

Indigenous Mental Health: Canadian Native Counsellors' Narratives

By

Suzanne L. Stewart
B.A., University of Victoria, 2001
M.A., University of Victoria, 2003

A Dissertation Submitted in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

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By

Suzanne L. Stewart
B.A., University of Victoria, 2001

Supervisory Committee

Dr. E. Anne Marshall, Supervisor (Department of Educational Psychology and Leadership Studies)

Dr. Blythe Shepard, Department Member (Department of Educational Psychology and Leadership Studies)

Dr. David de Rosenroll, Department Member (Department of Educational Psychology and Leadership Studies)

Dr. Chris Lalonde, Outside Member (Department of Psychology, University of Victoria)

Dr. Rod McCormick, External Examiner

Supervisory Committee

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Dr. Rod McCormick, External Examiner

ABSTRACT

A small yet growing body of literature recognizes the importance of a cultural perspective to mental health services for Canadian Indigenous clients. Although the role of culture has not been studied extensively in counselling psychology, a few investigators have attempted a systemic examination of the area. Using a narrative methodology, five Indigenous counsellors described their perceptions, beliefs and experiences regarding mental health and healing from an Indigenous perspective. A narrative analysis of the data employed story maps to yield within and across participant themes. Overall results included the metathemes of community, cultural identity, holistic approach, and interdependence as integral to mental health and healing for Native clients, with an illustration for counselling that contains specific elements for incorporating this conception into practice. The results are used to inform literature on an Indigenous paradigm of mental health, counsellor training programmes aimed at meeting Indigenous health needs, government policy, and to generate further direction for health research into the Indigenous paradigm in Canada and beyond.

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Chapter One: Introduction

Introducing an Indigenous Paradigm

Mental health is a vital aspect of overall health for Canadian Indigenous peoples. However, Indigenous cultural understandings of mental health and healing are distinctly different from understandings that have prevailed in most North American mental health provider settings, including in counselling contexts. Counsellor training in Canada and the United States is based almost exclusively on a Western paradigm of health that differs from an Indigenous worldview (Gone, 2004). These differences in paradigmatic worldviews can form a barrier to effective helping for Native peoples who seek counselling services from formally trained counsellors, including those who may be trained in cross-cultural or multicultural approaches. Further, Duran (2006) suggests that counselling Indigenous individuals from a non-Indigenous perspective (i.e., Western perspective) is a form of continued oppression and colonization, as it does not legitimize the Indigenous cultural view of mental health and healing. “A postcolonial paradigm would accept knowledge from differing cosmologies as valid in their own right, without their having to adhere to a separate cultural body for legitimacy” (Duran & Duran, 1995, p. 6).

Fortunately, some counselling educators, researchers, and practitioners are increasingly recognizing the inseparability of cultural foundations and mental health needs and are attempting to undertake more effort to explore traditional cultural conceptions of mental health and healing. In order to address more culturally relevant knowledge regarding mental health and healing, a first step is to more fully understand how Indigenous counsellors themselves experience mental health in their practice.

In my research, I sought to extend our understandings of Indigenous cultural conceptions of mental health and healing. This dissertation includes a review of current literature relevant to Indigenous cultural mental health and healing, a presentation of narrative inquiry as an appropriate methodology for the undertaking of mental health research with an Indigenous community, summarized results of my data collection, a discussion of these results, and finally, implications, conclusions, future directions, and my own reflections on the process. This project reflects my strong commitment to working with Indigenous communities to identify strengths and positive aspects of our cultures in order to resist colonialism and rebuild from its destruction. I have been practicing as a professional helper since 1998, and have also begun working as a counsellor trainer in 2003. My own experiences in the field of mental health service and education have led me to see how the Western paradigm dominates counselling and counselling education in our current multicultural society.

There are two main reasons for this study: 1) there is a lack of empirical data in counselling psychology related to an Indigenous paradigm of mental health and healing, and 2) despite a mental health crisis in many Native communities, there is an under-use of mental health services by Indigenous peoples.

Counsellors and other health professionals in Canada have been faced with a dearth of information relating to culturally appropriate methods of assessment and counselling with Indigenous youth and adults. Evidence exists to substantiate that Indigenous conceptualizations of mental health differ from dominant North American society's notions of mental health (Smith, 1999; Vicary & Bishop, 2005; Waldram, 2004). The extent of these differences in psychologies indicates that mental health interventions, such as counselling

and therapy, should be reconsidered in order to incorporate Indigenous conceptions of mental health and healing in order to be culturally appropriate (Duran & Duran, 1995; Trimble & Thurman, 2002). For counsellors, there is a need for more systemic exploration of Indigenous mental health approaches and practices that are seen to be successful in today's communities, because most currently existing research focuses on the health *problems* and not the health and healing *solutions*. Much research on Indigenous mental health in general emphasizes the difficulties and dysfunctions that face Natives either individually or as communities (see Alderete, 2002; Bohn, 2003; Royal Commission on Aboriginal Peoples, 1994, 1995; Waldram, Herring & Young, 1995; Young, 1988). In the spirit of my own personal values and research endeavors, I sought to focus on the positive aspects of health and healing, such as what is healthy for Native individuals and groups, in order to support my peoples in dealing with and recovering from the mental health challenges that shape our realities.

Additionally, despite disproportionately high rates of mental health problems in Native communities as compared to the rest of Canada, mental health services are under-used by Native peoples. Research suggests that this is because most services are based on non-Indigenous based conceptions of health and healing (Government of Canada, 1991; Health Canada, 2003a; King, 1999; Waldram, 2004). Trimble and Thurman (2002) state that counselling has not been successful for many people from non-dominant cultures, especially Aboriginal peoples, because counsellors are not educated about Aboriginal philosophies and worldviews; a counsellor may be using a Western-based counselling approach that does not value the client's worldview. A study by Blue (1977) found that Native clients do not utilize or value counselling services that are not adapted to a First Nations helping model. McCormick's (1996) study found that some British Columbia Aboriginals described a

successful counselling approach as one that was culturally-based in local tradition, included Native rules of behaviour such as respect, non-interference, and input of Elders. Thus mental health workers such as counsellors should be educated in terms of cultural notions of Indigenous mental health if they wish to meet Native clients' needs.

A counselling approach that includes a culturally-based conception of mental health and healing can contribute to developing forms of health services and promotion that respond effectively to the client needs created by the complex history and social context of Canada's Indigenous peoples (Trimble & Thurman, 2002). Further, traditional knowledge, values, wisdom, and healing practices of Indigenous peoples can be used not only to appropriately address and deal with community mental health dysfunction and healing, but as appropriate for other non-Native populations, where dominant cultural assumptions and arrogance have historically overlooked and denied the strengths of an Indigenous mental health and healing counselling model (Kirmayer, Brass, & Tait, 2000).

Statement of Purpose

The purpose of this dissertation is to address a gap in the literature on Indigenous perspectives of mental health and healing. The research question to be answered was: How do Native counsellors understand the intersection of traditional Indigenous cultural conceptions of mental health and contemporary counselling practice?

The field of counselling, including its approaches to practice and its training programmes, lacks information from an Indigenous paradigm (Duran, 2006). The purpose of this research was to gain an in-depth understanding of how Indigenous counsellors understand and describe what Indigenous mental health is in today's counselling context. The intent of this study was to extend theoretical and applied knowledge with respect to the

Indigenous paradigm in mental health. The results will contribute new information to the research literature on Indigenous mental health and healing from an Indigenous paradigm. Results will also inform educational and government policy to develop Indigenous paradigm-based training and programming for health initiatives in Native communities in Canada. In addition, data collected will be employed to develop teaching materials for community counsellors, support workers, psychologists, school counsellors, and other community members and health professionals who are supporting Indigenous peoples in mental health and healing. In January 2007, I interviewed five professional counsellors recruited through my contacts at a Native community agency in a medium-sized Western Canadian city. The stories that these five participants shared with me represent the crux of this research, which employed a narrative methodology within an overarching conceptual framework of Indigenous ways of knowing and social constructivism.

*Indigenous Ways of Knowing and Social Constructivism
as a Conceptual Framework*

A conceptual framework is important as a basis to research because it gives the research a clear and firm ground from which to act. A conceptual framework also informs the direction of the research in terms of the research question, methodological approach, research sites, and even participant selection. My conceptual framework reflects both who I am as cultural being and as a philosophical agent. These two frameworks allow others who read this dissertation to understand my perspective as researcher by giving insight to my values and philosophies as they underpin this project.

My conceptual framework includes two schools of thinking: Indigenous ways of knowing and social constructivism. I am linking these two frameworks together because they

reflect two different aspects of myself and this research project. Also, there is overlap between these two approaches in terms of some values and assumptions, but primarily these are approaches to which context is integral. Indigenous ways of knowing are based on what educators have termed Indigenous pedagogy. My approach to research is based on an Indigenous pedagogy that places research, like education, in the context of culture, values, relationship, and historical realities. It is this understanding of teaching and learning that provides me with the foundation of what Philips, Whatman, Hart, and Winslett (2005) have termed the “Indigenous Standpoint Pedagogy” (ISP), which is described as being the “inherently political, reformative, relational, and deeply personal approach that is located in the chaos of colonial and cultural interfaces” (p. 7). ISP fundamentally identifies and embeds Indigenous community participation in the development and practice of Indigenous perspectives, or standpoints, and is a multi-faceted process. It is mainly concerned with Native perspectives in education and educational research not as an alternative to Western approaches but as a legitimate form of practice in and of itself. I bring this perspective to my research by virtue of my identity and my desire to work from an Indigenous perspective in all aspects of my research methods. What this means in practice is that I value multiple perspectives in the research process and in my interaction with participants, community members and informants, such as linear and non-linear thinking, differing time orientation, holistic approaches and dualism, and community-based and individual focused connection. The foundation to this conceptual approach lies in relationship, as this is the centre of success for meaningful communication with participants and community members. “Yet only through communication can human life hold meaning” (Friere, 2003, p. 61).

Social constructivism is the other conceptual framework that I used. Social constructivism is an ideal mate for Indigenous ways of knowing because it recognizes the importance of culture and context in understanding what occurs in human interactions when constructing knowledge based on this understanding (Rogoff, 1990). Social constructivism is based on specific assumptions about a) reality, b) knowledge, and c) learning (Kukla, 2000; Mahoney, 2003; Rogoff, 1990). These assumptions are:

- a) Reality for social constructivists is constructed through peoples' interactions. People in societies invent the properties of the world through their interactions. For the social constructivist, reality cannot be discovered, as it does not exist prior to its social construction.
- b) Knowledge is also a human product and is socially and culturally constructed. Individuals within a society create meaning through their interactions with each other and with the environment in which they interact.
- c) Learning is seen as an active social process by social constructivists. Learning does not occur merely within an individual, nor is it a passive development of behaviours that are shaped by external forces. Meaningful learning occurs when individuals are engaged in activities in social relations with others.

Social constructivism is also concerned with the concept of intersubjectivity, which is a shared understanding among individuals whose interaction is based on common interests and assumptions that form the ground for their communication (Gergen & Davis, 1995). For social constructivists, communications and interactions conform to socially agreed-upon adopted worldviews and the social patterns and rules of language use (Rogoff, 1990). Construction of social meanings, therefore, involves intersubjectivity among individuals.

Social meanings and knowledge grow through communication within groups of people (Mahoney, 2003). Any personal meanings shaped through these experiences are affected by the intersubjectivity of the community to which the people belong.

In this study, I was interested in the stories that counsellors tell about their creation of meaning related to mental health and healing. There may be as many stories of meaning as people who tell them, and in this conceptual framework that links Indigenous ways of knowing and social constructivism, I was able to acknowledge that each of these stories is true for the context of person who is telling the story; a social constructivist perspective allows for this intersubjectivity. There is no absolute reality in social constructivism or Indigenous ways of knowing, and this view matched my research question regarding the cultural and contextual understandings of Indigenous mental health and wellness.

Definition of Terms

A definitions of terms used throughout this dissertation will clarify specific meaning used within the research. Terms defined include “Indigenous”, “mental health”, and “Western paradigm”.

Indigenous

“Indigenous” is a general term used to describe members of three distinct Aboriginal cultural groups in Canada: First Nations, Métis peoples, and Inuit (Assembly of First Nations, 2002; Health Canada, 2003a). The term Indigenous will be used interchangeably with the terms Aboriginal and Native. First Nations, Indian, Métis, Inuit are also used as specific authors cited have utilized them. In my own experience, Indigenous peoples often prefer to be referred to by their specific tribal or band affiliation such as Dene, Songhees, or

Red River Métis, for example, rather than in general terms such as Indigenous or First Nations.

Mental Health

It is hard to find a single definition of mental health, as the focus in much of the literature appears to be on mental disorders and illness. Mental health is a concept that is defined differently depending on the health services context. In the past, scientists and doctors in the Western world defined health simply as an absence of disease or illness. *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (1994) defines mental health as a state marked by the absence of mental illness. This is the definition that some Canadian mental health professionals, including most psychologists, psychiatrists, and some clinical counsellors employ in their training and practice. The term also appears in this dissertation as specific authors and researchers have used it. In 1948, when the World Health Organization (WHO) was founded, the following definition of health was established: "A complete state of physical, mental and social well-being and not merely the absence of disease or infirmity" (p.100). Thus, mental health was not always marked as only a state of mental illness.

More recently, Health Canada (2006) defines mental health as "the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective, and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality" (p. 1). This definition, moving toward more holistic perspective, is a general, widely held

conception of mental health used by some contemporary Western-trained counsellors in Canada, and is being used in this study.

Western Paradigm

Since the late 1960s, the term *paradigm* has referred to a thought pattern in any scientific discipline or other epistemological context (Lamarche, 1995). A dominant paradigm refers to the values, or system of thought, in a society that are most standard and widely held at a given time. Dominant paradigms are shaped both by the community's cultural background and by the context of the historical moment. In Canada, the dominant paradigm is known as the Western paradigm because it is based on Western culture (Lamarche, 1995). *Western* is a term used to refer to the cultures of the people of Western European origin and their descendants. It comprises the broad heritage of social norms, ethical values, traditional customs (such as religious beliefs), and specific artifacts and technologies as shared within the Western sphere of influence. The term *Western* is often used in contrast to Asian, African, or Indigenous nations across the world. The concept of Western culture is generally linked to the classical definition of Western world. In this definition, Western culture is the set of literary, scientific, musical, and philosophical principles which set it apart from other civilizations. Mussell et al. (2004) discuss the western paradigm in the context of Indigenous peoples, "Western paradigms typically furnish a view of reality whereby logic, rationality, objectivity, individualism, truth, unity, and trust in scientific methods are privileged. For centuries, this view of the world assumed primacy and was often accepted as 'the natural order of things'. This legitimized practices of social oppression and control, as well as destruction of the natural environment" (p. 14).

Thus the terms *Western*, or *Western paradigm* in a mental health context, refer to the dominant cultural attitudes and beliefs that are based on Western European philosophies and practices that inform counselling approaches and counsellor training in North America that are based on individual psychology (Lamarche, 1995).

Summary of Chapter One and Overview of Dissertation

There is a need for research to fill the gap relating to Indigenous perspectives on mental health and healing for a variety of reasons. This study sought to fill this gap by asking Native counsellors to tell their stories about how they understand the intersection of traditional Indigenous conceptions of mental health and healing as used in their counselling practice with Native clients. The first chapter included a brief background and rationale, and my conceptual frameworks for the research. I have defined relevant terms and laid out the context and direction of this project.

In Chapter Two, I present a review of relevant literature on Indigenous mental health and healing. The review includes a brief overview of the historical realities of Indigenous peoples in Canada, followed by some information on current health status, and an introduction of Indigenous conceptions and approaches related to mental health. Chapter Three presents the methodology used in this research, beginning with my reasons for choosing a narrative approach with reference to my research question. Also included is a detailed description of the procedures used in the study and the narrative analysis method used. Chapter Four contains a summary of the results from the narrative interviews using the story map approach detailed in Chapter Three. For each participant, I describe the within-participant analysis, including an in-depth discussion of each participant's story map and identified themes.

In Chapter Five I discuss the research data results as a whole. This chapter embodies an across participant analysis that examines four overarching themes that emerged as being important to all the participants' narratives. Chapter Five also contains my presentation of a depiction of metathemes for the practice of Indigenous counselling and healing.

Chapter Six, the final chapter, contains my conclusions regarding Indigenous mental health and healing and counselling practice based on the results of this research, and a summary of the study. I have also added some of my own personal reflections and insights that emerged in my field journal throughout the journey of this project, in order to leave you with the flavour of my own personal story as researcher.

Chapter Two: Literature Review

The present chapter contains a review of current literature relevant to the research topic. I begin with a historical overview of Indigenous health in Canada. I then discuss mental health according to Indigenous paradigms, which includes a cultural conception of mental health and healing, and notions of identity and community, with illustrative examples.

A Brief History of Indigenous Health in Canada

According to oral tradition, prior to first contact with Europeans in the 16th century, the incidence of health problems among Indigenous peoples in what is now called Canada was low (Waldram, 2004). However, contact brought a dramatic increase in physical and mental illness to Aboriginals (Kirmayer et al., 2000). Over 7 million Indigenous peoples are estimated to have inhabited North America prior to contact in 1492, with almost 90% of these people dying as a result of indirect and direct effects of European settlement by 1600, and infectious disease brought from Europe was the major killer, followed by a change in traditional diet to one of European foodstuffs (Young, 1988). Today there continue to be health problems, such as diabetes and obesity, in Native communities related to diet and epidemiology (Kirmayer et al., 2000).

Implementation of federal government policy has also destroyed Native cultures through the creation of land reserves, residential schools, and bureaucratic control. Native settlements were chosen by non-Native governments, who forced Indigenous groups off of their traditional lands and onto other territories, often grouping bands together that had previously no history of living together (Dickason, 1997). These groupings were forced to make new social structures and sustainable ways of life. Native groups were also relegated to lands with little or no natural resources, i.e., lands not deemed livable for settlers (Royal

Commission on Aboriginal Peoples, 1994). Referring to an example of this relocation, Kirmayer et al. (2000) observe: “The disastrous ‘experiment’ of relocating Inuit to the Far North to protect Canadian sovereignty--a late chapter in this process of forced culture change--revealed the government's continuing lack of awareness of cultural and ecological realities” (p. 609).

Prior to contact with European explorers, North American Indigenous communities had effective methods for preventing and treating illness and injury (Young, 1988). For example, Bopp and Lane (2000) have recorded how the Nuxalk peoples of British Columbia effectively survived the small pox epidemic by creating and following a plan to “avoid complete annihilation” (p. 7): Community members were ordered by leaders to scatter from villages in pairs and to remain “in shouting distance” apart, and if one partner died, the other was to bury them (p. 7). If the remaining person then became ill, he or she was to bury him or herself in shallow grave until dead. After one year of this separation, members were to return to their villages. All the Nuxalk then gathered near the river, and it was estimated that of the thirty-thousand peoples who were alive before the epidemic, two hundred and forty seven remained. Thus the Nuxalk peoples survived and treated a major illness.

Through the colonization, bureaucratization, missionization, and education processes of the Canadian colonial governments, the control of healing and other health practices was largely transferred from Aboriginal peoples to programs and institutions sponsored by the Canadian government (Waldram, 2004). According to Waldram, while this new system helped to mitigate some of the devastating health problems brought from Europe (such as influenza, tuberculosis, and small pox, which developed through the early contact period), it failed to protect the health and well-being of Aboriginal people in the four following ways:

1. The health care services provided by the Canadian Government had no foundation in the traditional knowledge and cultural values and practices of Indigenous peoples. The government's health care practices were unfamiliar and frightening for many Indigenous people and further undermined their trust in and identification with their own practices and resources. These services also took some Natives away from their communities, sometimes for extended periods, when they required certain types of medical treatment, such as for tuberculosis or pneumonia.

2. Traditional healers were ridiculed and persecuted by the dominant culture and by governmental legislation. Traditional healers were forced to practice their traditions such as Potlatch, Sundance, and shamanic healing in secret. Many Native people no longer availed themselves of the benefits of their skills and knowledge, either because they did not know how to access these services or because they had been taught to mistrust, fear, or condemn their own healing traditions. Through this process of eliminating the practice of traditional healers, a great deal of very valuable cultural knowledge has been lost.

3. The Western perspective that dominates mental health interventions has its roots in modernism, a worldview that values objective truth, rational thinking, and the constancy of measurement (Sue & Sue, 1990). This focus on a Western perspective to mental health means that Aboriginal communities only had access to certain Western types of treatment and prevention programs, mostly those which focus on individuals and diagnostic labels rather than on the type of healing and human and community development and interdependence which are needed to restore Indigenous individuals, families, and communities to a level of health and wellness (Smith, 1999).

4. Aboriginal people lost control over the institutions and processes which were supposed to protect the health of their people (Alfred, 1999; Waldram, 2004). Natives were taught that the dominant society knew best which services and programs they needed. Even now, as many Native communities are negotiating with the Canadian government for the transfer of health programs to their control, they are often being given administrative responsibility for existing programs but very little real power to actually re-create health and social service programming in order to move toward maximum health and well-being (Waldram, 2004).

Canadian Indigenous Population Health Indicators

Recent data show that almost one million people, or 976,305 individuals self-identify as Indigenous in Canada (Statistics Canada, 2003, see Table 1).

Table 1. *Aboriginal Identity Population within the Total Canadian Population*
Note. From Statistics Canada, 2003. Copyright by Statistics Canada. Reprinted with permission.

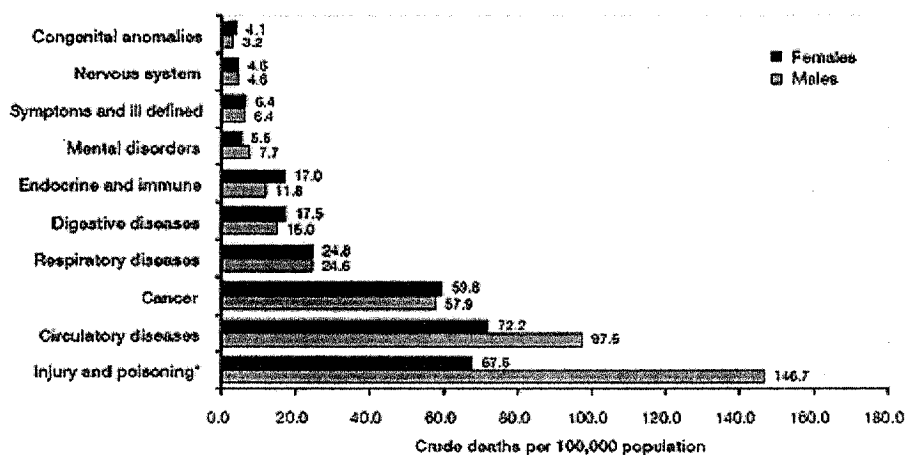
TITLE	Aboriginal Identity Population (3)		
	Total population	Total Aboriginal identity population	All others
Total – Area of residence	29,639,030	976,305	28,662,725
On reserve	321,855	286,080	35,770
Total off reserve	29,317,175	690,225	28,626,950
Rural non-reserve	5,782,375	196,130	5,586,245
Total urban	23,534,805	494,095	23,040,710
Urban non-census metropolitan area	5,575,480	214,225	5,361,265
Urban census metropolitan area	17,959,320	279,875	17,679,445

Almost 30% of Aboriginal people lived on Indian reserves and about 70% lived off-reserve in 2001. Of the off-reserve population, almost 49% lived in urban areas and about 20% lived in rural non-reserve areas—often in isolated northern communities. The Indigenous population is demographically different than the non-Native population; for

example, the mean age of the Native population is 25.5 and the mean age of the non-Native population is 35.4, with 33 % of the Native population younger than 15 years of age. Thus the mental health of youth and young adults is a concern to a good deal of the Native population. Also, there is vast cultural-identity diversity within the Native population, with 11 major language groups and more than 58 dialects, 596 First Nations bands, and 2284 reserves. An implication of this diversity is that a variety of health-related needs and practices must be met across Native communities, yet the reality is that health professionals often assume that Native cultural practices are the same across Canada.

Although comprising only about 3% of the national population, Canadian Native peoples as a group show a wide range of health problems at much higher rates than non-Natives (Waldram et al., 1995). For example, Natives are twice as likely to have a long term disability, are 3 times more likely to have hypertension and heart disease, are 4 - 5 times more likely to be diabetic, and have a 6 - 7 times greater incidence of tuberculosis.

Such Indigenous population health indicators reveal many areas of concern, and these are critical factors relating to overall Indigenous health and healing. According to Figure 2, which presents findings related to the leading causes of death in First Nations populations by sex, Indigenous people in Canada have 1.5 times the national mortality rate and 6.5 times the national rate of death by injuries and poisonings (Health Canada, 2003b). The suicide rate for Natives in Canada is 3 times the suicide rate of the non-Native population (Royal Commission on Aboriginal People, 1995). A deeper look reveals that in 1999, suicide and self-injury were the leading cause of death for Indigenous Canadians, accounting for 38% of deaths among youth and 23% of deaths for young adults (Health Canada, 2003b, see Figure 1).



Notes: * Included in this rate are suicides with a rate of 12.4 per 100,000 for women and 43.3 per 100,000 for men. Ranking based on mortality (deaths per 100,000 population) for First Nations in 1999.

Figure 1. Leading Causes of Death in First Nations, by Sex, 1999

Note: From Health Canada, 2003b. Copyright by Health Canada. Reprinted with permission.

Moreover, the Centre for Suicide Prevention (2003) suggests that these statistics may not accurately reflect the reality of injury and suicide in Native communities; the figures may actually underestimate the problem of suicide in Native communities, because data collected by Health Canada only includes status Indians, and not Métis or other non-status Indian residents of Canada. Also, non-fatal suicides or suicide ideation were not included in the Statistics Canada data pool, though both have serious impacts on Native families and communities.

Current Health Concerns

Thus far in the literature review, I have contended that Indigenous groups in North America, like other international Indigenous peoples, have experienced profound disruption and destruction of their traditional ways of life through cultural contact and colonization practices of dominant Western forces (Duran, 2006). In Canada, this has involved various processes, from first contact to present, including cultural assimilation tactics to destroy

Native cultural identity and community by enforced Federal and Provincial government legislation through:

- Relocation from traditional lands and confinement to reserves
- Parents and children (through many generations) suffering prolonged separation from family, culture, and traditional lands by forced placement in residential schools
- Loss of control of self and community governance, including language, religion, land use, food sources, clan structure, etc. i.e., colonial rule
- Gradual involvement in national and global economics
- Historic and continued political and social marginalization
- More efforts too numerous to itemize (Kirmayer et al., 2000).

The mental health implications of this colonial history are significant for Indigenous communities and individuals (Duran, 2006; Kirmayer et al., 2000; Waldram, 2004). They include high rates (compared to non-Indigenous populations) of:

- Grief and loss
- Depression
- Suicide
- Trauma
- Family violence
- Substance abuse
- Sexual abuse

(Health Canada, 2003c).

Trauma has been documented in the literature as a major healing issue in many Native communities across Canada (see Bopp & Lane, 2000; Caron, 2004; Wilson, 2004).

Bopp and Lane (2000) write that trauma for Native individuals and community is a complex and intergenerational phenomenon that has its roots in the colonial history that has taken away and destroyed much traditional Native cultural practices. They define trauma as, “the psychological, physical, and mental effects associated with a painful experience or shock,” (p. 25). Experiencing of trauma events puts an individual or community in a position of being overwhelmed emotionally with the traumatic experience. This overwhelm is dealt with in many different ways by different people and communities. People often turn to substance abuse, violence toward other or the self, suicide, and many other forms of self-destructive behavior. These effects are often described as indicators or consequences of trauma.

In a report based on a health study with the Nuxalk Nation of British Columbia, Bopp and Lane (2000) write that trauma can occur from a single event or a series of prolonged events, and that trauma can occur to individuals as well as communities. Regardless of the specifics of the traumatic events, the trauma itself creates certain characteristic effects on individuals and the way that they understand their environments and relationships. “Trauma affects whole communities by undermining social, cultural, economic, and political structures and relationships as well as the capacity of that community to interact in a healthy balanced way with the society around it” (p. 26). When trauma is on-going, or occurs more than once, a sense of helpless and hopelessness often sets in for the individual or the community. Bopp and Lane conclude that healing support for Indigenous communities and individuals dealing with trauma must address these core aspects of trauma.

Karmali et al. (2005) conducted a population based observational study that describes the epidemiological characteristics of severe trauma among status Indians in the Calgary health region. They discovered that in their sample, severe trauma--such as suicide or

accidental death--occurred about four times more among status Indians than non-Native groups. Further, large difference in rates was present for specific causes, such as suicide, assault, and car accident.

Caron (2004) points out that, in addition to understating rates and epidemiological characteristic of trauma in Native communities, issues of morbidity and accurate depictions of the real effects of trauma must be documented and understood in qualitative and quantitative terms, and must include all Aboriginal peoples and not only status Indians. Also, health care services, including mental health services, must be more accessible and more culturally appropriate for Native communities. Caron concludes that traumatic injury and death are easily preventable health problems, but that it would take the support of the health care community and greater society to work collaboratively with Native groups to deal with the effects of trauma.

Within the literature concerning health problems, there is substantial research on Indigenous suicide. Aboriginal peoples in general do not have the same health status as non-Natives in Canada, however when it comes to suicide, the difference is especially dramatic. The First Nations death rate for injuries, including suicide, is 2.9 times higher than for non-Natives. The 1999 crude death rate for Aboriginal males was 30% higher than for First Nations females, largely due to injury. One of the leading causes of death for injury among males was suicide.

