things to get to that understanding, that learning. […] So, the choices that you take, no matter which choices you make, no matter which road you go down,
no matter which experiences any way you go, in the end, where do you think you end up, in our teachings? The exact same place, the moment you’re supposed to be there in the end. And there’s that connectedness that we understand. (P.127)

Here this participant refers to an overall connectedness between our choices and the larger picture of our existence and connection to spirituality, offering a sense of groundedness and continuity in life.

Two helpers in particular described the importance of using the earth and nature as a means of connecting to one’s spiritual centre, as well as the healing effects of the spiritual connection to land. This female counsellor stated:

Spending time with family and being on the land is where I felt true peace and love. [...] And I’d lie on the rock, and whatever it is that I need to take care of and let go of, that’s what I do. And that’s what helps me. [...] I tell [clients] there are places in the city that have great peace, where you can feel that. And you can definitely smell medicines. You know, I live by a ravine. And I go through there and I can see the birds. And even just touching a tree. I think for me it’s quite simple. (P.156)

This passage describes experiences of being in nature and finding a profound sense of inner calm and connection with all existence. This fundamental source of healing is described by this participant as being simple to access and easy to benefit from. Another female healer agreed that healing work is facilitated by the outdoors: “And the best place for me to really connect with [clients] is out on the land. [...] Traditionally is to take them out on the land and just to be with them” (P.194). One of these helpers went on to offer a specific example of how she brings her spiritual relationship to the earth and nature into her healing work in a counselling session related to abuse. This description, offered by a female counsellor, is the
second case vignette of this Recovery section:

_Vignette 2._ He experienced sexual abuse. And he said he doesn’t have very good relationships with women. And doesn’t trust, doesn’t feel safe. […] And the other piece was that he likes to hunt, he likes to fish. And we talked about—what I wanted to show him was that—you know, he does have a relationship with that feminine energy. So I asked him about, “When you’re hunting, how does that make you feel?” He said, “I feel really calm and peaceful”. I said, “Well you feel really safe there. Mother Earth, she has provided for you, with your hunting”. What I did, you know, was show him that that is our mother and has that feminine energy, and you’re not having good relationships with those women, that feminine energy in your life, and one of those issues was with his mother. Not protecting him. So, um, so that’s one of the things that he has to take care of right? That relationship with his mother and his wife and having that same security. So, you know, I directed him to start with Mother Earth. Sit with her. “You feel safe with her already. She’s provided for you”. He was just like, “Yeah! I like to fish.” And that’s been there too, that energy in that womb. And so, he was just like, “I feel good when I’m on the boat”, and all that. So for me, it really is about our traditional ways and just the land and just sitting on the land is very healing too. And the thing is, when you’re on the land, you can just let it all out. You can lie on it, you can cry on it and you can feel safe, and you can walk away where you release something. (P.156)

This vignette indicates the simple healing powers of being on the land, connecting to Mother Earth, and feeling safe in those surroundings. This counsellor explains that a male client of hers had been sexually abused by a woman and consequently, had a great deal of difficulty
trusting women and feeling close to them. The counsellor used the analogy of Mother Earth to represent the feminine and used the metaphor that through his connection to the outdoors, he has already begun to experience a healthy relationship with the feminine. This participant draws several parallels between the spiritual energies of the earth, the maternal womb, and a sense of safety and serenity in nature. She goes on to state that the land is a safe place to cry and release emotions; again, stating that there is an aliveness to the earth, a spirit, that radiates positivity. These passages suggest that at times, it is the simple connections that can have profound healing effects. The following section looks specifically at *Traditional Healing* practices as another spiritual approach to healing.

**Traditional Healing.** As described in earlier sections, AHT offers clients traditional healing services in addition to traditional counselling services. Participants spoke of their support for using healing strategies that focus on “spirituality, traditional medicines and traditional healing” (P.156), as described by this female counsellor. These were seen to promote central cultural tenets of balance and wellbeing. *Traditional healing work* was described by participants as using a healer as a conduit through which the spirits in the spirit world can address illness and imbalance among clients during a ceremonial process:

> The way healers work—or medicine people work—is they don’t actually do anything themselves. They build their connection through their teachings, through their way of life, through how they live. And their connection becomes very strong. So what they do is, they do ceremony. And in that ceremony they actually are consulting with some of these spirits that people are experiencing. They consult with the people’s spirits. And when they do that they do that consulting, […] those spirits know how to help this person heal. (P.127)
This description, offered by a male healer, denotes that it is through communication with spirits that healers come to know what steps clients must take to progress on their healing journeys. Another female healer agreed that individuals who are born as healers are simply the tools of the spirit world and that “without the spirit world’s tools, we are nothing” (P.194). A male Elder explained these abilities with a helpful description, outlining how spirits assist healers through direct communication:

You can talk about spirit but it’s better to talk about what spirit tells you. I’m talking about the spirit outside of us, what we call “manidoo”, the grandfathers and grandmothers, the helpers that come to help us. And believe it or not, every race has this potentiality. We happen to be close to it and happen to be for many, many, many generations. But that was interrupted as well. Now we’re reclaiming that. [Let’s say] I’m starting to have anxiety. So I go see a healer and the simple answer is for clients: You go to the grandfathers and they say, well, he thinks too much. In other words, he’s out of balance. (P.172)

Several participants spoke about the importance of encouraging clients to seek out traditional healing services and to engage in ceremonies for personal healing, especially around trauma. This male healer explained: “[Trauma] has impacted us big time. And, uh, the only way to get that back is through ceremonies” (P.118). Another female healer supported the power of traditional ceremonies, where profound changes can be observed in a short period of time: “Sometimes as medicine people we just do one ceremony. And they change their life” (P.194). One female counsellor described the healing options clients suffering from sexual trauma have at AHT, where negative energies and experiences can be released through talk therapy or traditional ceremonies:
You have to get some of that stuff out of your body. You can do counselling or ceremonies, talk about it or whatever. But I think that’s the first step, just getting some of that out of them. Like, those bad emotions. (P.165)

What these practices share in common is the notion that negative emotions need to be discharged in order to move forward on the healing journey. Traditional ceremonies offer some healing options to facilitate this release. The following description outlines a detailed explanation of one female counsellor’s work with clients suffering from sexual abuse and trauma. The “releasing sweat” is depicted in the following vignette:

_Vignette 3._ I do traditional work with them. Even now people still come to me to ask them to do sweat lodges and ceremonies with them. […] And there’s different types of sweats. A sweat that I’ve done many times for individuals who have gone through trauma is a releasing sweat. And that’s a specific type of sweat that you do one-on-one with the person who has some stuff they’ve worked on in counselling. […] And it’s kind of like an extended counselling session in the sweat lodge. […] I’ll give you an example of somebody who had a family member pass on. And they were grieving that and they were kind of stuck in grief for many, many years. And it was complicated by the fact that this person was also their abuser when they were alive. […] So we did a releasing ceremony in the sweat lodge and each of the—and we did it based on the four directions, so each direction was a specific time in their life. We always started with when they were a child, and it was to release all the negativity and the bad experience that they had with this person. So it was actually having them—because it’s private they would actually have the time to talk about it and release that energy by talking about it and giving it a voice. And then we moved into
youth where there may have been some different stuff going on for them. And then to adulthood and Elder, um…it’s to go around all the directions so that each stage they’re letting go of something. And by doing that they come out of that and they actually feel that they have let go of stuff, because spiritually they have. They’re actually given—because so many people are told not to talk about their experiences. Uh, right from when they were a child and they told somebody. They probably told someone. “Don’t talk about that”, or, “We don’t believe you!” Their whole life they didn’t talk about it because they chose to deal with it in some other way. So when you give people a chance to have a voice for their experiences, they are in effect releasing that energy that they’re carrying from it. And it’s a step in healing to being a healthy person. So that is one of the big ceremonies that we can do with people. (P.130)

This narrative of the releasing sweat combines the sweat lodge ceremony, talk-therapy, and a medicine wheel approach to reflecting on the life course and pausing to take note of challenges in each of the stages of life. This description suggests that those who are “stuck” in a particular negative space can express difficult feelings during the sweat lodge ceremony. It allows clients to release negative emotions that they may have been carrying for some time, possibly due to norms of silence around sexual trauma and abuse. What is unique is the process of including both the emotional and spiritual experience of completing a sweat, which can be a powerful and revealing experience, with the structured approach of reflecting on life stages and experiences in a step-wise fashion. This exploration can take on a narrative approach, where the client can share her or his story of each of these life phases. This counsellor later stated that guiding the client to reflect on positive aspects of life within each stage, as well as positive outcomes of the challenges they faced, is also a central feature of
this healing ceremony. What is important about this narrative, is that although these interviews highlighted the taboo nature of sexuality that continues to permeate these settings, the sweat lodge ceremony offers an opportunity to give voice to sexual traumas. Inside the sweat lodge, reminiscent of a womb (often considered to be the earth’s womb), the environment is cramped, dark and warm. For some this may be a spiritually safe place, where they feel free to share and grieve. The ceremony itself also feels like a transformative process, more intensive perhaps than a counselling session in a typical office. There is a unique power involved in entering this sacred space.

The following section explores themes related to talk therapy, or counselling, as a recovery tool at AHT.

**The Talking Cure: Narratives & Traditional Knowledges.** Traditional counsellors, as well as traditional healers, discussed using “skills-based, client driven, strengths-based counselling […] geared to the pace the client needs” (P.130), as described by this female counsellor. One male counsellor recognized that “no two people are the same” (P.183) and another female counsellor described using approaches that clients “feel comfortable with” (P.156), suggestive of a person-centered approach to counselling. One female counsellor encouraged clients to explore difficult topics once they “developed that relationship of trust” (P.156) and one male counsellor recommended clients engage in “storytelling” only once they were able to ground themselves and tell “their story in a good way” (P.119). One female counsellor encouraged her clients to model healthy relationships developed in session with others in their lives (P.165). Within trauma work specifically,

23 During the data collection process, I was invited to participate in this sweat lodge ceremony with this traditional counsellor. Along with other participants, I witnessed first-hand the power of this type of healing practice.
these participants spoke about the importance of grounding clients and setting a slow pace. One male counsellor described a method which encourages clients to ease into their stories and to self-reflect frequently, being mindful of avoiding re-traumatization:

Using trauma theory and empowering the client with […] grounding techniques and the emotional containment side. Then be mindful: “When are you telling your story, to put it back into the memory, so it’s processed and done.” And, “How do you know when you’re going into your story and you’re back there again and you’re reliving it and actually retraumatizing yourself and setting yourself up for any number of consequences?” (P.119)

This male healer described the need to walk with clients on their healing journey in a unique manner with each individual, and to respect clients’ readiness and pace in moving forward:

It’s very gently. So the teachings that I share with you will be, you know, they will be given very delicately, per person, per individual, if they’re even ready for it. They have to be ready. And individual healers, like myself or therapists will know when they’re ready to take the next step, to get them to understand and to address these things. (P.127)

Another female counsellor recognized the importance of using solution-focused approaches in this work, focusing less on the details of what happened and more on coping mechanisms (P.141), in order to avoid re-traumatization. Alternatively, another male counsellor’s method did involve revisiting challenging moments with clients as a means of moving forward and becoming “unstuck”: “I conceptualize it in a nutshell is through the medicine wheel: If someone is impacted or traumatized at this part of the medicine wheel, until that is resolved, processed, the story is told, worked through…we cannot get through” (P.119).
Negative case analysis revealed this to be one area of difference among helpers in their approach to working through sexual abuse and trauma with clients, i.e., How much detail is required in the exploration of abuse histories in order for individuals to move forward on their healing journeys? Different participants had divergent ideas about this. However, what all helpers did agree on was the need to empower clients and use a strengths-based approach in counselling, as described by this female counsellor:

I don’t counsel at people, I counsel with people. And, um, yeah—I think it’s important that we empower, um, not just our clients but the whole community of Aboriginal—urban Aboriginals, like, that’s what we do here…if I’m holding everything in my bundle, and they’re holding nothing (in my opinion), then why am I sitting with them? Really, then I have nothing in my bundle because I don’t respect what they’re bringing. (P.141)

This passage indicates that respecting the strengths a client brings to session is paramount to empowering clients. Another female counsellor spoke specifically about supporting female clients in this regard, who she felt should be seen as strong individuals rather than victims: “I think it’s the same for women. Tired of being looked at as a victim, and, you know, “I need help”. Because we have our strengths” (P.156). Another female counsellor also spoke about empowering clients to stop cycles of abuse in their families using coping mechanisms that allow individuals to heal and move forward in their lives, rather than engage in damaging behavioural patterns:

I think trauma work needs to happen for growth. […] I do more coping mechanisms.

“So how do we cope with knowing you were sexually abused by your parent? […] How do we live day to day, not pick up the bottle, but cope with the knowledge of
this? How aren’t we going to repeat this cycle of life?” (P.141)

Overall, participants used strengths-based approaches to helping the clients share their stories and narratives of abuse and trauma at their own pace. The following sections consider the use of traditional knowledge as part of talk-therapy.

**Learning as a Journey.** Participants spoke about helping clients to understand their difficulties as part of a larger learning journey in life. One male counsellor encouraged clients to “look to those abuse memories now for richness or wisdom” and to try to “turn it around” (P.119). A male healer encouraged clients to “accept or make peace with [difficulties] or to learn from it as part of your journey” (P.127). This philosophy encouraged a positive attitude and a deeper investigation of the mysterious and complex workings of life.

Participants also spoke about learning from difficulties themselves and of seeing negative experiences as gifts that promote cultural and personal understandings, as described by this male healer:

> I like to say that all of these things I’ve experienced—I always like to look at them as teachings […] good or bad, they’ve helped me in my journey. They’ve given me a good understanding of myself and the community, and all Anishnawbe people, I guess. (P.118)

Another female counsellor recalled at first being surprised to hear another community member giving thanks for painful experiences, as difficulties are typically something to be avoided:

> I’ve heard someone saying their prayers in the sweat lodge and giving thanks. Even for those hard ones, the painful ones! […] It hurts, it’s painful…but we need to pick ourselves up […] So I reflect back on my painful experiences and what it has shown
me. And you know, and shaped me. And it’s given me strength and knowledge. (P.156)

This quote indicates that this participant learned through another’s example that challenges can promote growth, but that we must often shift our thinking to appreciate this fact. Likewise, one participant described life’s purpose as being “about learning”, and specifically “to understand Creator a bit more, how to get a little closer to him”. This male healer stated that all people share common experiences and common pain, and that these teachings are similar “for every human being on earth”. We “can’t change that”, but we are connected in our learning (P.127). This important distinction—to move clients away from self-pity and into a place where strength and learning can be drawn from difficulties—was a key factor in counselling strategies noted by these participants, and is an approach that is grounded in traditional teachings. In this sense, learning from life’s challenges was conceptualized as a journey toward wisdom and spirit.

**Traditional Knowledge & Metaphor.** Helpers spoke about using traditional tools to work with clients, such as the medicine wheel, traditional stories, drumming and crafts. One female counsellor offered a lesson that clients find helpful when dealing with mistakes they made: “One of the things is our traditional stories and storytelling. I don’t know if you’ve heard any stories about Nana-boo-shoo. But he made some foolish choices and he had to learn things the hard way” (P.156). Participants also spoke of using metaphor and simile with clients, which one male counsellor felt worked well, possibly due to the fact that oral tradition and metaphor was used regularly in the Indigenous tradition (P.119). Another female counsellor described using the medicine wheel as a visual tool for relaying traditional teachings to clients, stating that visual guides can often hold the clients’ attention longer:
I do find that with concurrent disorders and the Aboriginal population, if I don’t have visuals in a session, I’m going to lose a client. So I use the medicine wheel a lot.