Studies by Bagley, Wood, and Khumar (1990) and Bohn (2003) identified regional variations in Aboriginal community suicides, indicating that Health Canada's generalized statistics may not fit for specific Native communities. Chandler and Lalonde's (1998)

research, discussed below, further elaborates on this within-group difference as linked to Aboriginal self-government.

In the 1980s, the federal government began initiated a process meant to transfer health care responsibility to First Nations and Inuit governments. The rationale for this decision by the Government was that Aboriginal peoples best understood their community's health care and service delivery needs and thus should be in control of these services (Health Canada, 2003a). In 1994, Health Canada conducted a study on the success of this transfer of health care services programme and found that transferring management control had led to a decrease in health problems and issues within communities and more culturally sensitive health care delivery (Health Canada, 2006). In addition, health care, including dealing with suicide, became a priority that could be acted upon.

Research by Chandler and Lalonde (1998) examined suicide in the context of self government and local control of health care, education, and other infrastructure. In studying suicide among British Columbia's nearly 200 Aboriginal communities, they found that while some communities had suicide rates 800 times greater than the national average, in other communities, suicide was practically non-existent. Chandler and Lalonde further identified six protective factors that help make sense of the differing suicide rates across some Native communities. These factors are discussed as cultural continuity, could be considered an index of community level success in renewing or reclaiming cultural tradition: 1) land claims, 2) self-government, 3) education services, 4) police and fire services, 5) health services, and 6) cultural facilities. More specifically, Chandler and Lalonde found that communities with some form of self-government had the lowest rate of youth suicide. Land claims was the second and education the third most important factors in predicting a low suicide rate in the

communities studied. Communities possessing three or more cultural continuity factors experienced substantially fewer suicides than communities without such factors present. Thus these factors are important to consider regarding the mental health of communities in terms of suicide rates. Further study is needed to examine other correlates of mental health such as depression, self-esteem, addictions, and family violence with such factors of cultural continuity.

It is important in the context of this dissertation to have awareness of health problems currently facing Native communities. It is from the point of awareness and understanding of these problems that this research takes a turn to focus not on further explaining these dysfunctions but to instead identifying healing solutions. Culturally-based mental health and healing is a major issue for Indigenous peoples in Canada, as there is currently a health crisis in some communities. The reality of high rates of psychological maladjustment such as alcoholism, suicide, depression, and more, suggest that there is a need to look closely at the health and healing resources within communities (Vicary & Bishop, 2005; Waldram, 2004).

Challenges of Current Mental Health Services

This section identifies challenges that arise when a Western mental health care system is imposed on Indigenous individuals and communities. Three salient points within this topic warrant discussion: 1) Western and Indigenous notions of mental health are different, 2) counsellors trained in Western notions of mental health do not effectively service Indigenous mental health populations, and 3) using a Western paradigm of mental health in an Indigenous context is a form of continued oppression of Indigenous peoples.

Related to the first point, counsellor training that is based on Western notions of health and healing does not match Indigenous conceptions of well being, as it came up in the

above section on mental health. Western-based health interventions, such as Western-based counselling approaches, are culturally inappropriate in Indigenous contexts because the many values and ways of being and doing are different (Duran, 2006). Any Western approach would not be effective with Indigenous clients if it does not take into account the context of the client's life. Often, health policies and programs designed by non-Indigenous individuals or institutions have been inappropriate for dealing with Indigenous problems because the philosophies and ways of living that underpin each approach are very different (Vicary & Bishop, 2005). Indigenous healing is different to Western healing because it employs a holistic, which is defined as a whole person that includes mind, body, and spirit, approach to well-being (Waldram, 2004). Western approaches to counselling such as constructivism and family systems are often considered more culturally appropriate in Indigenous contexts because they consider contexts of the individual, however they are not based on Indigenous worldviews or paradigms that reflect notions of interconnectedness, spirituality, and Native rules of behaviour (Blue & Darou, 2005). Western culture in Canada emphasizes a hierarchical and individualist worldview, which is in opposition to Indigenous beliefs. Western approaches to counselling are largely based on individualism, such as the person-centred approach (Duran, 2006). McCormick (2000) maintains that the European-Western paradigm is built on a model of creation containing a hierarchy of God, humans, and nature, including concepts of domination of humans by God, of animals by humans, and of humans exploiting the land. An Indigenous counselling model, according to McCormick, would be based on connectedness, equality, and harmony between people and nature.

Sue and Sue (1990) suggest that mental health approaches in general could benefit from the worldviews of Indigenous healing methods. These are usually informal and

naturally existing help-giving methods present in all traditional Indigenous cultures that focus on interdependence or connectedness in healing. For example, in traditional Dene communities in Canada's north, grandparents not only took care of grandchildren so that parents could do valuable work for the community such as hunting and craft making, but these grandparents also passed on cultural knowledge that was vital for individual and group survival as a distinct people (personal communication, Stewart, 2006)

Related to the second point that counsellors who receive training only in Western approaches to mental health and healing are not meeting the needs of Native clients seeking counselling services, there is currently an under-use of mental health services such as counselling, by ethnic minority groups, including Indigenous peoples (Sue & Sue, 1990). Some researchers have suggested that this under-use stems from the fact that counselling approaches are not culturally sensitive to the Indigenous clients' values, beliefs, or worldviews: "Counselors may lack basic knowledge about the client's ethnic and historical backgrounds; the client may be driven away by the professional's counseling style; the client may sense that his or her worldview is not valued" (Trimble & Thurman, 2002, p.61).

King (1999) conducted a survey with an urban Indigenous adult population in Denver, Colorado, to identify their mental health needs. King concluded that mental health provider agencies are not meeting the current needs of urban Native adults, who stated a preference for Native health service providers or at least providers who are sensitive to cultural community needs. Over 90% of the adult respondents said they would use mental health services if they were made available by Native persons trained in mental health services or non-Natives who had training in Native sensitivity as well as mental health services. Community health was also a theme in King's data. The study's authors'

recommendations were that all levels of Indigenous community mental health are in dire need of mental health services that are grounded in an Indigenous paradigm. Mental health is underpinned by community health, according to King, and community level interventions that fit the Indigenous culture of the community, such as prevention and education are needed to address the mental health of individuals sampled in this community. Blue (1977), Blue and Darou (2005), and McCormick (1997) have also studied and written about how and why Indigenous peoples utilize services only when these services are grounded in a First Nations helping model. These researchers have worked in Canadian contexts and conducted interviews with Native clients in counselling.

To address the third point, a Western perspective on mental health forces continues the oppression of Indigenous peoples because it delegitimizes an Indigenous view of health and healing. According to the Aboriginal Healing Foundation (2002), conceptions of traditional health and healing are integral to current efforts by Canadian Indigenous peoples to face the legacy of suffering and dislocation brought on by the history of colonialism. For example, in 2000, the Champlain District Mental Health Implementation Task Force, in Ontario, began the implementation of mental health reform in two specific First Nations communities (Akwesasne and Golden Lake). This reform is marked by recognizing the need to support first Nations capacity to design, deliver, and control their own mental health services, and to respect traditional contemporary Indigenous approaches to healing and wellness (Poushinsky & Taillion-Wasmund, 2002). Further, the reform recommends that within First Nations communities, there must be at least one or a combination of three streams of available mental health services: traditional mental health services provided by traditional healers and healers through ceremonies; Indigenized mental health services

(Western mental health paradigms that have been converted and delivered by Natives); and Western mental health services delivery to Natives by non-Natives.

The intent and results that has underpinned much health research has been a tool of power and control over First Nations. Many mental health treatment applications have been designed to dominate and control people with mental illness. This process of social control has been explored by Foucault (1971), who wrote that when the church lost control of much of the general Western population in the 1800s, the medical profession seized an opportunity to control the masses. The movement of the medical profession at the time evolved into the present day mental health care system in the Western world. In this perspective, mental health care practitioners can be seen as possessing and exerting social control through the process of labeling in diagnosis and the sometimes subsequent taking away of a person rights when they are deemed not of sound of mind.

Indigenous Mental Health

The section presents my discussion of four aspects of Indigenous mental health: the Indigenous healing movement, Indigenous conceptions of mental health and healing, of identity, and of community.

The Indigenous Healing Movement

In Canada prior to 1980, when the Indian Act of 1876 began to undergo some reform, Indigenous communities suffered severely in terms of freedom, autonomy and cultural identification. Subsequent to 1980, and particularly in the 1990s, there has been a renewed awareness of spirituality, Native identity, and healing in many Aboriginal communities across Canada (Kirmayer et al., 2000).

Through an era of colonization and total oppression, many communities have preserved seeds of cultural knowledge through stories, songs, and sacred teachings of Elders (Medicine-Eagle, 1989). Many of these traditional forms of preserving and transmitting knowledge remained underground for generations due to religious and legal persecution by the Canadian government, as well as political repression. The 1960s was a period of political and cultural reawakening for many Indigenous peoples in North America (Alfred, 1999). The birth of the Aboriginal rights movement, through such organizations as the American Indian Movement (AIM) in the United States and the National Indian Brotherhood in Canada, marked the public and visible beginning of a new era in contemporary Indigenous healing (Mussell, Nichols, & Adler, 1993).

In addition to the political empowerment process, three other powerful streams have contributed to the emergence of what is clearly an Indigenous peoples' healing movement. The Aboriginal Healing Foundation (2002) has identified:

- a) The revival of traditional spirituality.
- b) The introduction of personal growth and healing as a primary line of action in community life through such programs as Alcoholics Anonymous (AA), and a whole host of strategies and programs for addressing substance abuse, sexual abuse, violence, and the need for personal growth.
- c) The health promotion and healthy communities movement.

Many communities have experienced the revival of old ceremonies, practices, and teachings such as smudging, the sweat lodge, the use of the sacred pipe, fasting, vision quests, and ceremonies for naming, healing, reconciliation, and personal or collective commitment (Mussell, 2005). For example in Alberta, the Nechi Institute has employed

traditional methods of helping and healing in terms of spiritual ceremony and teaching from Elders in a residential drug and alcohol counselling programme (Daniels, 1991). The success of the Nechi Institute's culturally based programme is shown in their high success rate of sobriety for participants and it serves as a model to other Native and non-Native treatment facilities (Alberta Alcohol and Drug and Addictions Centre, 2004)

The significance of the Indigenous healing movement is that it is bringing back and re-legitimizing traditional spiritual and cultural teachings, which has contributed greatly to community healing and development processes (Kirmayer et al., 2000). Foundational ideas about what constitutes healing, how healing can be promoted and maintained, and how it is intimately contained in a holistic philosophy that encompasses individuals, families, groups, and communities are now being borrowed and employed by dominant society health practitioners because they are so powerful and effective (Colomeda & Wenzel, 2000).

Indigenous Conceptions of Mental Health and Healing

In 1991, the Government of Canada published "Agenda for First Nations and Inuit Mental Health." It includes a description of mental health within a framework of holism and positive psychology as they are embedded in community and cultural identity:

Among the First Nations and Inuit communities, the term mental health is used in a broad sense, describing behaviours which make for a harmonious and cohesive community and the relative absence of multiple problem behaviours in the community, such as family violence, substance abuse, juvenile delinquency and self-destructive behaviour. It is more than the absence of illness, disease or dysfunction--it is the presence of a holistic, psychological wellness which is part of the full circle of mind, body, emotions and spirit, with respect for tradition, culture and language. This

gives rise to creativity, imagination and growth, and enhances the capacity of the community, family group or individual identities to interact harmoniously and respond to illness and adversity in healing ways. (p. 6)

This holistic description of mental health is guiding the approach taken in this proposed study. This description also makes an important point about the interrelatedness of spiritual, mental, social, and community aspects of health. Health as possessing an interrelated quality along with notions such as community and identity allows for an examination of mental health through a systemic lens that is grounded in an Aboriginal paradigm.

Mussell (2005) writes that mental health in the context of Aboriginal caregivers and policy makers is about focusing on the mental health issues that exist as the most serious detriments to the survival and well being of Native peoples. Part of a Native worldview is the notion of holistic health, which marks how Natives view themselves, their families, and their communities in a forward thinking manner. “Holistic health is the vision most First Nations peoples articulate as they reflect upon their future. At the personal level this means each member enjoys health and wellness in body, mind, heart, and spirit. Within the family context, this means mutual support of each other...From a community perspective it means leadership committed to whole health, empowerment, sensitivity to interrelatedness of past, present, and future possibilities, and connected between cultures” (p. 26). An integral concept to the notion of holistic health is the concept of interdependence, as pointed out by Mussell. For First Nations peoples, mental health problems result from lack of balance and interdependence among the four aspects of human nature, identified above. When balance, or harmony through interconnectedness, is restored through paying attention to the needs of the

four aspects of the self, the family, or the community, health is achieved in an Aboriginal worldview.

The medicine wheel model. Absolon (1994) defines the medicine wheel as “a paradigm that is relevant to the needs for assessment purposes in healing work, an expression of a First Nations Worldview, that views healing as a process that achieves a balanced relationship with the self, Mother earth, and the natural world,” (p. 25). Originating with the Plains Natives, the medicine wheel is an ancient and widely-used concept in Indigenous North American cultures, that models health and wellness for multiple aspects of a person or community (Mussell, 2005). When considering the medicine wheel, it is important to note that the term *medicine* as it is used by various First Nations people does not refer to drugs or herbal remedies (Thunderbird, 2005). Storm (1972) explains that medicine in Plains culture refers to the personal characteristics and strengths of individuals that comes to them through a particular animal reflection that occurs through the wheel. The characteristics of this reflection on an individual are determined by the nature of the animal itself (e.g., bear eagle, wolf, pheasant), and also by the location of the individual him/herself.

Storm, a Plains Native and teacher of the lessons of the medicine wheel, explains the philosophies of the circle. The medicine wheel is seen as demonstrating that we need multiple perspectives through its construction of the circle as a non-linear structure (Storm, 1972). She writes that the medicine wheel, as a circle, can be best understood in terms of a mirror that reflects all aspects of life and world. “Any idea, person, or object can be a Medicine Wheel, a Mirror, for man” (p. 5).

Teachings in contemporary Native communities based on the medicine wheel create an epistemological paradigm that employs a holistic foundation for human behaviour and

interaction; it informs a framework for mental health through a discussion of its four quadrants, each one a separate representation of North, South, East, and West (Thunderbird, 2005). For example, in the Sault Nation the construction of the wheel is meant to help people seek strong, healthy bodies (represented by the North facing quadrant), strong inner spirits (represented by the South facing quadrant), healthy minds (East quadrant), and inner peace (West quadrant) (Four Directions, 2005).

The medicine wheel embodies how Indigenous mental health can be conceptualized in a theoretical and pragmatic model for health care delivery (Poushinsky & Tallion-Wasmund, 2002). The Dze L K'ant Native Friendship Centre Society (2006) in Smithers, British Columbia, employs a holistic healing model based on the medicine wheel in their counselling programmes (see Figure 2). The medicine wheel model is described as one of the centre's tools for reaching the goal for mental health counselling, which is to "help Aboriginal and non-Aboriginal clients with serious forms of mental illness by supporting their ability to function in social relations and manage their daily lives" (p. 1). The Centre's model embeds practices of "mental health support" and "being in sound mind" through the acknowledgement of the four aspects of each person's personal "will" as depicted by the medicine wheel (Dze L K'ant Friendship Centre Society, 2006, p. 2). Mussell et al. (1993) have also created a medicine wheel as a working tool for mental health practitioners that depicts the same four components of mental health. Each component is linked to specific needs that individuals must meet in order to achieve balance, or health, in all parts of self, with a person's will in the centre, which represents the power to make decisions and act upon them. The needs of the intellectual aspect of self consist of concepts, ideas, thoughts, habits,

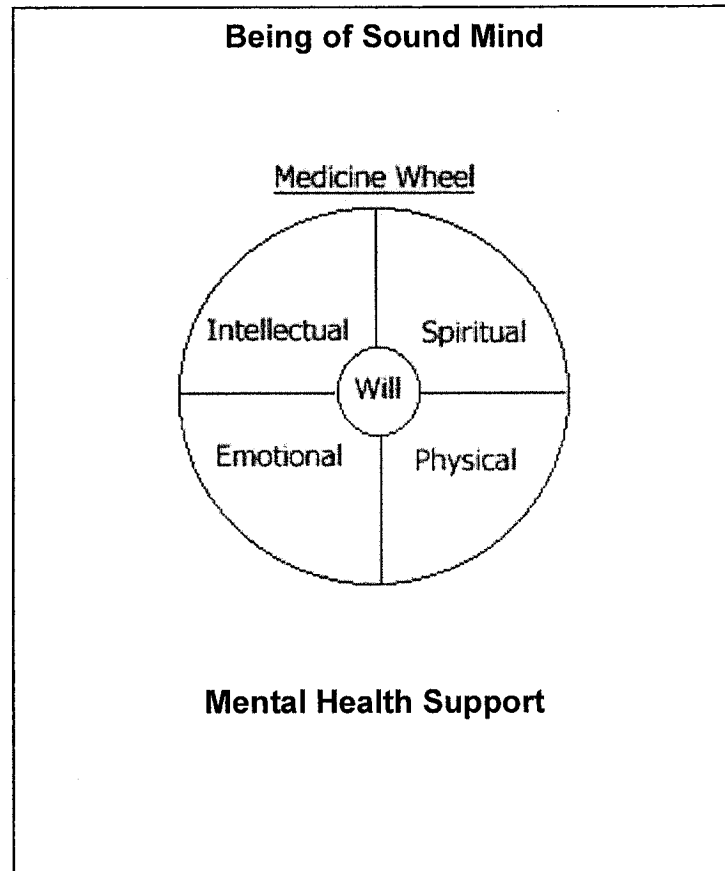


Figure 2. Medicine Wheel Model of Counselling Embedded in Mental Health Support and Being of Sound Mind

Note: From Dze L K'ant Friendship Centre Society, 2006. Copyright by Dze L K'ant Friendship Centre Society. Reprinted with permission.

and discipline. The needs of the spiritual aspect of self involve a sense of connectedness with others, and creations of the Great Spirit. Emotional aspect' needs include love, discipline, recognition, acceptance, understanding, privacy, and limits, while the physical aspect's needs consist of air, exercise, water, sex, food, clothing, and shelter. The ability of a person to meet this need is through their own personal power, throughout their sense of will.

France and McCormick (1997) also developed a healing circle based on medicine wheel teachings. They call this healing circle a helping circle, and it models a training program of a peer counselling service for First Nations university students. France and McCormick's First Nations Peer Support Network was created because they saw a need to make counselling services more accessible and culturally appropriate for First Nations students. The programme is based on local Indigenous philosophies and practices and employs several traditional cultural tools, including the medicine wheel, along with contemporary counselling approaches.

The purpose of the First Nations Peer Support Network is to provide an informal helping and support service using volunteers from the First Nations community to work with other First Nations people. What we hope will make the support network effective, is to combine both established helping practices with the traditional "spirit" that makes First Nations people unique" (p. 27).

The programme is implemented through a training model that is based on the circle of the medicine wheel, which is called the Helping Circle. The students training to become peer supports sit in a circle, which is opened with a prayer or excerpt of Native philosophy. A stone is passed to each person in the circle as a symbol of their opportunity to speak and share their story.

In the Helping Circle the facilitator should model the target skill and provide the participants an opportunity to practice the skill. The facilitator may choose to let all of the participants use the skill as a group or allow individuals to volunteer to use the skill (p. 28).

The authors explain that the First Nations helping approach must be based on the four principles as depicted in the medicine wheel. In the phases of the training for their programme, the four dimensions of the self are explored or employed. Further, the circle, as a model, which embodies a non-linear perspective, represents the cultural view of helping as counselling and teaches this to the students by use of the metaphor of the wheel with its emphasis on holism. "Helping generally does not move in a direct 'line.' In this sense, helping is cyclical as compared to a linear line or moving direct from a statement of the issue to a solution" (p. 31).

In contrast to the above models, mental health treatments in Canada have been predominately viewed in non-Indigenous ways that disregard ideas such as holistic health and healing. Mental health interventions typically utilize a range of Western-based perspectives from the DSM-IV's pathological model to person-centred therapy, where the focus is on the individual and not on interdependence with others as it would be in an Indigenous model. Duran (2006) writes that much of Western paradigm of mental health is marked by beliefs in logical positivism, linear thinking, and individualism that promote illness instead of Indigenous wellness, "Western trained therapists are trained to think within a prescribed paradigm that targets pathology" (p. 19).

Identity and Community

Within the context of mental health as wellness, two concepts arise as salient in the literature. They are concepts of identity and community, and they are important because they form a thread throughout much of the current data related to counselling processes and what is mentally healthy for Indigenous peoples. In keeping with my perspective on strengths, it is important to focus on what mental health is in term of wellness as opposed to illness.

Identity is an important topic in the current mental health literature concerning Indigenous peoples (see Dana, 1998; Struthers, 2003; Wilson, 2004). Conscious attention is now being paid to the multiple ways Native identity has been and continues to be constructed both by Native peoples themselves and non-Natives (Mihesuah, 1998; Weaver, 2001; West, 1990) and how this impacts aspects of mental health such as self-esteem, self-efficacy, depression, and suicide (Blue & Darou, 2005; Mussell et al., 1993). Mental health interventions, such as counselling and therapy, must include the importance of Indigenous cultural identity as it relates to a person's well-being (Chaimowicz, 2000). Thus, an Indigenous mental health model, for instance, would include traditional treatments that endeavor to address the holistic components of the client's identity and community in the context of wellness instead of illness (Colomeda & Wenzel, 2000; Wilson, 2004). Multiple research studies (see King, 1999; Vicary & Bishop, 2005) have shown that Indigenous peoples worldwide generally seek traditional interpretations and treatments of a mental illness that incorporate the importance of their identity and community wellness.

The relationship of health to community is also targeted as another integral force in Indigenous mental health literature, and has been linked to the interrelation of identities and relationships both within and outside particular Indigenous societies. Community is seen as central to mental health because Indigenous worldviews are traditionally collective (Waldram, 2004), which means that the group is more important than the individual.

According to some scholars (Chandler & Lalonde, 1998; Kirmayer, Simpson, & Cargo, 1998), the health and wellness of Native communities appears to be linked to its sense of local control and cultural continuity. Recent successes in negotiating land claims and local government, along with forms of cultural-spiritual renewal, hold out hope for improvements

in mental health status (Kirmayer et al., 2000). Attempts to recover power and maintain cultural traditions within community must contend with the political, economic, and cultural realities of consumer capitalism and globalization (Kirmayer et al., 2000). A main implication here is that health, including mental health has a significant relationship to community wellbeing and being part of that community.

Identity. The concept of identity has many uses throughout the social sciences and education. Weaver (2001) writes that many people experience pride in their identity groups, which furthers a sense of community and belonging. The psychological notion of identity in humans is usually intertwined with self-image, or one's view or model of oneself. According to Adler, Towne and Rolls (2004), psychologists and counsellors interest themselves in psychological identity or an individual person's sense of self, usually referred to as personal identity. Identity is important to mental health because it is underpinned by levels of self-esteem and self-efficacy. This is not to say that self-esteem is a measure of identity, but rather that it is linked to identity in terms of how we construct our identities.

According to Hodgson (1990), generations of colonial domination have caused shame and unworthy feelings for many Aboriginals about themselves and their culture. The long-term effects of oppression and acculturation can be seen in epidemic proportions of low self-esteem within Native communities, as documented by Green (1997). Green summarizes numerous empirical studies to conclude that low self-esteem in Indigenous communities is linked to achievement in life and the ability to adjust to environmental demands, as well, self-esteem influences individuals' general states of well-being, and a diminished sense of self can breed failure. Low self-esteem coupled with dysfunctional symptomology creates further obstacles to healthy mental functioning, including depression, addiction, suicide, and

poor cognitive functioning and performance, including academic performance as documented by empirical research (Johnson, Swartz, & Martin, 1995; Waldram, 2004; Waldram, Herring, & Young, 1995).

Elder and community leader support in raising self-esteem has been cited in one study as a necessity in restoring community mental health and wellness. Support for the Aboriginal healing process by the dominant culture, including mental health providers, is also required (Martin & Fares, 1994). According to many health professionals, there is a need for mental health approaches that address the issue of identity, as it is defined by Indigenous peoples and communities (Darou, 1987; France, 1997; Waldram, 2004).

Cultural identity, as reflected in the values, beliefs, and worldviews of Indigenous people, is the focus of this section. Those who belong to the same culture broadly share a similar conceptual map and way of interpreting language. According to research conducted by Sayyid and Zac (1998), people can identify themselves in many ways other than by their cultures. Theoretical constructs suggest that identity can be a composite of many factors such as class, race, region, education, gender, and religion (Dukes & Martinez, 1997; Grandbois & Schadt, 1994; Peroff, 1997). Hall (1996) writes that the influence of various factors or aspects of Indigenous identity is likely to change over time; identities can be viewed as fragmented, multiply constructed, and intersected in a constantly changing, sometimes conflicting intersection. The author of this paper acknowledges a limitation to a discussion of identity by virtue of this subjective nature. However, rather than solely as a limitation, it is hoped that this subjectivity can add an important dimension to the discussion.

Dana (1998) further elucidates the concept of identity by explaining that group identity and individual or personal identity are components of cultural identity, and this

distinction fits for a discussion of Indigenous identity, as it is related to a holistic notion of mental health. Generally, the term culture is used in reference to differences which may include but are not limited to ethnic or racial differences in values, language, attitudes, or behaviour (Duncan, 1995). Pedersen (1991) writes of an alternative to a broad definition of culture with a narrower description that distinguishes between cultural, demographic, and personal constructs as the important facets in differentiating minority from dominant culture. Pedersen's (1991) definition is most relevant to the context of this paper because it is related to the key concept of culture as denoting socially-constructed difference that is more than just individual difference. Regarding Indigenous identity, the work of three scholars is explored in more detail below: Mihesuah (1998), Vizenor (1998), and Weaver (2001).

Mihesuah's 1998 article, "American Indian identities: Issues of individual choices and development" in *American Indian Culture and Research Journal* is another conceptual piece that stresses the importance of cultural context in Indigenous identity development. How an Indigenous cultural identity is defined by Natives and non-Natives has been complex in both historically and contemporary contexts, according to research reviewed by Mihesuah. It would be erroneous to assume that all Indigenous people experience a Native cultural identity in the same way solely because they were born into a Native community or with Native ancestry. These assumptions disregard a multifaceted and evolving nature of identity, as well as cultural differences within and between Native nations or groups.

Internalized oppression occurs in Native groups/band/nations when group members disagree regarding who, based on various dimensions such as politics, religion, or phenotype, has legitimate group membership. This is thought to be a by-product of colonization, according to Mihesuah (1998). Often, the harshest judges of Indigenous identity are Native

people themselves, and consequently, internalized oppression is common in North American Indigenous communities. Mihesuah's writing illustrates this point by concluding that "Mixed-heritage members may see traditionalists as uncivilized and backwards. Traditionalists may believe that progressives are "less Indian" because of cultural naïveté and that multi-heritage people only claim tribal membership for land and annuity purposes" (p. 211).

Mihesuah (1998) asserts that such conflict among Indigenous individuals only serves to divide communities. And in the context of Indigenous identity as cultural identity, where group or community identification is key, a divided community can have a detrimental effect on mental health in terms of self-esteem, sense of belonging, and positive attitude toward the self and the group. Mihesuah also suggests that there are other people who are registered as Status Indians with a Federal Government, or who have visible Native heritage, but who know little about their cultures for various reasons, including because they have no interest or no one to teach them. In addition, skin color and phenotype, simply due to salience, can lead to assumptions about identity, suspicion, and lack of acceptance for many Indigenous people.

Vizenor's 1998 book, *Fugitive Poses: North American Indian Scenes of Absence and Presence* is a work of Indigenous philosophies drawing on Vizenor's own knowledge and those of other Native scholars and philosophers. Vizenor writes that stereotypes are a factor that strongly impact identity, particularly Indigenous identities in Canada.

Popular culture's images of Indigenous identity tend to be stereotypical and tied to a romanticized noble savage of the wild west or north from the past according to much conceptual research. As a result of such stereotypes, non-Natives often view all Indigenous people as having a harmonious relationship with nature and possessing an unspoiled spirituality and healing abilities. At other points, Indigenous people are viewed as noble

victims, tourist attractions, and historical artifacts. Vizenor (1998) opines that Indigenous identities have been shaped and censored by the media specifically and popular culture in general, and that non-Native people do not want to see aspects of Native people that do not coincide with this false identity, thus leading to a perpetuation of stereotypes. It is this form of erroneous identity recognition that has oppressed Indigenous people and held them captive within a false identity of “Indian” (p. 55).

Vizenor (1998) writes that the term *Indian* is used to portray images in old photographs, movies, museums, and anthropology research, and it is a label for people who are integrally unknown and erroneously recognized by Europeans. Thus, in this way, an “Indian” is constructed in the act of naming. In this way, the implications for a mentally healthy Indian identity, one that includes facts of high self-esteem, self-efficacy, and self-worth, are viewed as overshadowed by colonialism and a need for self-determination.

Weaver’s (2001) conceptual article entitled “Indigenous identity”, published in the *American Indian Quarterly*, suggests that identity boundaries can be defined by policy and law as well as convention. Weaver states that Native or First Nation bands have the right to determine criteria for membership, and that this regulation of membership, in some ways, is a form of regulating identity. The regulation of identity has implications for political access and resource allocation, as well as mental health in terms of individual autonomy.