“Let’s just reflect, on that South, that Mental—what’s going on there? How’s those relationships, how’s your thought process? What’s going on there?” (P.141)

Another female counsellor also introduced various art forms to the counselling session, suggesting that there exists a variety of ways of connecting therapeutically with clients: “Let’s make moccasins! […] Also beading. Because when you’re beading, you’re concentrating. There’s no eye contact and less intensity. They would tell me things that maybe would come out in counselling eventually. But it was a really nice way to connect” (P.165). A female counsellor reflected on the healing nature of the drum as a tool for processing painful memories, as its spiritual expression of prayer allowed clients to transition through emotional times:

…and he would drum until it went on. And he would pray while he was drumming, obviously. He would just pray for guidance and help. He would get through the moment. I have other people I work with who dance. (P.141)

Art therapy was also a tool employed by helpers at AHT and represented another form of personal expression where clients could access other senses and parts of the self, aside from purely cognitive processes. This male counsellor described:

They’re laughing and they’re talking, and sometimes they play music. Often she just asks them to express through a visual medium where they want to be five years from now, where they see themselves six months from now. […] Or music touches people. (P.119)

Helpers were creative in the ways in which they worked with the clients; one male counsellor
described taking “different angles” to promote “more possibilities” for healing (P.119).

These diverse modalities also encouraged clients to “keep their hands busy, rather than ruminating” over issues and traumas, as described by this female counsellor (P.141). As the participants noted, using a variety of approaches with clients assisted them to move through their difficulties, using various channels and creative art forms to express themselves from all sacred aspects of self on the medicine wheel.

The following section considers another theme that emerged related to Recovery: taking Action to move forward on the healing journey.

**Action: Healing is a Verb.** Participants agreed that an exploration into self through narrative means and other creative avenues is an important part of healing from sexual abuse and trauma; however, taking action is an equally important requirement for recovery. As one male counsellor described, change truly arrives when healing strategies are put into action:

> The one word I find is best with me is “action”. You know, talk is cheap. It’s the action—when you start implementing things and people see it, that’s when things start to change. […] You may have to struggle a bit but the more you struggle the stronger you get when you conquer it. (P.183)

This passage also suggests that strength emerges from overcoming difficulties, and that this process itself can be healing. Another male counsellor agreed that action must be part of the healing strategy; if this is neglected, clients will have a reduced chance of recovery:

> I often write on the board: Action, support, spirit. Those are the three things! […] So if you’re not doing action, you’re not getting lots of support, you’re not delving into the realm of the spirit as you understand—it’s personal to you, doesn’t have to be my way or her way or his way—good luck with this! (P.119)
One male healer agreed that clients need to take action to move forward and “actually do something about it” (P.127); another male counsellor stated that healing is “hard work—fact. And it’s worth it” (P.119). One female counsellor takes a positive look at clients’ difficulties, promoting step-wise action to facilitate healing: “Let’s not look at them as issues. You’ve got lots of things to take care of. So what would you like to take care of first?” (P.156). In the traditional sense, action can involve ceremonies and spirituality, as described by this male Elder:

> What are you doing in terms of your own spirit? Well there are things we can do. Or show you, or involve you to address that. There are ceremonies you can do, there are things you can do in terms of your own family. So it becomes prescriptive in that sense, it becomes animated, if you will. (P.172)

This quote reveals that a variety of healing measures, including ceremonies and making changes at home, can promote a forward momentum. Another female healer stated that help can only be offered once the client has shown a willingness to take action in her or his own life, and that one must be serious about making changes if spirits are to be called on, as spirits are not to be toyed with:

> I always ask them, “Why do you want me to heal you? Why do you want that change in your life? You have to give me a good answer because I need to know that you’re serious for the change. Because I can help you but tomorrow you can go back to the same way. […] You might need to go back to school, you might need to look and focus on what you want to become. And you can’t fall back. You’ve got to make that promise to the spirit world…and you can’t play with the spirits.” (P.194)

This passage highlights the importance of taking personal accountability for one’s own life
and of seeking help responsibly. Other helpers likewise identified that clients need to take responsibility for setting goals to move forward. One male counsellor highlighted that the benefit of accountability is empowerment: “I tell my clients a lot about it: The key to freedom is responsibility. You realize you’re responsible for your thoughts, your actions you words, your bank account, your career. You’re no longer someone else’s victim” (P.119).

Other interviews revealed that clients who tend to be doing well along their healing journeys are those who are motivated, working full time or volunteering. This is likely related to their positive routine and pride in their contributions; alternatively, one female counsellor stated that clients who were unemployed seemed to be “stuck in the past” (P.165), perhaps since they have free time to dwell on past difficulties. Helping individuals to feel “in control” was also an aspect of healing; for instance, one male healer noted that women who have been victimized should consider “going to women’s circles, women’s drumming […] being an activist for women’s rights, involving yourself, volunteering and going to support groups” (P.127). Overall, there were many approaches suggested to regaining control and feeling empowered. One prominent theme that emerged in this area was self-healing.

**Self-Healing.** Self-healing refers to the notion that individuals must be their own champions of healing, as individuals are unable to change others and can only change themselves. One female counsellor noted that healing needs to happen from within the client (P.141) and a male Elder explained that “good healing is self-healing” (P.172), suggesting that it can have a lasting effect as clients learn the skills to heal and are more prepared to manage future difficulties. One female counsellor described the phenomenon of self-healing on a personal level, stating that having a strong connection with spirit and one’s own strengths is a deeply rooted source of strength and wellbeing:
We are all healers within our own selves, have our own gifts. [...] Having that connection with Creator, with the land, you know, with my spirit and with my helpers...nobody can take that away from me. It’s mine, it’s personal. I—it’s my relationship. That I can build and I can feel secure. Because for me I’d rather go home and sit at home with my pipe. And I think that relationship with your own self—you know, when they say when we go fasting that we are taking a step closer to knowing who we are. Taking a step closer to Creator and creation. That’s the way I look at it. I’m building a relationship with all of these things in my life. With me. And no one can take that away. (P.156)

According to this participant, self-healing begins with a connection to the self, and that this is foundational to wellbeing. Once an individual is able to relate a strong sense of self to the larger creation around her, this sense of wellbeing can be extremely difficult to shake.

Another female healer likewise stated that clients need to stand on their own two feet and be “the best they can be. And that to me is a reward money can’t buy” (P.194). This healer goes on to explain:

I was raised on the land. I understand what it is to be a human. I struggled, we struggled, everything—but we understood how to survive it. [...] We have so much self-pity today that’s causing us to have sickness within our mind, body, emotion and spirit. So we need people that have great experience and that heal themselves to become teachers again. [...] We can’t sit back and say, “Well we’re going to get Dr. Jane to do this for us. Or maybe this mental health person to do that for us. Or maybe somebody else.” Why can’t we do our own healing? Because the Creator gave us all the healing tools on earth for us to do the healing ourselves. (P.194)
This passage describes this participant’s view of our current society, where individuals tend to suffer with self-pity, waiting for others to solve problems for them. This participant issued a call to action for all individuals to begin to take care of their own wellbeing. Another male healer agreed that individuals should “take care of each other” and “heal themselves” through their “connection to their own self” (P.127). One way to embark on self-healing is to practice the principles of daily health promotion, which, again, are inherent to Indigenous cultures.

**Wellness as a Lifestyle.** The practice of “cultural health promotion” as a lifestyle, as described in the section on Wellness, applies to this discussion related to encouraging clients to take action toward self-healing. Helpers remind clients that engaging in their spiritual practices on a daily basis is a positive way to promote wellness. One female counsellor suggested that daily acts of health promotion, such as smudging and praying, can offer strong tools for maintaining balance and overall wellbeing:

> It’s teaching little things like smudging every day, because it helps you for a moment actually just be in that moment and ground yourself. [...] We give teachings on why tobacco, why the medicines are important, and what that would do for you. So it’s like, you sit with tobacco and spend five minutes praying… you’re just in that moment focusing on something and asking for some help. [...] And a really important part of your identity is your spirituality. What you believe in and what it is that makes you feel good about yourself every day. (P.130)

Another female counsellor agreed that everyday practices help ground clients on their daily healing path and assigned activities in counselling to assist clients to reflect on traditional teachings around wellbeing:
And all of my assignments are based on my teachings—The Seven Grandfather Teachings. So I’ll ask one of my clients to pick one. “Which one stands out for you today?” “Honesty.” “Okay! Let’s come up with some things you need to start working on to improve your honesty”. So that’s what how I, um, use that teaching.

(P.141)

Giving clients a program to work through was a strategy that seemed to offer structure outside of the counselling session and many participants discussed giving their clients homework to complete. Following the Seven Grandfather Teachings was also raised by several participants. For instance, one male counsellor discussed the importance of using these teachings as a daily reflection to maintain mental health:

[The Healer] talks about getting up every morning and she prays and she does daily forgiveness work with the people who she needs to forgive. And it’s simple but most teachings are. I mean, the Seven Grandfathers: Honesty, truth, respect…not very complicated; but really hard to practice. […] So her teaching is that simple: Say you get up in the morning and talk to the Creator and do your daily forgiveness work on those you need to forgive. Cause if you carry the hate and resentment, it is poison for us. (P.119)

Ultimately, self-healing and following a healthy lifestyle involved daily practices that helped to ground clients in the traditional way of life and promoted balance and wellness.

The remaining section in this meta-theme considers the successful program of Recovery that AHT employs in its agency: The Integration of Western and Traditional Healing paradigms.
Integration: Universal Healing. Participants in this study reflected on the strengths of the integration model employed at AHT, which combines Western and traditional Indigenous services for clients. The support for these blended services was unanimous across traditional healers and counsellors. The term “universal healing” is also used in this section, as it denotes the fact that healing strategies are not mutually exclusive approaches to care in terms of cultural paradigms; although there are some fundamental differences between the strictly biomedical approaches to healthcare often found in Western approaches and the Traditional paradigm of healing outlined in the Literature Review chapter, there are many instances where these models overlap, i.e.,

As a male Elder states, common ground between these two paradigms can be achieved once each has an understanding of the other, as is the case at AHT:

But some place there’s a common ground. But to achieve a common ground you need a willingness to get there. And that requires appreciation of each other. And understanding. If you don’t have that, then middle ground is still far away. But we have, I think. Because there’s the day-to-day practice here of both, I think there’s a greater appreciation, a willingness to try to understand it more. And that goes a long way. (P.172)

This quote indicates that there is common ground between healing approaches and that a willingness to engage with both is required if integration is to be achieved. Another female counsellor acknowledges the overlap between these two groups, stating that all healing
traditions are respected within the medicine wheel teachings: “Western is on our medicine wheel, right? You know, we have four different races and if we’re truly coming from a traditional perspective, then we need to respect all [views]” (P.141). In this sense, to be truly “traditional”, one must follow the teaching that highlights sisterhood and brotherhood among all cultures.

Participants also shared their pride in the range of services providers at AHT, including a variety of counsellors, social workers, naturopaths and other alternative and complimentary health care providers. They also showed an appreciation for the availability of traditional healers at AHT. One male counsellor suggested that these kind of facilities should be used as a model for others and duplicated: “We need more places like this. […] You can see the healer once a month and then you can see your counsellor four times a month. So, where else can you get that?!” (P.183). A female counsellor acknowledged the benefit of having multidisciplinary teams “which are wholistic, which integrate Western and Traditional” (P.130), and that Western terminology is sometimes used by traditional healers and counsellors, especially for the benefit of clients who have “been through the psych system”, as this is the mental health language they typically understand (P.130). One male healer reflected on the practice of integration at AHT and the benefits of this model of care, stating that the Western and Traditional models can work well together when both teams of people practice sound communication with one another:

I have a lot of support [at AHT]. With the doctors, the counsellors, and we kinda communicate a lot. Regarding you know, clients and trying to meet, you know, looking at best ways of practice, and how to deliver our different practices and help the individual. And we’re dealing with the Western perspective and then we look at
the Traditional perspective. [...] And it seems to work well. Having both Western and Traditional really works well, eh? Really works well. (P.118)

The final vignette offered by a male counsellor reviews the practices used to run a trauma survivor group currently being held at AHT. This example highlights the integration of Western and traditional approaches to mental health care, specifically for survivors of trauma:

_Vignette 4._ We started a trauma survivor group. [...] So we looked at PTSD and psychoeducational for the first ten sessions then we went into a storytelling part. [...] So really I just see myself skipping back and forth. Taking what works for me and maybe emphasizing that more, the PTSD side, doing some basic psychoeducational training with clients and maybe using some grounding techniques and tuning into the five senses, and then we suggested praying with a grandfather or rock, help to ground them when they’re triggered. And then giving the AHT crisis number 24-hours a day. And then we have a sweat lodge at the end of the trauma survivor group to celebrate and acknowledge it. And we smudged through the whole process. [...] [We had] a lot of talk here about the links between trauma and substance abuse and really psychoeducation, trying to make trauma theory come alive. Um, CBT, MI and then the medicines, traditional teachings as appropriate… I’m trained Western and I’m also trained traditional, have many traditional experiences and teachings that have been given to me, so I feel like I skate around between. [...] And I think- I really do believe that what we do at AHT is best, and I don’t think it’s been shown yet that really the hybrid model of traditional healing, traditional teachings, traditional ceremony, along with the best of what Western has to show. (P.119)
This example illustrates how traditional and Western approaches can be combined to address experiences of trauma with survivors and indicates the multitude of healing possibilities such a diverse approach can offer. The group process includes traditional aspects of healing, such as smudging, using a sweat lodge, drawing from traditional teachings, and using prayer, as well as Western approaches, including psychoeducation and cognitive behavioural therapy, motivational interviewing, and other modalities. The group also uses universal healing approaches, such as storytelling/narrative, grounding techniques, the promotion of self-awareness and the talking circle. Again, the trend of having individuals express themselves through narrative is present here, as well as the notion of taking parts of each type of healing and using “what works”. The following section offers a brief review and summary of this Results chapter.

**Summary**

Wellness, Loss and Recovery were the three meta-themes that emerged from this study’s analysis. Findings reveal that Wellness is rooted in Traditional Indigenous Teachings related to *Balance*, the medicine wheel, *Spirit* as central to wellbeing, a *Caring Culture* which fosters interdependence among community members, and the availability of * Culturally Safe Healthcare Services*. Clients access mental health services at AHT once they have experienced Loss—in the case of this study, this loss relates to suffering and imbalance due to *Sexual Abuse* or traumas. Helpers identified many facets to this Loss, including its relationship to *Colonial* histories and oppression, residential schooling and other policies, and subsequent *Intergenerational Traumas*. Again, central to Loss was the notion of individuals suffering from *Complex Traumas* and a *Broken Spirit*. The meta-theme of Recovery explored tools and services that healers and helpers employ to support clients on
their healing journey, and include *Reconnection* with traditional culture and identity, using *client-centered Narratives*, and encouraging clients to access *Traditional Healing* services that draw from the wisdom and power of the spirit world. The also discussed the uniqueness of AHT, as it employs an *Integrated* approach to healing. The following chapter will contain a discussion of the results in the context of mental health service delivery and its implications of traditional healing for sexual health vulnerabilities.
Chapter 5: Discussion

Organization of the Discussion Chapter

This study sought to understand how Indigenous helpers conceptualize and address the needs of clients who have experienced sexual and complex traumas. To explore this research question, interviews were held with traditional healers and counsellors at Anishnawbe Health Toronto, the findings from which were presented in the Results chapter and structured around three meta-themes. These three meta-themes, Wellness, Loss and Recovery, are pictured again here, and will also provide the structure for this Discussion chapter.