Similarly, membership, or lack of membership, in an Indigenous band has implications for how a person perceives him or herself and is perceived by others, both within and outside of the Native community, and this affects sense of belonging and a person’s level of self-worth. Weaver (2001) writes that there are many Indigenous people with tenuous community connections, and some of them try to reassert an Indigenous identity

and find their way home to their cultures, as a way of reasserting a state of homeostasis or mental health balance.

Establishing community connections is not a simple task, nor can it be accomplished overnight. Some Indigenous people may offer support and guidance to those who try to find their way home to their ancestral communities. This can be a positive experience of reintegration and cultural learning for many. Yet for others, support is not necessarily forthcoming, and many roadblocks are raised by other Indigenous people or non-Natives in the dominant society. An implication for mental health practice is that counsellors and other practitioners need to support Natives in finding resources in their own lives and communities that will support them in discovering and defining their own distinct cultural identity.

Weaver (2001) also contends that non-Native validation, arising from outside the community, of Native identity, is not grounded in a reasonable or legitimate foundation. The only source of legitimate Native identity for community members comes from other members within that particular Native community. Weaver's main argument is that while it makes sense that a community should define its members, it does not make sense for an external entity to define an Indigenous person or group. Likewise, for example, it is not up to the Plains Nations peoples to define who is truly a Mohawk person or what constitutes a Navajo community. Should there be a way to give the Indigenous person and communities space and freedom to define their own cultural identities, individual and community mental health could see a positive impact in terms of empowerment and higher self-esteem. This, in turn, could lead to a possibility for reduced suicide rates, a reduction in drug and alcohol use, increased interest in employment and education, and increased health seeking behaviour.

Indigenous identity is a complex and often contentious concept. Weaver's (2001) review indicates that there is little agreement on precisely what constitutes an Indigenous identity, how to measure it, and who possesses it. Firstly, there exists a plethora of terms: Indians, Natives, Aboriginals, Indigenous peoples, First Nations, Métis, as well as particular groups such as Dene, Coast Salish, Mohawk, Cree, and many more. Also, there are layers or facets of identity—self-identification, community identification, and external identification. These facets also relate to a broad conception of cultural identity.

Indigenous cultural identity is reflected in the customs and beliefs of Indigenous peoples own communities. Developing a cultural identity consists of a lifelong learning process of cultural awareness and understanding that are a necessary part of mentally healthy functioning in terms of sense of belonging to a community, self-worth, and possessing a drive and belief in succeeding in life. According to Weaver, because the formation of identity takes place over time, a strong cultural identity may increase with age. In addition to a growing cultural attachment, as individuals get older, there appears to be growing interest in revitalization in Indigenous cultures and communities both across Canada and internationally, which has broad implications for the an increase in self-esteem across Native societies.

Individual cultural renewal and collective or community cultural renewal are intertwined. In other words, when the community acquires a strong cultural identity, its individual members also do so and become mentally healthy in terms of knowing who they are and what they are capable of doing. There are different facets of identity construction, such as have been discussed, which interact with and sometimes reinforce or challenge each other. Given the strong emphasis on the collective nature of Indigenous cultures, it is

problematic to have an individual who self-identifies as Indigenous yet has no community sanction or validation of that identity. This lack of community identification could impact the mental health and wellness of a person whose identity is thus not complete. Native groups or bands can be seen fighting between and among themselves, sometimes accusing each other of not being Native enough based on differences in politics, religion, or phenotype.

In summary, these authors have discussed identity as connected, in some way, to Native mental health, including issues of self-esteem, belonging, self-efficacy, and suicide. Aboriginal cultural identity continues to evolve and respond to the ongoing challenges of healing both the individual and community from the injustices of continued colonization efforts. Traditional and contemporary notions of identity meld to operate as survival skills to assist in defining and strengthening mental health and wellness for Natives from all communities.

Community. The following section will be a presentation of several studies, some empirical and some conceptual, regarding the connection between community and cultural Indigenous mental health. These studies present compelling evidence for the centrality of the community to notions and experiences of mental health for Indigenous peoples.

Community is central component of mental health for Indigenous people, as it is the platform on which all other aspects of society must intertwine in order to function in healthy ways. A concept of Indigenous mental health, as defined by the Government of Canada (1991) is: “behaviours which make for a harmonious and cohesive community and the relative absence of multiple problem behaviours in the community...the presence of a holistic, psychological wellness which is part of the full circle of mind, body, emotions and

spirit, with respect for tradition, culture and language....” (p. 6). The studies to be discussed include those by King (1999), Kirmayer et al., (2000), and Kirmayer, et al., (1998).

King’s (1999) study, “Denver American Indian mental health needs survey” in *American Indian and Alaska Native Mental Health Research*, addressed the mental health needs of urban American Natives. The purpose of the survey was to gather data from Native adults, youth, and their community mental health service providers. The goal of the study was to provide data related to the breadth of mental health of the Denver Native American population.

The sample consisted of 442 urban Native adults and youth residing in or near downtown Denver, Colorado. The estimated population of Natives in Denver is 20,000, thus the study totals is approximately 2% of this population. Participants were recruited through posters placed in health providers’ facilities. A survey was employed for the Native youth and adults. The survey was developed by compiling a number of mental health and health surveys designed for both Native and non-Native populations. The survey was administered over a six month period in 1992 with the help of professional Native mental health agencies, in which all of the survey interviews took place. A questionnaire was administered to mental health providers at three community agencies. There were high rates of attrition in the youth samples, in that none of the youth completed their surveys, thus their data was not used, and the study results focused only on the sample of Native adults.

Consent was obtained through the reading and signing of a consent form. At the time of signing participants received a small honorarium. The survey design focused on three main sampling domains: Phase one on urban Native adults; phase two on Native adolescents; phase three on service providers. The survey was not, nor was it intended to be, a

representative sample, but rather one of convenience. The survey was intended as a community effort, as many questions were obtained from community members, whose input and criticism were solicited throughout its construction.

The survey focused on three domains of mental health: a) past and present personal problems, b) problems experienced by household members, and c) perceptions of problems existing in the community. Within these areas, questions were posed regarding psychological problems, personal trauma, substance abuse, and service utilization (i.e., if and why services were sought). Other questions related to ethnic identification and to lists of what they viewed as critical mental health needs of the urban Native community.

As the goal of the survey was to provide frequencies of the various mental health problems in the community, statistical procedures were descriptive in nature. Thus the study provides only descriptive data for the adult Native population sampled.

Of the large amount of data, the following results were discussed: demographics, general health care, personal problems, household problems, mental health problems for American Indian community, counselor preference, community input of mental health prevention (perceived availability of services, current problem areas, and activities needed for youth and adults in the community).

Demographics of the sample included gender, age, family size, marital status, tribal enrollment, degree of American Indian blood, education, years in Denver, employment, and income. The major problems in this group were financial and job related. Most in the community lived below the poverty line, with unemployment extremely high.

Over half of the adults surveyed have experienced mental health problems, with about 30% currently experiencing a minimum of weekly symptoms of psychological problems.

There were reported high levels of child neglect and abuse, family violence, and marital and family problems.

Despite the high incidence of problems reported, more than 50% of respondents reporting such problems did not seek professional help. Those that did seek help tended to first consult with community spiritual leaders or traditional healing persons. Lack of affordable health care was also a dominant theme here.

In conclusion in King's (1999) research, mental health provider agencies are not meeting the current needs of Native adults, who stated a preference for Native health service providers or minimally providers who are sensitive to cultural community needs. Over 90% of the adult respondents said they would use mental health services if they were made available by Native persons trained in mental health services or non-Natives who had training in Native sensitivity as well as mental health services. Community health was also a theme in the results. The study's final recommendations were that all levels of community mental health are in a state of dire need. Mental health is underpinned by community health, according to the results of this study, and community level interventions such as prevention and information dissemination are needed to address the mental health problems of individuals sampled in this community.

Kirmayer, Brass, and Tait's (2000) article, "The mental health of Aboriginal peoples: Transformations of identity and community" in the *Canadian Journal of Psychiatry*, is a conceptual paper that summarizes empirical evidence for the social origins of mental health problems currently experienced in Native Canadian communities by exploring specific mental health issues. The central argument is that cultural discontinuity and oppression are linked to high rates of alcoholism, suicide, depression, and violence for many Indigenous

groups, particularly youth. Yet that many communities continue to grow and even thrive despite such challenges.

The authors review the history of health and colonization, beginning in the 1500s and continuing into current times. The authors link specific health problems, such as obesity, diabetes, low-self esteem, depression, and suicide to this colonial history and oppression. In short, there are social origins for the health distress currently being experienced in Native Canadian communities. These social origins include government policy that created residential schools, and poverty and economic marginalization.

Residential schools are presented as a major source of cultural extermination for Aboriginal peoples. From 1879 to 1973, the Canadian government mandated church-run boarding schools to provide education for all Native children. Aboriginal children were forcibly removed from homes and relocated to residential schools, often geographically far from their families, with siblings usually sent to separate schools, in order to fulfill the policy goal of systematically breaking down Aboriginal culture and family. In residential schools Aboriginal children were denied all ties to their cultures, including language, customs. In short, their identity as Aboriginal was completely taken away. Physical and sexual abuse by teachers and clergy was rampant in residential school life, and these atrocities are only recently acknowledged by the government and churches.

Poverty and economic marginalization are also discussed as part of Aboriginal history, and as its current legacy of mental health problems. Effects of poverty are third-world living conditions, especially on reserve, and high rates of chronic health problems that exist in today's communities. Authors state that:

the effects of poverty are seen in the poor living conditions on many reserves and remote settlements that lead to chronic respiratory diseases, recurrent otitis media with hearing loss, and tuberculosis; in the past, these necessitated prolonged hospitalizations that further subverted the integrity of families and communities. (p. 610)

This economic marginalization is seen as a creation of the social order in which Native peoples are embedded within Canadian society. Further, it is suggested that the presence of mass media in such communities today makes the values of consumer capitalism central and creates feelings of deprivation for those community members where none previously existed.

Kirmayer et al. (2000) note that health research in Native communities does not always allow for differences in incidence and prevalence of specific mental health problems among and between communities, but rather tends to generalize information to all Native communities. To circumvent this problem, it is suggested that research would need to include systemic comparisons of communities. However, this would raise ethical issues due to potential negative effects of findings on specific community and individual self-perceptions, as well as concerns regarding confidentiality and anonymity. Yet this form of study is seen as necessary by the authors for mental health promotion across all Native communities.

Kirmayer et al. suggest that in Indigenous contexts today, there are constant transformations of forms of community, and that this sort of evolution is at the root of recovery, or “revitalization and renewal” (p. 611). Further, it is the “mediating mechanics”, or what are described as individual and self-perceptions, contributing to social and mental health problems that are closely related to issues of individual identity and self-esteem (p. 611).

These factors are influenced by the collectives of communities. For example, the wide variation of suicide rates across Native communities indicates that it is important to consider the nature and health of the overall communities and how these communities respond to the ongoing stresses of colonization and governmental control, including sociopolitical marginalization.

Culture, in general, is a constantly changing phenomenon, and in Aboriginal communities today, it is also true that collective and individual identity can be seen as a response to current events, such as community healing and the ongoing process of decolonization. Yet cultural stereotypes, romanticizations of culture, identity, and traditional spiritual practices, including their appropriation by mainstream culture, all contribute to continued community stress. Aboriginal identity is associated with a connection to the land, animals, and the self in what authors term an “ecocentric” concept of Aboriginal cultural psychology (p. 610). In this view, damage to the land can have damaging repercussions for maintaining personal and community health in terms of self-esteem and self-concept. Concepts of illness and health are integral to a discourse of Native identity in many communities.

There is some discussion of the pan-Indian healing movement currently underway in both Canada and the US, with citations of Waldram’s (1997) study of symbolic healing in prisons and Brass’s (1999) ethnographic study of a Native run halfway house and treatment centre. These studies are used to illustrate a point that Aboriginal mental health and healing must come from within the community and be rooted in Indigenous practices of spirituality and language.

The concept and experience of trauma is also cited as a current issue in Native mental health, but Kirmayer et al. (2000) caution that it contains complex issues of mental health and healing. The metaphor of trauma focuses on narrating personal trauma because many types of violence against Native peoples are structural or implicit and so may remain uncommunicated or “hidden” individual accounts (p. 612).

Kirmayer, Simpson, and Cargo’s (1998) article in *Australian Psychiatry*, “Healing traditions: culture, community, and mental health promotion with Canadian Aboriginal peoples” is a literature review crafted to identify concepts and issues that could guide mental health promotion strategies with Canadian Native groups, and is designed more in terms of implementing strategies rather than identifying concepts, as in Kirmayer et al.’s (2000) work. Kirmayer, Simpson, and Cargo considered literature examining the connections between the mental health of Canadian Natives and the history of government led colonialism. The review suggests that currently there are high rates of mental health problems in Native communities due to a history of colonization and oppression by European settler governments. These health problems include psychological and social ones such as suicide, depression, demoralization, substance abuse, and family violence.

There is compelling evidence to suggest that a multi-generational history of cultural oppression and marginalization of Native populations has contributed to the high levels of mental health problems occurring in many Native communities. There is also some evidence that renewing and strengthening Native cultural identity, political empowerment, and community integration can improve mental health at the community level. In conclusion, it is suggested that the social origins of mental health challenges in Aboriginal communities requires political and social solutions.

Suicide and self-harming behaviours are not a part of traditional Aboriginal society (Waldram, 2004). However, suicide and self-harm are now frequent in Aboriginal communities and are often associated with mental health problems and with the use of alcohol or other substances, which may increase the risk of impulsive acts (Kirmayer et al., 2000). A high rate of intentional injuries in any community, by violence or self-harm, can be an indicator of mental health problems and community distress. The rate of hospitalisation due to intentional injury is significantly higher among Indigenous people, both males and females, than for the Canadian population as a whole.

Trauma and grief are also identified as significant issues for Native communities and individuals. Many Indigenous peoples carry a significant burden of loss and bereavement from an early age, through the high rates of mortality, illness, incarceration, and family breakdown. Individuals and communities also continue to be affected by the effects of European colonisation, in terms of the loss of their traditional lands, the forced separation of families and the loss of cultural identity. Many Indigenous people have also experienced abuse, discrimination, sexual or physical assault, and domestic violence.

Alcoholism is also a social and mental health issue in many Native communities. The consumption of alcohol at hazardous levels is associated with alcohol dependence, liver disease, high blood pressure, stroke, brain damage and foetal alcohol spectrum disorder. It is also a contributing factor to injuries from road accidents, assault, and self-harm, as well as social problems such as family breakdown, domestic violence, and financial and legal difficulties. Apart from being a significant health concern in its own right, substance abuse is often indicative of many social and emotional difficulties, in individuals and communities.

Although all of these problems impact individuals, their high prevalence reinforces the need for community-level approaches. Further, from a view of community mental health promotion, Kirmayer et al. (1998) pose, and attempt to answer, several integral questions: What are the origins of social problems in Indigenous communities? How can professionals link the personal and collective aspects of illness and healing? What are the community needs of the current and next generations of Native Canadians?

The origins of social and mental problems in Aboriginal communities are rooted in the impact of European colonialism, which sought to destroy and assimilate Aboriginal cultures from coast to coast to coast. Aboriginal peoples in Canada have faced cultural oppression through forced governmental policies, missionary zeal, and trade and military alliances. Residential schools forced children from their families and communities beginning in 1844 through the 1980s. Mental health consequences of cultural suppression and forced assimilation are evidenced in epidemiological studies and qualitative studies.

Aboriginal culture and tradition includes distinctive cultural concepts of personhood and community. Aboriginal person is usually defined by relational or communalistic, ecocentric, and cosmocentric concepts. Currently there is great diversity of Indigenous cultures and communities, yet local worlds are embedded in a large global system that brings diverse people together through the mass media, migration, and other forms of exchange and contact. As a result, most Native communities today have access to and participate in multiple cultures, including their own. Kirmayer et al. (1998) posit that the Native identity of communities is rooted not only in the blood but in forms of life that exist in the confluence of historical and contemporary forces. Aboriginal identity comes from family and community,

and Native peoples are currently re-articulating themselves in a modern world that often conflicts with traditional culture and value.

Re-articulating tradition is a present event in Native communities as an attempt to restore individual and community health. Events specific to this are the Oka Uprising of 1990, Royal Commission on Aboriginal Peoples hearings and reports beginning in 1991, Aboriginal claims for reconciliation and reparation for damages related to residential schools, employment of community justice programmes such as sentencing circles, addressing trauma and loss in communities through renewed spiritual practices, and by trauma therapy.

Aboriginal youth play a key role in community life both in past and present times. Thus the mental health of the community is also related to the mental health of individual and collective youth. Mental health promotion programmes for youth empowerment aim to restore positive youth mental health and a sense of cultural identity are currently underway in many Native communities. These programmes may represent a contemporary re-articulation of traditional egalitarian Native practices that hold central the role of youth in the health of the community.

In conclusion on and summary of the section of community, the social origins of prevailing mental health problems in Native communities require social solutions. Individual self-esteem and identity can draw strength from community identity. Mental health promotion must go beyond an individual focus to include and empower communities. Collaborative approaches to dealing with these mental health problems must include community transfer of knowledge, skills, power, and authority, if there is hope of remediation of individual mental health. These articles on community differ in terms of research and writing styles, however, all span a common theme of community. Notions of

community are always, in one way or another, linked to mental health for Indigenous peoples. Linked in terms of connectedness, that is, a person within a Native community cannot be mentally healthy unless his or her community holds the seeds of mental health in terms of, for example, suicide rates, local control over infrastructure, self-government, self esteem, and more. Many types of community have been cited throughout these articles, yet the form of community in terms of mental health that cannot be emphasized enough is the one that renews and maintains traditional notions of community, including community control over peoples, government, infrastructure, etc. This point of interaction between traditional community control and health indices is where mental health begins and ends for Native peoples today.

Summary of Chapter Two

In summary, the historical realities of colonization and current population health indicators demonstrate that there is a health crisis in many Indigenous communities. Mental health is a critical component of overall health and well-being. Health professionals, counsellors, and community leaders are increasingly concerned regarding the mental health of Indigenous peoples and how to address this problem today. Cultural identity can play a significant role in the counselling relationship within the spectrum of mental health interventions. Culture provides a resource for positive mental health and fulfills a person's need for identity (Sue & Sue, 1990). Traditional cultural practices, such as living within a Native worldview of holism as depicted by the medicine wheel, are what define mental health in Canada for Native groups (Kirmayer et al., 1998). The health indicators described in this section suggest a pessimistic view of conditions in Canadian Aboriginal communities (Royal Commission on Aboriginal Peoples, 2004). However, there also exist many positive

and empowering initiatives and health indicators, which are currently taking shape. There are tremendous resources and strengths within Native communities that are working to re-build social support systems to improve individual, family, and community well-being (Kirmayer et al., 2000). Identity and community have also been identified within the literature as cornerstones to health mentally functioning in a variety of ways. In the current literature I have discussed several aspects of Indigenous mental health and healing approaches and the Indigenous Healing Movement.

The picture of mental health and wellness from Indigenous perspectives is not well defined. There are at least three challenges inherent to delivery Western models of mental health care to Indigenous populations. There is little systematic research that informs counselling education and practice from an Indigenous paradigm of health and healing. Before counsellors and counsellor educators can address the largely unmet mental health needs of Native peoples, we require information from Indigenous counsellors regarding how they conceive of, or define, mental health and healing, through the meanings they make in offering mental health services to their Native clients. The present study addressed this need by soliciting the stories of Native counsellors who work with Native clients. In the next chapter I will discuss the research methods employed for the study.

Chapter Three: Methodology

Thus far, in this dissertation I have presented an outline of why Indigenous mental health and healing should be reexamined from a Native cultural lens. By asking Indigenous mental health workers to tell their stories of how they understand mental health and healing when working with Native clients, I was able to explore the essential components of their cultural conceptions of counselling. This chapter will discuss the specific ways I employed a qualitative approach in the form of a narrative methodology and analysis.

Qualitative Approach to Research

A fundamental assumption of the qualitative research paradigm is that meaningful comprehension of the world comes only through examining events in naturalistic settings rather than through artificial experimental conditions (Anderson & Arsenault, 1998). A goal of qualitative researchers is to provide ways of understanding experience from the perspective of those who live it (Schwandt, 1994). This approach is appropriate for the research question. Within the qualitative approach there are many specific frameworks for research (Creswell, 2003); narrative inquiry is one approach that fits the research question and is grounded in my theoretical basis of social constructivism. The Indigenous context is qualitatively different from other contexts, and social constructivism, with its focus on meaning making, links to my interest in the meaning of Indigenous mental health within a cultural context. "Methodology is important because it frames the questions being asked, determines the set of instruments and methods to be employed and shapes the analyses.... Indigenous methodologies are often a mix of existing methodological approaches and Indigenous practices," (Smith 1999, p. 143).

I am aware of the profound implications of this approach as well as its limitations. I have taken a focused and deep approach to the narratives of my five participants. The stories these participants have shared with me, in the context of a research relationship, are deeply entrenched in cultural context. I believe that each participant shared his or her story with me from a place of honesty and trust that, for me, must be mutual in a research relationship between a University and Native community. In accordance with my conceptual framework of social constructivism and the employment of a narrative methodology, I acknowledge my role in the co-construction of the narratives during the interviews of the five participants. In the context of the narrative interview, each participant and I, together, constructed a reality that reflected legitimacy and meaning for both of us at that time, in that place.

Research Question and Focus

Given that my research question concerns how individual meaning is made about mental health through the experience of counselling, a qualitative approach was appropriate for my study. Bogdan and Biklen (1992) write that “the qualitative researcher’s goal is to better understand human experience” (p.38). I collected data using a small number of specific questions that related to the general research question, and five participants were interviewed. It has been suggested that in order to have internal validity, qualitative research should be designed so that its methodology, conceptual framework, and research focus are an appropriate match (Rudestam & Newton, 1992). This form of triangulation was met in this research. The focus of my research was Indigenous counsellors and how in their experience of working with Native clients, they have come to understand their own stories around cultural conceptions of mental health healing. For my conceptual framework, I carried out the research through a lens of social constructivism.

Indigenous Ways of Knowing and Social Constructivism

Indigenous ways of knowing hold knowledge and understanding of that knowledge in a particular cultural, social, and historical context (Philips et al., 2005). That context is embedded in the discourse of being freed from the colonial experience (Duran, 2006). From the perspective of social constructivism, the stories that people tell concern the creation of meaning, also in a particular context, such as time, cultural or physical location, experience, etc. (Corey, 2005). There could be as many stories of meaning as there are individuals who tell them, and each story is seen as true for the person who tells it at the time they are telling it (Gergen, 1999). Thus as a social constructivist and as a person who comes from an Indigenous way of knowing, I viewed this research as a collaborative, between myself and each participant, as I worked to carry out the research interviews with each participant rather than on each participant. Instead of seeking to get a participant's story, my aim was to create a climate that took into account the context of both the participant and myself as we actively co-created the stories from our unique cultural and historical perspectives, and subsequent story maps through the data analysis. The narrative methods used to plan and carry out the data collection and analysis laid the groundwork in assisting participants and myself as researcher to co-create the meaning in stories to generate new possibilities for understanding mental health and healing from an Indigenous cultural context.

Narrative Inquiry

It should be stated that there is no unified narrative theory for research, but rather narrative concepts and principles that can be applied when conducting qualitative research. In exploring the possibilities of a narrative framework for the human sciences and its potential value in cross-cultural (i.e., Indigenous) mental health research, it is recognized that narrative

approaches to psychological research are still evolving. Narrative inquiry remains in need of further definition under shared philosophical assumptions and communal standards within the academic and non-academic communities. As I strived to explain in this dissertation, narrative perspectives entail particular ontological assumptions about the nature of narrative accounts and human discourse in context. Being a qualitative methodology, it should not be expected to reflect the level of standardization as in experimental research. This research represented part of this evolution in terms of the success of this approach in answering the research question and the development and use of the data analysis tools, such as the story maps, which will be discussed further along in this chapter.

The reality was that the analysis process for this project was, to some extent, evolving, as I did not really know what would come out of these interviews prior to conducting them. I had anticipated, due to my experience in Native contexts, that participant responses would be constructed as stories that contained facets of their identities which were interwoven with their understandings of mental health and healing. My set of research questions, and the research analysis tools that I chose for the study, were purposeful in terms of fitting the research question, the methodology of narrative inquiry, and the context of an Indigenous community.

Narrative analysis. In order to analyze the counsellors' stories, I used a narrative framework that served as a lens through which the story of the participant was viewed. This framework, also, more importantly, becomes a way for a participant to holistically reflect on earlier or current perspectives in order to construct or reconstruct meaning in one's life world. The stories of the participants were not intended here as works of literary art, rather they reflected "a kind of life story" which enabled me to examine "how humans make meaning of

experience by endlessly telling and retelling stories about themselves" (Connelly & Clandinin, 1990, p. 14). A "life story" can be constructed or fantasy or fiction, but also could "be factual, as in the telling of an event that has happened in your personal life" (Lauritzen & Jaeger, 1997, p. 35). I have analyzed each life story using a framework which allowed me to examine "all requirements of story: setting, characters, action directed toward goals..." (Lauritzen & Jaegar, 1997, p. 35).

Beginning with a discussion of narrative research methodology, narrative concepts, and perspectives on interpretive validity and other issues in narrative inquiry, I will then give my rationale for employing this methodology.

Narratives. Labov (1972) defines narrative as "one method of recapitulating past experiences by, matching a verbal sequence of clauses to the sequence of events which (it is inferred) actually occurred" (p. 359). A fundamental issue in narrative theory and research concerns the definition of a narrative (Franzosi, 1998). Few narrative theorists have been satisfied with the minimalist definition that regards any set of utterances or segment of written text as narrative. Most narrative theories require a temporal and/or causal coherence in the meaning structure of a narrative (Richardson, 2000). The narrated text, also known as a story, should be sequentially connected in time or coherent in terms of antecedents and outcomes. The concept of narrative smoothing further acknowledges that narrative construction often involves condensation and omission so as to provide some degree of closure and wholeness to a given story (Cortazzi, 1993; Spence, 1986).

Narratives in qualitative research are viewed as socially constructed because they represent the storyteller's unique perspective within a specific context. The focus of social constructivism is to uncover the ways in which individuals and groups participate in the

creation of their perceived reality, including their narratives of such reality (Bruner, 1991). Social constructivism involves looking at the ways social phenomena are created, institutionalized, and made into traditions by people. Socially constructed reality is seen as a dynamic, continual process, in which reality is re-produced by people acting on or narrating their knowledge and interpretations of it (Mishler, 1996).

Stories. Stories are a first-person account by respondents of their experience in relation to a nominated subject, and are event-centred and historically particular. They are a form of narrative that contains human actions, more specifically social interaction, and are characterized by troubles or surprises (Mattingly & Lawlor, 2000). Narratives form structured stories that contain a distinct beginning, middle, and end (Ricoeur, 1984). According to Labov and Waletzky (1967), stories expand on generalized scripts by incorporating particularistic (non-canonical) events, adding evaluative elements which reveal the narrator's viewpoint regarding these particulars. Thus stories will evaluate a script as good, bad, successful, tragic, surprising, and so on (Mattingly & Lawlor, 2000).

Gergen (1992) asks "In what ways are narratives useful?" in terms of a therapeutic value. (p.178). Gergen suggests that there is "narrative multiplicity" (p. 178), in which an individual has multiple inner lenses that are fluid and created in collaborative dialogues that create meaning.

Narrative inquiry is a qualitative research method. Polkinghorne (1991) states that narrative is the fundamental scheme for linking individual human actions and events into interrelated aspects of an understandable composite. Today, narrative inquiry is a first-person account by respondents of their experience in relation to a nominated subject. This particular

research method explores how respondents in the course of an interview make sense of questions and comments raised in relation to events and actions in their lives.

Researchers today use a narrative method if they wish to gain a rich perspective through a holistic and dynamic view of their subject matter. Given the multiple ways of defining narrative research and the present state of narrative inquiry practice, it seems safest to consider narrative theory and concepts as methodological principles rather than as a codified methodology (Riessman, 1993). Some proponents of narrative inquiry see it as an empowering social science methodology insofar as it gives respondents the venue to articulate their own viewpoints and evaluative standards.

Narrative analysis allows the researcher to see how respondents impose their order on experience and environment by commenting upon their relationships between events and actions through stories (Ricoeur, 1984). Therefore, narrative enables the researcher to identify the transitional stages leading to a given situation, and to identify similarities and differences between groups.

Narrative analysis is analysis of a chronologically told story, with a focus on how elements are sequenced, why some elements are evaluated differently from others, how the past shapes perceptions of the present, how the present shapes perceptions of the past, and how both shape perceptions of the future (Ricoeur, 1984). Narrative analysis is seen as a more in-depth alternative to survey research using psychological scales.

This approach is therefore well suited to contemporary studies that are based around identity and subjectivity. The research process is based upon different primary experiences of attending, telling, transcribing, analyzing, and reading. One limitation, however, with these

forms of representation, is that they all have text and talk that might represent the story partly, selectively, or imperfectly.