These areas of Wellness, Loss and Recovery represent the transition between states of mental health, from enjoying mental wellness, to experiencing loss and managing ill health, to the process of recovering back to a state of mental wellness and balance. The meta-themes of Wellness, Loss and Recovery, and the sub-themes that fall within these areas, as presented in the Results chapter, point to several areas of convergence between this study’s results and those of other research findings in the psychological literature. In particular, the results emerging from this study reflect trends described in the Literature Review chapter (Chapter 3
of this dissertation) in the areas of Indigenous women and men’s health, the social
determinants of Indigenous people’s health, and Indigenous healing as mental health
promotion for this population. What the findings from this study have confirmed is the
importance of engagement with Indigenous cultures as foundational to healing, the
uniqueness of the use of Spirit and tools from the *spirit world* for healing in an Indigenous
(in this case, Anishnawbe/Ojibway) model, and the relationship to the land as fundamental in
creating balance and serenity in our lives. These topic areas will be described below in the
discussion on *Wellness*.

Extending from these areas of convergence with the Indigenous psychological
literature, are several new and key areas emerging from this study which merit further
discussion, including the notion that sexual trauma and sexual abuse are not unique entities,
but rather can be seen as embedded traumas within a constellation of complex and multiple
traumas common within many Indigenous communities and relating to the fundamental *soul
wound* (Moffitt, 2004) of colonization. The notion of sexual abuse as a continued taboo
within certain circles and the silencing of this topic due to shame and stigma will also be
explored in the context of directions forward for healing from sexual trauma. These areas of
discussion will be elaborated on below in the section on *Loss*.

The final section of this Discussion chapter will consider topics related to *Recovery*. For
instance, unique components of Indigenous talk therapy, relating in part to the principles
of Western narrative therapy, yet extending beyond these in their use of traditional teachings,
metaphor, and other alternative means of connection between helper and client, will be
discussed in the context of this study’s findings. Recovery for Indigenous clients seeking
therapy also necessitates that all mental health services for Indigenous peoples be culturally
safe and culturally competent. The provision of culturally safe services will also be explored in this discussion section. Finally, the unique directions AHT has taken in the provision of integrated (Western and traditional) mental health services will be highlighted with an exploration of the strengths of such an approach. As a final point of discussion within this theme of Recovery, an integrative model for psychotherapy to address client issues of sexual and complex trauma will be introduced. The organization of the Discussion chapter is presented in Table 3.

Table 3.

*Organization of the Discussion chapter*

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**Wellness**

The meta-theme of Wellness, as derived from this study’s results, offers a starting point for this Discussion chapter. Key areas of convergence between this study’s findings and trends described in the Literature Review chapter, describe a common conceptualization
of what it means to have “mental health” in an Indigenous context. This construct is wholistic in nature, and relates to notions of cultural identity, spirituality, and connection to one’s environment. Each of these areas will be considered in sequence.

**Culture is Healing.** The first area to be explored in this discussion is the common theme of traditional culture as a healing construct. As noted in the Results chapter, helpers identified traditional culture as linked to notions of wellness, balance and health promotion. The notion of (re)enculturation into traditional ways as a foundational concept of Indigenous healing is not a unique finding to this study. Several other studies around Indigenous mental health and wellbeing have emphasized that the recovery of tradition and culture can be healing in itself (Adelson, 2001; Kirmayer et al., 2003; Stewart, 2008). The harmful effects of colonial policies on cultural continuity within Indigenous communities has been clearly illustrated here as well as in other psychological literature; authors refer to the “oppressive genocidal behaviours and policies” (Coyhis & Simonelli, 2008, p.1929) driven by colonial forces and passed between generations, resulting in significantly high rates of stress and mental health issues within many communities (Stewart, 2008). In fact, cultural discontinuity stemming from these damaging policies has been linked to depression, alcoholism, suicide, violence and other harmful behaviours (Kirmayer, MacDonald, Bass & Tait, 2001). However, mainstream mental health services have “come to culture” relatively recently (Waldram, 2001, p.146) and therefore may not take these historical contexts into account as a natural aspect of general practice. Mental health services risk not meeting the needs of Indigenous clients if helpers ignore (or are simply not aware of) unique cultural identities, histories, and socio-political contexts that still affect clients today (Smye & Mussel, 2001).
Encouraging clients to explore their traditional Indigenous cultural roots may be healing for several reasons. First, many of these traditional norms and customs provide guidance for individuals as they move through life’s stages, and promote a “caring culture” philosophy, as presented in the Results chapter. Indigenous cultures are noted as having a richness of resources in terms of a spiritual and psychological understanding of the world (Kirmayer et al., 2001). For instance, various cultural teachings promote the notion that the natural growth process for all living things involves an evolution through conflict and struggle; in this sense, challenges can be incorporated as opportunities for positive change and individuals can hold faith and confidence in a future resolution (Coyhis & Simonelli, 2008). Teachings like these offer a sense of meaning and purpose in one’s life and contribute to overall wellbeing (Kirmayer et al., 2001), and cultural teachings and practices also promote historical consciousness as well as community connectedness through social gatherings and practices, all of which contribute to group solidarity and personal resilience (Kirmayer et al., 2003).

A second benefit of enculturation pertinent to this discussion relates to the notion of identity. Through the process of colonization, individuals have been threatened with a sense of loss related to personal and collective identity. There continues to be a lack of historical awareness among Canadians related to the impacts of colonization on Indigenous peoples, and racism and discrimination—whether subtle or overt—continue to be a reported as a widespread experience amongst Indigenous peoples (Kirmayer et al., 2003; Shah, 2005). Psychological research in Indigenous communities has emphasized the importance of Indigenous identity as an integral aspect of overall mental health, especially when used as a tool to buffer oneself against these types of oppression. For instance, a study on promoting
Indigenous mental health using traditional counselling methods by Stewart (2008) emphasized that positive identity was associated with a sense of meaning related to the significance of being Indigenous in our contemporary society, a sense of individual purpose, and a feeling of pride in oneself. One participant in this study suggested that her identity and connectedness to culture allows her to truly “know” herself; from this present place of understanding, she can gain a clearer picture of how to change, to grow and to move forward in her life. Another study by Herbert and McCannel (1997) on the healing journeys of Indigenous women who experienced childhood sexual abuse found that “learning how to feel good about being a First Nations person” (p.62) was central to the promotion of wellbeing among several participants. Adelson, an anthropologist working in Indigenous health, describes this process of identity (re)formation as an experience of “(re)-awakening or renewal” among Indigenous peoples, and of “taking back” land, cultural autonomy, and traditional spirituality in order to restore balance (2001). It is clear that negative identity relates to a strong sense of psychological coping, self-esteem, and sense of self in the community and larger society (Kirmayer et al., 2001) and is necessary to repair the discontinuity of Indigenous cultural transmission under the backdrop of Canada’s oppressive history.

Indigenous authors also remind us that returning to traditional values need not require individuals to return to traditional ways of living; Adelson (2001) warns that too often, academics and other authors adhere to a static notion of tradition and culture, and do not acknowledge the lived contexts of Indigenous peoples as part of contemporary society. Walters (1999) reminds us that Indigenous peoples have survived centuries of oppression by maintaining and transforming traditional cultures through the integration of the ‘best of both
worlds.’ What may be more relevant than a return to traditional lifestyles for Indigenous peoples therefore, is simply a return to positive values and to individual and collective control over one’s life in the face of systemic oppression. Keeping this in mind, understandings of cultural identity among mental health professionals must recognize cultural adaptability and diversity among Indigenous clients (Kirmayer et al., 2003) while promoting decolonization through dismantling of continued and harmful paternalistic control by outsiders.

The key to wellbeing within this discussion on cultural integrity and personal identity likely rests in what is known in Rogerian psychology as congruence, where aspects of the self (for instance, the perceived self, the ideal self and the actual self) are aligned, and the road to self-actualization is paved (Rogers, 1962). In a general sense, congruence can be regarded as having an experience of harmony with one’s identity, where Indigenous clients are buffered against mainstream oppressive sentiment through the internalization of positive identity attitudes (Walters, 1999). Through identity congruence or harmony, “people thrive, are resilient beyond expectation, and [can] contribute in a synergistic manner to those around them with their energy” (Hodge et al., 2009, p.216). An understanding of historical locatedness and pride in one’s heritage, promotes a more harmonious identity, from which negativity from the surrounding environment is more easily deflected. In a society where many Indigenous people grow up with marginalized identities, promoting a return to a vibrant and healthy cultural identity may serve to strengthen inner harmony.

This section reviewed the importance of enculturation as central to wellbeing and as a tool for healing. Directly related to these concepts around cultural continuity and the promotion of positive identity are other aspects of traditional culture which facilitate healing.
The following discussion explores lessons on wellbeing emerging from the Results chapter related to the healing effects of Indigenous spirituality and connection to the land.

**Spirit-Based Medicines.** Spirit-based medicine has always been an integral aspect of traditional Indigenous healing, and this tenet did not differ within this study’s findings. Practicing spirituality-based healing is a way of life (Native Women’s Association of Canada, 2007) that promotes connection with others, the natural world, and the spirit world, and helps to address “cultural dislocation” and ill-health within Indigenous communities (McCormick, 2000, p.25). Within Indigenous traditions, spirituality helps to overcome ego boundaries and connect to all creation—from a Western perspective, this coincides with Frankl’s “logotherapy” (1962, as cited in McCormick, 2000), which uses an existential-humanist approach to connect individuals with sources of meaning in their lives. For Indigenous peoples, spirituality offers not only a sense of meaning, but is also a central focus in re-engagement with traditional cultures and therefore additionally offers a source of empowerment, pride and balance in the lives of individuals who practice Indigenous spirituality as daily health promotion (Hunter et al., 2006). Spiritual practices may include the sweat lodge ceremony, healing circles, communication with Spirit ancestors who provide medical knowledge and guidance, and other ceremonies, in addition to the less conspicuous practices and the more subtle spiritual relationships of daily living that belong to complex and wholistic belief systems (Adelson, 2001).

While these spiritual beliefs are not necessarily incongruent with Christian faiths and for some Indigenous communities are enmeshed with Christian practices (Adelson, 2001), they are, however, inconsistent with Western scientific models and therefore have not received much support through empirical research in psychology (McCabe, 2008). This is
not surprising given the fact that Western research emphasizes that only evidence-based models are acceptable for understanding phenomena; McCabe (2008) writes that adherents to this philosophy of empirical validity see Indigenous spirituality as “anecdotal at best and witchcraft at worst”\(^24\) (p.143). This contention may also relate to the antireligious bias of the scientific enlightenment worldview, stemming from which Western therapies have often classified spiritual phenomena as “dysfunctional” (Hodge et al., 2009, p.217) as they cannot always be understood rationally. Interestingly, while over 90% of the world’s population currently adheres to some form of religious and/or spiritual following (Koenig, 2009), approximately 50% of health professionals in the United States describe themselves as agnostic or atheist (Seybold & Hill, 2001). This trend suggests that it might be unlikely for mental health professionals to routinely explore spirituality as part of wellness with their clients. In addition, few psychology training programs address spirituality (Hill & Pargament, 2008) and most Western-trained therapists offer services that ignore or discount spirituality (Yeh et al., 2004). In a review of spirituality in mental health research, Hill and Pargament (2008) found that journals in mainstream psychology have virtually no quantitative articles that include either spirituality or religion as a variable, and in the rare cases where these are included, they are often “add-on” variables in the context of other research agendas. The lack of focus on spirituality within mainstream empirical psychology points to an important gap in the field, given that spirituality is integral to psychological coping and identity in many cultures (El-Khoury et al., 2004) and our communities within large cities are becoming more and more culturally diverse.

\(^{24}\) This is despite Western reliance on crucial Indigenous plant knowledge for medicinal purposes.
While Hill and Pargament’s findings (2008) indicate that few empirical studies in psychology investigate the relationship between spirituality and mental health outcomes, the studies which do so indicate that religion and spiritually are actually quite robust variables in predicting health-related outcomes. For instance, spirituality has been related to subjective well-being, life satisfaction, optimism, acceptance of difficulties, a sense of meaning and purpose in life, cohesive social networks, and positive lifestyles that encourage health-enhancing behaviours (Baetz & Toews, 2009; Corley, 2003; Seybold & Hill, 2001). Spirituality has also been associated with a decrease in suicidality, addiction rates, anxiety, psychotic episodes, hypertension, stroke, cancer, and coronary artery disease (Corley, 2003). Other physical health advantages include benefits to the endocrine and immune systems, lower cortisol reactivity to stress, and increased blood flow to brain areas that promote focus (Baetz & Toews, 2009; Seybold & Hill, 2001). Several authors attempt to explain these findings. Corley (2003) explains that spirituality includes multiple domains (cognitive, affective and behavioural), all of which interrelate and affect daily living (for instance, stress may be the mediator through which these systems relate); she argues that the biopsychosocial model of health be expanded to include spirituality as an integral and necessary component of health. Hill and Pargament (2008) reflect on possible avenues through which spirituality affects one’s sense of wellness. For instance, a perceived closeness to Creator may represent the ultimate ‘attachment relationship,’ from which comfort and reassurance can be drawn during times of conflict, stress and loneliness. These authors also describe the orienting and motivating factors inherent in spirituality, where guidance for living offers stability, support, direction and pathways for action during difficult times. They also emphasize the benefits of social support through spiritual communities. Finally, they explore stress-related growth
related to the struggle of doubt, questioning and searching all people encounter on their journeys of development.

Within this subset of the literature there is little to no discussion on mystical or supernatural explanations of how and why spirituality is healing; research continues to draw reason about the functioning of Spirit through biological and cognitive explanations. An area of interest may therefore relate to whether or not there is something inherent to the spiritual experience itself that contributes to wellness (Hill & Pargament, 2008). A 1996 study by Levin on how religion influences morbidity and health examines pathways to wellness and, aside from coping, placebo, stress-reducing and psychoneuro-immunology/endocrinology pathways, Levin also refers to the “superempirical” effects of spirituality. Other Indigenous authors agree that the unseen world, or spiritual world, while figuring prominently in healing, cannot easily be measured (Coyhis & Simoni, 2008). Not only is each experience of spirituality unique, but also often our deepest spiritual experiences are “too deep for words” (Blazer, 2009, p.282), and therefore extremely challenging to research. Likewise, Joseph Gone (2010), a prominent Native American psychologist and scholar, discusses the secular-sacred divide in psychological research and practice, explaining that while rational approaches to knowledge hinge on human reasoning to solve problems, mystical approaches to understanding may be inescrutable to humans, and remain partially unexplained and mysterious; therefore, mechanistic explanations of healing in the spirit world require “tremendous caution” (p.205). This sentiment was echoed by an Elder who participated in this study who stated that as spirit cannot be measured empirically, he simply chooses not to engage in these kinds of debates with non-believers.
To summarize this section on spiritual healing, both Indigenous and Western research in psychology point to a plurality of pathways and mediating factors through which relationship to Spirit promotes mental health. While some of these can be empirically studied, such as cognitive, affective and physical pathways, others requiring a supernatural or mystical explanation cannot. As I am not a traditional healer, I respectfully decline to attempt to devise such an explanation for these phenomena in this Discussion chapter; through my cultural safety lens I simply accept these truths for Indigenous followers and recognize that I, myself have had enough mystical experiences in my life to tell me that there may be phenomena that lie beyond our material reality. Aside from these age-old debates for which no “evidence” exists either way, it is clear that what spirituality truly offers, is an added dimension of being in this life: it offers a depth, flexibility and increased possibility for understanding and experience. Through this added dimension of an interconnectedness with all living things, including the ecosystem around us, the spiritual relationship serves to curb our existential isolation. One fundamental aspect of spirituality within traditional cultures lies in the healing effects of the interconnected ecosystem. This will be explored next.