Overwhelmingly, the underlying premise of narrative inquiry is the belief that individuals make sense of their world most effectively by telling stories (Bruner, 1991; Clandinin & Connelly, 1999, 1994; Ricoeur, 1981; Riessman, 1990; Sacks, 1986, 1992; Smith, 1981; White, 1981; Wiltshire, 1995). Narrative analysis, within the qualitative paradigm, involves the examination of participant stories identified in interview data (Bailey, 1998; Mishler, 1979, 1990, 1996). For the interpretive researcher, "The historical truth of an individual's account [story] of an event is not the primary issue" (Riessman, 1993, p. 64). The researcher recognizes that storytellers select the components of the stories they tell (reconstruct) in order to convey the meaning they intend the listener to take from the story.

Perspectives and experiences are the two main dimensions through which researchers can learn about participant storytelling in narrative inquiry, and these will be discussed next.

Perspectives. Stories allow for subjectivity, as it is reflected in real life perspectives of individuals. By giving totally free rein to subjective story-telling, the narrative analyst taps a rich vein of anecdotal information at the expense of all the usual social scientific considerations (representative sampling, operationalization of terms, use of controls, multivariate causal analysis). As Labov (1997) notes:

The discussion of narrative and other speech events at the discourse level rarely allows us to prove anything. It is essentially a hermeneutic study, where continual engagement with the discourse as it was delivered gains entrance to the perspective of the speaker and the audience, tracing the transfer of information and experience in a

way that deepens our own understandings of what language and social life are all about. (p. 87)

Experiences. Action, rather than words, is what is at the core of a narrative's structure. Complicating action is said to be essential to recognizing a narrative (Labov, 1972). Toolan (1989) states:

Labov works on the broad assumption that what is said... will not be the core of the story; that rather, what is done will be. The what is done: then becomes (or may become) the core narrative text of clauses—actions—while what is said becomes evaluative commentary on these actions. (p. 157)

In other words, human experience in action is central to the narrative. Narratives give researchers and the individual who is telling the story another way to understand the actions that underpin the rest of the events in life. Ricoeur (1984) says “There is no structural analysis of narrative that does not borrow from an explicit or implicit phenomenology of doing something” (p. 56).

It is this emphasis on action, also viewed as experience, which leads us to privilege experience over words in the narrative. Here is an example of a text from the Oxford Independent (1997) that clearly highlights the emphasis of experience in the narrative:

Neville: After my wife kicked me out I spent several weeks living in my car. Being homeless, she wouldn't let me see my son....I really missed Ricky. A friend suggested that I go to a Shelter. I was a little apprehensive... frightened to go in, but they were brilliant. It's a bit like a hotel, it's very clean and the staff are great. Best of all my wife came round to check out the place and lets my son visit me. It's let me rebuild my family life. (p. 15)

A story is a narrative because it deals with “the temporal character of human experience” (Ricoeur, 1984, p. 52). It is the experience of the storyteller that allows for the richness and wholeness of the story to emerge. The bit and pieces of experience in each story can come together in a grand, or whole, narrative (with a beginning, middle, and end) that allows for insight and understanding. The act of retelling a past experience can be therapeutic in terms allowing the narrator to see a new or different perspective on their own experience (Barton, 2004).

Rationale for a Narrative Approach

Indigenous peoples usually describe themselves as having an oral-based story telling tradition (Medicine-Eagle, 1989), thus a narrative approach is deemed culturally appropriate because it uses stories to elicit information; a narrative approach seeks the participants stories from their unique perspective (Tesch, 1990), and it is specifically the stories of Native mental health workers about their approaches and intentions toward health and healing that I sought. Narrative inquiry is also described as an academic research method of examination of metaphors, rituals, epiphanies, routines, and every day experiences, all of which are filled with culturally-based complexities, hopes, and intentions (Mattingly & Lawlor, 2000).

Another reason for using a narrative approach for this research question was the conception of narrative inquiry as a “relational methodology” when used in an Indigenous context, where epistemological implications of Native ways of knowing for academic interest, demonstrate how Indigenous epistemology can influence knowledge and practice in research (Barton, 2004, p. 519). In other words, narrative inquiry can be viewed as a way of incorporating Indigenous ways of knowing in the research process by, for example, using Indigenous epistemology such as storytelling as means of data collection or analysis. Barton

(2004) also suggests that through the interpretive activities of both researchers and participants, the process of co-constructing and co-participating stories is inherent in a narrative inquiry, and this reveals a circular, or continual, understanding of experience.

Validity and Knowledge Claims in Narrative Research

Issues of validity and knowledge claims in narrative study have received considerable attention. Spence's (1986) distinction between historical truth and narrative truth has moved narrative understanding from the Freudian archaeological mode of reconstructing the past to a construction of meanings that does not necessarily have a referential basis. This view of narrative truth can be formulated in terms of pragmatic validity, in the sense that an interpretation has truth value if the parties involved regard it as useful. In spite of the philosophically problematic implication that historical truth can be outside of language and the narrativization of experience in some way—a criticism of Spence by Sass and Woolfolk (1988) for misunderstanding hermeneutics and maintaining objectivist assumptions—the concept of a narrative truth has held its appeal. This study was thus concerned not with the objectivity, or the historical truth, of the counsellor's stories, but rather the subjectivity of the stories in terms of the participants' own understanding of their narrative in the context of each participant's own experience.

Constructivist views and narrative conceptions of identity (Gergen & Davis, 1995; Shotter & Gergen, 1989) further imply a dialogical form of validity, whereby intersubjectivity in the co-construction of meanings is key. Constructivist and dialogical perspectives in narrative theorizing have appealed to the counselling and psychotherapeutic fields because of alignment with relational theories of therapeutic practice and cultural views of identity development. Nonetheless, counselling and clinical phenomena as social

construction (McNamee & Gergen, 1992; Neimeyer & Raskin, 2000) co-exist in professional understanding and practice with other approaches to clinical inquiry and intervention that subscribe to objectivist notions of historical truth. Thus there is a tension between an idea of an historical, objective truth and a notion of socially constructed reality. These philosophical differences in the field are important to keep in mind because questions of validity and how knowledge claims are to be supported in narrative inquiry depend on the philosophical positions of researchers and reviewers (Morrow, 2005). The approach in this study was consistent with social constructivist and narrative relational theories.

Narrative inquiry involves decisions that are both philosophical and methodological in nature (Clandinin & Connelly, 1999). Whose narrative truth to privilege, what one makes of narrative smoothing in human dialogue, and how subjectivity becomes foregrounded are some of the procedural choices involved. Such choices affect the understanding one will achieve in a given narrative analysis. A radical constructivist epistemology that implies limitless meaning-making and interpretations is problematic for those who prefer a pragmatic or dialectical form of validity in dealing with narratives (Bailey & Tilley, 2002). Pragmatic validity is concerned with the purpose and effects of narrative accounts as tested in application. Dialectical forms of validity also acknowledge the point the narrator is trying to make to the other or oneself but grants a reciprocal consideration of figure-and-ground and self-and-other in the comprehension of meaning. Contrary to the ontological assumptions of radical constructivism, interpretation is not arbitrary or unrestricted by social, cultural, or political context (Bailey & Tilley, 2002).

Constructivist approaches to psychology can inform our thinking about validity issues within narrative inquiry (Polkinghorne, 1991). The narrative understanding of human

experience and its contextual representation involves a part-to-whole process, referred to as a hermeneutic circle (Heidegger, 1962). The interpreting agent revises such understanding against a cultural context and changing background of knowledge that is both cognitive and affective. Polkinghorne (1991) suggests that the pragmatist and hermeneutic traditions allow for one to “expand on one's socially and culturally internalized understanding about self, other, and the world through experience and participation in inquiry” (p. 465). Polkinghorne further cited Gadamer's (1994) philosophical hermeneutics in support of a dialogical process of narrative understanding in which the awareness of incomplete background understanding opens us to engagement with the other. The hope of such engagement is to achieve shared cultural horizons that can serve as improved interpretive horizons. Viewed from this hermeneutic and cultural perspective, human understanding is always partial, and the validity of knowledge claims can only be contingent. Dialogical and pragmatic forms of validity applied to narratives should be premised on this hermeneutic conception of partial and contingent knowledge (Bailey & Tilley, 2002). Recognizing that the criteria for supporting narrative truth claims require continuing development, I suggest that the validity of this study be judged on contingency of perspective; the perspective on which this study rests is grounded in a social constructivism within a cultural context that does not merely accept intersubjectivity but encourages it in order to attain the internal validity that embodies the results of this study.

Research Process

Researcher Position

I am from the Yellowknife Dene First Nation (Northwest Territories, Canada), am a member of the urban Aboriginal community in Victoria, and have formed both personal and

professional contacts with various local, out of province, and national Aboriginal organizations and groups, including those who agreed to be involved in this study. A Native community agency that delivers mental health support had agreed to collaborate with me to conduct this research, and I had obtained preliminary and on-going consent from both the First Nations band offices nearest the location of this agency, the participants, and my consultant at the agency. It must be noted that following Native protocol as laid out by Dr. Clare Brant's Native Rules of Behaviour (1990) was very important to me through the entire research process, and even beyond the end of the project. Even once this project was completed, I remained, and continue to be, committed toward giving back to the communities that shared their stories and resources with me. Giving back to the community for me includes volunteering my service as a professional counsellor to the organization so that they can meet their client's needs, assisting the Band offices with funding proposals, and helping organize the youth sports events that occur in the local Native community.

My own interests in mental health and healing stem from a long familiar history of the helping; my grandfather was the shamanic drummer in our community until the day he passed away in 1997, and there are many generations of helpers and healers in my family tree on both my father's and mother's sides of my family. I had naturally assumed both formal and informal helper roles throughout my life. When I entered University as a student, it was with the express purpose of gaining education in the formal helping field so that I could work within the Native context as a mental health professional to deal with the devastation of colonialism that had rocked my own life and that of those in my own family and community.

Participants

The specific site of the study was a Native owned and operated community agency in medium-sized Western Canadian city, whose mandate is to meet the social and health needs of urban Native peoples from a cultural perspective. The agency employs over 50 staff members ranging from administrative staff to clinical and employment counsellors, social workers, and youth and child development support workers and runs dozens of individual and group programmes for Native peoples from diverse cultural backgrounds. Traditionally, the medium sized city in which the agency is located is _____ First Nations territory, currently with intersections of a number of other First Nations peoples. The British Columbia Aboriginal population is about 170,000, or about 17% of the total Aboriginal population in Canada (Statistics Canada, 2003). British Columbia Statistics (2003) reported in 2001 that in this particular city in which the study took place, there were 8700 individuals identified as having Aboriginal ancestry, comprising 4185 males, and 4510 females.

Participants were recruited through professional connections at a Native community agency where I had a previously established relationship with staff and administration prior to the implementation of the research project. This previously established relationship was as a result of a role I had served as a consultant and liaison for the agency regarding University of Victoria counselling programming and research collaborations. Recruitment occurred through letters (see Appendix A) that I distributed to individual mailboxes of all of the workers at the agency. I also hosted an informal information session at the agency during their lunch break, where I invited all staff to attend in order to meet me and learn about my research project, and at that time I also handed out recruitment letters and invited possible participants to contact me for more information.

Participants were individuals of Indigenous ancestry who worked in a counselling or support capacity with Native clients at the agency. Five participants were interviewed from the pool of available mental health workers. Participants had post secondary education in Western approaches to counselling, with training from at least one of the following disciplines: social work, counselling, psychology, and child and youth care. Participants had been employed for several years as a counsellor, and the range of experience was from 3 to 15 years; this requirement ensured that participants had more than short term experience as mental health workers. “Selection of informants rest more on the careful identification of persons, often in advance, who are representative of the culture and show potential to reveal substantive data on the domain of inquiry” (Leninger, 1985, p. 47).

Procedures

Figure 4 contains a summary of the research procedures and depicts the specific sequential steps of the research methodology. Each phase will be described below.

Preliminary Phase	-Proposal to PhD committee - UVic Human Research Ethics Board application	- presented and successfully defended proposal to committee - applied for and received ethics approval from UVic - Journal notes taken
Phase 1	In-depth Interviews #1	- Obtained oral and written consent with individuals - Presented participants with list of interview questions - Field and journal notes taken
Phase 2	Preliminary Analysis	- Initial narrative analysis by researcher - Reviewed research questions - Reviewed initial themes & story maps - Field and journal notes taken
Phase 3	In-depth Interview #2	- Second interview to go over initial story map - Field and journal notes taken
Phase 4	Final Analysis & Writing	- Wrote final analysis into Dissertation chapter, community newsletter - Journal notes taken - Present to committee
Phase 5	Dissemination	- Distribute final results to participants, community agency, Native Bands - Discuss, celebrate, & implement uses for the results in participant communities - Write scholarly articles, presentations, & policy reports

Figure 4. Overview of Research Procedures

Preliminary Phase. In this phase I began a book of field notes in which I recorded the processes and steps undertaken in the study, and kept this on a regular basis throughout the entire dissertation process. A second book that I called my “field journal” was also started and contained my personal reflections and insights on the research process, which was recorded side by side with the book of field notes. Both books are methods of recording my own processes and experiences through this research, and offer tools for generating awareness, insights, and understandings.

Informal contacts and consultations took place with two First Nations Band offices, as well as with the Native community agency regarding this project. Contacts at both Band offices include two Elders, whose consultation and input were important to inform me at various steps throughout the project’s process, from beginning to end. A contact who was an employee in management at the agency had shown interest in collaborating on and supporting this project and had agreed at this point to serve as a consultant throughout the project.

Once the research proposal was approved from the University of Victoria’s Human Research Ethics Board (Appendix B), I made contact with a local First Nations Band office in order to request permission from the Chiefs and Council (Appendix C). Once I received their permission, I contacted the community agency about starting the research process of collecting data. I set up a meeting with my consultant at the agency and asked for her direction in contacting possible participants, who were Indigenous mental health workers in that agency. An introductory meeting in the form of an open-house luncheon was set up in order to introduce me to the pool of possible participants. At the presentation I with introduced myself and describes the purpose of the research and specified the role of the

participants throughout the three phases of the research process. This was the beginning of the recruitment process. At the same time I distributed recruitment letters to the mailboxes of all the workers at the agency. The recruitment process was guided by the participants' interest in the research topic, participants' willingness to share their story through interviews, and by need to meet the purposive sample requirement detailed in the above section on participants. In addition, participants' willingness to commit time to the project, agreement to informed consent, anonymity, and confidentiality was also taken into consideration.

Phase 1: In-depth interview #1. Interviews were conducted over an approximately 1 to 2 hour time frame. I began the interview by verbally reviewing the consent letter (Appendix D) with the participant, allowing them to read it as I did so. Once informed consent had been established, I invited the participant to share his or her story using the following statements as a guide: (Appendix E):

1. I would like to hear your story or stories of how you have come to be a helper.
2. I am particularly interested in how you understand mental health and healing for Indigenous clients.
3. Has this understanding changed from past to present, and how do you see it into the future?
4. How, in your past, present, and future experiences, does culture inform your story of mental health and healing and your story of counselling practice?

These statements were posed to participants in an open-ended and unstructured manner. Prompts such as “Tell me more about that” were used to encourage open-ended answers that facilitated participants’ narratives.

As the interview drew to a close, I honoured each participant’s time and effort with a small gift certificate to a local bookstore and proposed a future date in order to review initial themes and the initial story map that emerged from his or her interview.

Phase 2: Preliminary analysis. Preliminary analysis for each participant’s data comprised a general process of transcription, chunking, mapping, coding, theme identification, and lastly, integration. More specifically, this process was broken down into a series of steps that are detailed below to culminate in a holistic approach to analyzing the data. This analysis process could be described as looking at the narrative interview as a whole (the verbatim transcript for each interview), analyzing it by breaking it down into parts (the thematic statements and the coding of these statements), then placing those individual codes that represent the thematic statement into the story map to bring the pieces of the narrative back into a meaningful whole.

The story maps became meaningful when I examined them after their initial construction and noticed an overarching theme throughout all of the codes that represent chunks of a participant’s statement or story made during the first interview. The story maps were constructed in order to get a schematic picture of each participant’s story of mental health and healing and how that intersects with counselling practice, their identity as a helper, Indigenous culture, and community. The two narrative interviews that I created were successful in allowing me to co-create a story map for each participant, as the transcripts, once analyzed for content into thematic statements and codes, mostly filled the story map

with few to no blank spaces in each participant's map. Any blank or sparse spaces in a participant's map were addressed in the second interview, in which the participant was invited to add to, take away, or change any aspect of the story map that I had initially created from their first interview. How the analysis was precisely carried out is described in a series of seven steps:

1. Transcribing the interview into a verbatim transcript

Firstly, the audio-recorded interviews were typed into verbatim transcriptions. The goal of verbatim transcription is to transform the oral interview in a way that preserves it for analysis and interpretations. Verbatim transcription for this study means to include personal inflections such as ahh, hmmm, pauses, laughter, and crying in the transcript in order to give a deeper context to the actual words uttered and not take away any of those subtleties from the text. Lapadat and Lindsay (1999) suggest that each researcher must clarify what is meant by "verbatim" in transcription, as it speaks to the researcher's particular theoretical assumptions and stances (p. 28). Most qualitative methodologists agree that the transcription and analysis process remains interpretative, and that researchers must acknowledge this process as limited by a notion of social construction of meaning (Mishler, 1996), which fits with my conceptual framework of social constructivism. Further, transcription is an active process, which in my experience requires more effort than simply listening to a recording and typing it out coherently. From my experience, transcription is an initial level of data analysis where the researcher begins a deeper entry into the world of the participant, and it is another starting point for my own perspectives and insights on the participant's narrative to begin to take shape in my field notes and in my field journal.

Verbatim transcript excerpt from P1: Ummm, as soon as I read that I just had a vision of myself when I was little (laughter). A lot of my personal development has been around recognizing a role. So some of that has been very helpful some of that has been difficult. I was the oldest of 5 children and my mum as the single mum in Saskatchewan and we lived with different aunts and cousins in my growing up years, through my development years, and I was responsible for taking care of my younger sisters, (pause)...um, not just physically, ummm, my mum wouldn't leave us alone, we were never abandoned. (pause) But there was always a consistent checking in about how your sisters are doing, is everything ok? Ummm, and that carried on right thorough my growing up years as a teenager, then as an adult and parent I had to navigate that role, had to shift or change, that I wasn't the alternative parent to my sisters, that I was in fact (laughter) a sister to my sisters!

Field notes (from transcribing of P1): *Transcribing P1 took a lot longer than I had planned, as there was a lot of detail and stories embedded within larger stories here. The slant of P1 seems to be emerging here in a way that I hadn't noticed during the interview. Though she didn't actually talk about interconnection per se as a determinant or necessity for mental health and healing, it was embedded in almost every one of her statements in relation to how different elements connected to create healthy situations of environment for her clients.*

Field journal (after transcribing P1): *I am feeling somewhat overwhelmed by the amount of confiding that this participant has done in me; she really trusted me and shared stories about their own personal life development as a helper as a it related to the work she was/is doing and wished to do in the future. I really see how your*

identity as a helper shapes how you practice and see what mental health and healing here. This really makes sense to me as a researcher and as a helper, as I had never thought about my own identity as helper in this way before now. I am also struck by the power of the narrative--though narratives are nothing new to me—to allow you to see a familiar story in a new light.

2. Reading and rereading the transcript

When the transcription was completed for each interview, I read and reread the transcript, making notes in my field notes book and in my personal journal regarding images, ideas, or emotions that came up for me either personally (field journal) or related to making meaning of the data (field notes). Also, I referred back to my field notes and field journal for the entries made at the time of each interview, in order to get more information about the context of the interview and the participant and what I noticed at that time, so that I could integrate that into what I was reading for in the present.

Field notes: The stories in P4's transcript really jump off the page to me when I see the part of the transcript chunked in themes like this. It's like a big puzzle, with each little story that is told about one particular theme fitting perfectly within the larger story of how this person understands mental health and healing as whole. The breaking down and looking at pieces of her story in this way makes it really clear to me that she is talking about being interdependent in terms of a mutual reliance that forms the crux of what she has said in most instances here.

Field journal: For my own process, again I am struck by how privileged I am that these people chose to open up to me and share some personal aspects of themselves and some important part of it that informs their work as helpers. It really underscores

the importance of relationship, particularly an Indigenous research context, where research has so often had a negative effect on participants and communities. I am inspired by these stories and to continue my relationship with these participants in ways that are helpful to them and their work and that goes beyond the research relationship in a way that is also beneficial. Respect is an important part of too.

3. Chunking the transcript into thematic statements

Beginning at the top of the first page of each transcript, and going through all responses in the order they were made in the transcript, I chunked each statement into a thematic statement that gave meaning and understanding to the whole of that statement.

Excerpts from the chunking of P3's transcript:

Feeling good at the beginning of my journey as a helper [thematic statement] I actually started here as a client. My husband and I were separated at the time (pause), and he was on course in Halifax in the military at the time. My cousin was working here at the centre... this was my first thing at being a single mom and my cousin happened to be co-facilitating the nobody's perfect parenting programme and asked me if I'd be interested in taking it, so I said yeah, that would be a really good thing, so took the course and it was really good and learned volumes and got familiar with the movement and felt really comfortable.

Learning through my journey as a helper over changing times [thematic statement]

It's a good place to be and I'd like to do more here. I started to just volunteer here where I could, ummm, I would do my job and do other things on the side, umm, like, ummm, the First People's Festival, and, ahh, other things, just to get better feel for what was going on here, and (pause), slowly, over the years I worked my way up the

ladder, I was clerical support, the secretary receptionist, then where I am now....(pause, smile) and in the whole time there was changeover, I think I have seen no less than 9 executive directors in the 16 years I have been here (laughs), and each person that came through that door I learned something from....”

4. Assigning a descriptive code to each thematic statement that reflected the meaning of that theme.

At this stage I read and reread each thematic statement and the verbatim excerpt beneath it and asked myself: What is the essence of this statement. Adapting the Lazarus counselling technique described in Egan (2002, p. 238), I asked myself to use one word to describe the essence of the participant’s statement. Then by reading and re-reading the quotation and thematic statement with this question in mind, I was able to come up with a descriptive code which was one word that accurately portrayed the meaning of the statement in general rather than specific terms.

5. An initial story map was then constructed by putting the code labels onto a map within the map’s structural elements of content and time orientation.

Narratives have specific, distinct structure with formal and identifiable properties, as outlined by Mishler (1996), and this step is where I create this structure using a story map. Riessman (1993) states that the unpacking of structure within a narrative is an important stage in early analysis and that the researcher should avoid analyzing only for content at this point. Thus the structural elements that I anticipated in my analysis, based on my literature review and research questions, the elements were: self as helper (identity), Indigenous culture, community, mental health and healing, and counselling practice. These structural elements were plotted onto a story map and were placed across the top of the map to

represent the structural categories of the participant's story. Also, an important part of the structure of narratives is time orientation (Polkinghorne, 1994), as stories become meaningful when they exist or evolve over time. Thus, the vertical axis sets the above content categories into a time orientation of past, present, and future. The story maps were constructed for this study in a way that understood the narrative inquiry process as closely linked to oral storytelling traditions of Indigenous peoples. The story approach to a participant's experience also provided descriptive knowledge that had to be understood in context, as befits the qualitative paradigm. Clandinin and Connelly (1999) suggest that stories can allow for reflection on life and explanation of the self to others and that studying "life narratives" is a context for making meaning. In analysis I located the voice of the participant in a particular time and context (Clandinin & Connelly, 1999) in order to find the voice in the story.

Richmond (1999) examined the life story of adult learners using a narrative methodology, and I have adapted her "story map" technique for use in my study (p. 3). The story map creates an organized schematic representation of the content of a person's story (see Figure 5). Richmond (1999) writes that "The story map organizes the [participant's] recounting of past and present experiences and future intentions under the rubric of character, setting, events, conflicts, incidents, themes and resolutions" (p. 2). This map helps give a visual structure to a participant's stories and allows for a more penetrating analysis of the research question because it effectively allows the researcher to use story in a way that reveals patterns within that story. The patterns that emerge to both the story teller and researcher allow both to reconstruct and make sense of what is being told or heard in a different or deeper way (Richmond, 1999). Through using the story map as an analysis tool, the story becomes a meaningful way of organizing thinking. In this step of the research, the

initial story map for each participant was then constructed by putting the code labels I created in the previous step onto the map within the map's content and time orientation.

This step began with adding a time orientation of past, present or future, to each descriptive code that had been assigned throughout each transcript. Attention to the structure of the narrative includes looking at the temporal organization of the story (Riessman, 1993), and for me that means putting each statement in to the past, present and future orientation of the story map I was using. For example, in P4's transcript, I added past to the descriptive code of Helper Role, to make sense of the quotation that talked about her development of self as helper in the context of time orientation, which in this case, was the past.

	The World of _____				
	Self	Indigenous Culture	Community	Mental Health & Healing	Counseling Practice
Past Experiences	<ul style="list-style-type: none"> • Background • Self-identity • Roles 	<ul style="list-style-type: none"> • Roots • Personal history • Events 	<ul style="list-style-type: none"> • Setting the context • Past connections 	<ul style="list-style-type: none"> • Incidents • Sites 	<ul style="list-style-type: none"> • Past work experiences
Present Experiences	<ul style="list-style-type: none"> • Current status • Level of awareness 	<ul style="list-style-type: none"> • Current support 	<ul style="list-style-type: none"> • Current connections 	<ul style="list-style-type: none"> • Community experiences 	<ul style="list-style-type: none"> • Current work experiences
Future Intentions	<ul style="list-style-type: none"> • Outcomes • Personal development • Self-identity 	<ul style="list-style-type: none"> • Future support 	<ul style="list-style-type: none"> • Future Connections 	<ul style="list-style-type: none"> • Plans for future schooling 	<ul style="list-style-type: none"> • Future work expectations

Figure 5. Adaptation of Richmond's Story Map for Data Analysis

Excerpt from P4's transcript:

Helper Role - Past

When I was growing up, umm, I also saw other people, umm, like my friends around me that didn't have that sort of family [like I did] or support from their family, so I wanted to work in that capacity to work in a way that supports others who may not have that support in their own family or in their own life.

I acknowledged the socially constructed nature of the process of this sort of research, along with the lived-reality of needing to transcribe the interview to “get my hands on” (as it were) the content of the stories, in order carry out a narrative analysis using a story map rubric. The story map is a research analysis tool that was developed by Richmond (1999), and that I have adapted to the research question of this study.

6. I then went back to the transcript 2 to 3 times and revised and refined the map as per the descriptive codes in the transcript.

This was a process of going and back and forth from the maps to the coded transcripts in order to be clear about my understanding of each statement and of where they fit both in time orientation and within the skeletal structure of the map.

Field notes: With each revisit and revision, the map gets clear and clearer. It's as if it constructed itself directly from the interviews—however I know that this is not true, as it has been hours and days of breaking down these stories and building them back up again into this meaningful whole of the story map. The story maps just seem like such an effortless flow from the raw data of the verbatim transcript, and I am feeling very satisfied with the soundness of the research at this point, as it is evident that the credibility and the integrity of these maps follows directly from the words that were

shared with me in the interviews, despite several stages of deep analysis that I led the data through.

Field journal: I am feeling quite pleased with the how smoothly the analysis has gone, as I had been concerned that my worst fear (the story maps would in no way make sense of the data) would be substantiated. Alas, no such thing. My worst fears were not grounded in reality. Grounded in reality is the smoothness and flexibility of my qualitative method and particularly the structure and safety it afforded me by a narrative analysis. This is the moment when I can unequivocally state with conviction and evidence that I have chosen best methodology for this study—and most important, I can say exactly why!

7. I examined the story map holistically to identify an initial overarching core message and other initial themes that appear strongly salient throughout the map.

From the story maps, I identified overarching, or meta-themes, that appeared repeatedly throughout individual interviews and across all participant interviews, as well as individual or unique themes.

Field notes: Identifying overarching themes is rather like getting at the crux of all participants' stories, thematic statements, and descriptive codes. I really had to look within the context of these three aspects of the data, but also beyond them. I have to look at the participant's identity, incorporate my perspective on them and what they have said, and also take into account what my own biases and perspectives are as the researcher. My biases are centred on accentuating the differences between Western and Indigenous approaches to mental health, and perhaps I would do well to stop thinking in this comparative manner and instead remain aware of this bias so that I

can focus on what is important to Indigenous mental health and healing rather than what's different about it.

Field journal: I must keep a focus on myself here, my own process. I am feeling mounting excitement here, as what is emerging as metathemes seems to be similar across participants, and this very exciting for me, as I feel that by giving voice to these helpers I have really created a place for them to be heard—and they all seem to be saying almost the same thing! And that thing is that we as Native peoples are irrevocable caught in a holistic world, where all things and people, and even what's inside people, is interconnected in some way. And this notion somehow calms me, makes me feel safe and secure. Secure because I know that from here my research is sound—not only is it written in the stars (as my Granny would say) but it came from the mouths of participants in a well-structured, ethical, and theoretically grounded research project.

Phase 3: In-depth interview #2. Preliminary results were presented in a second interview with each participant, in which participants further reflected on the research question and gave feedback to the researcher about initial story map and core message and themes that I created and identified through the preliminary analysis process. Participants were also given copies of their transcribed interviews, their chunked and themed transcripts, their transcripts coded descriptively, and the across participants' metathemes.

The second interview followed this format (see Appendix E):

1. From your narratives in your interview I have constructed a story map...how does this map illustrate your views?
2. What is missing from your story map? What would you like to add?

3. Do you have anything else to say about your story map?

These statements were posed to participants in an open-ended and manner. Changes were made to the initial story maps and themes as per the responses received from the participants. This feedback will be detailed for each specific participant in Chapter Four. I continued to take field notes and personal journal notes throughout the second interview.