**Land-Based Healing.** Several of the participants discussed the healing properties of nature and its link to spirituality, such as the vignette that described healing through Mother Earth. Traditional Indigenous cultures have always promoted living in harmony with nature as a central value, where nature was regarded as a great teacher and mental wellness was related to the experience of interconnectedness with all living things (Coyhis & Simoni, 2008). Western psychological research has supported this notion that natural settings are good for the body, mind and soul, through nature’s stress-reducing and calming effects (Hartig, Mang, & Evans, 1991). Specifically, literature has described a reduction in
neurophysiological arousal, a reduction in mental fatigue, an improvement in attention, alertness and cognitive performance, as well as decreased fear and anger, stemming from time spent in nature (Frumkin, 2001; Hartig et al., 1991). This notion of mental restoration is especially relevant in today’s society, where the demands of modern life often reduce one’s tolerance for frustration. In fact, our “over-civilized” society (Frumkin, 2001, p.235) could benefit from the soothing, tranquil, and restorative effects of nature, amidst the increasing number of hours in the day devoted to our ever-stimulating “electronic immersion” (Louv, 2005, p.59). Therapy involving natural elements, such as care for animals, horticultural therapy and others, have been cited as being helpful for psychiatric patients, emotionally disturbed individuals, sexual assault survivors, and individuals living with PTSD and addictions, among others (Frumkin, 2001). Moreover, healing within nature not only has positive mental health-enhancing features, but it is typically affordable (or free!) and certainly has significantly fewer side effects than pharmaceutical interventions.

Richard Louv, a well-known American journalist and author, wrote the best-selling and award winning novel, “Last Child in the Woods: Saving our children from nature-deficit disorder” in 2005. Louv’s central argument hinges on the notion that humans have an innate affinity for the natural world, as we ourselves are “part of that wilderness” (p.9). Therefore, mental health measures must take into account the impact of nature on health (Louv calls for an environmentally-based definition of mental health), and we must reforge bonds between children and the outdoors so that they may grow to once again take their place as environmental stewards. In his book, Louv draws from many psychological studies which

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25 It is interesting to reflect on Frumkin’s use of this term within the context of this dissertation, given the pejorative use of terms related to Indigenous peoples as “uncivilized” or “savage” throughout Canada’s colonial history. That we would now be accusing our contemporary society of being “too” civilized, and in extension, unhealthy, is ironic.
demonstrate better coping with psychological distress among children who live in high-nature conditions as compared with those who do not, and that natural spaces help to inoculate children from stress, especially vulnerable children living with conduct disorders, anxiety and depression. Louv makes reference to our contemporary “cultural autism” (p.63) in North America, emerging from a deprivation of nature, where we experience feelings of containment, isolation, and an atrophy of the senses. He argues that the rich, open and diverse environments offered in natural settings allow individuals to play and experience life through the senses, whereas rigid and bland environments limit healthy development. Authors like Louv also refer to the link between nature and spirituality; Louv writes of the meaning, beauty and inspiration that can be derived from nature. Frumkin (2001) likewise refers to wilderness rapture, which includes feelings of awe, wonder and humility derived from natural settings, where all is interconnected and all is miraculous. These comments relate directly to the mental health benefits of spirituality, as inner peace, meaning and purpose relate both to spirituality as well as to our connection with our surrounding ecosystem.

What is especially interesting about the relationships between spirituality, the natural world and mental health, is that these represent foundational healing principles for all peoples. What the West stands to gain from taking an ‘indigenist stance’ on these topics is its own return to land-based wellness practices amidst an increasingly technological world. While scholars, authors and artists across all disciplines have made these types of arguments for generations, these principles of natural and spiritual healing are not central to the current dogma in the field of psychology. As helpers, we must promote this traditional knowledge (shared by all Indigenous cultures) among our clients, rather than relying solely on
manualized psychotherapy modalities and psychopharmaceuticals to ‘treat’ individuals. It
goes without saying that a secondary benefit to the promotion of these eco-values related to
the health benefits of nature within society at large, is a return to a philosophy of *stewardship*
rooted in our inextricable relationship with nature, with the intention of protecting natural
habitats for future generations of human animals and other animals.

These sections have touched upon the contributions that Indigenous healing
principles make to Western psychotherapy, through the wisdom shared by the participants in
this study on culture, spirituality and land-based healing. These points offer a starting point
for understanding mental wellness in an Indigenous context, and offer sage guidance for all
peoples seeking to achieve balance and harmony in their lives. The following section will
consider emerging findings from this study relating to the meta-theme of Loss; specifically, it
will consider loss related to complex and sexual traumas, the main focus of this research
study.

**Loss**

Loss was presented as the second meta-theme in the Results chapter, and again ties
into this Discussion chapter, as it considers the mental health impacts of experiencing
multiple traumas throughout the life course. Due to the colonial legacy, many Indigenous
peoples in Canada have experienced trauma and the participants in this study echoed this
important issue. The following section will consider how these study participants
conceptualized trauma for the clients they work with at Anishnawbe Health Toronto,
focusing on the varied and diverse nature of the reported traumas, as well as the ‘taboo’
nature of sexual abuse as a discussion point.
**Trauma as a Constellation.** As noted in this study’s results, participants reported that the clients with whom they work typically experience multiple issues throughout their lives, echoing the literature on Indigenous health. In terms of mental health needs, what sets Indigenous peoples apart from many other groups in Canada is their shared history of trauma, as noted by several participants in the Results chapter. This collective wounding is rooted in historical traumas, including coercive migration to reserve lands, harmful residential school experiences, custodial care and others, and culminates in intergenerational family violence, abuse, substance misuse and addiction, and mental health issues such as depression, PTSD, and others (Smye & Mussel, 2001; Walters, 2002). Researchers and psychologists consider these instances of unresolved grief and childhood abuse to be the sources of both specific and cumulative traumas (Walters, 2002). While this study specifically sought to understand traditional counselling and healing approaches with clients struggling with histories of sexual abuse and violence, it became quickly apparent that counsellors recognized sexual abuse as embedded within a constellation of all forms of trauma (i.e. neglect, assault, family violence) and other difficulties faced by clients (i.e. poverty, addictions, housing instability, unemployment). This understanding of all sexual traumas as part of a constellation of all traumas (other personal, interpersonal, family, community and Nation traumas) was a key finding within this study.

In their comprehensive paper introducing a Social Context Complex Trauma Framework for Indigenous peoples, Haskell and Randall (2009) lay the groundwork for an approach to therapy that also reflects the views of this study’s participants around the complexity of traumas that clients bring to therapy. Haskell and Randall suggest that considering Indigenous traumas through a typical trauma framework is not broad enough to
understand the larger context related to these traumas, including social, cultural, and socio-economic inequities. For instance, chronic stress faced by many Indigenous peoples is in many cases rooted in fundamental human rights violations stemming from oppressive government policy. Haskell and Randall’s social context framework considers the broader scope, and moves beyond the individualistic focus that has been typical for psychological approaches to trauma, which have minimized social contexts that are relevant for understanding lived experiences. These authors consider individual psychological responses to complex trauma, such as sadness, depression, attachment issues, affect dysregulation, alterations in self-perceptions, and others, as well as social or macro-level conditions, such as ongoing experiences of hopelessness and loss, childhoods characterized by abuse and/or neglect, poverty, and a general “social undervaluing” (p.51), or denigration related to inequalities of racism, sexism and colonial dispossession.

Haskell and Randall (2009) also touch on all three of the symptom clusters related to trauma in the findings of this dissertation (i.e., relational instability, addiction as coping, and spiritual loss): their discussion highlights substance abuse as a method of coping with affect dysregulation subsequent to complex trauma; it notes that disrupted attachment is a core feature of complex trauma, wherein individuals experience an inability to trust others and/or cycle through revictimization and unstable relationships; and it highlights what Haskell and Randall refer to as “Alternations in Systems of Meaning” (p.59), wherein victims carry a sense of despair and hopelessness, not unlike the ‘wounded spirit’ construct in the Results chapter. Finally, these authors also conceptualize trauma as a constellation rather than a single event for many within this population, arguing that for the majority of Indigenous clients, “trauma itself is multi-factorial and not reducible to a single event” (p.7).
Steven Gold is another psychologist specializing in trauma whose work focuses on developmental issues in the wake of complex trauma. His research (2000) indicates that many families in which abuse takes place show similar patterns, including higher levels of control, rules, conflict and coercion, and lower levels of cohesiveness, emotional expressiveness, independence and the encouragement of intellectual and cultural pursuits. Gold states that as a result, children in these households learn to not question authority, to say ‘yes’ to others, and to be unassertive, therefore remaining vulnerable to being victimized by others throughout the life course. In addition, Gold states that growing up with this family pattern undermines the individual’s ability to fully function in adulthood and manage day-to-day stressors. For instance, individuals may have a restricted capacity to connect with others, judge who to trust, balance emotional dependency and autonomy, be self-aware, distinguish thoughts and feelings, control impulses, and think critically. This leads to poorer coping and decreased resilience, as these individuals are like “confused and frightened children unable to cope effectively in an adult world” (Gold, 2012, p.12). Haskell and Randall (2009) lend further insight to this phenomenon: “People who endure severe and chronic abuse in many cases develop what might seem like a bewildering array of problems and difficulties throughout their lives…[these] are seen as self-inflicted to those who fail to understand abuse, trauma and its reverberating effects” (p.53). Therefore, clients must not only process past incidents of trauma, but they must also struggle with a diminished ability to cope with daily stressors in its aftermath. Gold (2012) states that resolving the trauma alone will not recover these capacities; clients need additional support to develop these skills.

The Adverse Childhood Experiences study by Felitti et al. (1998) surveyed over thirteen thousand adults in the United States to understand the links between childhood
trauma and adult health outcomes. The researchers asked participants about histories of psychological, physical and sexual abuse, as well as household dysfunction categories (i.e., was there someone in the family living with a mental illness, a substance addiction, involved in criminal activity/in prison, and/or was their violence against the mother in the home). The study found a significant dose-response relationship between the presence of these categories during childhood and future risk factors for serious health issues in adulthood (i.e., heart disease, cancer, lung and liver disease, etc.). The following figure (Figure 5) by Felitti et al. (1998) was created out of this study and is indicative of these relationships.

![Figure 5](image)

*Figure 5. Potential influences throughout the lifespan of adverse childhood experiences*

This figure shows the step-wise fashion in which these factors interact to affect an individual’s overall health. Gold’s description offered in the previous paragraph describes the links between adverse childhood experiences and impaired social, emotional and cognitive functioning in adulthood (2000). The adoption of health-risk behaviours may stem from these diminished capacities, and may lead to using coping strategies that numb pain. This
echoes results presented in this dissertation related to the use of substances as coping tools and the feeling of being spiritually lost among abuse survivors.

What is interesting about the findings related to the disciplinary and regimental family structure of typical abusive households outlined by Gold (2000, 2012), is the similarity of these environments to those of the residential schools, as documented in various survivor’s accounts (Knockwood, 1992). Through these childhood experiences in residential schools, parenting styles rooted in punitive measures and lacking in warmth and intimacy were passed on intergenerationally (Kirmayer et al., 2003). Due to this system, it became increasingly more difficult to transmit traditional Indigenous family values across generations, and in many cases, negative patterns of parenting and coping persisted (Menzies, 2008). As a result, high numbers of Indigenous people are living within traumatized families and communities (Haskell & Randall, 2009) where oppressive conditions are normalized (Menzies, 2008), the root causes of which become part of the unseen historical backdrop. In addition, the Adverse Childhood Experiences study indicated that trauma in childhood has a cumulative effect on an individual’s social, emotional and cognitive functioning. Since most Indigenous people seeking counselling have experienced several of the adverse experiences listed on the Felitti et al. survey (1998), it is likely that they are facing a multitude of social, emotional, cognitive and physical difficulties. These models also help to explain why some community members continue to turn to addiction to cope with trauma and why others may have difficulty maintaining steady employment and housing, among other challenges.

What the combined teachings from the voices of this study’s participants, Haskell and Randall’s social context model (2009), and Gold (2012) and Felitti et al.’s (1998) work on
trauma sequelae offer, is an understanding of how these factors might intersect in the lives of Indigenous peoples living with complex trauma. The following figure (Figure 6) is therefore included as an alteration of Felitti et al.’s model (1998) that is more inclusive of the Indigenous context:

**Figure 6.** Potential mechanisms by which adverse childhood experiences influence mental health status among Indigenous peoples (Reeves & Shah, 2012).

In this case, the features within the model remain the same as Felitti et al.’s original figure, save for the addition of the larger contexts in which adverse childhood experiences occur in the lives of Indigenous children and youth. This model recognizes that due to the larger backdrop of colonization and historical traumas (distal factors), parental and community capacity is diminished. Due to disruptions in transmission of healthy cultural practices in parenting tied to poverty, personal crisis, addiction, stress, oppression and others (proximal factors), many children are exposed to adverse childhood experiences. These traumatic experiences may cause lasting social, emotional and cognitive impairments such as a
diminished capacity to connect with others, judge who to trust, control impulses, and think critically (Gold, 2000). Therefore, counsellors must be aware of the challenges of daily living that may be facing their clients, in addition to sequelae from trauma itself. In this model, the circular shape suggests that these relationships are not altogether linear; there is also an interrelatedness and bi-directionality among these factors. Still, despite the ongoing challenges of managing complex traumas and their sequelae among certain individuals within Indigenous communities, the extent to which many continue to live happy, healthy and balanced lives speaks to the incredible resiliency of this population of individuals in the face of damaging colonial policies.

Complex Trauma and Silence. An additional concern related the constellation of traumas discussed in the previous section is of the ongoing silence around sexual abuse and other adverse experiences. It became apparent during the interviews that the topic area of sexual abuse and trauma continues to be taboo in many contexts and participants agreed that there needs to be more openness about this within the clinic and the wider community, as abuse and trauma have affected so many lives. This taboo and silencing is not unique to this study; ongoing trends in our larger society around shame, denial and non-disclosure around these experiences due to stigmatization and victim blaming remain (Courtois, 2012). Courtois describes various types of trauma, including impersonal (i.e., caused by natural disaster) and interpersonal (i.e., abuse, assault). She states that while impersonal traumas are made public and strangers are happy to offer aid to victims, interpersonal traumas are often silenced, and little recognition and assistance are offered. In addition, Haskell and Randall (2009) argue that the theme of neglect and emotional invalidation of Indigenous people’s experiences of trauma is mirrored by larger tendencies by the mainstream to deny social
responsibility for producing marginalizing conditions for Indigenous communities. These many layers of silence can lead people to feel disconnected from their communities (Haskell & Randall, 2009). In the study by Herbert and McCannell (1997) on abuse experiences among Indigenous women, many participants stated that they could not share with family members or others about the trauma as it would have undermined implicit norms around keeping secrets and “family loyalty” (p.60); in this sense the women felt powerless in voicing their pain and carried their burdens alone for many years. Among the participants in this dissertation, many called for more transparency around these high rates of abuse at the organizational level and for more training in this area for staff. I was aware that this topic may have been sensitive for participants, as several of them live and work in communities with ongoing social issues and thus embody the construct of wounded healers. We look to helpers and healers to take clients on a healing path, but must keep in mind that helpers themselves require ongoing supports to heal and to function as advocates to publicly acknowledge community-wide trends of sexual abuse and other traumas.

The section on cultural safety as a skill for working with Indigenous clients must therefore be expanded to acknowledge the need for competence and safety in working with individuals who have been abused and living with an array of symptoms related to trauma sequelae. Trauma-informed services are described as those which are sensitive to trauma-related issues among clients and which accommodate the vulnerabilities of trauma survivors to avoid inadvertent retraumatization (Jennings, 2004). This approach is relevant to all helpers, including those from AHT who require support in developing these skills. This section on complex trauma touched on many of the subtle and overt array of symptoms associated with the experience of trauma and abuse, including social, emotional and
cognitive impairments; in addition, clients may suffer from physical health outcomes such as gastro-intestinal issues and migraines (Courtois, 2012; Gold, 2012). Many professional caregivers are not aware of the physical and psychological health impacts of trauma, and when helpers fail to recognize the underlying issues, interventions may be inappropriate, may lack adequate support, and clients may be perceived as “difficult” (Haskell & Randall, 2009). Clients have also stated that the lack of understanding from professional helpers has led to fears of being judged by these healthcare practitioners, resulting in a further distrust of authority figures (Schachter, 2012). This potential for distrust of authority is likely more predominant among Indigenous clients, who have seen communities devastated by such authority figures in the apprehension of children into residential schools and custodial care, involuntary commitment and more (McCormack, 1999). Therefore, it is possible that high dropout rates in mainstream therapy relate to both a lack of cultural safety among providers as well as a lack of competence in trauma-informed care. Given the high rates of trauma in the Indigenous community, all counselling with this population should therefore be trauma-informed, recognizing that this issue is widespread and may affect clients lives, whether or not this is their presenting concern in therapy.

The following section will consider the third and final meta-theme within this Discussion chapter: Recovery. The participants in this study offered several suggestions for managing and addressing the mental health needs of those who have suffered complex traumas, several of which will be expanded on below.

**Recovery**

This final discussion section will explore results of this study related to Recovery, and will reflect on unique forms of narrative talk-therapy used by participants in this study,
where identity work is embedded within context and story, as well as culturally safe therapy services and integrative methods for mental health provision at AHT.

**Learning Through Metaphor.** What has been presented in this study’s results suggests a unique kind of talk-therapy common to all participants, where “teachings” shared by the helper are included as part of the therapeutic process. As stated previously, traditional healing is not only a medicinal tool but also a way to approach life and a philosophy for living, passed on through narrative and metaphor. One participant described using analogies of Mother Earth to help a client deal with a distrust of women; another participant shared traditional teachings on women and men’s social roles to impart lessons around traditional sexuality; one participant described his experience in activating a drum to describe community healing; other participants described using the medicine wheel teachings and the Seven Grandfather Teachings with their clients as markers for progress. What these examples hold in common is the use of cultural mythology and cultural symbolism to lead the client on a journey of understanding and the use of story and cultural idioms to restructure clients’ issues (Kirmayer et al., 2001).

The restructuring of personal stories in therapy is well-known among narrative therapists, who see life as mediated through the stories we tell about ourselves (Madigan, 2011). In a narrative therapy model, these stories can be considered within a particular historical and social context, and the dominant cultural discourse that has shaped an individual’s story of self can be revealed and challenged (Madigan, 2011). This is particularly useful for clients who have unique contexts of understanding, due to the

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26 This refers to the Anishnawbe ethical guidelines on human conduct between individuals. The “Seven Grandfathers” include: Wisdom, love, respect, humility, truth, honesty and bravery.
experience of belonging to a marginalized population, of facing racism, and of being stripped of heritage, among others. In this sense, identity exists in context and the words we use to describe our stories exist in social and power-based relationships. Narrative therapy gives the client a relational context to view herself from many perspectives and to situate the issue outside of her (Madigan, 2011). Likewise, Indigenous authors describe traditional counselling as a process wherein healing stems from sharing one’s story and identity emerges through personal narratives (McCabe, 2008; Shepard et al., 2006). The sharing of stories and the reflection and interpretation through cultural myth allows for catharsis and restructuring of client issues (Waldram, 1993).

The findings from the interviews conducted for this study indicate that many helpers use these principles of storytelling in their therapy, coupled with the use of traditional teachings to make sense of client difficulties. Whereas many Western counsellors are trained to take a passive role in the therapeutic encounter, traditional helpers in this case seemed to take on a more active role in the therapy as guide, facilitator, cultural expert and the bearer of tradition, through whom narratives can be made sense of (Kirmayer et al., 2001; Yeh et al., 2004). What was clear from the interviews was that there was no fixed modality presented as ‘the Indigenous laws of therapy’; participants did not advocate for a set method of working with clients ‘in a traditional way’. The description of their talk-therapy methods included the use of cultural teachings to loosely guide the therapy and a narrative therapy style, which allows for individual stories to emerge. This lack of rigidity in their descriptions is itself ‘indigenist’ in nature, as each client case was treated as unique and participants did not argue for the supremacy of one therapeutic style (Madigan, 2011). As stated by one traditional healer in this study, the work is “gentle”, and the teachings are given “delicately” depending
on the client’s needs. Using traditional knowledge and metaphor in session also offers the added benefit of reintegrating clients into traditional cultural values and ethic, the mental health benefits of which were described in a previous section.

One aspect of enculturation through traditional metaphors that presents an important finding within this study’s results is that interviews revealed these teachings and values to be genderless; participants used the same cultural narratives and metaphors for male and female clients and indicated that all clients, regardless of gender, are equally wounded by multiple traumas. This lack of gender division in healing is in keeping with the traditional culture of this territory, as conveyed by staff at Anishnawbe Health Toronto. This is likely the reason why participants responded to interview questions using examples of clients of both genders in their answers, despite my specificity in querying about women’s mental health. Given this move away from viewing pain, trauma and wounding as distinct by gender, I felt my female-centric questions to be inappropriate, as it seemed at once confusing for the participants, as well as unsuitable to ask only about women’s health while ignoring men’s. What became clear as the interviews progressed was that for this group of participants, there was no need to differentiate helping and healing work between male and female clients. Instead, what remains common to all clients is that “a great learning must take place” (Coyhis & Simonelli, 2008, p.1930) through the course of therapy, and this is assisted through a narrative therapy style that is adapted to include cultural teachings and other traditions. The following section reflects on the promotion of cultural safety within the provision of mental health services.

**Cultural Safety Among All Mental Health Practitioners.** Participants in this study described seeing AHT as a safe place where they could reconnect with their own identities as Indigenous individuals and through which they derived a sense of community. In turn, they
shared this sense of community with their clients in therapy, and together helpers and clients built strong therapeutic alliances. A shared understanding of colonial histories affecting the lives of their clients also facilitated this understanding. Conversely, participants described what they see as the continued practice of culturally unsafe care by mainstream mental health practitioners, referring in particular to the lack of wholistic care in these approaches. They also showed concern that mainstream practitioners may not understand client’s identities within the context of historical marginalization, and that this may impact the therapeutic techniques used in therapy, and the outcomes of that therapy.

Scholars of Indigenous psychology remind us that counselling is neither culturally nor politically impartial (Shepard et al., 2006). While psychotherapy in a Western sense is often argued to be a neutral and scientifically based practice, where specific mental health issues are isolated and targeted, all peoples live and function within a particular context created by their family, community, and history (Hodge et al., 2009). Mainstream therapy sees high dropout rates of Indigenous clients, likely related to the fact that the philosophy of care they receive falls outside of their worldview; clients may perceive the cultural ignorance of Western therapists as marginalizing and oppressive (Hodge et al., 2009). Another paper by Gone (2007) explores the postcolonial experience of Native Americans vis-à-vis mainstream mental health services. In this paper, Gone describes how one Indigenous participant felt as though White psychiatrists sought to wipe out traces of his history, and referred to this as the modern form of ethnic cleansing: “I guess it’s like a war, but they’re not using bullets anymore” (p.294). Gone suggests that what this participant is referring to is cultural imperialism within the healthcare system. This argument suggests that since the social scaffolding upon which our healthcare and education systems are built is derived from
Eurocentric models, and that systemic racism is ever present in our contemporary society, it is likely that the system and practitioners within it are carriers of oppressive beliefs and practices, whether they are cognizant of this or not. Therefore, healthcare facilities like Anishnawbe Health Toronto offer important directions for mental health care, through the use of Indigenous-centred program planning and delivery at their core (Kirmayer et al., 2003). Given the identification of colonization as the root cause of systemic racism, and of cultural revitalization as part of the solution (Gone, 2007), AHT is well positioned as a trailblazer in the provision of culturally safe care.

It is clear that mainstream techniques in psychotherapy are likely ineffective without an understanding of individual context (McCormick, 2000), and as such, many non-Indigenous professionals have demonstrated an increased desire to learn about Indigenous cultures and histories (Hunter et al., 2006). This process can begin through the adaptation of a cultural safety lens in all mainstream healthcare facilities. The term cultural safety was explored in research and healthcare contexts in previous chapters; however, as a reminder, it can be regarded as the notion that with self-awareness and empathy for clients’ multiple identity contexts, care can be improved and health outcomes ameliorated (Shepard et al., 2006; Shah, 2011). This first requires an understanding of culture as something that is complex and multifaceted, which shifts over time and is context specific, and which represents only one identity variable in the counselling context (Waldrum, 2001). Indigenous communities in particular have seen dramatic changes between generations in recent history (Kirmayer et al., 2001), and not all individuals are alike in their relationship to traditional spirituality and other important identity factors such as enculturation, goals and aspirations, etc. Like all cultures, there is a wide diversity of cultural identity within this group
Waldram therefore suggests that practitioners learn to “discern culture without essentializing and stereotyping it” (2001, p.156).

The process of using cultural safety as a tool for connection in health care includes being aware of one’s own culturally-based assumptions, biases and worldviews, as these have a significant impact on therapists’ clinical judgment (Waldram, 2001; Yeh et al., 2004). Therapists should actively seek to understand the worldview of their clients, which may prompt them to learn about Indigenous histories and Indigenous healing, to seek out clients’ views on healing, to participate in Indigenous healing and community events (where available and/or appropriate), to form alliances with community members and healers, and to keep a list of Indigenous healers to whom clients can be referred (Waldram, 2001; Yeh et al., 2004). Therapists should also understand that culture can affect personality development, help-seeking behaviour and other areas relevant to counselling, and therefore develop culturally appropriate treatment strategies in consultation with Indigenous clients (Shepard et al., 2006; Waldram, 2001). Therapists may also want to take up a role of advocate on behalf of their clients (i.e. navigating social systems on behalf of a client and speaking with community leaders about Indigenous issues) in order to combat systemic oppression and racism (Shepard et al., 2006; Yeh et al., 2004). Finally, all culturally safe relationships must foster an empathic relationship of trust and honesty, which may include (where appropriate): an informality in approach and dress, a commitment to mutual learning, a respect for traditional spirituality, an encouragement to partner with traditional healers and an invitation to family/community members into session (Aboriginal Nurses Association of Canada, 2009; Shepard et al., 2006). These changes must begin with education and training within the field of psychology, including the incorporation of Indigenous content into core courses and
having guest lecturers from the Indigenous community present in class (Hunter et al., 2006; Yeh et al., 2004). Gone (2007) states that those who remain truly committed to diversity, collaboration, and empowerment of Indigenous peoples, will always be respectfully welcomed into the Indigenous community.

The following section will discuss unique findings from this study with respect to the provision of integrated counselling (traditional and Western) with individuals experiencing sexual trauma and violence. The benefits of using such an integrated approach will be expanded on with a model for treatment.

**Universal Healing: Integration of Western and Traditional Methods.** Several participants in this study noted that using both Western services and Traditional approaches work well for the clients who use AHT’s mental health services to process trauma and other difficulties. In particular, one traditional counsellor described the specific modalities used in the trauma survivor group, which applies traditional aspects of healing, including traditional teachings and ceremonies, as well as Western approaches such as cognitive behavioural therapy. With respect to trauma work, Haskall and Randall (2009) agree that integration between Western trauma treatment and traditional Indigenous approaches to healing as a ‘hybrid’ approach (i.e. involving two or more ways of knowing) (Stewart, 2008) is beneficial. Other research looking at Indigenous clients in therapy has found that hybrid forms of therapy have been meaningful to Indigenous clients, especially given the fact that many Indigenous peoples today are acculturated to some degree to both traditional ways and mainstream culture (Kirmayer et al., 2001; Walters, 1999). In fact, some Indigenous psychologists have pointed out that most psychotherapies hold in common certain universal healing features, including engaging in a therapeutic relationship with the client, explaining
client symptoms with a conceptual scheme/rational/myth, and using a procedure/ritual to restore client health or balance (Gone, 2010). Hybrid approaches can work harmoniously if fundamental tenets of respect for both approaches and kindness toward the client are upheld.

Taking into account the lessons these participants have shared through their interviews and stories, including the need to approach all clients with an understanding of trauma-informed care, the following figure (Figure 7) denotes a model of care for this population of clients. This model of care emerging from this study’s results suggests that three pillars of support can be used to help clients move forward in addressing the impacts of complex trauma in their lives.

Each root of the tree represents an aspect of care that must be integrated and balanced and include Culture-informed care, Trauma-informed care, and Caregiver Support. These pillars will be described in sequence, including specific strategies for mental health treatment within each of these areas (represented in this model by the branches and leaves). There are likely
multiple approaches to care that may prove useful for this population; this model simply
denotes the common factors emerging from this study’s findings.

**Culture-Informed Care.** Based on the findings and discussion in this study,
implementing aspects of traditional culture into therapy can have positive effects on
Indigenous clients, especially those who are interested in spirituality and those who may not
be aware of the colonial history. The following schema (Figure 8) identifies aspects of
Culture-Informed Care that will be discussed below.

![Figure 8. Features of culture-informed care](image)

In this model, traditional healing represents a wide array of approaches to care,
depending on the expertise of the helper (i.e., some healers lead sweat lodge ceremonies,
some helpers utilize the Seven Grandfather teachings, and others converse with spirit
ancestors, for example). What these traditional healing approaches share in common, is the
focus on spirit as central to healing, and the fact that embedded within the culture are
traditional teachings offering guidance for dealing with life’s stressors. For instance, this
dissertation highlighted the notion that health promotion is built into many cultural practices
that restore mental wellness and balance, such as smudging and other rituals and prayers.
Traditional customs also provide resources for making sense of the stages of growth and
development in life. Spiritual practices and teachings offer a sense of meaning in people’s lives and improve mental health outcomes, enhancing well-being, optimism, and acceptance, as well as minimizing stressors. Traditional healing also promotes communion with nature, which also has been linked to lasting mental health benefits, including ‘wilderness rapture’, wherein feelings of wonder and humility promote a sense of connectedness. Approaching care with a respect for traditional healing and spirituality helps to close the “secular-sacred divergence” (Gone, 2010, p.204) present between many mainstream and traditional therapies.

Culture-informed care also recognizes the importance of positive identity construction among this population of clients, as colonization has disrupted cultural integrity for many communities and individuals. Informing clients about the colonial history and how it may have impacted their communities intergenerationally can offer an explanation of potentially unseen factors influencing their wellbeing. Gaining an understanding of harmful colonial tactics, as well as community resilience, can offer a deep sense of cultural pride and purpose. This experience of renewal or reawakening (Adelson, 2001) relates to a sense of self-esteem, coping and sense of ‘place’ in society. This understanding of how racism, oppression and discrimination may have affected the lives of each client (Shepard et al., 2006) relates directly to skills needed to provide culturally safe care, as techniques in therapy are largely ineffective without an understanding of individual context (McCormick, 2000). Therefore, the tenets of cultural safety described in the previous sections apply to this model of culture-informed care.

**Trauma-Informed Care.** Trauma-informed care is also relevant to this population of clients, given that extremely high numbers of Indigenous clients seeking care at AHT have a history of complex trauma. Figure 6 above outlines an adapted model to understand the
effect of distal factors, including historical and intergenerational traumas, on the lives of Indigenous individuals and communities today. Given the implications of long term cognitive, social and emotional impairments on individuals raised in setting where they are exposed to ongoing traumas, helpers must address the multiple dimensions of mental health issues stemming from these factors. The following schema (Figure 9) breaks down aspects of Trauma-Informed care that will be expanded on below.