Phase 4: Final analysis and writing. In this phase I refined the core messages and themes and individual story maps into final results for each participant. I did this by listening to the second audio taped interview, reviewing field and journal notes that I had written during that interview, and making changes to the story map and themes as per participant responses. These steps culminated in the co-creation, from my own analysis process and the feedback of the participant, of the final story map and themes for each participant.

I also examined all of the story maps to uncover several metathemes that describe the overall results of the study, including consideration of the interview data, my field notes, and field journal. This final analysis allowed me to carry the within participant results one step further by reaching overarching conclusions about the meaning of the results.

Ultimately this phase of analysis was finalized in writing the within participant results, across participant results, and implications and conclusion chapters of my dissertation, which were completed in this phase and sent to my committee for perusal prior to setting a defense date. At this point the draft Chapters 4 and 5 were delivered to the participants, the community agency, and the two First Nations band offices, with invitations for feedback. Feedback received was only positive and supportive from each who received these and included comments such as, "This is right on," and "These really says it like is."

Phase 5: Final results and dissemination. Participants were given a summary of the study results (a draft), a copy of Chapters Four and Five of this dissertation. Also, a community newsletter (Appendix F) was distributed within the Native agency and outside of it to other Native agencies in the local, provincial and national arenas. The First Nations band office was also given a copy of the research results in the form of the completed dissertation and the community newsletter. After the successful defense of this dissertation to my committee, the results and recommendations from the study will be drafted into reports to various Indigenous and non-Indigenous government agencies, such as recommendations for mental health care delivery and training programmes, as well as needs for further research. Other dissemination will include scholarly journal articles and conference presentations. A training manual for counsellors or other mental health workers who deal with Indigenous clients will also be developed. The results will also be used to formulate a workshop for the agency that participated to use in their programmes and share with other Native social service agencies as they deem fit.

Criteria for Soundness of the Study

The basis for judgment of the soundness of a research study can be challenging for qualitative researchers, as the goal of most qualitative research is not generalizability, which was been the longstanding cornerstone of sound scientific research from the positivistic perspective. Soundness has been described in quantitative terms as the validity and reliability of a study (Creswell, 2005). Within the qualitative paradigm, some criteria have been developed to deal with concerns of this kind, such as are questions that deal with the trustworthiness and internal validity of the results. Whitemore, Chase, and Mandle (2001) have proposed criteria that are presented as necessary to all sound qualitative research. These

criteria comprise primary and secondary facets of evaluation that examine what might be considered the “internal validity” of the data. Research should have credibility, authenticity, criticality, and integrity in order to be considered sound and rigorous in a qualitative context. In the following sections, I address each of these criteria as related to my study.

Credibility. “Do the results of the research reflect the experience of the participants in a believable way?” (Whittemore et al., 2001, p. 534). This question is designed to get to a concern of verity for the data in the participant’s context. The credibility of the study was a concern to me from the inception of the project, as I was eager in the planning of it to ground it in the subjectivity and reality of the participants and their context. I strove to meet this criteria by firstly, choosing to do the study within an ethical framework of collaboration with the community: I consulted first with the larger Native community leaders (the Elders from the band office) and then with my contact-cum-collaborator at the agency where I recruited participants and conducted the interviews. These consultations remained ongoing throughout the research process. This form of collaboration served to ground the study in the reality of the context and ethics of the community. Thus a strong relationship based on trust, honesty, and collaboration developed between myself, the Native communities involved in the project, and the participants. Special attention paid to the context in terms of cultural norms, local protocol, and my prolonged presence in the field all served as the foundation of the ongoing collaboratory nature of the study that meets the need for credibility. Clarity of the data analysis method, such as the story maps presented to participants, allowed participants to see themselves and their views expressed validly in the data, and they were given voice to collaborate these constructed maps. Theoretical claims made from the data by myself in

terms of the themes were supported with evidence from the participants' stories and answers to questions that were designed to verify the believability of these claims.

Authenticity. "Does a representation of the emic perspective exhibit awareness of the subtle differences in the voices of all participants?" (Whittemore et al., 2001, p. 282). In my research I took a committed and active role as a researcher to be open to hearing the multiple voices of the participants, what Lincoln (1995) describes as "Multiple voices and interpretations of the work" (p.282). Giving voice to participants requires the researcher to also include the notion of intersubjectivity, which I actively include in my adopting of social constructivism as my theoretical framework, and of the use of a narrative methodology to structure the design of gathering, analyzing, and interpreting the data. I took two distinctly different sets of notes throughout the research process to track my relationships with participant voices and with voices of the data itself. One was of field notes, which comprised my reflections that represented the process and procedures of the research itself in terms of methodology. The second set of notes comprised a field journal, which recorded more personal reflections related to what I was thinking and feeling in terms of my own personal processes that went along side the research-oriented process of the field notes. Lastly, representation of participants' voices in the analysis and results of the data occurred when participants were given copies of their transcribed interviews, their chunked and themed transcripts, their transcripts coded descriptively, both their story maps, and the final themes and the across participants' themes. All of these texts were given with the invitation of feedback and clarification from each participant, as well as having all participants read Chapters 4 and 5 of this dissertation. Feedback that required revisions was incorporated into the data and results.

Criticality. “Does the research process demonstrate evidence of critical appraisal?” (Whittemore et al., 2001, p. 534). By this, these authors intend to evaluate the study in terms of its rigor and professional decorum. In answer to this question, yes, I demonstrated evidence of critical appraisal in three ways: 1) by a process of triangulation whereby I gathered and analyzed the raw data of the participants in conjunction with my field notes and journal notes in order to seek several ways to understand the data analysis, 2) I consulted regularly with my supervisor to get feedback, input, and direction on my research processes, and 3) I challenged myself in my field notes and field journal to write in a way that was reflexive, tackling my own assumptions, biases, and explanations for each topic that arose.

This process included examining contradictions and inconsistencies both within the data and within my own personal processes. When inconsistencies could not be explained within the data or myself, I would take my concern to the participant in our second interview, or in an additional telephone or e-mail contact. For example, when I was concerned that I may have been misreading the theme of a story from one participant, perhaps due to my own biases or preconceived notions, I called the participant to ask her if the theme I had come up with fit with the specific story she had told in her interview. She confirmed my theme and I then felt confident about proceeding with that stage of the analysis.

I also followed the University of Victoria’s protocol for conducting research in Aboriginal communities, and the Educational Psychology & Leadership Studies department’s protocol for conducting ethical research. In addition, I worked from my own experience in Indigenous ethics, based on my Master’s thesis, which articulated a First Nations research ethic through the voices of Aboriginal youths.

Integrity. “Does the research reflect recursive and repetitive check of validity as well as humble presentation of findings?” (Whittemore et al., 2001, p. 534) Any phenomenon, including research, that has integrity has nothing hidden or mystical. All is out in the open and demystified. This study was open to participants and the community agency with whom I partnered from its inception. I strove to maintain an open research process that was explained and made clear to the community and its members, including a local First Nations band, as well as the entire staff of the agency where the research was conducted in an introductory meeting where I put myself and research proposal out there for possible participants to evaluate. I integrated input and feedback at every step of the research process with the agency as my partner, and once data was gathered, took input and feedback from each individual participant at each step of the analysis process and dissemination. Specifically, I gave each participant copies of the text at each of the stages of the analysis process detailed in the above section, I asked for participants to give input for specific sources of dissemination for the data, and followed their direction. I have also made the results available to participants and took input and feedback from each individual participant at each step of the analysis process and dissemination. I have also make the results available to the greater Indigenous community through a newsletter that has been sent to all Native health agencies in the University of Victoria region.

Maintaining field notes and a field journal also spoke to the integrity of the project, in that they allowed me to keep a written file of my activities and processes that could be viewed should the need arise to question this aspect of the study. Thus through checking my field notes or field journal entries I could refer to the tones and moods of the research and my own processes, and see how decisions were made related to analysis and results.

The respect that I held for my participants and community in which I carried out the research also enforces the integrity of the study. To respect local Indigenous protocols, I asked permission of local First Nations bands, the agency director and board of directors, and acted at the direction of my informant at the agency to ensure that the research was serving to benefit the community as well as further knowledge. Part of respecting this protocol included viewing consent as an ongoing process, which entailed that I revisited consent with participants at each meeting, as well as with the agency and by keeping in touch with the First Nations band offices and informing them of my progress at each step of the research. As well, being open to input and feedback, and its incorporation into the study, from the community has been a part of the showing of respect. Following the direction and consultations with local Indigenous peoples formed the cornerstone the ethical dimension of the study and served to hold me accountable not only to myself as researcher but to individual participants and community. Without the involvement of community at this level, this project would not have been carried out or completed with the integrity and value that marked its results and conclusion.

Summary of Chapter Three

In Chapter Three I presented the methodological approach to the research. Narrative inquiry within the conceptual framework of Indigenous ways of knowing and social constructivism was discussed as appropriate for the research question and the context of the project. A narrative approach to analysis, which employed a modified story map based on structural elements of story, was described, and the procedures used to gather, analyze, and present the data were explained.

In the next chapter I will present the summarized findings from the five participant interviews, in which I will first present a brief character sketch of each participant, followed by my first story map created from their first narrative interview, then a description of my second interview with each participant, finally followed by our co-constructed second story map and final themes identified within the maps.

Chapter Four: Within-participant Results

Chapter Four presents individual participant results and within participant analysis. This comprises a brief character sketch, a description of the initial story map and themes, a brief discussion of the second interview, and the final story map and core message, and themes for each participant. The character sketch is a snapshot of the participant as it is related to their role as a professional helper, and is intended as an introduction to give the reader a mental image of the participant. The character sketches are based on my own views of the participants during the research process, incorporating their own words and phrases from the formal interviews and any follow up interactions. The core message represents the strongest overall theme throughout a participant's interview that stood out as the core or main message of his or her stories. Other dominant ideas within their data are labelled as themes. Participants are presented in the same order in which they were interviewed.

Participant One

Character Sketch

Participant One (P1) is a female professional helper from the Métis Nation. She is in her forties and has been working in Native communities as a helper for about six years. She received college education in counselling after making a career change from dental office management. Her career change was predisposed by the fact that she had reached the top of her field and could no longer gain further promotion. Her ambition drove her to seek further education and to retrain in the professional helping field. She made a conscious choice to take her skills into the Indigenous community because she strongly believed that she had a calling to help others, which was a role that began for her

in early childhood. In her family, where she holds position of oldest child, she was responsible for her siblings and often extended family members, such as cousins, nieces, and nephews. As an adult she still sees herself in this care giving role both within her family and the greater Native community. P1 sees her calling to be a helper in the Indigenous community as a gift that she must honour through on-going work that is based on a strong sense of Indigenous identity, spirituality, and community connection. She is a direct communicator, confident, capable, and knowledgeable in many ways.

First Interview

The first interview with P1 was marked by an air of excitement and anticipation for both of us, as we were both eager to talk about Native mental health in the context of this dissertation. I began the interview by going over the consent form orally and in writing. Once consent was obtained, I gave P1 a list of the interview questions. P1 was relaxed and verbose throughout the interview and did not give me much opportunity to say anything other than ask my questions. She answered each question thoroughly and did not need any prompting for elaboration. She was very direct and certain about her answers and had no trouble in divulging many of her personal experiences of mental health and healing as they related to her position as mental health worker. Our interview lasted about 90 minutes, however we could have extended this time had I been seeking further detail to each question, as she had a wealth of information and experience to share. The initial story map was constructed during the analysis of this interview, as per the process explained in Chapter Three (see Figure 6). After the creation of the initial story map for P1, I uncovered a core message and several themes from the map and the interview. The initial core message for P1 was interconnectedness. The themes were

Initial Story Map P1	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past Experience	<ul style="list-style-type: none"> • Family Role • Family Support • Helper Role • Calling • Journey 	<ul style="list-style-type: none"> • Cultural Identity 	<ul style="list-style-type: none"> • Interdependence • Connectedness • Lack of Family Connection in Community 	<ul style="list-style-type: none"> • Lack of Access to Healing • Colonization Effects 	<ul style="list-style-type: none"> • Only non-Native Services Available • Services Not Relevant • Under-use of service • Service Unbeneficial • Lacking Spirituality
Present Experience	<ul style="list-style-type: none"> • Helper Role • Cultural Identity • Calling • Family Value 	<ul style="list-style-type: none"> • Discrimination • Helping Value • Interconnectedness • Respect • Self Care 	<ul style="list-style-type: none"> • Interconnectedness • Resiliency • Interdependence 	<ul style="list-style-type: none"> • As Wellness • Culturally Based • Colonization Effect • Interconnected • Interdependence • Cultural Identity • Stories as Healing • Healing from Trauma • Long-term Healing Journey 	<ul style="list-style-type: none"> • On-going support • Under-use of Services • Services Unbeneficial • Beginning Paradigm Shift • Needs to be Culturally-based • Developing cultural competencies • Lacks Cultural Relevance • Using interconnectedness • Connecting with Cultural Identity • Using Stories • Supporting • Food as a Tool • Western paradigm unbeneficial • Holistic approach • Trauma healing • Spirituality
Future Intentions	<ul style="list-style-type: none"> • Bigger Helper Role 	<ul style="list-style-type: none"> • More Interconnectedness 	<ul style="list-style-type: none"> • Creating More Interdependence • Creating more Interconnectedness 	<ul style="list-style-type: none"> • Colonization Effect • Need to Educate non-Natives • More Interdependence • More Interconnectedness • Long-term Healing Journey 	<ul style="list-style-type: none"> • Increased Cultural Competencies • Need to Educate Non-Natives • Creating more Interconnectedness • More Connecting with Cultural Identity • More support for long-term Healing • More Connection with Community • More Use of Food as a Tool • Long-term trauma treatment needed • Need for greater paradigm shift • More focused on Spirituality • Self Care for Helpers

Figure 6. Initial Story Map for P1

healing journey from trauma, holistic approach, and helping and healing must be culturally-based.

Feedback from Second Interview and Final Story Map

I met for a second interview with P1 to discuss with her my analysis that formed the initial story map, core message, and themes. I began the interview with a detailed explanation of the data analysis process, which outlined how I took the whole of her story, broke it down into smaller parts through coding for thematic content, then reconstructed the transcript into a story map, which represented the whole of her story in a schematic organization. Through the process of looking over the initial story map, the core message and themes emerged as I carefully read and reread the map and the analyzed transcript. I followed my set of questions for this interview. In response, P1 made minor changes to her story map, that are highlighted in Figure 7: 1) she added the desire to seek further education in the helping field in the future, and 2) she changed “only non-Native services available” in the past section of Counselling Practice, to “limited Native services available”. The first change was made a result of seeing her story organized in a time-oriented fashion, in which it was clear to her that education was a future direction for her self as a helper. The second change was due to her reconsideration of her story that dealt with the lack of culturally based Native counselling services and that my initial coding of that story with “Only non-Native services available” was too strong a statement and rewording was a better fit for her story. These changes are highlighted in the story map below.

She stated that the rest of the map and the core message and themes I presented were an appropriate fit with the stories she gave me in the first interview. P1 told me that

Final Story Map P1	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past Experience	<ul style="list-style-type: none"> • Family Role • Family Support • Helper Role • Calling • Journey 	<ul style="list-style-type: none"> • Cultural Identity 	<ul style="list-style-type: none"> • Interdependence • Connectedness • Lack of Family Connection in Community 	<ul style="list-style-type: none"> • Lack of Access to Healing • Colonization Effects 	<ul style="list-style-type: none"> • <u>Limited Native Services Available</u> • Services Not Relevant • Under-use of service • Service Unbeneficial • Lacking Spirituality
Present Experience	<ul style="list-style-type: none"> • Helper Role • Cultural Identity • Calling • Family Value 	<ul style="list-style-type: none"> • Discrimination • Helping Value • Interconnectedness • Respect • Self Care 	<ul style="list-style-type: none"> • Interconnectedness • Resiliency • Interdependence 	<ul style="list-style-type: none"> • As Wellness • Culturally Based • Colonization Effect • Interconnected • Interdependence • Cultural Identity • Stories as Healing • Healing from Trauma • Long-term Healing Journey 	<ul style="list-style-type: none"> • On-going support • Under-use of Services • System Service Unbeneficial • Beginning Paradigm Shift • Needs to be Culturally-based • Developing cultural competencies • System has lack of Cultural Relevance • Using interconnectedness • Connecting with Cultural Identity • Using Stories • Supporting • Food as a Tool • Western paradigm unbeneficial • Holistic approach • Trauma healing • Spirituality
Future Intentions	<ul style="list-style-type: none"> • Bigger Helper Role • <u>More Education</u> 	<ul style="list-style-type: none"> • More Interconnectedness 	<ul style="list-style-type: none"> • Creating More Interdependence • Creating more Interconnectedness 	<ul style="list-style-type: none"> • Colonization Effect • Need to Educate non-Natives • More Interdependence • More Interconnectedness • Long-term Healing Journey 	<ul style="list-style-type: none"> • Increased Cultural Competencies • Need to Educate Non-Natives • Creating more Interconnectedness • More Connecting with Cultural Identity • More support for long-term Healing • More Connection with Community • More Use of Food as a Tool • Long-term trauma treatment needed • Need for greater paradigm shift • More focused on Spirituality • Self Care for Helpers

Figure 7. Final Story Map for P1

seeing her views expressed through a map really made them more clear and coherent to herself, and she felt that her understandings of mental health and healing had been fully articulated and refined through this process.

Final Core Message and Themes

The themes did not change as a result of the second interview with P1. The core message is interconnectedness. The themes were healing journey from trauma, holistic approach, and helping and healing must be culturally-based.

Interconnectedness. Interconnectedness is a thread that holds together almost all of the statements that formed P1's first interview and this is why interconnectedness represents a core message in her story map. She describes the connection between people as integral to the system that supports people in being mentally health,

Now I think that I work in an agency that creates that subsystem of support for people, that's why I work at the _____ [community agency], we try to do that in many ways, and we try to provide that for many people who come here disconnected.

It takes effort to create connectedness for people, sometimes using food as a tool, for example, and this is a way that counselling programmes in her workplace set up a system of mental health support. "I have come to see that we need to work harder to create opportunity for connectedness in how we do our service delivery...some of that has been around food, when we have programmes, do we have food for people?"

She had experienced in her work as a counsellor an understanding of the necessity of being interconnected within a family system in order for a person to not suffer emotional or psychological distress. She expressed this by saying,

Also in my practice the concept of family and interconnectedness, that there is an acceptance and understanding of that person's role in their own family, that it's hard for that person to be away from their home territory, understanding that the very fact of being away from their own place that can create distress that can be seen as a diagnosable disorder, so to understand that someone is not just homesick and that they have to suck it up.

She also explained that for counselling to be successful in an Indigenous context, it must be based on a model that values interconnectedness,

So I say that helping is of an interconnected model because we live in an Aboriginal urban setting, not everyone has the luxury of having their extended family, and many people create or have that secondary family setting. I will use family to describe the circle of support for the individuals and what I have come to understand is that that is essential for the individual to gain health and healing, and so if that's not incorporated into their counselling plan, their system of care, their discharge plan, their whatever terminology works within the mainstream health care system, that person is not going to do well.

Interconnectedness becomes vital in times of mental health crisis, in her experience. She explained that, when clients are suicidal, it is often the connections with people in their lives, such as family, that helps them hold on to their lives. "You have to have some sort of connectedness in life to what keeps you here...I [as a counsellor] need to understand what the piece that keeps them here is. And nine times out of ten it's their family, their children or grandchildren."

Working in an Indigenous agency has changed P1's view of what mental health and healing is, and she has come to appreciate the value of stories and the connection they create to health and healing. "The stories are really important, the connectedness, I really have come to see that as the key [to counselling and mental health]."

Healing journey from trauma. Recovering from trauma was an important issue in counselling for P1. She used the words "healing journey" to connote that this process of recovery is ongoing and nonlinear in nature. Viewing healing from trauma in this way was necessary to work effectively with her clients, and she explained that the mainstream health care system did not currently support this view when saying,

[The mainstream health care system] expects behaviours to change overnight, expects because it is built into a plan of care that someone taking two parent courses or ten parenting course will suddenly wake up with the skills and abilities to look after their own children, even though they have their own trauma and history that walks with them everyday.

For P1 there is a commitment to staying with clients on the long term healing journey in terms of continuing with the counselling process for as long as the client requires support, which is often longer than government policy recommends. "I would look at my change in attitude and belief that not only is it an expectation [to receive long term counselling] but that it's unkind to start a journey with someone that you are willing to pull the rug out from under them after just six months!" There is a need for counselling services to meet these long term journey needs, as current counselling practice supported by mainstream mental health is not doing so. "We, um, right now, do not have the capacity to provide that [long term counselling services] and I don't' think that our

mental health system does either, long term trauma treatment—I don't see that happening in lots of places.”

P1 talked about trauma as a major mental health issue in the context of her practice of counselling, and how important it is to deal with it in an on-going approach. “When we look at the issues of mental health and wellness...trauma is the underlying cause, which it is predominately, trauma is not something that changes overnight.”

The future of mental health services is seen as filling this need for long-term counselling and services for Native clients dealing with trauma not individually but in the context of their family and community. “What I hope to do in the future is providing ways that service delivery that will respect that and actually create service delivery that is reflective of that need [for long term trauma healing], that is not just on a one-on-one basis, set on one appointment...”

Holistic approach. Another general theme for P1 is a holistic approach to mental health and healing. P1's experience of working in the Indigenous community as a professional helper has shown her that healing is about balancing four aspects of person's inner world. These four aspects of emotional, physical, mental, and spiritual form a basis for understanding the worldview of her clients. Clients connect in these four ways with their mental health needs, such as needs for family and belonging. “It [working in the community] has really given my practice [of counselling] more empathy, understanding that it physically, emotionally, mentally, and spiritually affects their heart and soul when they are not connected to their own family and home place.” An important component of the holistic approach is spirituality, as it has a foundation to mental health in P1's understanding of a holistic approach. “Well, spirituality is really there [in mental health

and healing], and I haven't touched on it separately because its part of everything, um, part of the holistic approach.”

Helping and healing must be culturally-based. Mental health service is not always experienced in the Native community as helpful, particularly when that service does not include a cultural component. She explained this in saying,

Then I began to understand the issues of a service that exists that may not be a benefit, a service that exists that may not be inclusive...may not be respectful of cultural attitudes and beliefs that are separate from health care.

This understanding was clarified in her work as helper in the Native community and helped to better understand her clients mental health needs as also being cultural needs. Thus mental health is viewed by P1 in the context of Native culture. She explained this by way of the seven teachings, which are Native cultural norms that explain values inherent to healthy individual and community functioning. She said that her work as a counsellor must be based on these cultural teachings in order to successful in supporting clients. “In mental health, respect is a cultural teaching, one of the seven teachings, as is wisdom, humility, bravery, and I think that you need all of those seven teaching to be with people as a support.”

Participant Two

Character Sketch

Participant Two (P2) is a middle-aged male professional helper who has been working in the Native community for a number of years. He received post-secondary education in the helping field after a career change in mid-life; after 20 years of working on tugboats in Northern British Columbia he made a sudden change in career paths. P2

felt strongly that he had needed a change in his life at the time and welcomed a new career path as timely within several aspect of his life, i.e., his children had grown and left home and no longer needed his financial support, and, after several decades of living away from his family, out at sea, he was seeking a vocation closer to home. Also very important to P2 was the idea that being a helper was a calling for him. This calling to be a helper was something he believed that he was meant to do in terms of his historical family role, stemming back to childhood, his teen years, and even many experiences he had working as part of a team during his years on the tugboats. Like P1, he is the oldest child in his family of origin birth order, which he saw as influential in shaping his earliest role as a helper. He was a caretaker of his younger siblings and cousins. Also important to P2 is his Indigenous heritage as Métis, which was set as a foundation to all of the thoughts, feelings, memories, and stories that he shared with me.

First Interview

P2's first interview began with the informed consent process. P2 seemed a little uncertain as we began, but as rapport was established through a process of getting to know each other, he was markedly more relaxed by the end of the 90 minute interview. He was given a copy of the interview questions at the outset, and like P1, answered each question in full detail with little prompting needed from me, other than minor verbal encouragers and some paraphrasing to ensure that his messages were clearly understood. P2 had a lot of life experience that went beyond the bounds of the helping relationship, however, all of the experiences he shared in this interview were relevant to his work as a helper and how he understood mental health and healing in Native contexts. From this interview I constructed an initial story map, and from this map I found a core message of

connection, and themes of cultural identity, spirituality, healing from colonialism, and relations with non-Native communities (see Figure 8).

Initial Story Map P2	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past Experiences	<ul style="list-style-type: none"> ▪ Discrimination ▪ Family support ▪ Calling ▪ Helper role 	<ul style="list-style-type: none"> ▪ Discrimination ▪ Losing cultural values & practices ▪ Trauma from colonialism ▪ Regaining cultural identity 	<ul style="list-style-type: none"> ▪ Family connections ▪ Connectedness within community ▪ Community values 	<ul style="list-style-type: none"> ▪ Losing cultural healing practices ▪ Spirituality almost lost but regained 	<ul style="list-style-type: none"> ▪ Not knowing cultural ways of helping ▪ Learning cultural ways of helping ▪ Learning about spiritual practice ▪ Starting healing journey fr. colonialism & trauma
Present Experiences	<ul style="list-style-type: none"> ▪ Strength in helper role ▪ Clear helper role ▪ Protector of culture ▪ Healing journey 	<ul style="list-style-type: none"> ▪ Strong cultural identity ▪ Active engagement ▪ Family connections 	<ul style="list-style-type: none"> ▪ Interdependence ▪ Connecting with spirituality ▪ Work with communities ▪ Share knowledge with non-Native communities 	<ul style="list-style-type: none"> ▪ Spirituality ▪ Holistic health ▪ Community health ▪ Your self identity within community ▪ Healing from colonization 	<ul style="list-style-type: none"> ▪ Using ceremony ▪ Using spirituality ▪ Connecting with cultural identity
Future Intentions	<ul style="list-style-type: none"> ▪ Stay on healing journey ▪ More helper education 	<ul style="list-style-type: none"> ▪ Further strengthening cultural self identity ▪ Family connections 	<ul style="list-style-type: none"> ▪ Strengthening the connections ▪ Strengthening community cultural identity ▪ Continue to share knowledge with non-Native communities ▪ Improve relations with non-Native communities 	<ul style="list-style-type: none"> ▪ Healing from colonialism ▪ Healing from trauma ▪ Strengthening connections with spirituality ▪ Connecting with cultural identity 	<ul style="list-style-type: none"> ▪ Continue helping others to connect with cultural identity ▪ Go deeper into traditional cultural helping ways ▪ Connect more with spirituality

Figure 8. Initial Story Map for P2

Feedback from Second Interview and Final Story Map

Our second interview was characterized by a relaxed atmosphere, as we had done some relationship building through our first interview and both felt more at ease about the process. P2 was very excited seeing his story map, and as he looked it over told me that it was a good representation of his views shared in our first interview. I explained the detailed research analysis steps to him and how I came to create the story map from the stories he shared in our first interview. He was very positive about his map and saw nothing in it that was not representative of the things he had previously shared. However, P2 said that after giving further thought to some of my questions, there were a few things that he wished to add to his story map, which are highlighted in the final story map in Figure 9. The first thing that he wanted to add was that he had an interest in pursuing more education in the helper field. Secondly, he wished to add that in the present he saw himself as a helper role model to others in his personal and professional contexts. In his present experience of community, he added “Having to create divides.” By this he meant that he felt that he had to create divides in the community in terms of custody and separation or divorce issues or mandating clients to counselling in order to carry out some of his work as a professional helper, particularly when the Ministry of Children and Family Development (MCFD) was involved. Also, in the future time orientation of community, he added that he wanted to avoid having to create this divide within community, and to focus more on strengthening spirituality within the community of clients that he serves. In future orientation, he also added that mental health and healing will need to include educating non-Natives about the importance of spirituality and holistic healing. Lastly, he wishes to focus more on holistic healing in mental health and healing. In his

Final Story Map P2	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past Experiences	<ul style="list-style-type: none"> ▪ Discrimination ▪ Family support ▪ Calling ▪ Helper role 	<ul style="list-style-type: none"> ▪ Discrimination ▪ Losing cultural values & practices ▪ Trauma from colonialism ▪ Regaining cultural identity 	<ul style="list-style-type: none"> ▪ Family connections ▪ Connectedness within community ▪ Community values 	<ul style="list-style-type: none"> ▪ Losing cultural healing practices ▪ Spirituality almost lost but regained 	<ul style="list-style-type: none"> ▪ Not knowing cultural ways of helping ▪ Learning cultural ways of helping ▪ Learning about spiritual practice ▪ Starting healing journey fr. colonialism & trauma
Present Experiences	<ul style="list-style-type: none"> ▪ Strength in helper role ▪ Clear helper role ▪ Protector of culture ▪ Healing journey ▪ <u>Role model</u> 	<ul style="list-style-type: none"> ▪ Strong cultural identity ▪ Active engagement ▪ Family connections 	<ul style="list-style-type: none"> ▪ Interdependence ▪ Connecting with spirituality ▪ Work with communities ▪ Share knowledge with non-Native communities ▪ <u>Having to create divides</u> 	<ul style="list-style-type: none"> ▪ Spirituality ▪ Holistic health ▪ Community health ▪ Your self identity within community ▪ Healing from colonization 	<ul style="list-style-type: none"> ▪ Using ceremony ▪ Using spirituality ▪ Connecting with cultural identity ▪ <u>Forced to chose sides with clients by Western helping system (limited autonomy)</u>
Future Intentions	<ul style="list-style-type: none"> ▪ Stay on healing journey ▪ <u>More helper education</u> ▪ <u>Keep role modeling</u> 	<ul style="list-style-type: none"> ▪ Further strengthening cultural self identity ▪ Family connections 	<ul style="list-style-type: none"> ▪ Strengthening the connections ▪ Strengthening community cultural identity ▪ Continue to share knowledge with non-Native communities ▪ Improve relations with non-Native communities ▪ <u>Strengthen spiritual connections</u> ▪ <u>Avoid making divisions</u> 	<ul style="list-style-type: none"> ▪ Healing from colonialism ▪ Healing from trauma ▪ Strengthening connections with spirituality ▪ Connecting with cultural identity ▪ <u>Teaching non-Natives about role of spirituality</u> ▪ <u>Teaching non-Natives about holistic healing</u> ▪ <u>Focusing more on holistic health</u> 	<ul style="list-style-type: none"> ▪ Continue helping others to connect with cultural identity ▪ Go deeper into traditional cultural helping ways ▪ Connect more with spirituality ▪ <u>Avoid choosing sides with clients (more autonomy)</u> ▪ <u>Western paradigm accept spirituality in practice</u> ▪ <u>Western paradigm accept holistic helping practice</u> ▪ <u>Practicing more holistically</u>

Figure 9. Final Story Map for P2

present experience of counselling practice, he said that he is forced by the Western system of helping to choose sides with clients, particularly when he is working with families who are involved with the MCFD or the justice system. In the future he added, “Avoid choosing sides with clients” as he wishes to no longer have to choose sides when working with clients in those contexts. He also explained that he would like to see the Western paradigm of counselling practice accept spirituality and holistic helping as practice, and in the future he would like to practice counselling in a more holistic way. He validated the core message and themes that I had identified from his story map. He said that they were accurately representative of his stories on mental health and healing and counselling practice.