![Figure 9. Features of trauma-informed care](image)

All psychotherapy must begin with a therapeutic relationship that promotes empathy, acceptance and genuineness (McCabe, 2008). The same assumption is made within this model of care. The therapeutic relationship is particularly important for clients who have experienced complex trauma, as they are often dismissed as “too complicated, unreliable, and treatment-resistant” (Sochting et al., 2007, p.325, as cited in Haskell & Randall, 2009). This may be related to their lack of skills for managing everyday stressors (Haskell & Randall, 2009). To briefly review the relationship between trauma and these mental health sequelae, children in families low in expressiveness (lacking in communication and displays of affection), cohesiveness and independence, and high in conflict and control (higher in rigid rules and coercion), experience an increased risk for victimization in childhood and
revictimization in adulthood (Gold, 2012). These individuals show a decreased resiliency in adulthood, and show gaps in socialization as well as impairments in developmental achievements and effective adult functioning (Gold, 2012). In particular, adults experience difficulties in interpersonal relationships (restricted capacity to connect with others, balance emotional dependency and autonomy), experience emotional impairment (diminished ability to distinguish thoughts from feelings, identify and express feelings), experience behavioural problems (diminished ability to control impulses, think before acting), and experience cognitive limitations (diminished ability to think critically, engage in sound decision-making) (Gold, 2012).

In order to address these trauma-related sequelae, trauma-informed care must include a component that builds these skill sets, which may be lacking. Psychoeducation around trauma and its aftermath must be provided for clients in order to empower them to pursue areas of growth. This includes an understanding of the impacts of complex trauma on attachment, physiology and physical health, as well as coping mechanisms (Haskell & Randall, 2009). Cognitive Behavioural Therapy and Motivational Interviewing are cognitive-based treatments that can help to address shame and self-critical thoughts associated with being challenged by activities of daily living (Gold, 2012). These tools can also promote the development of capacities around socialization and functioning in an adult world. A Cognitive Behavioural approach might be helpful for this aspect of treatment as it is goal oriented, structured and can be used as a practical tool for those who may be experiencing cognitive impairments (Somers, 2007). Motivational Interviewing is another method that can be used to promote a desired change, in that it explores and resolves ambivalence and increases motivation within the client to facilitate change (Venner, Feldstein & Tafoya,
This method does not impose change on the client but rather finds internally driven means to change that are consistent with individual values and beliefs (Venner et al., 2006). Together, these modalities offer skills for teaching, coaching and reinforcing desired behaviour change while identifying and managing emotions that are linked to old behaviours (Somers, 2007). The Motivational Interviewing manual created by Venner et al. (2006) offers directions for applying this modality in conjunction with Indigenous healing methods and spirituality, and can be used as an Indigenous-Western hybrid tool for promoting change with Indigenous clients.

Within the model of trauma-informed care, the Memory Walk (Cale, in press) is the perhaps the most emotionally vulnerable component, as it incorporates principles of Emotion-Focused Therapy as well as Narrative Therapy to address the painful memories of the trauma itself. A Memory Walk is a therapeutic tool used by educator and nurse, Gini Cale, to process grief and trauma through life’s stages. In her vignette about the releasing sweat, one healer in this study used the principles of the memory walk to lead the client on a journey through the four stages of life, as represented by the medicine wheel. The method used by Cale (in press) is similar but instead walks through Erikson’s stages of development in order to process positive and negative experiences and to clarify what areas require healing. Either approach to the memory walk is acceptable and both compliment Narrative Therapy’s emphasis on storytelling and healing through story and through re-storying (Shepard et al., 2006).

Focusing on resolving particular emotional injuries, Sandra Paivio (2012) developed a tool for using Emotion-Focused Therapy for healing from complex trauma. These emotion focused tools may prove useful for processing the areas requiring healing as revealed by the
memory walk exercises. Paivio’s approach emphasizes empathic attunement with the client, empathic responding to the client’s injuries, and addresses the client’s painful emotion scheme (including memories, thoughts, beliefs, behaviours and physiological reactions) in a wholistic way. The intention of this modality is to transform and process maladaptive feelings through ‘imaginal confrontations’ with perpetrators and other exposures, in an effort to modulate dysregulated affect and promote self-soothing among clients. Where appropriate, this aspect of the memory walk can assist clients to process unresolved grief from particular traumatic episodes that may continue to affect them to date.

The intention of this section has not been to provide an exhaustive approach to trauma-informed care; it simply touches on general areas for treatment that require further specification should they be pursued in session. Additionally, it is imperative that this model of trauma-informed care be understood within a broader context of colonization and historical marginalization for Indigenous peoples. It is well understood in the field of psychology that oftentimes, individuals who have experienced multiple traumas throughout their lives may encounter significantly more barriers in developing skills for everyday living, as discussed throughout this Discussion chapter. However, this must not be viewed as a failing on the part of Indigenous clients who fit this profile; any lack of skills or lack of personal resources must be considered through a compassionate lens that sees these outcomes as being related to the historical context of harms perpetrated against Indigenous peoples by colonial forces and imperialist agendas. As helpers, we must be extremely cautious to not infer that certain clients lack skills due to personal shortcomings, as this risks further pathologizing Indigenous peoples.
**Caregiver Support.** A final component of this integrative model for addressing complex trauma relates to supporting the helpers and healers who work in these settings. The following figure (*Figure 10*) indicates aspects of Caregiver Support that will be discussed below.

![Caregiver Support Diagram](image)

*Figure 10. Features of caregiver support*

Not only are helpers working with clients who have high rates of trauma, they are also Indigenous community members who have likely experienced similar difficulties in their lives or in the lives of family members or friends. For these reasons, the potential for caregiver burnout is likely higher among this population of caregivers (Bloom, 2012; Crosato & Leipert, 2006). In order to act as helpers for others, caregivers must first undergo personal healing and must practice self-care. In his paper on compassion fatigue among psychotherapists, Figley (2002) describes this phenomenon as a reduced capacity or reduced interest in bearing the suffering of others based on emotionally and psychologically demanding work. He states that factors such as prolonged exposure (the ongoing sense of responsibility for the care of a suffering individual over an extended period of time), traumatic recollections of client experiences or personal experiences, as well as general life disruptions for therapists, can all contribute to compassion fatigue and caregiver burnout. Figley states that desensitizing therapists to traumatic stressors, enhancing social support
within the workplace and outside of the workplace, increasing a therapist’s sense of achievement and satisfaction with her helping efforts, managing stress and improving self-soothing techniques for therapists are all tools to reduce compassion fatigue.

Participants in this study called for more support for the work they do; caregiver support is therefore included in this model as an equally important aspect of healing within the therapist-client dyad. In particular, participants noted that they would like to undergo further training in the area of complex trauma in order to serve the needs of their clients. They also noted a desire to undergo personal or group psychotherapy, engage in talking circles at work, and visit a traditional healer on a regular basis. This was motivated by the desire to both undergo their own healing journey and to process emotional content that surface during their work as helpers. An added benefit to promoting personal healing relates to the earlier discussion section on complex trauma and silence. Participants stated that sexual abuse and sexual traumas continues to be somewhat of a taboo topic in many community contexts and that more openness about this topic within the clinic could prove to be beneficial to staff and clients. Breaking the silence around this topic, however, might bring to light sensitive content and therefore healing for staff and helpers is a valuable aspect of Caregiver Support.

Work-life balance is also required to create a working atmosphere where helpers thrive and continue to be motivated and driven to carry out this emotionally laden work. An organization that facilitates work-life balance allows employees to meet the multiple demands of their lives and fulfill work responsibilities without causing loss in their personal life (Lee, Reissing & Dobson, 2009). Work-life balance improves both employee well-being and productivity levels within the workplace (Lee et al., 2009). Bloom’s work focuses on
training mental health facilities to regain this type of balance at the organizational level, especially those health centers that see clients suffering from higher incidence of trauma (2012). Bloom warns that due to caregiver stress and a lack of work-life balance, organizations often begin to operate in a state of ‘chronic crisis’, similar to their clients. Her program to assist organizations with this type of restructuring will be reviewed in the Conclusion chapter in the discussion around directions for mental health policy.

**Summary**

This Discussion chapter reviewed findings related to the three meta-themes of *Wellness, Loss, and Recovery*. Specifically, it explored discussion topics related to culturally relevant care, trauma-informed care, and the need for therapy with this population to be culturally safe. It included a discussion of the mental health benefits of spirituality and connection with nature, as well as an overview of what society at large stands to gain from an acknowledgement of these Indigenous values. Traditional teachings were discussed as a means of offering direction within the therapeutic process, and the importance of healing through establishing harmony with one’s identity was emphasized. This chapter also reviewed components of culturally safe care, and the importance of empowering all clinicians to work competently with Indigenous clients in therapy. Key findings included the fact that Indigenous clients often present with complex and multiple traumas and therefore sexual health issues are not typically considered uniquely, aside from other traumas. This finding suggests that all treatment with Indigenous clients be trauma-informed. This discussion also underscored the need to focus on community-wide healing around issues related to intergenerational abuse, sexualized traumas, silencing from taboo topics and healing for healers. It concluded with a model of integrated care, including Western based
and Indigenous based approaches, rooted in the findings of this study. The following chapter offers concluding remarks for this study.
Chapter 6: Conclusion

Overview of the Biskanewin Ishkode Study

This research project extended from the findings from a Canadian Aboriginal AIDS Network (CAAN) study, which examined relationships between sexual violence and HIV among Indigenous women in Canada. The participants in the “Our Search For Safe Spaces” study (CAAN, 2009) called for more research into the mental health outcomes of Indigenous people living with sexual trauma and violence. The proposal for this dissertation study developed from that call, and this project sought to understand the spiritual, mental and emotional well-being of Indigenous women affected by sexualized violence, sexual traumas and other abuses. This study was conducted in partnership with Anishnawbe Health Toronto, wherein the mental health staff and administrators contributed their voices and ideas to its development. Specifically, the research question guiding this study was, how do traditional helpers conceptualize and address the mental health needs of Indigenous women experiencing sexual health vulnerabilities?

This study was qualitative in nature and followed a narrative inquiry to interview traditional mental health workers (including traditional healers and traditional counsellors) at Anishnawbe Health Toronto to understand their conceptualization of: a) mental health sequelae stemming from sexualized trauma and abuse, as well as b) what modality of treatment they apply with this population of clients. This study allowed for the voices of Indigenous peoples to emerge and therefore an added exploration into an Indigenous paradigm of wellness and healing was undertaken. This study was timely and relevant, as it reflected a critical gap in the psychological literature in its consideration of Indigenous healing as a culturally appropriate and responsive treatment for this vulnerable population.
This study sought new understandings of mental health treatments and supports that are culturally relevant and successful for this population of service users. Given the higher rates of sexual violence, abuse and trauma in many Indigenous communities, mental health issues stemming from these injuries are contemporary areas of concern for Indigenous peoples (Brownridge, 2003; Pearce et al., 2008). The psychological literature shows that many survivors of sexual trauma and abuse experience relational difficulties, are more likely to engage in self-destructive behaviours, and are more likely to meet criteria for mental health diagnoses (Beckerman, 2002). Still, there are high dropout rates among Indigenous clients accessing Western mental health services and this likely relates to the lack of cultural appropriateness of the services being provided. Counselling work must be attuned to the value systems and unique cultures of clients in order to be successful, and it is unlikely that many Western services are adapted culturally to meet the needs of Indigenous clients (Kirmayer et al., 2000).

In order to correct the widespread neglect of following respectful Indigenous protocols among Western researchers in the past, this study was conceived and progressed in keeping with community-based ethics. The topic of the study emerged from community women from the CAAN study and the research project developed in partnership with Anishnawbe Health Toronto. The researcher and organization signed a partnership agreement and community Elders approved of the study. Within the University of Toronto, ethical approval for this study was granted expeditiously, and there were no difficulties obtaining participants for this study. No participants discontinued their involvement with this study prematurely; in fact, several commented that the process of clarifying their understandings, beliefs and values around topics related to mental wellness and the provision
of healthcare services was a healing experience. I continued to work part-time at Anishnawbe Health Toronto throughout the duration of this project, as the coordinator of a cultural safety project whose mandate is to educate and sensitize health care practitioners and students to Indigenous cultural competency and safety. It is likely that I will continue to work at the organization on various mental health-related projects following the dissemination of these findings. This emphasis on ongoing relationships with research partners is in keeping with ethical protocols for Indigenous research (Tuhiwai Smith, 1999) and is mutually beneficial to both researcher and organization.

While the purpose of this project at its outset was to consider mental health conceptualizations and treatments for female survivors of sexual vulnerabilities from the perspective of Indigenous counsellors, helpers and healers, what quickly emerged from the interviews with participants was a shift in dialogue. Helpers and healers instead focused their responses on mental wellness and treatment for both male and female clients. In addition, they conceptualized sexual abuse and victimization within a lens that considered a wide array of traumas, stating that clients did not come to therapy to deal solely with sexual abuse, for instance, but rather with a host of concerns stemming from complex and multiple traumas. These shifts in responses away from the interview guide questions, which asked specifically about sexual violence and sexually transmitted infections for women, are indeed important findings to this study and reveal much about how these issues are conceptualized by helpers at AHT. A further review of these findings will be elaborated on below.

**Major Findings from this Study**

The literature review for this study revealed a gap in the psychological research around resources on Indigenous healing for sexual trauma, both in terms of traditional
conceptualizations of injury or distress, as well as directions for mental health treatment. This study sought to address this gap in the literature by describing an Indigenous perspective on these important areas of mental health provision for this population.

As described above, notable findings from this study emerged through the use of qualitative methods, which allowed participants to shift the research focus. Narrative inquiry, as a flexible and social constructivist method of data collection, allowed for participants’ responses to mould the direction of the study—in this case, it became apparent that the participants did not differentiate by gender in their responses related to treatment and mental health sequelae, and readily used examples from clients of both genders to share their narratives of healing. Also, they did not respond strongly to questions about sexually transmitted infections and rather than focusing solely on sexual trauma, they expanded their discussion of psychological ‘wounds’ to include traumas of various natures. They positioned their stories of helping and healing within a historical and cultural lens in order to highlight that sexual traumas do not stand alone, but rather exist within a historical context involving intergenerational issues and colonial policies that have been very damaging to communities and individuals on various levels, including socially, economically, spiritually, and others. This narrative method was also valuable as it prompted self-awareness, self-discovery, reassessment, and resilience around perspectives and methods of healing, which participants noted and appreciated. In fact, several participants contacted me months following the interviews to once again thank me for the experience and to remark on how stimulating our dialogues had been.

In terms of the specific results from the interview questions, meta-themes of Wellness, Loss and Recovery emerged from the stories of participants. These meta-themes
related to one another in that mental wellness was described as living in a state of balance; however, this balance could be disrupted by loss. Descriptions of Wellness and Loss revealed how the helpers conceptualized the mental health needs of their clients. Recovery as a theme represented their treatment approach to return clients to balance and wellness. Within the domain of Wellness, participants’ emphases lay predominantly on the concept of balance as well as connection to traditional ways, including spirituality as a central focus of wellness. Therefore, Wellness centered on living in balance between the sacred aspects of the self on the medicine wheel, as well as connecting to important social networks within the community. Traditional teachings were also described as offering directions for living well on a daily basis, which was referred to as ‘Organic Health Promotion’ in the Results chapter, meaning that practices of daily living to promote balance and wellness are embedded within the cultures.