Final Core Message and Themes

All of the themes remained the same for P2 through our second interview. The final core message for P2 is connections. The themes for his final story map are cultural identity, spirituality, healing from colonialism, and relations with non-Native communities.

Connections. P2’s core message was that connections underpin mental health and healing in his experience as a professional helper. Connection was a concept that was interwoven throughout many of the stories P2 shared, and this idea of connection formed the basis for his understandings of an Indigenous mental health and healing. For P2 connection could occur in a multitude of ways, but basically, everything in the Indigenous world was interconnected in a way to form a path to health and wellness, including connections between people, between communities, from people to nature, and even within an individual. Linking things together, such as a client with their cultural

identity, with their spirituality, with their own family, or even with their own interpersonal resources such as courage, strength, hope, or resiliency are what formed the essence of P2's message. He explained this necessity of connection in how a client could connect with spirituality as a part of the healing journey,

I think spirituality comes from within...I think that's why spirituality is a component of the Aboriginal world, historically, is to maintain a connection within yourself at the individual level, at the family, level, then at the community level to be mentally healthy and to heal.

For P2 it is the act of connecting that represents the crux of mental health and healing, and this notion remained dominant throughout the themes that follow.

Cultural identity. Cultural identity formed a foundation to mental health and healing in many of P2's stories. He viewed cultural identity as something that could be healing for a client in terms of giving them meaning and pride in their own life. "Err, with regard to Aboriginal mental health I think that culture is a tool we can use to help people become who they want to be with an identity, um, with a sense of purpose with an understanding of what its like to be Aboriginal and be proud of that." Without a sense of cultural identity as a Native person it is difficult to be mentally healthy in terms of self esteem.

And I think that if people have lost their identity, um...and they want to find it they should be encouraged to find that And that as you go through that process then no question is a stupid question, if you have burning desire or a question that is burning at you then you should try to the best of your ability to find those answers for yourself so that you can become the person that you are meant to be,

historically, whoever you may have been in your family or community and to regain those kinds of things and be proud and feel good about yourself, um, your self esteem, in order to mentally healthy and heal.

Cultural identity is also foundational in terms of P2's role as a counsellor. His cultural identity informs how he practices counselling in that it keeps him grounded and gives him confidence to be himself and share his cultural knowledge with clients and family in ways that can promote healing. "My culture as an Aboriginal person informs my practice because it keeps me grounded...it's who I am, it's my identity as an Aboriginal person, it keeps me within my culture and allows me to share that with other people [to work on mental health and healing]."

Addressing cultural identity in the helping process is vital to successful healing in P2's experience because it allows clients to understand their own personal history in a beneficial way, as well as connect with their spirituality, which is a part of Native identity.

So with mental health it's [Native identity] something that I believe that we can incorporate into our practice of helping, because it is very beneficial for people to understand that part of their life, to be connected to it. Because a lot of people I work with don't understand their culture and roots, and are ashamed of that. I think that if we can use spirituality and culture as a tool for mental health then it's beneficial.

Spirituality. Spirituality is an important part of Native culture in P2's experience as a Native person and as helper. P2 explained that through colonial history, cultural practices have been taken from many Native peoples, so returning to traditional Native

spiritual ways can be healing for clients because it connects them with their own history and culture.

Because some of the things that have happened historically have taken us away from that and I think that there is a bit of revival of those kinds of things [for mental health and healing] and spirituality is part of that, people are going back to the old ways in understanding them, and learning about a lot in their own lives about spirituality.

Spirituality is an integral part of Native living and a necessary part of healing for Native peoples. "Spirituality is very important in the Aboriginal world for people to heal and find their path in life with regard to getting over some of the things that have happened historically to Aboriginal peoples." And because of the centrality of spirituality to Aboriginal culture, P2's professional work includes a spiritual approach. "I think that spirituality is something that I try to incorporate into my helping work. I always feel there is a spirituality component that I do with all of the families that I work with." Examples of the incorporation for P2 include encouraging and supporting clients in engaging in drumming and consultations with Elders, and using prayer and ceremony in counselling practice.

Non-Native health care services do not usually recognize spirituality as a necessary part of mental health and healing for Native peoples. "I think the biggest part about mental health and healing that might be different from the outside world's is the spirituality piece that is often overlooked in the mainstream." Using spirituality in a counselling context for P2 should be done in an open and forthright manner so that it can be accepted as a necessary and important part of Aboriginal mental health and healing.

“We need to be open and communicate in a good way, and spirituality is a big part of that. I think that if the mainstream world could understand more about Aboriginal spirituality, then our relationships and own healing processes are going to be that much better.”

Healing from colonialism. A major mental health issue in P2’s work as a helper is the need to heal from the effects of colonial history. “I just hope that we can get to a place where we can be mentally healthy as Aboriginal people because the effects of colonization have certainly done a lot of harm.” Healing from colonialism, from P2’s experience, entails returning to traditional practices and ceremonies that were taken away by governmental assimilation tactics. P2 feels that the desire to heal through spirituality was historically so strong for Native peoples that it survived the governments’ process. As a mental health worker he has a responsibility to help people heal in this way from colonialism.

The ceremonies, the passages of rites, the naming, the potlatches, of the West Coast Aboriginal groups, um, a lot of Aboriginal groups did those things. And a lot of that stuff was taken away by the government, it was banned and made illegal, then it was eventually given back. Umm, but I think that the spirituality part is so strong that it survived and it went underground, they couldn’t take that away, I, I, um, I mean, um, the resistance to keep the knowledge was very powerful. Through assimilation through oppression, through colonization I guess the dominant culture was never able to do that, to take that away. I think it made people stronger and band together that much more to protect the culture, so that’s

why we need to heal from colonialism [for mental health] and that's what I have to keep up as a helper.

In his practice of counselling, P2 found that colonialism sent many Native people into imbalance, particularly in taking away spirituality from their lives. He states that balance of spirituality with the other components of the self such as mental, emotional, and physical, is necessary for mental health.

Um, because of colonialism, I think spirituality has been fragmented, it's something that I, um, and others, um, have had to regain for my, um, their, mental health. It's about keeping life in balance with regard to all component that are holistic, mental, physical, emotional, spiritual, um, it's all about staying in balance.

Part of the colonial experience for many clients was attending residential school. This is a focus in his work as a helper, in which healing from this experience takes place through connecting with aspects of culture. "The effects of things such as residential schools are a legacy that we are still dealing with. Um, I, I, I think that through spirituality and identity that we can get stronger and be healthier as Aboriginal people."

Healing from colonialism is a salient issue in P2's helping practice. He believes that many with whom he works within the community are beginning to deal with this issue. "I just hope that we can get to a place where we can be mentally healthy as Aboriginal people because the effects of colonization have certainly done a lot of harm, and I think we are just getting over the hump right now."

Relations with non-Native communities. One issue that arose in P2's stories was a link between relations with non-Native communities and mental health and healing for

Native peoples. Because Native communities have been dominated by government and mainstream culture, P2 sees building positive relationships, including receiving support from, non-Native communities as a way to deal with mental health and healing issues.

One big way [to deal with mental health issues] is to formalize [relationships] with other peoples outside the Aboriginal world and invite them into our world...share meals and knowledge with them...open our doors. It's not something they can learn about in a day, it has to be ongoing, but that door is open. It's about the relationships, if you build on community relations with groups outside of this Aboriginal agency, to inform people and give them knowledge [that we can do mental healing work], then we'll have support and understanding necessary to, um, do the healing.

Educating non-Native communities about Native culture and knowledge can be done in a way that is beneficial to the Native community as well. Sharing Aboriginal knowledge with non-Natives can be positive and meaningful in that it can increase understanding and support for Native issues.

It's important to have those allies in the [non-Native] community. I think it's always good to be able to have good working relationships with those people outside the Native community...it doesn't mean that we have to be sell outs, we still have to protect our identity and who we are, but we can share our knowledge without feeling like that if we do share our knowledge it will come back to haunt us in some way, or that a way that [sharing knowledge and relationships with non-Native] can be positive in terms of [non-Natives] supporting us.

Specifically, teaching non-Native communities about what is important to healing, such as spirituality, will also allow those in non-Native communities to share in the healing process thereby making it more successful for everyone.

I educate and try to share my knowledge around those sorts of things. And I make it very important for them to know that spirituality has to be a part of what we do. And it's also in the children and family and community service act that says Aboriginal people be afforded those kinds of things, and I make sure that I adhere to that. Of course the Aboriginal person has to want to do that sort of thing too, which allows the [non-Native] community member or the client to be part of that process.

Participant Three

Character Sketch

Participant Three (P3) is a female in her early middle age who has worked in the helping field in her Native community for over fifteen years. She has completed post secondary education. She has two almost grown children, and is strongly dedicated to family and community in every movement and word uttered throughout our interviews. Indigenous culture has played a strong role throughout her development, and during our interviews she recounted many stories that spanned from childhood to the present. Indigenous culture is central to her worldview and how she tells her stories of helping and healing. Her personal life and work intertwined to form the fabric for the blanket of spirituality and calm that carried us through her stories. Wisdom was a strong force emanating from her as we shared time and words. She had a lot of experience and insight to the helping field, particularly in terms of how helping and healing impacted the helpers

in an agency setting. She appeared in stature as a tall and imposing woman but in proximity she was warm and welcoming. Her knowledge and experience in the Indigenous community is a tremendous resource to her work in the community agency in terms of how she deals with clients, co-workers, and administrative tasks. She was very open about sharing these experiences with me in our interviews. Her honesty was strong and reflexive in that it forced me to reflect upon myself and my own actions both within this research project and as a human being.

First Interview

The first interview began with a welcoming by P3 that was warm and genuine. She was relaxed and clear about the interview as I went through the informed consent process with her. I gave her a copy of the interview questions, and when I posed each one she gave me ample and detailed answers. I asked for clarification on several points but no prompts for elaboration were necessary. P3 was very candid and open with me throughout the process and shared liberal amounts of experience from many years of work as helper in her community. Her gentle leadership skills were strongly apparent in each response she gave to my questions in that there was no hesitation or uncertainty regarding what she was about to say, yet no words came out as forceful or absolute. The interview took about 2 hours, however because she was such a refined story teller, whose stories seemed to hold wisdom and teachings that I recognized as profound and valuable, this time passed in what seemed like only a few minutes. There was clearly a lot between the lines of her words in terms of metaphors and complexities which I hoped to unearth in the analysis process. I constructed an initial story map from the analysis of this interview (see Figure 10). From this story map I came up with the initial core message and several

Initial Story Map P3	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past Experience	<ul style="list-style-type: none"> • Journey • Calling • Helper role 	<ul style="list-style-type: none"> • Helping as a value • Cultural identity • Losing cultural knowledge • Traditional helpers roles 	<ul style="list-style-type: none"> • Community values • Interconnected • Community helping 	<ul style="list-style-type: none"> • Health as illness • Colonization effects 	<ul style="list-style-type: none"> • Culturally based informally only • Not as on-going support; only as short term
Present Experience	<ul style="list-style-type: none"> • Self awareness • Personal work • Journey • Being spiritual • Helper role • Striving for balance 	<ul style="list-style-type: none"> • Helping as a value • Culture as a way of life • Diversity within • Sharing values & practices • Strength within • Traditional helper roles 	<ul style="list-style-type: none"> • Community values • Inclusion • Support from non-Native communities • Ethics • Balance 	<ul style="list-style-type: none"> • Interconnectedness with community • Connecting with non Native communities • Respect • Connected with community • Interconnected with individuals • Balance of self • Balance of community • Letting go • Culturally based • Holistic • Health as wellness • Spirituality • Calling on ancestors • Interdependence 	<ul style="list-style-type: none"> • Connecting with differences • Holistically based • Culturally based • Connected to community • Building relationship • Spiritually based • Supporting (not directing) • On-going support • Connecting with cultural identity • Modeling • Respecting within group differences • Finding balance • Indigenous healing helping non-Native communities
Future Intentions	<ul style="list-style-type: none"> • Finding more balance 	<ul style="list-style-type: none"> • Finding more strength within • Focus on helping as a value • More traditional helper roles 	<ul style="list-style-type: none"> • Ethics • Working with non Native communities 	<ul style="list-style-type: none"> • More Connected with community • More interconnected with individuals • More spirituality • More calling on ancestors • Support from non-Native communities • Making paths • More interdependence 	<ul style="list-style-type: none"> • More holistically based • More culturally based • More connected with community • More respecting of within group differences • Paradigm shift (legitimize Native worldview) • Indigenous healing helping non-Native communities

Figure 10. Initial Story Map for P3

themes for P3. The core message is interconnectedness, and the themes are interdependence, cultural traditions, helping as cultural, holistic approach, and spirituality.

Feedback from Second Interview and Final Story Map

In our second interview, minor changes were indicated by P3 regarding the initial story map. No changes were indicated for the core message or themes. Her support for my construction of her initial story map was reflected in statements such as: “This is exactly what I mean,” and “Seeing this map really helps me to clarify my own understanding of where mental health and counselling have been and are going.”

However, upon reflection in this interview in response to my schedule of questions, she added some information to some of the sections of her story map and did not ask to change any of the existing codes. These changes are highlighted in Figure 11 which presents the final story map from P3. In the section of Counselling Practice, Past Experience, she added that there had been a lack of self care for helpers and no awareness of lateral violence in the workplace. In Present Experience she added a new awareness of lateral violence and a new protocol for dealing with it. In her past experience of mental health she added that mental health was seen as a stigma and not as holistic wellness. Lastly, she added in Future Intentions of Self as Helper, setting boundaries to ensure self care. The changes gave more detail to her story, which will be useful in across participant analysis, which follows in Chapter Five.

Final Core Message and Themes

The core message for P3 is interconnectedness. The themes are interdependence, cultural traditions, healing from colonialism, helping as supporting, holistic approach, interdependence, and spirituality.

Final Story Map P3	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past Experience	<ul style="list-style-type: none"> • Journey • Calling • Helper role 	<ul style="list-style-type: none"> • Helping as a value • Cultural identity • Losing cultural knowledge • Traditional helpers roles 	<ul style="list-style-type: none"> • Community values • Interconnected • Community helping 	<ul style="list-style-type: none"> • Health as illness • Colonization effects • <u>Mental health seen as a stigma (not as holistic health)</u> 	<ul style="list-style-type: none"> • Culturally based informally only • Non on-going support; only as short term • <u>Lack of self-care and awareness for helpers</u> • <u>No awareness of lateral violence in workplace</u>
Present Experience	<ul style="list-style-type: none"> • Self awareness • Personal work • Journey • Being spiritual • Helper role • Striving for balance 	<ul style="list-style-type: none"> • Helping as a value • Culture as a way of life • Diversity within • Sharing values & practices • Strength within • Traditional helper roles 	<ul style="list-style-type: none"> • Community values • Inclusion • Support from non-Native communities • Ethics • Balance 	<ul style="list-style-type: none"> • Interconnectedness with community • Connecting with non Native communities • Respect • Connected with community • Interconnected with individuals • Balance of self • Balance of community • Letting go • Culturally based • Holistic • Health as wellness • Spirituality • Calling on ancestors • Interdependence 	<ul style="list-style-type: none"> • Connecting with differences • Holistically based • Culturally based • Connected to community • Building relationship • Spiritually based • Supporting (not directing) • On-going support • Connecting with cultural identity • Modeling • Respecting within group differences • Finding balance • Indigenous healing helping non-Native communities • <u>Awareness of /dealing with lateral violence in workplace</u>
Future Intentions	<ul style="list-style-type: none"> • Finding more balance • <u>Setting boundaries to maintain self care</u> 	<ul style="list-style-type: none"> • Finding more strength within • Focus on helping as a value • More traditional helper roles 	<ul style="list-style-type: none"> • Ethics • Working with non Native communities 	<ul style="list-style-type: none"> • More Connected with community • More interconnected with individuals • More spirituality • More calling on ancestors • Support from non-Native communities • Making paths • More interdependence 	<ul style="list-style-type: none"> • More holistically based • More culturally based • More connected with community • More respecting of within group differences • Paradigm shift (legitimize Native worldview) • Indigenous healing helping non-Native communities

Figure 11. Final Story Map for P3

Interconnectedness. Interconnectedness was the core message throughout all of stories. For P3, interconnectedness of people with each other, with community, with family, with culture, with spirituality, and within the self, formed the crux of all her experiences. And when this interconnectedness was missing, it impacted the helpers' ability to work effectively with clients.

It was not just enough to have a constitution _____ [community agency], there was something missing that would bring all of us together. My part of helping was to take that on, and say, we all need to all be on the same page. We need to be more supportive of each other, and not think apart, because that's not our way. And we also need to realize that all of us work with four elements that need to be in balance: mental, physical, emotional, and spiritual well-being is really important, and if we weren't balanced in those four areas then it's like the blind leading the blind. We aren't really doing as much as we could in the community if we don't have the balance and connection within us, some of us were doing it as individuals but we weren't doing it as an organization.

Mental health as based on being interconnected was seen by P3 as very important to how counselling services are provided to the community. And this sense of interconnectedness can be practiced by accepting the within group differences among the clients who come to agency for help.

I have always thought of the _____ [community agency] and the [Aboriginal] movement, almost like an embassy of First Nations peoples, because there is representation of so many different cultures here, all the First Nations culture that come here, and even the people who aren't of Aboriginal ancestry that

work here have a connection to this place and, somehow they see what we see here.

Similar to making connections to clients from differing Native cultures, is the practice of helpers connecting with each other in the workplace in a supportive way that improves services to clients through modelling and ethical counsellor conduct. “As helpers we all need to work together, support each other here, connect in whatever ways we need to for our mental health and healing... I can help provide a space where they [other helpers] can debrief and disclose what they have to disclose in a safe, confidential way so that they don’t have to carry stuff around with them. I can encourage spiritual cleansing so that they feel that their space is welcoming and not heavy with things that are disclosed to them in their spaces. I can listen to people who need to debrief for whatever reason. I can encourage finding their own path that works for them for their own health, mental health, spiritual health sort of thing. I can provide support to their clients as a network, where does that come from, these are the general practises from their territory, get them to try these things, explore...we should all have basic code of ethics that we all follow...”

Cultural traditions. Working from a place of cultural traditions came up as general theme in P3’s stories of mental health and healing and counselling practice. Her illustrations of traditional practices were often used to explain this use of culture to me. “No matter where you are from, First Nations peoples use seasons to govern their decision making, um, so this is season of acknowledgement, this is the season of renewal, this is the season of being with family, and this is the season of action, and that’s how we do things around here.”

Helping clients and helpers through mental health issues is often about coming from a foundation of cultural tradition.

I think that because the First Nations peoples come from their culture, they have so much to offer the mainstream society, it's not about making the most money and it's not about being at the top of the ladder. Its about, if you are successful you always give a hand to the person beside you, and its that sharing that has to happened, and think that's something that has to happen in all of the cultures for mental health and healing to occur.

Healing from colonialism. A salient theme for clients in her experience is healing from the effects of colonialism in terms of the residential school experience, for example.

Because I think that a lot of people struggle, I know people my age who were part of the sixties scoop and never grew up with traditional knowledge, nothing, and have only sort of got snippets here and snippets there and have tried to build up pieces of their lives and sort of put together a puzzle that was shattered.

Healing from these experiences is necessary for mental health in today's communities, with today's Native clients, and being self aware as a helper is an important part of modelling this to clients.

I think that one of the things that I bring to the Centre and one of the things that I do for myself with mental health is being aware of my own triggers and learning to cope with that and work through it. Um, because I think that everyone here, for a large portion of everyone here, um, it's been there, done that, and that we are here today [in terms of the colonial experience]. And we want to convey that hope

that there is light at the end of the end of the tunnel and let others [clients] know that we can move on and make that contribution [to healing].

Helping as supporting. Helping clients deal with mental health issues was seen as supporting rather than curing or healing clients in a direct way. This was very important to P3, whose experiences showed that culturally, traditional helping is about giving support and not direction to clients. She explained this by saying,

And I think that we have to make what we already do here, make suggestions, provide opportunities or whatever, but I don't think that we can say, you need to do this, or you need to do this, like you need to take this prescription, sometimes I think that it's the way we say things or present them that is much more welcoming to people as opportunities, and not take two of these and call me in the morning. It's our way of being and doing to help, to support, and that has been traditional for thousands of years.

Holistic approach. Another theme in P3's stories was about mental health and healing as coming from a holistic approach. What this meant was that four aspects of a person must be addressed when dealing with specific mental health issues in counselling practice. She talked about this holistic approach in this way,

I think it [mental health and healing] is all about being interconnected with the four elements, and they all; have a domino effects with each other, mental, physical, emotional, and spiritual, if any one of them is out of balance then it throws them all off kilter and when you figure out what it is that's missing, and you take a good look at it, and some people are reluctant to do that, or maybe they can't have the tools to do that, that's when you have repeated behaviour that

doesn't go anywhere...so that's what we try to do here are the Centre in our practices, come from that holistic approach.

P3 emphasized the importance and brevity of coming from the holistic approach when dealing with clients from their first contact at the centre, as it could open possibility for healing. She made an emphatic statement that was couched in a story of a client,

To always see an individual with those four elements in mind, so, for example if somebody comes in the door really only asking for help with their resume, I want to look for a job, can someone photocopy my resume, but if in the process of doing that you see that the person has not really held a job or a position for any length of time, there could be an underlying issue there, an underlying problem. We don't say, you need to talk to so and so, but we can say that if there is anything else we can do for you, you know where are some really solid people here if you want some help with anything, and you can give us a call. Really putting that offer out there, and really saying well we have this event happening in the future and we'd like you to join us, really making it feel really open and welcoming, to all aspects of the person, making it feel almost like a living room you can come in to here and just be in.

To be mindful of a holistic approach is also important to P3 because she has seen what it was like when a holistic approach wasn't taken. "And there was a time when for staff and clients, holistic mental health wasn't really important. It was only important in terms of things that were immediately happening, like in addictions or family violence, all the crisis." She explained that dealing with crisis often predisposed helpers from taking a holistic approach,

You had to put out the fires and then we'd talk about mental health but we never got there. We would see the same client for years and years and years but they would be stuck, yeah maybe we know they had addictions or family violence issues, and while we would talk to them and say how are things for you today, there was no actual movement toward them to own the problem, or look inside, or deal with the four aspects of the person.

Interdependence. A deeper look at the core message of interconnectedness reveals a finer tuned idea of interdependence that surfaced in some of P3's stories. As she talked about mental health and healing, the notion of its interdependence both within the holistic aspects of the individual and within the community of helpers at the Centre, became clear. "If it [a casework load] is dropped in your mailbox with a big deadline on it, um, you are adding stress, you are adding anxiety to everyone at work, the way my contribution for the staff for their mental health is to be much more respectful of the workload that they already carry, to be more aware of their needs, spiritual, mental, physical, and emotions—all of those things are valued, and to find them real tools to work through what they need to work through, if they need quiet, or if they this or that, or whatever they do here ... um, we should all be able to move together as an interdependent community."

P3 used many examples from her traditional Kwakwaka'wakw culture to explain how interdependence is important to the practice of mental health and healing in her work and the counselling services provided at the Centre. She explained interdependence by saying,

On the coast here, when we were travelling from our winter ground to our summer ground and back, um, you know, for fishing, (pause) we would only travel as fast as the slowest canoe, we would never leave anybody behind, and the reason being of course was because if the canoe flipped over and there was no one there to hear the people in the water, you wanted everyone to move together because there was safety in numbers to protect and take care of each other and support each other. And that's what we needed to start doing at the _____ [community agency], not just for each department to struggle in their own little areas but for everyone to work together as a community as a family to help each other and provide services to the community.

Creating and maintaining interdependence is necessary for mental health and healing for clients and for helpers, in P3's experiences at the Centre. She said,

That path [of interdependence] is there, it's always been there and we need to find that path again. And that path is that we need to support each other, we need to be there for each other, not judge each other, not put each other down, we need to really truly help each other and realize that we are all connected in one way or another, and it's only when we are able to think as a community that we will be able to move forward [in mental health and healing].

Spirituality. Spirituality arose as another important theme for P3. Spirituality was part of the holistic approach but also needed to be seen on its own because it was really connected to mental health per se. P3 tells how she uses spirituality in her work,

And I think that we need to not be afraid to talk about how mental health and spirituality are connected. I really think that these two things are connected, and I know

for myself, that when things get really tight, aside from just going to the ocean, I have to call my ancestors to help me, to help me to say the things that I have to, to be helpful, help me to recognize what I am not being respectful or am judging or those kinds of things, because those incidents play havoc with your mental health, like feelings, taking ownership of a lot of things, I think that for myself as well one of the things that I have been learning to kind of work with here.”

All of the helpers that she works with at the agency are encouraged the employ spirituality in their practice. P3 works with the other helpers on incorporating spirituality into counselling practice. “I can encourage spiritual cleansing so that they [the counsellors] feel that their space is welcoming and not heavy with things that were disclosed to them in their spaces.”

Reflecting on the spiritual teachings of her culture, she shared a story about how spirituality can be used to deal with mental health issues such as stress and anxiety.

She [my grandmother] said go to the ocean for clarity and go to the cedar tree for help. And I have always done that. When I was having my children it was the same thing, I don't want the stress that I might be experiencing to be related to that child, so I will go to the ocean to bring that calmness back and I will go to the tree for help. And it's always worked, maybe its just ritual but I think it's really important, I think that everybody needs to have this in their toolbox.

Participant Four

Character Sketch

Participant four (P4) is a female in her late twenties who has four years of experience in the professional helping field in the Native community. She has completed

post secondary education and looks forward to a lifetime of fulfilling her calling to helping others in her family as well as her community of work. Her knowledge and intelligence in the helping field is clearly evident through her stories shared. She is an open and honest young woman who believes that peoples should have the freedom to choose their path to mental health and wellness and this is the journey that, in the Indigenous world, takes place in the context of spirituality and personal growth, which looks different for each person. Family is a very strong force in her personal life and she strives to help others get connected and has that sense of interdependence and belonging that she feels are one component to health and wellness. Our interviews were marked by her optimism and flexibility that seemed inherent in her personality

First Interview

Once informed consent was obtained we began the interview in earnest. P4 appeared slightly uncertain about how to answer some of my questions and her answers were somewhat tentative. With liberal use of verbal prompts and encouragers, she became more confident in her answers, and by about 30 minutes into the interview her answers became more clearly formed and articulated. The interview lasted about one hour, and by the end of it P4 was happy, relaxed, and quite talkative. I created an initial story map from this interview (see Figure 12). From this story map I discerned a core message of interdependence, and themes of active engagement with culture, helping as part of healing, spirituality, and supporting.

Initial Story Map P4	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past	<ul style="list-style-type: none"> • Family support • Helping role • Helper role models • Calling 	<ul style="list-style-type: none"> • Discrimination • Learning cultural identity • Ignorant of cultural conceptions • Connectedness to family 	<ul style="list-style-type: none"> • Work with communities • Learning community values • Connectedness • Family 	<ul style="list-style-type: none"> • My healing journey • Learning about spirituality • Community based • Learning multiple perspectives • Connected to identity 	
Present	<ul style="list-style-type: none"> • Helping as healing • Clear helping role • Connectedness for healing 	<ul style="list-style-type: none"> • Shared cultural identity • Spirituality • Active engagement 	<ul style="list-style-type: none"> • Family • Community values 	<ul style="list-style-type: none"> • Holistic • Active engagement • Journey • Spirituality • Connectedness • Family 	<ul style="list-style-type: none"> • Supporting • Spirituality • Under-use of services
Future		<ul style="list-style-type: none"> • Bigger role 	<ul style="list-style-type: none"> • Work with communities 	<ul style="list-style-type: none"> • Traditional models • Culture based • Benefit to other communities • Benefit to our community • More connectedness with community, family, cultural identity 	<ul style="list-style-type: none"> • Paradigm shift in service • Culture based • Helping others connect • Continue in a supporting role

Figure 12. Initial Story Map for P4

Feedback from Second Interview and Final Story Map

The second interview with P4 was more relaxed than the first. We had built some relationship and this seemed important to her. It was clear that her interest was piqued by the research and that she was becoming excited by the results that I was sharing with her from my preliminary analysis. She expressed hope that this study would inform policy change and help to improve Native mental health both within the community and in terms of educating the mainstream about the challenges currently being faced by Native peoples. In fact it was this conversation about the research itself that led to most of the changes that she made to her story map. She did not change anything that I had placed in terms of thematic codes from her interview, but she added in the Self as Helper category, Future intentions: more education, working more with children, and advocate for policy change. In the Indigenous culture category, she added in Future Intentions that there be more respect from the mainstream. Also in the Counselling Practice Category, Past experience, she added Family nurture, volunteer basis, and childcare basis, indicating that her past experiences of counselling had revolved around volunteering as a helper, how her family had nurtured counselling approaches within her family system, and that being in a child caregiver had formed the basis of much her past counselling experience. The changes to her initial story map are highlighted in the final story map for P4 in Figure 13.

Final Core Message and Themes

The final core message for P4 is interdependence, and the final themes for P4 are active engagement with culture, spirituality, and supporting.

Final Story Map P4	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past	<ul style="list-style-type: none"> • Family support • Helping role • Helper role models • Calling 	<ul style="list-style-type: none"> • Discrimination • Learning cultural identity • Ignorant of cultural conceptions • Connectedness to family 	<ul style="list-style-type: none"> • Work with communities • Learning community values • Connectedness • Family 	<ul style="list-style-type: none"> • My healing journey • Learning about spirituality • Community based • Learning multiple perspectives • Connected to identity 	<ul style="list-style-type: none"> • <u>Family nurtured</u> • <u>Volunteer basis</u> • <u>Childcare based</u>
Present	<ul style="list-style-type: none"> • Helping as healing • Clear helping role • Connectedness for healing 	<ul style="list-style-type: none"> • Shared cultural identity • Spirituality • Active engagement 	<ul style="list-style-type: none"> • Family • Community values 	<ul style="list-style-type: none"> • Holistic • Active engagement • Journey • Spirituality • Connectedness • Family 	<ul style="list-style-type: none"> • Supporting • Spirituality • Under-use of services
Future	<ul style="list-style-type: none"> • <u>More education</u> • <u>Working more with children</u> • <u>Advocate for policy change</u> 	<ul style="list-style-type: none"> • Bigger role • <u>More accepted in mainstream</u> • <u>More respected in the mainstream</u> 	<ul style="list-style-type: none"> • Work with communities 	<ul style="list-style-type: none"> • Traditional models • Culture based • Benefit to other communities • Benefit to our community • More connectedness with community, family, cultural identity 	<ul style="list-style-type: none"> • Paradigm shift in service • Culture based • Helping others connect • Continue in a supporting role

Figure 13. Final Story Map for P4

Interdependence. The key core message for P4 was independence as an integral force to the intersection of counselling and mental health and healing. Interdependence in terms of meaning mutual reliance between people was very important to P4's understanding of what constitutes mental health and healing for clients both in their own

personal lives and with the helping relationship. For P4, interdependence can be seen in family, for instance. “Family, extended family, are closer, more like siblings to me. And family is important to culture to be connected...and this informs how I work with clients on things to do with mental health.”

Interdependence formed a cornerstone to what defines mental health and healing in P4’s experience as a helper, and this conception formed the basis of her practice of helping and how she views the system of mental health care. P4’s hope is that the mainstream health care system will accept and respect the interdependent nature of mental health and healing for Native peoples. “Well, I am hopeful that the mainstream and the funding will shift away from the illness/mainstream model and to incorporating cultural views and holistic view of mental health and healing that are about interdependence.”

Active engagement with culture. It came up as theme in P4’s stories that people actively engage, or chose to connect with their culture, as part of their mental health and healing. P4’s experience spoke to this process. “People make choices to be part of their culture, some people really chose to get to know and engage in their culture and some don’t want to or have a need to do or have seem reason why they don’t want to go there, and that’s part of their healing, part of what we do here.” How people chose to engage in their culture varies, yet invariably clients make the choice to engage with culture as part of their healing journey. She explains,

When people are disconnected from their culture, like one lady I know, it makes me wonder why they are so. Being disconnected from your culture matters in terms of how important culture is to you as an individual. I know that culture is

important to me. A healing journey could or could not be connected to culture... people are engaged somewhat in their culture just by coming here. I guess if healing is an individual thing it be up to the individual how important culture is for their healing journey, but for me, in my own healing journey, I can say that culture is very important.”

Spirituality. An important theme in P4's stories was how spirituality, as part of culture, informs her work her as helper who comes from a Native perspective. She states, Spirituality is also very important to culture, and there are different ways to be spiritual in each culture...there can be lots of forms of prayer in different cultures, and mine has changed...it used to be a formal prayer...now I have learned that you can pray whenever in any way, and I use this in my work with clients.

Spirituality is necessary to healing for the clients she has worked with because as part of culture, it has been taken away to the detriment of mental health in the past and still in the present. “Spirituality will hopefully be a bigger part of mental health and healing and support work...because so much has happened...in Aboriginal history to take culture away, spirituality needs to come back for mental health and healing to continue to occur.”

Yet her understanding of spirituality in the helping profession has evolved because spirituality is missing from mainstream education of helping. “Five years ago I couldn't even define it [spirituality]. Education at college and university gave me the mainstream, DSM-IV knowledge and definitions of it, the cultural conceptions changed me again through my work in the communities.”

Spirituality has really come to be understood as a practice of holistic health and a personal engagement with healing. “Spirituality can be a big thing, like ceremony and sweat...It’s also an individual thing, it’s a personal journey.”

Supporting. Mental health is seen as rooted in the action of supporting clients, supporting clients in their journey to wellness. “Having support is key [to mental health and healing], to family or even through social networks. Mental health and healing here for Natives is different to mainstream mental health.” which is about illness, Native mental health is about emotional health and getting support for that.” Supporting is really a key aspect to what P4 does as a helper, and she explained that this is how she sees a beneficial structure to all mental health services. “I think that cultural approaches to mental health with Native peoples would be better using a Native cultural approach that emphasised supporting people.”

Her experiences are that Native peoples’ healing needs centre around support on many different kinds, and that mainstream mental health services do not meet these needs for support.

A lot of people aren’t accessing mental health services because of this and it’s a problem that peoples are getting over prescribed drugs and not the support they need in terms of someone just being there to listen. Um, but, but the business of mental health care is so big that it runs so much –I worry that the system will just keep giving pills to people and not dealing with their real healing needs (like community connectedness, family, spirituality, finding their own individual healing journey, taking a holistic view of their mental health).

Participant Five

Character Sketch

Participant Five (P5) is a male helper in his thirties whose interests in helping were fostered from an early age. He has a gentle and non-interfering way of communicating that demonstrated his strength as a helper and warrior in the current context of healing in Indigenous communities. He demonstrated flexibility in understanding the stories of his clients and his own evolving story throughout the process of our interviews. His experience in professional helping included university training that culminated in a degree in family support work. His emphasis in his work and his personal life is on supporting connections both between himself and community members and within community. The connections that he hold with his own family was also a strong thread that held together many of his beliefs and understanding about mental health and healing, and how family influences the direction or path that the healing journey takes.

First Interview

I gave P5 a copy of the interview questions. P5 was led through the informed consent process, then we began the interview. Figure 14 contains the initial story map that I created from the analysis of this interview. Embedded within this map I found a core message of connecting, and themes of cultural identity, community, resiliency, holistic health, and journeying. He was quiet and soft spoken throughout the interview, though he did not appear nervous or uncertain. He was quite clear in each statement, though quickly into the interview I noticed that his statements were quite brief and to the point, often just a one or two word sentence. As is common in my experience with some Native peoples, particularly men on occasion, there is little value placed on small talk, so

Initial Story Map P5	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past Experience	<ul style="list-style-type: none"> • Family Support • Role Model • Calling • Journey • Seeking education • Feeling supported 	<ul style="list-style-type: none"> • Helping as a value • Helping as a tradition • Receiving teaching • Losing identity 	<ul style="list-style-type: none"> • Supporting • Resiliency 	<ul style="list-style-type: none"> • Disconnection • Colonization effects 	
Present Experience	<ul style="list-style-type: none"> • Natural role • Seeking stronger connection with family 	<ul style="list-style-type: none"> • Resiliency • Receiving teachings • Helping as a value • Helping as a tradition • Seeking stronger cultural identity • Finding identity 	<ul style="list-style-type: none"> • Resiliency • Interconnecte dness • Dealing with colonization 	<ul style="list-style-type: none"> • Removing boundaries • Connecting with a helper • Connecting with culture • Connecting with spirituality • Holistic • Interconnected with spirituality • Connecting with cultural identity • Resiliency • Colonization effects • Connecting with Elders • Connecting with community • Long-term Journey • Disconnection • Unemployment • Connecting with the self 	<ul style="list-style-type: none"> • Connecting with cultural identity • Connecting with spirituality • Connecting with culture • On-going individual support • Connecting with resiliency • Supporting • Addressing disconnection • Using interconnectedness as a tool • Building relationship
Future Experience	<ul style="list-style-type: none"> • Returning more to roots • Staying on helper journey • Journeying home 	<ul style="list-style-type: none"> • More receiving of teachings • more connecting with identity 	<ul style="list-style-type: none"> • More focused on health and healing • More interconnecte dness 	<ul style="list-style-type: none"> • More connecting with culture • More connecting with Elders • More connection with community • Stay on journey • Addressing disconnection • Staying on long-term journey 	<ul style="list-style-type: none"> • More on-going individual support • More connection with culture • More culturally based • More connecting with community • More building relationship

Figure 14. Initial Story Map for P5

many of his answers to my questions were quite short, initially too short to be placed within a narrative framework. However, I used a lot of prompts and encouragers. I also asked him to tell me more about specific aspect of an answer that he gave me to each question, and in this way I was able to coax out more detailed answers that finally came in the form of stories about past, present, and future experience that, for the most part, answered my questions.

Feedback from Second Interview and Final Story Map

In the second interview I presented P5 with the initial story map, core message, and themes, a copy of the interview transcript, and a copy of the transcript in chunked and coded stages. I talked about the analysis process I had completed with the data and invited his feedback on the map, the core message, and the themes. As our first interview had been difficult to get going in terms of story, there were several gaps in information in the story map, and I asked him about these and what information he would place in these spaces now. Upon careful reflection, he was able to fill in the gaps with thoughtful; and detailed answers that, unlike in our first interview, did not require teasing out in our conversation. These changes are highlighted in the final story map for P5 (see Figure 15). In counselling practice, past experience he added: Based mostly on non-Native practice; Evolving; and Changing to incorporate Native ways. For these additions he told short stories illustrating examples of how counselling practice was known to him in the past in these three ways. Under Self, Future Intentions, he added: More education. He talked about his desire to return again to school, hunger for more knowledge and expertise in the field of professional helping, as for him, learning was seen as a lifelong journey. These changes are highlighted in the story map below.

Final Story Map P5	Self	Indigenous Culture	Community	Mental Health & Healing	Counselling Practice
Past Experience	<ul style="list-style-type: none"> • Family Support • Role Model • Calling • Journey • Seeking education • Feeling supported 	<ul style="list-style-type: none"> • Helping as a value • Helping as a tradition • Receiving teaching • Losing identity 	<ul style="list-style-type: none"> • Supporting • Resiliency 	<ul style="list-style-type: none"> • Disconnection • Colonization effects 	<ul style="list-style-type: none"> • <u>Based mostly on non-Native practice</u> • <u>Evolving</u> • <u>Changing to incorporate Native ways</u>
Present Experience	<ul style="list-style-type: none"> • Natural role • Seeking stronger connection with family 	<ul style="list-style-type: none"> • Resiliency • Receiving teachings • Helping as a value • Helping as a tradition • Seeking stronger cultural identity • Finding identity 	<ul style="list-style-type: none"> • Resiliency • Interconnectdness • Dealing with colonization 	<ul style="list-style-type: none"> • Removing boundaries • Connecting with a helper • Connecting with culture • Connecting with spirituality • Holistic • Interconnected with spirituality • Connecting with cultural identity • Resiliency • Colonization effects • Connecting with Elders • Connecting with community • Long-term Journey • Disconnection • Unemployment • Connecting with the self 	<ul style="list-style-type: none"> • Connecting with cultural identity • Connecting with spirituality • Connecting with culture • On-going individual support • Connecting with resiliency • Supporting • Addressing disconnection • Using interconnectedness as a tool • Building relationship
Future Experience	<ul style="list-style-type: none"> • Returning more to roots • Staying on helper journey • Journeying home • <u>More Education</u> 	<ul style="list-style-type: none"> • More receiving of teachings • more connecting with identity 	<ul style="list-style-type: none"> • More focused on health and healing • More interconnectdness 	<ul style="list-style-type: none"> • More connecting with culture • More connecting with Elders • More connection with community • Stay on journey • Addressing disconnection • Staying on long-term journey 	<ul style="list-style-type: none"> • More on-going individual support • More connection with culture • More culturally based • More connecting with community • More building relationship

Figure 15. Final Story Map for P5

No other changes were made to the existing information in the story map, and he stated that everything else “looked about right” in the map, and that he agreed with its illustration of his views. He expressed happiness for participation in this project and thanked me for allowing him to express and share his views on mental health.

He agreed that the core message and themes were reflective of his story map and the words he had shared in our first interview, and had no wish to change these.

Final Core Message and Themes

The final core message for P5 is connecting. The final themes are community, cultural identity, holistic health, journeying, and resiliency.

Connecting. Connecting was the core message throughout P5’s interview. P5s stories held a common thread of connecting that wove through almost all of the other themes in his stories. The act of connecting served as foundation for helping and healing.

For the people I work with, the issues that they deal with on a daily basis, like mental health and healing, I think hearing and talking about it helps them relieve some of the stress, instead of holding it all in, um, just connecting with someone. Helping clients connect not only through talking with a counsellor but by connecting with their culture through that talking, supports mental health and healing.

Talking with them [the clients] about the sort of cultural background they come from, um, I like to, um, think that differentiated First Nations cultures deal with mental health in different ways.

Connecting with spirituality was another important way that clients are helped in the counselling process. “My own cultural way would be longhouse, and that would be

more of a spiritual thing. I think that everything is connected in the four aspects when I work with clients, we look at how they do spirituality to heal.”

Community. Community is also necessary component to the mental health and healing of clients in P5’s experience. P5 has seen disconnection from communities for some clients and disconnection within community as having an adverse effect on the functioning of individuals and groups in terms of healing processes.

Regarding community, I think it’s just that disconnectedness that we have with one another really has this negative effect on people, like you are from this family and you’re from that family and we’re not supposed to get along, so it’s just really hard to work with in some spots. When there is disconnect among community, it’s tough on healing.

Cultural identity. Cultural identity is one of the pieces necessary to mental health and healing for many clients seeking support, and for P5, helping clients connect with their cultural identity is main focus in supporting clients. Learning who you are and where you come from has great benefits in P5’s practice of helping in terms of improving the mental health of clients.

If we are talking about all peoples, including the clients I see here at the _____ [community agency], well, um, speaking culturally, I, I think that having clients connect with their cultural identity and be learning as much about their culture would, um, does, most benefit their mental health and healing.

Holistic health. Taking a holistic approach to mental health is also foundational to P5’s work. For P5 a holistic approach means incorporating different aspects of the self,

such as the spiritual dimension, into the practice of helping. It can be challenging, however, to meet all aspects of the holistic approach, sometimes due to within group differences. For example, spiritual practices, as part of holistic health, vary from community to community, and when clients come from outside the local region, connecting this aspect of the whole in counselling can be difficult. He explains this in these words,

Spirituality as part of holistic health, being in an urban setting it is a bit more challenging, ah, people are looking for somewhere to go for spirituality. Um, moving into Victoria, um, and Saanich area we have the Coast Salish tribes out here, um, but we also have a variety of different background of Native and there is a multitude of them, so I guess they are feeling a little bit disconnected from their own spirituality, so trying to fill that void is sometimes tough because you have so many clients come in who are not from this particular area and are from so many different areas and we try to connect with that piece. I think, yes, we do have Elders who come in and interact with our clients and they are pretty great on the spirituality. We also have drummers group every week to help people connect with the spirituality.

Journeying. Addressing mental health and healing as a helper and from the client's perspective is explained by P5 as a journey. Mental health and healing is an ongoing process that is viewed in a non-linear way through his helping approach,

I am continually learning myself so whenever I encounter people [as clients] I try to take as much as I give so each time I am open and it's a learning process, um,

on-going, um, I, I um, feel all of life is learning process, um, really, and I will never stop learning as a helper or healing, um, myself, as Native person.

Clients access support from P5 with an approach to the process as on-going, and it is this aspect of the relationship that is continuous that reflects the journeying aspect to counselling that is beneficial to clients in P5's experience,

They [the clients] come here for help with their issues and they can take something good from it, you know, and um, they come back and, um, back. So rather than coming here feeling like they are disconnected they can instead feel really connected here, it's, um, part of the journey, it's about the journey.

P5's own personal healing journey was intertwined with his journey as a helper, and this was important to his development and practice as a helper. "Yes, the journey, (laughter) I feel that as much as I have put in is what I take out." P5's journey into the future is clear and laid out like a path for him that connects with more education and his cultural roots and identity. "I'd like to go back to school and get more education one day." P5 was clear about a journey to mental health and healing as being connected with his own community. "I'd like to ideally see myself working in my own community and to incorporate some different culturally active processes in my own community to be a helper, and um, get to know myself better too, um, its part of my journey."

Resiliency. Resiliency in P5's experience means surviving adversity, such as growing up through an era of colonization, and for P5's Native clients, it is this ability to simply survive colonialism that supports mental health and healing. "I think that if you have that resiliency it's very important for the Native person, growing up with the social issues like colonization." Resiliency is seen as being inherent to the culture of Native

peoples as a whole, as a piece of what has traditionally sustained mental health for Aboriginal societies. “I think it’s their tenacity, Aboriginal peoples are very static, I mean very resilient people, I mean the social and cultural background of people gives them strength and the will to carry on with mental health.”

Counselling that serves to help clients connect with a personal sense of resiliency is what embodies mental health healing in much of P5’s work. His experience of understanding resiliency and working to incorporate it into the helping relationship involves actively supporting the client through verbal encouragement and connecting the client with things or people in their life that are strength-based resources to mental health and healing,

I try to help them [clients] realize their own strengths and boundaries and try to work on those and build upon them, and I do this mostly through talking, and if they are going through something that is really difficult for them then I have them try to take a step back and see what they have in front of them and try to see, to find the best solution that will work for them.

Summary of Chapter Four

In Chapter Four I presented the within participant analysis and results for the five participants who shared narratives about the intersection of mental health and healing and counselling practices. This presentation included a character sketch and initial and final story maps as well as discussions of the two interviews conducted for each participant. Details of the core message and themes were also discussed for each participant. All of the core messages were overlapping and many of the themes were similar. Chapter Five will contain my presentation of across participant analysis and results.

Chapter Five: Discussion of Across Participant Metathemes and Proposed Illustration of Indigenous Healing and Counselling

Chapter Five contains my understanding as a whole of participants' experience of mental health and healing as intersecting with their practices of counselling. This includes discussion of the technique used for identifying the metathemes, in-depth examination of each metathemes, and an explanation of how they relate to each other.

Across Participant Analysis: Metathemes

A detailed discussion of the technique used to identify these metathemes is necessary for several reasons. According to Ryan and Bernard (2003), discovering themes is important because (a) the basis of a majority of qualitative social science research is to develop themes, (b) being explicit about how themes are established allows for rigorous assessment of methodological procedures, and (c) qualitative researchers require an explicit vocabulary to communicate across and within disciplines and across epistemological positions regarding their procedures such as data analysis.

Themes in qualitative data were first defined by Opler (1945) as culturally-based expressions of "a limited number of dynamic affirmations" (p. 198). Opler also suggests that the importance of a theme in data rests on how often it appears in the data, how pervasive it is across different cultural practices and ideas, how people react when the theme is violated, and the degree to which the force, number, and variety of a theme's expression is mediated by specific contexts.

Tesch (1987) uses the term "metatheme" to represent the totality of the phenomenon being researched (p.231). In the present study, the metathemes are common

themes across all participants' narratives that describe their overall understanding of mental health and healing in a counselling context.

The metathemes identified in this study are not simply abstract concepts, they are expressions found embedded in the data as whole, including participant interviews, story maps, field notes, and my field journal. These metathemes come from the interview data (an inductive approach) and from my prior theoretical conceptions of Indigenous mental health (an a priori approach). My a priori understanding of what constitutes Indigenous mental health and healing come from what I have identified in the literature review and from my own set of values and personal experiences, which are recorded in the context of this study in the field notes and field journal. Strauss and Corbin (1990) label this a priori understanding as "theoretical sensitivity" (p. 41), and suggest that it offers a rich source of themes and conceptions in the analysis process. In my analysis, the metathemes are not additive concepts created by separate smaller themes or concepts within the interviews. Rather, these metathemes are shared across all participants' data as a whole. There is considerable overlap between individual participant's themes and common metathemes.

I have identified four across participant metathemes, under which many aspects of counselling related to Indigenous mental health fall: community, cultural identity, holistic approach, and interdependence (see Table 2). These metathemes represent overarching ideas that epitomize an Indigenous conception of mental health and healing.

Across Participant Metathemes			
Community	Cultural Identity	Holistic Approach	Interdependence

Table 2. Metathemes from Across participant Analysis

The metathemes were identified through reading and re-reading all of my previous field journal entries, listening in one sitting to all of the participants' interviews again, and adding memos in the field notes, field journal, and discussion sections of this dissertation. From this reflexive process, the idea of overlapping circles seemed to best represent the four overarching metathemes in the data.

Field journal: In order to analyze the counsellors' stories as whole, I maintained a narrative framework that served as a lens through which the greater story of all participants was viewed in order to generate broader results. This, also more importantly, becomes a way for me to holistically reflect my own earlier or current perspectives in order to construct or reconstruct meaning in terms of some overarching themes, or what qualitative researcher Renata Tesch as has called metathemes. The individual stories of the counsellors, are not literary type stories, instead I view them as a sort of life story of their development as helpers and their understandings of mental health and healing. I have read in the literature on narrative methodology that (obviously) in general, peoples' stories, and particularly life stories can be based on their understanding of a truth or constructed from fantasy. In particular, in terms of these participants, I hold that these stories, my reflection in here in my journal, and in my field notes, reflect a legitimacy that fits the reality of Indigenous mental health and healing in context.

Figure 16 contains a schematic representation of the four metathemes in a non-linear format. It is designed to represent the circularity of these themes occurring in a non-hierarchical flow, to describe how Indigenous mental health and healing is conceived by

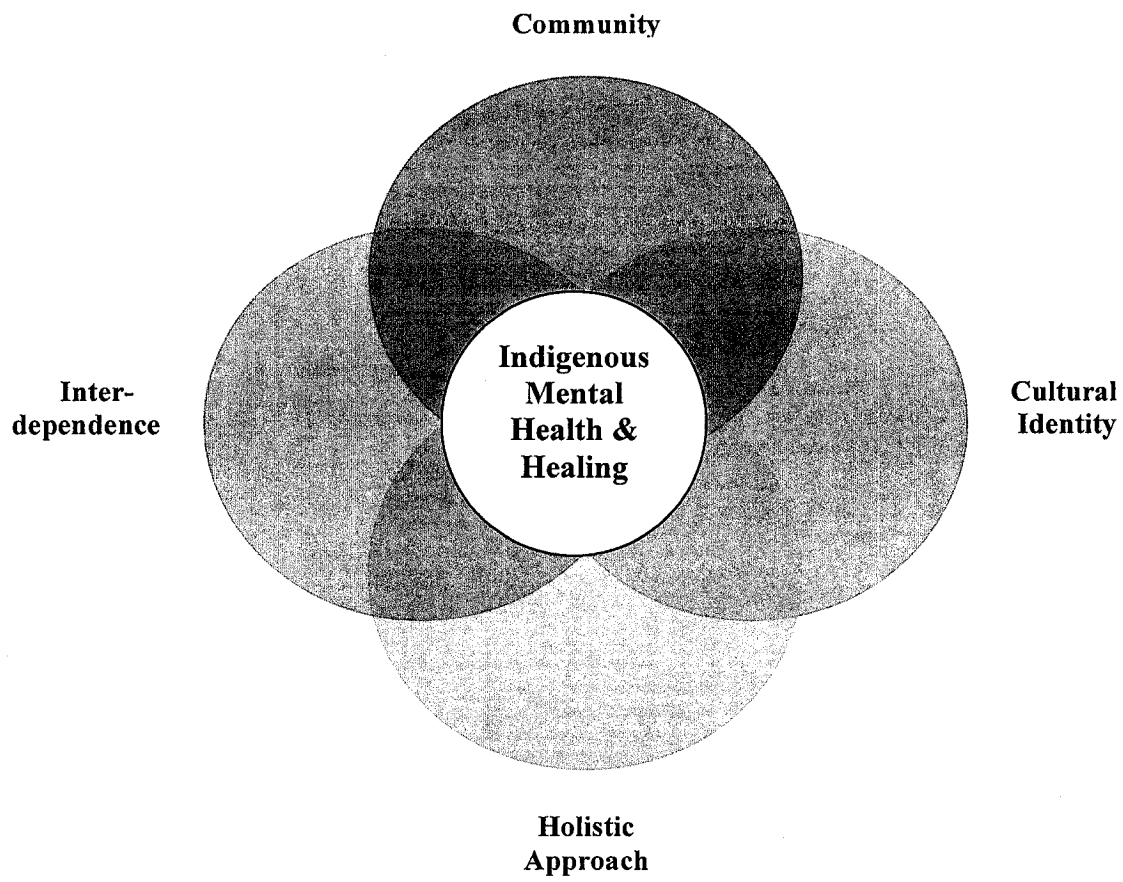


Figure 16. Participant Metathemes of Mental Health and Healing

the participants in a cultural context. In many Native cultures, the circle is used to depict a non-linear understanding of life and lifeways. Each circle represents one of the metathemes. The centre represents the core conception of Indigenous mental health at the point where the four circles of the metathemes overlap or intersect. This intersection implies that these four metathemes are essential to a conception of mental health and healing in a particular context. A discussion of the metathemes in alphabetical order follows, as there is no hierarchy of or sequence to their order.

Metatheme: Community

This study is significant in terms of identifying community's place in Indigenous mental health. Community is an overarching theme throughout the interviews and as a metatheme community demonstrates how the inclusion of the concept of community is necessary to authentic health research results. In a Canadian Indigenous context, Mussell et al. (2004) define community as a "value shared by Aboriginal peoples. The spirit that holds a relatively healthy group of families together is embedded in community" (p. 8). Participants defined community both in Western general terms and in terms of Mussell's conception, as where they lived and the other people who lived there with them such as by cultural affiliation bound in spiritual ways that was of importance to their ways of life. Community is not necessarily a home community or traditional family community but a concept that includes community of relationship amongst peoples.

Community was identified as a metatheme because all participants spoke clearly about it as a necessary and specific component of mental health and healing for Indigenous peoples within the counselling process; it is part of the foundation of what

clients need to establish and maintain mental health. Community was referred to by participants not solely or specifically as clients' ancestral or traditional community but as any community of other Native peoples to which they might belong. Thus community more generally refers to social/collective grouping with others, any others, with whom some link to Indigenous culture exists. Native society has traditionally been of a collective orientation, and the participants echoed this orientation as a key aspect of Indigenous mental health in the ways they talked about the importance of community. These thoughts are similar to what was included in the Government of Canada's (1991) description of Aboriginal mental health: "behaviours which make for a harmonious and cohesive community and the relative absence of multiple problem behaviours in the community..." (p. 6). All of the participants in this study shared stories about mental health and healing that were linked in some way to community, either in terms of community wellness linked to individual health and healing, or of the presence of community linked to mental health and healing in clients' lives. P1 said, "What I have really come to understand [in my work as a helper] is that the individual's healing must be done in the circle of community." P3 echoed this comment with her statement, "I think that one of the contributing factors to mental health is...thinking more along the lines of community, healthy community."

Kirmayer et al. (2000) make the point that Aboriginal mental health as defined as wellness and healing is rooted in collective community health and cultural community practices, such as speaking Native languages and engaging in ceremonial practices. The authors explain that despite many changes throughout history and into current times, many Native communities have survived and prospered. "There are constant

transformations of forms of community, and this sort of evolution is at the root of recovery, or revitalization and renewal (2000, p. 611). Further, it is the “mediating mechanics” that contribute to community level mental health problems that are closely related to individual health issues such as depression and self-esteem, (2000, p. 611). These health issues, Kirmayer et al. show, are influenced by the collectives of communities. They cite for example, the wide variation of suicide rates across Native communities as an indicator that it is important to consider the nature and health of the overall communities and how these communities respond to the ongoing stresses of colonization and governmental control, including sociopolitical marginalization. In this dissertation, all participants were clear about the need to rebuild and heal at the community level from colonization, and specifically discussed how this was linked to mental health and healing for the individual clients with whom they work. And while this need for community healing is not a descriptor of mental health as wellness, it was talked about in terms of part of the journey to mental health as wellness or healing.