With respect to Loss, participants recognized the overarching effects of colonization and subsequent complex traumas, including sexual abuse, stemming from distal factors, such as colonial wounds, and proximal factors, such as intergenerational traumas. The helpers suggested that no trauma stands alone; therefore, when working through client challenges in session, helpers do not look solely at sexual abuse but instead focus wholistically at the array of traumas and resulting impacts on individual’s lives. Participants conceptualized the wounds stemming from these traumas within three main themes: clients may experience attachment issues that interfere with the attainment of healthy relationships, they may suffer from addictions, which were seen as coping tools that help to numb pain, and they may be suffering from a ‘broken spirit’ wherein they have lost their way and lost meaning in their lives.
Recovery as the third meta-theme represented healing tools that helpers used to assist clients to overcome issues related to trauma and its aftermath. Directions for healing included assisting clients to find their way again, through gaining an understanding of their historical context and making sense of intergenerational and community traumas. Recovery also involved teaching clients traditional knowledges that provide direction for living and that connect clients back to their culture. Traditional healing methods, such as consultation with healers and Spirits, as well as ceremonies, including the sweat lodge ceremony, seasonal ceremonies, and naming ceremonies, were also means to help clients along their healing journeys. Central to this journey was a reconnection with spirituality and identity, often assisted by the receiving of a spirit name. Participants emphasized the need for clients to take an active role in recovery, as self-healing is considered to be the most deep and sustaining form of healing. This was also facilitated through lifestyle change. Finally, the strengths of applying an integrative model of health, including the strengths of both Western psychology and Indigenous healing, were discussed. The notion of ‘universal healing’ was introduced in these results and underlined areas of convergence between these two approaches to care.

These findings relate to those in the psychological and Indigenous healing literature in several ways. First, other authors have also noted the importance of contextualizing trauma through an historical lens, including an understanding of the systemic abuse that was widespread during the residential schooling era (Million, 2000; Royal Commission on Aboriginal Peoples, 1996). Other authors have also described the resultant family breakdown and lack of transference of positive parenting skills between generations following the residential school legacy (e.g., Kirmayer et al., 2003); similar discussions emerged from these interviews. Secondly, other research has linked trauma and abuse to subsequent
difficulties with addiction (Pearce et al., 2008) as well as difficulties interpersonally and with attachment (Haskell & Randall, 2009), as was the case in this study’s findings within the discussion on helpers’ conceptualizations of the wounds that result from trauma and abuse. While the psychological literature suggests that many survivors of abuse find it difficult to maintain intimate relationships due to distrust of others, the Discussion chapter described how this distrust is likely more prominent for Indigenous clients due to historical and contemporary traumas at the hands of authority figures, through unjust governmental policy, apprehension of children, and other acts of violation (McCormack, 1999). Third, disruptions in positive personal identity following abuse have also been described in the psychological literature, including feelings of guilt, shame and low self-esteem among survivors (Baima & Feldhousten, 2007). This discussion supported those findings and further outlined various ways in which difficulties with maintaining positive identity may be exacerbated by clients’ experiences of holding a marginalized status as an Indigenous person within mainstream society. Finally, previous psychological research also identified that survivors of abuse often experience emotional blunting and a loss of feeling stemming from abuse (Barnes, 1995; Howard et al., 2003). The findings from this study indicated a similar wound stemming from abuse, but conceptualized it within the Indigenous context as a ‘spiritual loss’—a loss of meaning and a loss of direction in life.

The contributions from this study of value for counselling psychology include a description of types of Indigenous healing methods and hybrid (Western and traditional) treatments used to support clients on their healing journeys. The psychological literature does not point to successful treatment directions for addressing sexual violence and complex trauma within this context for Indigenous clients; it simply identifies that Western therapies
often do not meet the needs of Indigenous clients as indicated by the underuse of these services by members of the Indigenous community. The descriptions of these methods from helpers at AHT therefore present lessons for mainstream counselling psychology. The tremendous gifts associated with the inclusion of traditional culture and knowledge, including the central aspect of spirituality in healing and an approach that considers balance and harmony over diagnosis, was evident from these narratives of healing. In addition, the sense of family and having a cultural ‘place’ within the healthcare setting was demonstrated through descriptions of the caring culture. Ceremonies that can be practiced daily or weekly that nourish the spirit and address all sides of the medicine wheel can help individuals remain grounded and represent skills that are not widely used in Western therapeutic models. The four healing vignettes presented in the Results chapter offer more detailed descriptions of community healing through reconnection with tradition, spiritual healing through interconnection with nature, healing from trauma through a sweat lodge ceremony involving a memory walk, and group therapy for sexual abuse survivors using a Western and traditional hybrid model of care. The common focus of these therapies is the centrality of connection as a healing path for clients, including connection to the self through spirit, connection to one’s history and life journey, connection to other survivors of trauma and those with shared experiences, connection to the larger community, and connection to nature and all living things.

**Limitations of this Study**

There were some limitations to this study. While the number of participants allowed diverse and unique perspectives to emerge from the data, there were personnel limitations related to the number of AHT staff who qualified as potential participants. Having access to
more helpers who specialized in the area of sexual abuse treatment would have added more specificity to the findings, which queried specifically about these types of trauma. However, this sample size is typical for qualitative studies (Guba & Lincoln, 1989), and is reflective of the views and narratives of traditional counsellors and traditional healers currently serving these clients at AHT.

This partnership with AHT may also have resulted in biased findings around cultural healing. Clients who elect to access traditional healing services and helpers who offer these services both show a natural inclination for culture-bound care. As discussed in the Literature Review, Indigenous peoples today are themselves multicultural and extremely diverse in terms of degree of acculturation to traditional Indigenous and Western paradigms (Coyhis & Simonelli, 2008). Therefore, these findings may be transferrable to other Indigenous groups who also maintain a traditional connection; however, they may be less relevant for Indigenous peoples who do not wish to engage in culture-informed care.

Another shortcoming of this study was that the results did not address mental health outcomes associated with the diagnosis of sexually transmitted infections, which this study proposed to do, given that rates of STIs and HIV continue to be higher in the Indigenous population. This suggests that clients may not be raising concerns about STI diagnosis in therapy; perhaps it is not a relevant concern for them, or perhaps they have more pressing concerns that they would like discuss in session. In this sense, it is possible that broad issues of trauma are so pervasive for clients at Anishnawbe Health Toronto that these physical health issues are secondary. Were the research to have taken place in another health centre, such as a women’s reproductive health clinic, unique findings with respect to physical health burdens for women may have emerged.
In addition, as noted throughout this Conclusion chapter, interview responses diverged somewhat from interview questions; while questions were posted specifically about women’s health and healing from sexual trauma and sexual vulnerabilities, responses were more broadly focused on healing for all clients and healing from trauma generally. Perhaps this was an oversight on the part of the researcher; while staff partners did contribute to shape this project and did approve of the interview guide, perhaps this proposal should have described this phenomenon of sexual abuse and multiple traumas more broadly from the outset, allowing participants to shape the content of the matter as they saw fit and in a manner that was relevant to their work. Therefore, future research designs should maintain the storytelling methods of the narrative inquiry in order to leave questions open ended so that participants can shape the study design and results, as they are the experts on these topics. While this study asked particular questions in the interview guide, such as questions on definitions/concepts of mental health, mental health sequelae and wounds, and directions for treatment, a more appropriate interview guide for future studies might simply ask for their stories around the issue at hand (i.e., healing from complex trauma), and allow them to more freely narrate their point of view, punctuated by emergent questions or prompts from the researcher.

A final limitation to this study related to my personal bias as the investigator of this research. Within a constructivist inquiry, the researcher is a part of the project, she helps to guide and shape the interviews (and thus the interview results), and she is the central instrument of data analysis and interpretation. Therefore, these findings are a product of the views of both participant and researcher, with assumptions and values intertwined. The Introduction chapter includes a detailed account of my personal story in order to present
transparent understanding of how I am situated within this field of study and within this project in particular. Of course, bias is inherent within qualitative inquiry and is recognized as an unavoidable and integral part of this methodology (LaBoskey & Lyons, 2002).

**Implications for Counselling Psychology**

The Discussion chapter offered detailed descriptions of how these culturally-embedded tools for healing are relevant to this population of clients, and included descriptions of the mental health benefits of spirituality, evidence of the power of healing through nature, and the importance of addressing potential disruptions in identity by giving clients the tools they require to comprehend the history of colonization and its impacts on their communities and families. Not all Western trained therapists will seek to become trained in traditional healing (as this poses significant ethical concerns regarding cultural appropriation and traditional knowledges and is beyond the scope of this discussion); however, Western therapists can respect these values related to spirituality and interconnection, and can endeavour to provide clients the resources to seek out traditional healers (should clients be interested) and to incorporate some Indigenous values into their practice. It is likely that many Western trained therapists already do so; however, perhaps these practices within mainstream counselling are not accounted for in research studies, or perhaps clinicians practice this wholistic style of therapy in private practice settings, which are largely inaccessible to this population for economic reasons. Overall, it is clear that all therapists working with Indigenous clients must have a strong understanding of the historical context of the lives of their clients, including the complex traumas stemming from intergenerational abuse. It is virtually impossible to address episodes of trauma in the lives of clients without a wholistic understanding of their lived experiences.
Cultural safety is a term that was introduced many times throughout this discussion and it merits revisiting here as it has far-reaching impacts for the practice of counselling with mainstream therapists’ Indigenous clients. It is likely difficult for clinicians to fully grasp the magnitude of injury experienced by many Indigenous communities over the past centuries without first establishing some training in cultural competency and cultural safety. In order to develop a wholistic understanding of the lived experiences of clients, helpers must not only begin to explore Canada’s history of colonization at large, but they would also benefit from learning the unique regional or community history of their client’s life in order to situate their narrative in an appropriate context. In addition, the practice of cultural safety requires that individuals begin to deconstruct and examine their own lived experiences, including social location, experiences of disadvantage or privilege, and biases about healing and assumptions within cross-cultural encounters. This involves a continual process of maintaining self-awareness, revising one’s understandings of contemporary stereotypes about Indigenous people, and repositioning oneself as an advocate and ally to Indigenous causes. This bridge between helper and client may also serve to repair interpersonal damage experienced by clients through instances of discrimination in our wider society.

In addition to understanding the cultural lens of clients, this study revealed that nearly all clients using mental health services at AHT have experienced multiple and complex traumas, according to these participants. Therefore, care with this population should also be trauma-informed; counsellors should be educated about the nature of complex trauma and the need to build other skills of daily living with clients. Understanding the long term cognitive, emotional and social effects of trauma can also help to explain client behaviour in session and may lend more empathy for clients who are deemed to be ‘difficult’. Overall, there is a
place for Western counselling with this population, as the model of integration introduced in the Discussion chapter suggests. This model involves a hybrid approach to counselling, utilizing the strengths of cognitive-based therapies for skills building and emotion-focused therapy for processing difficult memories and for addressing interpersonal and attachment issues. A narrative therapy approach might also be useful here, as this approach challenges oppressive and dominant structures in society and gives voice to ‘alternative’ stories emerging from the lived experiences of those from the non-dominant society. Narrative approaches also encourage storytelling, which has been deemed to be a culturally appropriate method of therapy and one that allows stories to be revised with new understandings. The culture-informed aspect of care introduced in the integrative model emphasizes spiritual content and historical locatedness for clients and suggests that attention to identity construction might be relevant to these clients. While Western therapists themselves might not address the aspects of the model that call for traditional healing, they can link their services with those of a traditional person and can encourage clients to pursue learning the traditional teachings and seeking spirit-based forms of healing.

The importance of healing for healers also emerged from these interview results; helpers stated that they require more training to manage complex trauma cases and that personal healing services would be welcomed to manage potentially triggering experiences as helpers. As noted in the Results and Discussion chapters, this group of helpers typically experienced many of the community-based issues that their clients have faced, and thus may require additional support to carry out their own healing journeys. Clearly, self-care work is important for all helpers; however, when a helper works in a field where each client presents with compounded and multiple traumas, the risk of caregiver burnout is even greater.
Solutions for organizational stress at the policy level will be described in the following section.

**Implications for Mental Health Policy**

Participants in this study praised the important work that Anishnawbe Health Toronto does for the Indigenous community in Toronto, estimated to be a population size as large as 80,000 people (City of Toronto, 2009). Participants noted that it is rare in the city to have access to the number of diverse helpers and healers that are available at AHT for Toronto’s Indigenous community and that the organization is very fortunate to employ as many healers as they do. Participants called on governmental support for more agencies like AHT, who are able to offer clients access to traditional healers, to offer ceremonies such as the sweat lodge within the urban centre, and to offer hybrid Western and traditional services to clients. Therefore, funding for urban-based Indigenous healing centres should be maintained and expanded, given the rapid increase in the number of Indigenous people who are migrating into urban centres. Currently, over 60% of Indigenous people live in urban areas (Statistics Canada, 2009) and that number is growing. In addition, in order to offer continued support to Indigenous mental health services like those offered at AHT, traditional counsellors should continue to be offered ongoing training and continuing education in order to meet the needs of their clients, who often present with complex difficulties. Finally, there is a need to consider how to implement training programs to increase the number of traditional healers who are able to service the community. Traditionally, this journey of training would take many years—possibly even decades—through an apprenticeship model with a senior healer. Currently, management at AHT is considering how to create a program wherein more Traditional Healers can be trained to fill the growing need in the population for these...
services. Future considerations at the mental health policy level should investigate the feasibility and ethics of such endeavours.

There is also a need to monitor organizational stress within health centres that service clients with high rates of trauma. Dr. Sandra Bloom is a psychiatrist who trains mental health organizations to operate as a ‘sanctuary’ for clients and staff. She has identified that many organizations dealing with clients who present with chronic traumas often operate in a state of chronic stress at the organizational level (Bloom, 2012). Due to caregiver stress and burnout, organizations begin to function in a state of ‘chronic crisis’, fail to instill long term solutions to organizational issues, experience increases in conflict between staff and decreases in trust and safety between staff, and show a lack of communication and critical thinking skills within the organization. In short, they begin to function like their wounded clients. Bloom’s team enters mental health facilities like these to promote an organizational culture change in order to minimize stress and burnout. Workers in the present study did not claim to be in a state of crisis currently; however, mental health clinics dealing with many clients who present with complex trauma may wish to take advantage of ‘sanctuary’-based programs like that of Dr. Bloom in order to create policies promoting well-being and balance within the organization. This type of sanctuary policy could be expanded on for an Indigenous organization like AHT, to involve group healing from historical trauma for staff. Models such as that of the Takini Network in the United States, which is a program developed by Dr. Yellow Horse Brave Heart to address community healing (Haskell & Randall, 2006), could be used as a guide. This model of care offers education and training to assist communities struggling with anger, lateral oppression, and substance abuse, which often continue in the wake of historical and intergenerational traumas.
Finally, the promotion of culturally safe and competent practice when working with Indigenous clients is relevant to all therapists, no matter their theoretical orientation. Therefore, training at the university and college level for mainstream therapists should involve gaining an understanding of the true history of Canada and its relationship to the First Peoples of this territory. This chapter has described the importance of applying a culturally safe lens to therapeutic work with Indigenous clients, including an understanding of Indigenous and colonial history, the implications of governmental policies and the social determinants of health on the lives and well-being of Indigenous peoples today, and the importance of self-reflection when working cross-culturally. Altering educational policy to include an understanding of these areas is already underway at several post-secondary institutions who recognize the importance of closing gaps in education, employment and health among Indigenous peoples. The Ontario Institute for Studies in Education is an example, through their promotion of a special advisor to the Dean on Aboriginal education.

**Directions for Future Research**

In their insightful paper on a complex trauma model for addressing mental health issues in the Indigenous community, Haskell and Randall (2006) call for more research on the role of trauma in the lives of Indigenous peoples. They suggest that there is a need to understand the nature and effects of trauma in order to design and deliver effective and culturally appropriate community interventions and individual treatments. The findings from this study support this call for future research, as concerns related to the magnitude of client care needs were strongly voiced by these participants. Future research should consider culturally appropriate treatment strategies for these clients, and I would add that trauma-informed treatment strategies should also be investigated for this population. If more funding
for agencies like AHT require empirical evidence, future research may evaluate the successes of treatment interventions, such as the “Indigenous healing for complex trauma” model introduced in the Discussion chapter.