The overall results from this dissertation agree with Kirmayer and his colleagues’ findings, but go beyond their understanding of community as linked to individual mental health and healing. The present participants experiences suggests that without community as part of an individual’s healing process, healing cannot occur for the clients they have worked with. Community, in the counselling practice of these participants, is not merely foundational to maintain mental health and healing, but is a necessity that must be in place. It must be an active part of an individual client’s life in order for them to begin a healing journey and to stay within a place of wellness. In the present study, community is part of the holistic balance of an individual’s life.

Similar to the present study, King's (1999) descriptive research, earlier discussed in detail in Chapter Two, suggests that if there are problems at the community level, or even perceptions of problems in the community or collective, then this has a negative impact on the mental health of the individual. A major finding for King was that respondents reported that their own mental health was negatively affected in terms of higher depression, low self esteem or self efficacy, or higher self-harming behaviours when the community's collective mental health needs, such as a need for education, services such as counselling and interventions, were not met. In other words, King found a direct link between an individuals' mental health status and a community's unmet mental health needs. The present study's participants suggest that without the inclusion of some form of community, healing is a daunting challenge.

Linking community and mental health for Indigenous peoples is necessary but often challenging. Communities have varying degrees of similarities and differences. Kirmayer et al. (2000) write that health research about Native communities does not always allow for differences in incidence and prevalence of specific mental health problems among and between communities, but rather tends to generalize information to all Native communities. These authors suggest comparative research between communities in order to identify and promote community health. In this study, it was clear that my results show that within community differences must be acknowledged and respected in terms of delivering mental health services, such as counselling. This point underscores the need to examine individual healing on a community basis and to look at individuals within that community. Participants in the present study made clear that each community has major commonalities in definitions of mental health, yet also different

understandings of mental health. These differences are grounded in local Indigenous ways of knowing and being. P3 discussed this need to respect differences between and among Native communities in her experience of delivering mental health services, these differences impacted how clients practiced mental health and healing within their Native cultural context. P3 explained this by saying:

I think it [mental health and healing] will be different for every person that will come through the door, and I think that's one of things that we have to learn to treat peoples as individuals. Even if we have two people from the same community we have to learn to treat them as individuals. For example, say we have two people from my community, they are both people from Kwaguiluth territory, one is from _____ and one is from _____, their language and Nations are the same but their approaches to mental health might be very different, not hugely different but enough different that I think that that difference needs to be respected.

Research on the effect of community has been carried out by Chandler and Lalonde (1998), whose work links levels of community control and suicide rates among Aboriginal peoples in British Columbia as discussed in Chapter Two. In the present research, the participants spoke of community health in terms of engagement with cultural identity or traditional cultural practices such as ceremony, drumming, or prayer. Being functional (as opposed to dysfunctional) was related to individual members' mental health and healing. The participants suggest that mental health and healing is about what is occurring at the community level, including how involved individual members are in community and vice versa, to what extent the community is recovering

from its colonial history or trauma, and how the well the community functions interdependently as a collective. These aspects of community not only impact mental health and healing, which as Chandler and Lalonde suggest can be measured by specific health indicators such as suicide rates, but also form the basis by which mental health is judged by the counsellors who work with clients on a daily basis. This involvement of mental health and healing with community suggests that counselling for Native clients should be carried out in the context of their community and not in an individually-focused approach. Counsellors should be asking clients how mental health and healing looks in their specific communities. What practices promote community wellness, and, thus individual mental health and healing?

Metatheme: Cultural Identity

An important focus of this dissertation was to gain a clearer picture of a cultural conception of Indigenous mental health and healing. Cultural identity has been defined as “a set of behavioral or personal traits by which an individual is recognizable as a member of a cultural group,” (Mussell, Cardiff, & White, 2004, p. 8). Cultural identity was something that participants experienced as explicit and necessary to mental health and healing in their own personal lives as helpers and in their work with clients. Kelm’s (1998) research on the history of British Columbia Aboriginals shows that historically, ill health, such as physical and emotional problems, in Aboriginal communities was linked to weakened cultural identity.

Many government reports make explicit the connection of cultural identity to mental health for Indigenous peoples, and state that strengthening cultural identity is one way to improve Native mental health (see Assembly of First Nations, 1994; Health

Canada, 1997, 2003b; Royal Commission on Aboriginal Peoples, 1994, 1995, 1996). The present study substantiates this claim that cultural identity is an important force in Indigenous mental health and healing. The overall view of participants suggests that having a clear Native identity is part of mental health; the act of finding or strengthening Native identity is what healing is about. P1 explained this by saying:

The reality is that if you don't have some iota or some speck [of understanding] of yourself as a person on the planet that has value and connectedness to who you are [culturally], it is very hard to change behaviour, build on behaviour, change thinking, build on different skills or abilities that will change your day to day experiences.

Burgess (2000) writes that cultural identity in Native contexts is important to mental health because it creates a mechanism by which people are better able to deal with mental health problems and other negative impacts of victimization that have occurred through the colonization process. The present study's results indicate that cultural identity gives Native peoples the strength and wherewithal to consider healing possibilities through personal self growth, connections with family, community, and Indigenous cultures. P2 explained how gaining cultural identity impacts mental health, in terms of self esteem and the ability to cope with life:

We [Native peoples] have quite a rich history of culture, which is something that you can explore and research and be proud of, so you can know who you are, have an identity. Having an identity is huge for everyone; it helps people go through life and be healthy if they understand who they are.

Thus cultural identity can play a significant role in the counselling relationship within the spectrum of mental health interventions. Culture provides a resource for positive mental health and fulfills a person's need for identity (Sue & Sue, 1990). In social psychology, identity is related to self esteem and self concept, and further, it is greatly influenced by culture in terms of language, norms, and practices (Adler et al., 2004). Chaimowitz (2000) writes that counselling interventions in Native communities need to include attention to Native cultural identity because it is important to individual well-being and mental health in this context.

Earlier, in Chapter Two, there was a discussion of Weaver's (2001) study in which she stated that Native identity was based on various factors, including community membership, personal experiences that created either positive or negative views of the self as Native, perception of the self and of the self by others. This form of identity construction was talked about by participants in terms of how it impacted mental health. To belong and be accepted as a Native person within a community had a tremendous impact on ability to feel good about one's self, to feel good about one who is Native. One participant explained that it could sometimes be an emotionally difficult experience to be accepted as Native by a community, and that this process did affect whether or not a person sought needed mental health services. P1 explained,

It's [cultural identity] also been one of the hardest things: I am not visibly First Nations, I have not had to live with physical discrimination against me personally, but I am connected by heart and spirit. Then when you're talking about a system of [mental health] care, when I self identify as an Aboriginal person, there is still perceptions about what does Aboriginal look like...because people have an

attitude or belief around what Aboriginal people look like, and this impacts what is received and how they are treated [in mental health care].

The implication of this need for acceptance of Native identity is that counsellors who work in Native contexts should refrain from invalidating a client's cultural identity. Weaver (2001) writes that counsellors and other practitioners need to support Natives in finding cultural resources in their own lives and communities that will support them in discovering and defining their own distinct cultural identity. Participants in the present study said that traditional cultural practices, such as learning and speaking Native language, engaging in spiritual acts like dance and ceremony, are some ways Native identity can be actively incorporated into clients' lives within their counselling practice. P2 said, "I think that culture is a tool we [counsellors] can use to help people become who they want to be with an identity, a sense of purpose, an understanding of what it's like to be Aboriginal and proud of that."

This means that, as counsellors, they have made arrangements for clients to participate in drumming groups, dancing groups, or to learn a Native language. Participants have also used prayer, smudging, and the incorporation of Elders in the counselling relationship with individual clients. P4 said, "Sometimes with some clients we say prayers together...." Working with people in the community, such as client's family, community groups, healing circles, and drumming circles, have also been incorporated by participants into their counselling practice in addition to the foundational therapeutic alliance that is the cornerstone for relationship and change in Western approaches to helping. All participants had received formal training in Western approaches to counselling, including approaches such as person-centred, cognitive-

behavioral, and critical practice of social work. None of the participants suggested that the basis of the Western approaches, such as building and maintaining a strong therapeutic alliance, in which the goal of helping of helping is to support the client through change, be eliminated or disregarded in an Indigenous approach. Rather, participants saw the basis of the Western approach incorporating Indigenous concepts such as cultural identity in order to be more effective when being used with Native clients.

Participants clearly spoke about this need to incorporate cultural practices into Western counselling as a way of strengthening cultural identity and thus fostering health and healing. Participants also said that this was something that they wished to do more of yet this required the support of the mainstream health care system. Working with clients from within the milieu of the cultural resources available in the community is what this study suggests. The incorporation of cultural practices into the counselling relationship is a relatively new and undervalued notion in many Western mental health delivery programme, which are often based solely on values of Western health and counselling (Duran, 2006; Sue & Sue, 1990). As P4 said, “I would like to see more [Native] cultural practices of mental health and healing be more accepted and incorporated into the mainstream, and not have the mainstream model of health so pushed and in your face in the helping fields.”

The health indicators of Native populations employed by government, described in an earlier chapter, suggest a pessimistic view of conditions in Canadian Indigenous communities (Royal Commission on Aboriginal Peoples, 2004). However, there also exist many positive and empowering initiatives and health indicators, such as the

presence of a Native cultural identity in clients' lives, which, according to participants, are playing an important role. P5 said, "I think it's tenacity. Aboriginal peoples are very resilient people...the social and cultural background of people gives them strength and the will to carry on, and I think that for mental health, too." There are tremendous resources and strengths within Native communities that are working to re-build social and political systems to improve individual, family, and community mental health, and cultural identity has a strong role in this process (Kirmayer et al., 2000).

In Mussell et al.'s (2004) research with Aboriginal informants on health, it was reported that one of the ways in which cultural identity is important to Native people's health is in terms of sustaining mental health in non-Native environments. The present study's participants maintain that cultural identity gives Native peoples a clear understanding of who they are in terms of history, traditions, and current practices, and that this understanding gives way to an ability to better interact in contexts that are different to their own, contexts which might otherwise negatively impact mental health and healing. Colomeda and Wenzel (2000) write that currently most Natives come into contact with the Western world on a daily basis. This study suggests that having a strong cultural identity could reduce psychological stress from the interaction with Western culture, i.e., reduce the fear of or problems with acculturation or assimilation, or improve the ability to deal with racism or bias from the mainstream culture. In essence, participants all stated that mental health and healing had a lot to do with knowing yourself in terms of your culture, yourself, your family, and your community histories, as well as how to incorporate that knowledge that comprises your cultural identity into a power that sustains mental health and promotes healing. Often, simply having or gaining

an awareness of cultural identity was enough to be considered healing for clients in all participants' experiences. Overall, the concept of cultural identity was seen by participants to be in keeping with a strength-based approach to mental health and healing that they all agreed formed the basis for a cultural understanding of health.

Metatheme: Holistic Approach

Mussell et al. (1993) write that from traditional to contemporary times, First Nations peoples have defined mental health through a cultural lens. This lens holds that "health means balance and harmony within and among each of the four aspects of human nature: physical, mental, emotional, and spiritual," (p. 19). Therefore, mental health is inextricably linked to a holistic approach that takes into account the physical, emotional, mental, and spiritual health of the individual. A key part of the holistic approach is spirituality. According to participants, the reason spirituality was emphasized when they discussed the holistic approach was because this aspect of health is not addressed in the current mainstream health care system, nor is the spiritual generally valued in Western society. Participants felt that spirituality was a neglected aspect of the holistic approach that really needed to be addressed in counselling practice. P1 explained that "Spirituality has been the missing piece in counselling, in helping, and that's been a big problem." The holistic approach to health was viewed as integral not only to maintaining mental health but to healing. P2 said, "Spirituality has been in Aboriginal culture for 12,000 years, has been a big part of life for Aboriginal peoples...that's something that I believe and I advocate for in [counselling] work...spirituality is a big component of what clients need to heal..."

In Native culture, mental health is negatively affected when there is a lack of balance or harmony in one or more of the four aspects of the whole self (Duran, 2006). Before European contact, the value for balance of holistic health was integral and respected in all activities of daily life of Native peoples (Mussell et al., 1993). Family and community norms and practices provided means thorough which holistic health was taught and maintained throughout communities, and Native cultures had healing practices such as ceremonies (which differed from nation to nation and regions to region) that maintained and restored health through addressing each aspect of the person: body, mind, emotions and spirit (Wilson, 2004). Thus, mental health is not simply a function of an individual but of the structure of community, including clan, family, leaders, teachers, and others (Mussell et al., 1993). These societal structures held distinct social orderings with definitive rules of behaviour (Brant, 1990), which included attention to the holistic self (Mussell et al., 1993).

The mental aspect of health in Native culture includes attention to your thoughts, ideas, habits, and self-discipline (Mussell et al., 1993). Participants talked about the mental aspect of the self in terms of how clients take care of themselves, i.e., their personal self-care habits, the negative thoughts or ideas they have about themselves or others, and how they make choices or exercise a sense of free will in their lives. All participants felt that paying attention to clients' thoughts was an important part of the holistic approach, and that sometimes changing a client's perceptions, as is often done in Western approaches such as cognitive therapy, was necessary also in an Indigenous approach. For example, P5 explained that he often talks with clients about the choices

they have for change in their lives, and how simply talking about these choices can be helpful in terms of clearing problematic thoughts from a client's mental world.

I try to help them [clients] realize their own strengths and boundaries and try to work on those and build upon them. And I do this mostly through talking, and if they are going through something that is really difficult for them, then I have them try to take a step back and see what they have in front of them and try to see, to find, the best solution that will work for them to clear their mind...I try to help them see those options and support them in making their own choices.

P5's example also shows how he has integrated a Western talk therapy with an Indigenous holistic approach by talking, listening, and supporting the client, while making an effort to address multiple aspects of the self in the counselling process.

In the present study, all participants maintained that a fundamental notion of a holistic approach to mental health was central to their practice of counselling. Examples included having food in their counselling sessions, integrating ceremony or prayer into their practice, including Elders or traditional healers in the process, and taking clients into nature or into their social community. In an Indigenous counselling relationship, practicing from a holistic approach means including more than only the "mental" as the focus of counselling. P2 said, "To be in balance clients need to be spiritual and balanced with the other components of the self, to be balanced from a holistic point of view." Counsellors would make use of all four aspects of the self in order to address whatever problem or issue arose in a session in order to address health and healing from a holistic approach. Attention to the physical might mean getting enough exercise, sleep, and healthy food. It might also mean seeking attention from a medical doctor for diabetes. It

might also mean practicing safe sex. The emotional aspect of the self can be talking about feelings, writing about them or, or using art to express feelings and experiences.

The significance of the holistic approach has its roots in a point raised earlier in this dissertation, which is that Western counselling approaches often neglect to pay attention to multiple aspects of the self. Western approaches are often helpful when dealing with single aspects of the self. For example, Gestalt therapy address mindfulness, cognitive therapy deals with correcting irrational thinking patterns, somatic experiencing examines physical sensation, and family therapy works within a family system. Often Western psychology practitioners integrate multiple therapies in order to address multiple aspect of the client. In essence, the point being made is that Western approaches to counselling are also different within the group, there is no homogenous Western approach to mental health, though it may be true that, like Indigenous approaches to helping, they all share certain values and characteristic, but the way in which mental health is achieved will differ both between and within approaches.

An Indigenous holistic approach is concerned with more than once aspect of the person's functioning and addresses such aspects on the basis of imbalance or need. Holistic healing models such as the medicine wheel and healing circles (see The Dze L K'ant Native Friendship Centre Society, 2006; France & McCormick, 1997; Mussell et al., 1993) discussed earlier in Chapter Two put into practice the importance of a holistic approach to mental health. The present study validates this holistic approach to counselling practices but also suggests that a holistic approach be a part not only of the procedures used in counselling but be a foundational piece to the construction of a counselling philosophy that is rooted in an Indigenous paradigm. Many Native scholars

and supporters of Native paradigms have written that Indigenous healing holds its biggest difference to Western healing in the importance of a holistic approach (Duran, 2006; Kirmayer et al., 2000; Kirmayer et al., 1998; Mussell, 2005; Waldram, 2004). Western mental health services, as put forward throughout this dissertation, rely mostly on Western approaches that are grounded in individualism, linear-thinking, competitiveness, and other values that often diametrically opposed to traditional Indigenous values and worldviews (see Blue & Darou, 2005; Duran, 2006; McCormick, 2000,). Thus, it has been suggested in the literature that such approaches are inappropriate at best (Vicary & Bishop, 2005), and a continued form of oppression at worst (Duran, 2006) when used with Native clients seeking mental health services.

This metatheme offers an empirical claim for the importance of a holistic approach to the practice and philosophy of counselling. A holistic approach to counselling could accommodate the within-group identity differences both across and within First Nations. It has been documented both by the participants in this study and the relevant literature that individuals and communities differ in terms of their understandings of mental health, yet it has also been pointed out that certain commonalities in terms of worldview, such as the holistic approach, tie peoples together. Balance, in an Indigenous holistic approach, is thus unique and different in each context, however achieving balance remains an important aspect to achieving mental health. In addition, the participants were unanimous in proposing that a holistic approach to mental health and healing not be regarded as an alternative to mainstream mental health service, but become a legitimate and unquestioned part of that service to the broader community of peoples seeking mental health services. Sue and Sue (1991) have suggested that

Western society could benefit from non-Western approaches to mental health. Counselling that includes holistic approaches discussed in this section could benefit many clients throughout society, Indigenous and non-Indigenous. Thus through the legitimization of the holistic approach in counselling practice and philosophy, an Indigenous paradigm of health could become legitimate outside of its Native context to become accepted by settler governments, whose mandates purport the desire to meet Canada's Indigenous populations' mental health needs and whose purse strings control how that need is being met. Further the adoption of a holistic approach could help many non-Natives in Canadian society, many of whose mental health needs also go unmet.

Metatheme: Interdependence

In Native philosophies, the concept of interdependence goes back as far as time immemorial, and it is common to all different Indigenous cultures in North America. (Little Bear, 2000). Ross (1996) writes that in the Native world all things are connected in some way and must be so in order to exist. Mussell et al. (1993) use an example of the common Native closing phrase "All my relations," to explain the essence of the theme of interdependence in Native cultures as meaning that we are related and we are all mutually dependent. Interdependence is also manifested in the importance of community and family within the structure and behaviours of Native societies (Ross, 1996). McCormick and Amundson (1997) write that traditional First Nations healing processes are interdependent because they involve the mutual dependence of community and family and members in relationship in order to create balance, or health, in clients' lives.

Interdependence has been identified as a metatheme in this research, and refers to the reliance on things or people on each other in a way that implies a mutual necessity.

Mussell et al. (2004) describe interdependence in First Nations cultures as defining the relationship between peoples, the environments, and the spirit, "Interdependence...is often symbolized by the sacred circle or medicine wheel, which includes the teachings about the interconnections among all of creation" (p. 17). Throughout world history, many people have advocated individual freedom or independence as a sort of ultimate good; others, such as Native cultures, do the same with commitment to one's family, community, and culture (Ross, 1996). Interdependence recognizes the validity in each position and weaves them together. Storm (1972), a Plains Indian teacher, explains that interdependence within and between people is at the root of understandings of ourselves and each other. "As the Coyote sings, his song is echoed by many other Coyotes. These songs, the Teachers tell us, are the songs of many Reflections that live within all of us," (p.14).

The link between interdependence and mental health and healing becomes clear when we consider it from an Indigenous worldview in which all aspects of the life co-exist in mutual dependence. McCormick's (1997) research on Aboriginal healing through interdependence also documents a strong connection between health and connectedness in British Columbia First Nations. "Aboriginal health and healing start from the position that all elements of life and living are interdependent. By extension, well-being flows from the balance and harmony among all elements of personal and collective life," (Royal Commission on Aboriginal Peoples, 1996, p. 11). Interdependence was described in this way, as being directly linked to mental health and healing, by all participants as they recounted stories of their counselling experiences. Participants clearly explained that relying on each other was an integral notion that acted within their worlds. This

interdependence occurred in all of their relationships, including with clients, with co-workers, within family, within community, and from community to community.

Relationships predicated on interdependence were seen as one of the necessary components of establishing, maintaining, and furthering mental health in an Indigenous context. P3 explained this in her story about how First Nations culture successfully meet the helping and healing need of their clients, in which the key to that success rested on community members' actions and intentions that reflect the notion of interdependence,

I think that because the First Nations peoples come from interdependence in their culture, they have so much offer the mainstream society--it's not about making the most money and it's not about being at the top of the ladder. It (being healthy) is about, if you are successful you always give a hand to the person beside you, and it is that sharing, that source of interdependence, that has to happen [for health and healing to be present].

According to participants, mental health and healing requires interdependence in the lives of clients, and there are elements counsellors can use to make this core concept of the helping process. Participants explained that helping clients make connections with family members, other helpers in the agency, Elders in the community, programmes in the community, and even other people within the Native community who were not relations or with whom one had previous social connections, could be beneficial to the healing process for clients. Participants also said that they needed more support from the mainstream health care system to act in ways that would connect clients with strength-based resources such as interdependent relationships. P4 said, "I am hopeful that the mainstream [mental health system] and the funding will shift away from the

illness/mainstream model and to incorporating cultural views and holistic view of mental health and healing that are about interdependence.”

The thrust of interdependence as a metatheme within the data is that in cultural worldview and practice, Indigenous people find strength and mental health and healing through togetherness. This togetherness is naturally mutually beneficial and works to strengthen the individual, the community, and all those who come into contact with them. Further, interdependence complements the concept of cultural identity, a holistic approach, and community in Indigenous counselling processes because it works alongside, not competitively or hierarchical with the other factors. Interdependence strengthens the other factors, as the other factors strengthen interdependence and each other. An excerpt from my field journal written during the across participant analysis phase shows how the importance of the concept of interdependence began to emerge within my understanding of participants’ stories.

Field journal: Connecting with clients along various dimensions has been important to all of the participants within each of their story maps. But when I step back and I look at all of the story maps, then recall the interviews, look back at my field notes and field journal, I see that what’s important about connecting in mental health and counselling in a Native context is the quality of the connection. An important quality of this connection is that it is mutually reliant, mutually beneficial—it is interdependent in every way.

An Illustration of Indigenous Counselling

Narrative analysis of the data in this study suggested that four metathemes of community, cultural identity, holistic approach, and interdependence occur together to

represent core concepts that give a comprehensive picture of what comprises mental health and healing for Native counsellors who work with Native clients. These results, coupled with previous research, are interpreted as suggesting that for mental health and healing to exist for Native peoples, these core concepts (and possibly others) should be present both within the counselling relationship as tools or approaches and within the client's life outside of the counselling setting. As a part of my commitment to benefiting participants and community participation in this study, I am proposing to put these theoretical concepts into a practical illustration that will show how the metathemes derived from the data are employed by these participants. This illustration of the counselling narratives of these five participants is intended as a tentative conception that requires further development in research and practice. In keeping with the notion of the medicine wheel or healing circle used throughout this study, this illustration places each core concept in a circle that overlaps a centre circle in which are listed some specific counselling elements derived from the metathemes (see Figure 17). These counselling elements were described specifically by all participants as essential components of the counselling relationship. These counselling elements or aspects are not distinct in terms of flowing directly from one specific metatheme; rather, any of these elements could be used to incorporate any one or more of the metathemes into the counselling relationship.

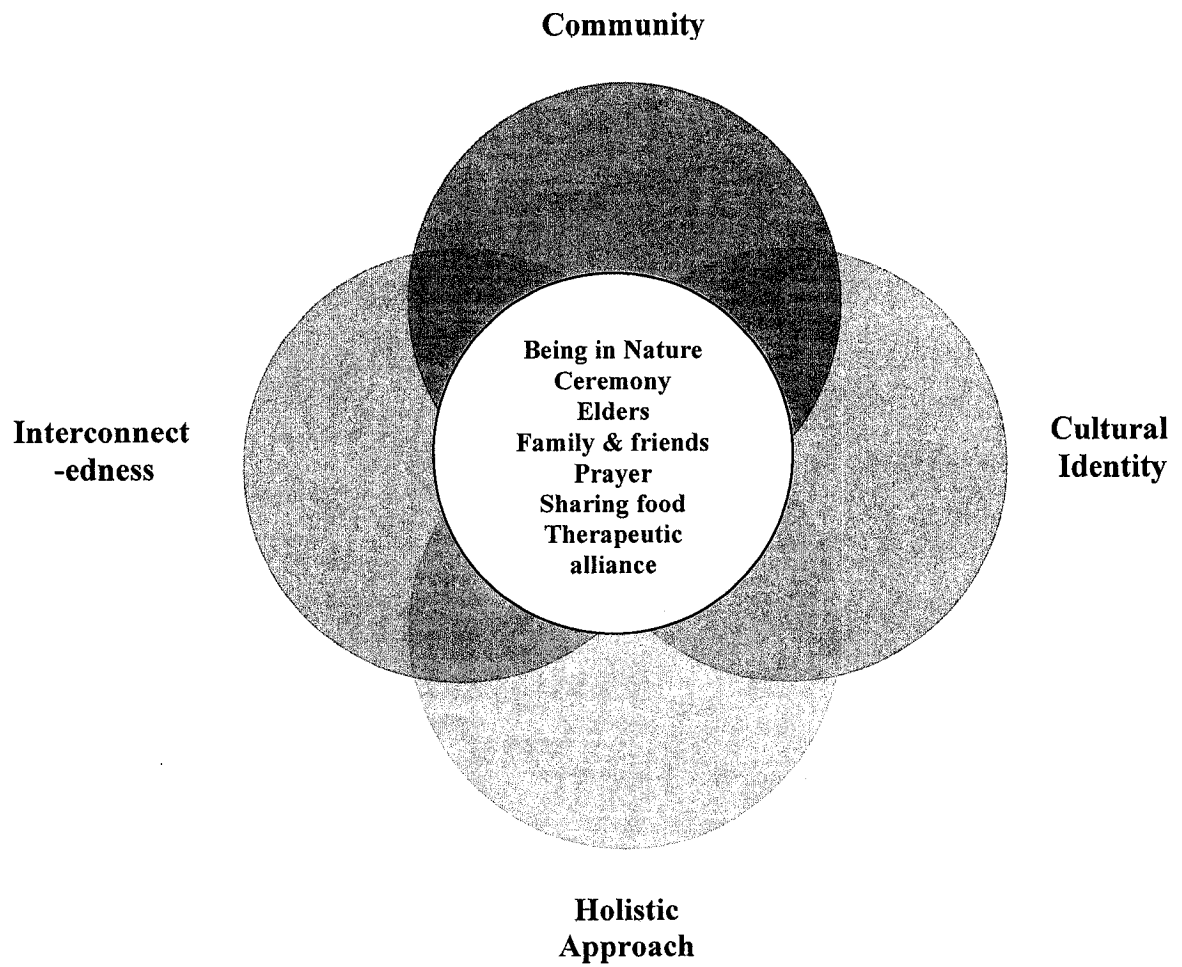


Figure 17. Illustration of Indigenous Healing and Counselling

Each of these counselling elements will be carried out differently in each counselling relationship depending on the specific Native culture in which they are used and the cultural resources available to each client and counsellor. These counselling elements are designed to reflect the within and between group cultural differences of Indigenous peoples. For example, ceremony in a Nuu-Chah-Nulth community might be attending a potlatch, whereas in a Plains community it could be attending a round dance or sun dance. Sharing food in counselling will also be different in each community depending on which foods are traditional for each peoples and the availability of traditional foods. Elders will also play a different role in helping and healing in each community. The therapeutic alliance refers to the relationship between client and counsellor. This is a relationship built on trust, respect, talking, and listening, and all of the other components that make an effective counselling alliance in Western approaches to helping. None of these elements are more or less important to the mental health and healing process, but what is important is that at least one or more are present as elements in the counselling relationship in order to actively incorporate aspects of the four metathemes in the process. This illustration for Indigenous healing and counseling has been titled as such because it represents a counselling practice that is grounded in an Indigenous paradigm and shows how the philosophical tenets of the four core concepts can be used in the practice of counselling.

As I discussed earlier in Chapter Two, Indigenous mental health is viewed by government service policy from the perspective of a mental health crisis, in terms of what mental health problems exist for Native peoples. This illustration for Indigenous healing and counselling does not follow a health crisis perspective, but rather follows the view

that Native mental health is concerned with moving forward from problems through healing. Mussell (2005) writes that part of a Native worldview is the notion of holistic health, which marks how Natives view themselves in a forward thinking manner.

Holistic health is the vision most First Nations peoples articulate as they reflect upon their future. At the personal level this means each member enjoys health and wellness in body, mind, heart, and spirit. Within the family context, this means mutual support of each other...From a community perspective it means leadership committed to whole health, empowerment, sensitivity to interrelatedness of past, present, and future possibilities, and connected between cultures. (p. 26)

This counselling illustration's four core concepts are important in an integrated way, in agreement with Mussell's assertion that holistic health is tied to interdependence, community, and who individuals are as cultural peoples. This counselling illustration is consistent with the present study and Mussell's work on an Indigenous worldview by identifying community, cultural identity, holistic approach, and interdependence as necessary core factors to mental health and healing and by suggesting that these concepts work interdependently to form a basis to mental