Alternatively, a study considering the value of integrating other Western based strategies with traditional healing could be undertaken. For instance, emotion focused therapy for complex trauma has recently gained empirical support (Paivio, 2012); this could be combined in a trial with traditional healing in the following way in Figure 11 below:

![Figure 11. Model for integrative research trial addressing complex trauma](image)

This trial could run for fifteen weeks, for example, and evaluate the impacts of using an integrative approach to therapy alongside a Western approach for clients healing from complex trauma. The Native Women’s Association of Canada suggests that research describing how traditional healing can be effectively combined with other health services would be of tremendous value to the community (2007); therefore studies like these are likely to receive support from Indigenous community members and service agencies.

Research that considers sexual abuse and trauma for Indigenous men might also represent a valuable direction for future research. There is a lack of focus on these issues for men in the Indigenous psychological literature, and the participants in this study indicated that almost as many men who come into the clinic for counselling and healing are the victims of sexual vulnerabilities as women. Therefore, research that sets out to consider sexual abuse
and trauma for both genders from the outset would be valuable for this population. Research could explore differing displays of these issues among men and women in order to ensure that regardless of presentation, client needs are met and wounds are addressed. This research may also consider directions for healing that are valuable to both genders, as described in this project.

Finally, further research looking into the connections between spirituality, mental health and healing would be a valuable addition to the psychological literature and would promote the importance of Indigenous spirituality within Indigenous healing. This type of healing does not emerge from reviews of contemporary mainstream psychotherapy practice, yet is a valuable aspect of healing for many cultures. Given the multicultural nature of this geographic area around Toronto, it would be prudent to inform psychological practice about the mental health benefits of spirituality. It would also offer support to service agencies like Anishnawbe Health Toronto, whose focus on spirituality is central to traditional healing.

Conclusion

This project set out to examine how traditional healers and counsellors at Anishnawbe Health Toronto addressed and treated instances of sexual trauma among female clients. The research question guiding this study was: how do traditional helpers conceptualize and address the mental health needs of Indigenous women experiencing sexual health vulnerabilities? A narrative method was used to gather stories of traditional healers and counsellors about this work. Given the higher rates of sexual abuse, trauma and violence within many Indigenous communities, mental health outcomes stemming from these issues are a concern (Pearce et al., 2008). Moreover, counselling services must be oriented to the needs of Indigenous clients, which may be unique given the colonial legacy. This study
engaged in a partnership with Anishnawbe Health Toronto and followed respectful protocols for research with Indigenous peoples.

This project revealed understandings of the wounds arising from complex traumas from an Indigenous perspective, and examined culturally appropriate healing tools for addressing these wounds. While the project set out to understand the experience of female survivors around sexual abuse and trauma, interview results indicated that helpers did not differentiate healing strategies by gender and that sexual traumas were seen as part of a broader array of socio-political, historical and personal traumas that their clients struggle with. The qualitative methodology used in this study allowed participants to mould these findings in this new direction. In addition, many participants revealed that sexual abuse and trauma continues to remain a taboo topic; therefore, a limitation of these findings may include the fact that it is difficult to gather specific stories around a subject area that continues to be silenced.

In particular, meta-themes around Wellness, Loss and Recovery emerged from these interviews and highlighted the stages of mental health: Wellness represented living in a state of balance, practicing daily health promotion, having a strong sense of cultural identity, understanding one’s historical locatedness and benefiting from a sense of spirituality; Loss represented a disruption in Wellness—in this case, through historical losses related to colonization generally, and sexual abuse in particular, which was the focus of this study. The wounds stemming from Loss caused by sexual abuse and trauma, including relationship issues, addictions and the experience of having a “broken spirit,” emerged as major thematic areas in these interviews. Recovery as the third meta-theme highlighted the approaches and tools helpers and healers employ to assist clients to return to a state of Wellness, including
reconnecting with cultural identity, spirituality and traditional ways, and empowering clients to return to a healthy lifestyle. The importance of providing Indigenous clients with culturally safe healthcare services emerged, as along with the strengths of using an integrated approach (Western and traditional Indigenous) in helping clients on their healing journeys.

These findings were linked to the Indigenous psychological literature as well as the trauma literature in several ways. The model introduced by Felitti et al. (1998) highlighting the impact of adverse childhood experiences on mental health issues later in life related strongly to these findings, and the model describing disrupted attachment and community trauma introduced by Haskell and Randall (2003) related to the historical wounds described by the participants in this study. The Discussion chapter offered an abridged version of Felitti’s model to explain the lifetime mental health impacts of adverse experiences within Indigenous populations by including the additional determinants of historical and intergenerational traumas in the lives of Indigenous clients. The Discussion chapter also introduced an integrative model of psychotherapy for this population, including culture-based and trauma-informed treatments in order to promote culturally safe mental health treatment with this population of individuals. The importance of healing and supports for helpers was also underscored in this model of care, as well as suggestions for policies that serve to reduce chronic stress levels within organizations that see a constant influx of challenging and traumatic cases. Finally, a model for an integrative research trial addressing complex trauma with Indigenous clients was presented in this chapter as a suggested direction for future research.

Overall, this study offers support to the integrative (Western and traditional) care that is being offered at Anishnawbe Health Toronto, a unique health care facility servicing
Toronto’s large Indigenous population. It also honours the important work that helpers and healers at AHT are undertaking every day, working with many of the most marginalized within the Indigenous community—those dealing with complex traumas and resultant mental health sequelae, including addictions and attachment issues, compounded with economic insecurities and other challenges. While many staff admitted to requiring further training in the areas of treatment for complex trauma, the fact that these helpers continue along a healing path with clients facing such challenges each day is a testament to their courage to persevere through spiritually and emotionally difficult therapeutic work, as well as to their enormous heart and grace—both of which are required to remain committed to serving their communities. It is important that all research involving Indigenous peoples be relevant, timely and purposeful within a community context (National Aboriginal Health Organization [NAHO], 2007). This study satisfied these criteria as it reflected current mental health issues among a significant population of Indigenous clients who use therapy services at Anishnawbe Health Toronto. Moreover, this study did not simply describe and define health issues in this population but sought to indicate directions for interventions to support these clients on their healing journeys by identifying mental health treatments and supports that are culturally relevant and successful.

In closing, I would like to include the inspiring words of Elder Dan Smoke of the Seneca Nation on the importance of caring for one another in order to heal from colonial wounds. Dan’s words have encouraged me to pursue this course of study since he first began sharing traditional teachings with me when I was an undergraduate student. Dan and his partner Mary Lou have continued to offer sage council and guidance for me since that time.
This passage is included with permission of the author, and speaks specifically to Indigenous women’s rights, representing part of my motivation for pursuing this dissertation research:

Our Elders tell us that a Nation is not defeated until the Hearts of the Women are on the ground. Ojibway Elder Art Solomon used to always tell Mary Lou and I that Cheyenne Quotation. So, we believe strongly in what you’re doing27. We support it wholeheartedly. My only thoughts are that our Elders tell us that we must know where we come from, in order to know where we are going. So, it’s important for us, as men, to know our history. We should know that our ancestors used to always have a central teaching: that the men’s role was to take care of the woman; and that the women’s role was to take care of the man; and that both the men and women’s role was to take care of the children. That is how we try to live. So, we were role-modeled this behaviour by several Elder-couples who showed us how to respect one another. In our teachings, the Clan Mother would watch the young boys and see how they treated their siblings, how they treated their mother and father, their Grandma and Grandpa, along with their extended family. And so the Clan Mother would see how he related to women, and how he showed sacred respect to her, as the giver of life. If he was respectful in all of his responsibilities, relationship and affairs with women, then, he would be regarded as a candidate for “royaner” or Chieftainship of the Clan and Nation. So, this is how our Chiefs were selected. They were selected by a woman, a Clan mother, who had this role and responsibility to ensure her Clan and her Nation were well represented by a Man who takes care of his clan family. So, this is where we have come from. Where the men had roles and responsibilities and the women had roles and responsibilities.

27 This is a reference to the Hearts of Nations publication from which this passage was borrowed. This passage is included with the permission of the author to use in this dissertation.
This was “gender equity” for lack of a better term. I can only think in academic terms, and will come up with a word from the language, that better describes our society.

Today, we have absorbed a negative learned behaviour, in the way we treat women today. We regard them in the same way that western Civilization, the Europeans did when they came to Turtle Island. They came with violence and they wanted our land and all the resources of the land. They didn’t listen to us, when we told them that there was enough land to go around for everyone, and for future generations. So, we negotiated Treaties with the settlers on how we were going to “treat” one another. So, following this, the treaties were broken by a dishonourable Crown and a dishonourable Country of Canada. We always kept and honoured our side of the Treaty which said we would share our land and the Settlers would remain “unmolested unto perpetuity.”

Women have become commodified and they are treated with violence. This is the way the European mindset was, when they arrived on Turtle Island. So, for us to work in solidarity with Indigenous Women is to reclaim our roles and responsibilities to bring history forward by restoring Indigenous Women back to their roles and responsibilities in our communities, families, clans and Nations. Even in our agencies, schools, institutions et al. (Smoke, 2011, p.6).

These words of Elder Dan Smoke reflect a historical time where community was central to traditional peoples’ way of life and strong connections between individuals allowed for health and wellness to flourish. He shares that in the wake of colonial traumas, communities and personal connections are now often fragmented, resulting in a loss of wellbeing within Indigenous groups. He reminds us that simply caring for one another and restoring traditional
values will bring about healing. As I reflect on his words I am also reminded of the Anishnawbe name for this study, *biskanewin ishkode*. I am struck by the similarity between Dan’s call to action to restore traditional values and the meaning of this study’s name offered by Jake Ago Neh and the spirits: *The fire that is beginning to stand*. Just as fields are burned to make way for new growth, the healing fire can rise within each of our spirits to clear away old wounds. This healing fire can also make way for the re-growth of ancient seeds of Turtle Island: traditional Indigenous values. May their restoration bring balance to us all.
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Appendix A

Recruitment Email

INDIGENOUS MENTAL HEALTH RESEARCH

I am a Counselling Psychology student at the University of Toronto and I have a partnership with Anishnawbe Health Toronto to explore how traditional healers and counsellors in mental health help female clients who have experienced sexual health issues, abuse and violence.

+ Are you an Indigenous (Aboriginal) helper over the age of 18?
+ Have you worked with women who have experienced sexual health issues and traumas?
+ Are you willing to discuss your ideas and experiences with this type of healing journey in a private interview?

If you answered “yes” to all of these questions, and you are interested in participating in a 1-2 hour interview, please contact me for more information.

Miigwetch - Thank you very much!

In Spirit,

Allison Reeves
Telephone: 416.822.8805
Email: allison.reeves@utoronto.ca
Appendix B

Interview Guide

1. What are traditional Indigenous ways of understanding mental health issues?
   For instance: What in your own journey informs your way of understanding mental health issues? How do you work as a healer?

2. What are traditional Indigenous ways of understanding the wounds (mental, emotional and spiritual) left from sexual health issues & traumas?
   For instance: What is the impact on the emotional, spiritual and mental “self”?

3. How do you help female clients deal with sexual health issues & traumas in counselling?
   For instance: Can you share stories or examples of this type of work? What cultural tools help to manage their mental (and emotional/spiritual) health needs?

4. What needs to happen moving into the future?
   For instance: How can we help these women heal? What should happen in the field of counselling/helping?

5. Is there anything we haven’t covered that you feel is important to share on this topic?
Appendix C

Consent Form

_Biskanewin Ishkode (The fire that is beginning to stand): Exploring Indigenous Mental Health_

_and Healing Concepts and Practices with Women Experiencing Sexual Vulnerabilities_

You are being invited to participate in a study entitled that is being conducted by Allison Reeves, a PhD student in the department of Adult Education and Counselling Psychology at OISE – University of Toronto. Should you have any concerns about the research, you may at any time contact Dr. Suzanne L. Stewart (supervisor) at (416)-978-0723 or Allison Reeves at (416) 822-8805 or by email at allison.reeves@utoronto.ca.

Allison Reeves has a partnership with Anishnawbe Health Toronto for this study. The purpose of this research project is to gain an in-depth understanding of the ways Indigenous healers and helpers at Anishnawbe Health Toronto work with women who are using mental health services to address sexual health issues.

Research of this type is important because rates of sexual health issues are higher among Indigenous women and there are negative implications for mental health and wellbeing following sexual health issues. Also, research has demonstrated that there is an under use of Western mental health services by Indigenous peoples due to cultural differences. However, there is currently a lack of research related to the successes and challenges of using an Indigenous healing approach that addresses sexual health and mental health issues with Indigenous women. This study will contribute to new information on Indigenous health and wellbeing, and will inform the development of useful healing strategies for Indigenous women experiencing sexual vulnerabilities.

You are being invited to participate because you are a mental health helper at Anishnawbe Health Toronto who works with these types of clients. If you agree to voluntarily participate in this research, your participation will include one 1-2 hour audiotaped interview that will take place in a private setting (e.g. Anishnawbe Health Toronto office) of your choice. There will be a second interview to review your interview results which will take approximately 30 minutes. The total time commitment is approximately 2.5 hours, and participation in this study should not cause you any inconvenience other than the interview time.

There are some potential psychological and emotional risks from your participation in this study. You may feel upset if we discuss a topic related to abuse or trauma (although I will not be asking you any direct questions about your experiences with this). To protect you from this, we have discussed this risk during our pre-interview meeting and I have shared the interview questions with you so that you can prepare for the interview. If you become upset during the course of the interview we can take a break or terminate the interview completely.
The potential benefits of your participation in this research include clarification of your own story or understandings related to the healing journey and the benefits of Indigenous healing. Potential benefits to society include informing education and policy about helpful mental health practices for Indigenous peoples in Canada, and informing academic literature about Indigenous philosophies of healing that have proven to be important, valid and beneficial.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time, or refuse to answer certain questions without any consequences (both personally or professionally) or any explanation. In the event that you withdraw from this study, your audio-taped interview and all accompanying notes will be destroyed.

Any conversation that we have is confidential and nothing you say will be used against you at your workplace. However, there are some exceptions: If you indicate that you are a danger to yourself or others or if you disclose information about apparent, suspected or potential current child abuse, I am both ethically and legally required to contact the appropriate authorities. To preserve your anonymity, your name will not appear on any of the data or research reports. A code or a pseudonym of your choice can replace your name. Audiotapes and data will be stored in a locked filing cabinet. Only the researcher will have access to the data. The audio-tapes from your interview, the transcribed data, and any notes taken during the interview will be destroyed after five years.

As a way to cover your transportation costs and time, and to show respect and thanks for your participation, you will be offered a gift card for a book store at the time of the interview. Should you decide to withdraw from the study at any time, this honorarium is yours to keep.

It is anticipated that the results of this study will be shared with you and others in the following ways: directly to participants by hand delivery of results in a research report, through published articles in scholarly journals, in policy reports to Native and non-Native governments and health organizations, and at scholarly conferences/meetings.

In addition to being able to contact the researcher and her supervisor, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Office of Research Ethics, 416-946-3273 or ethics.review@utoronto.ca.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

_________________________  ______________________  ____________
Name (print) (signature) Date
Appendix D

TAMS Analyzer Software

Open Coding using TAMS Analyzer software:

This image shows a raw transcript of an interview along with the list of codes in the left-hand column. A section of data is being highlighted in order to apply the “interconnection” code to that passage.
Search options in TAMS Analyzer program: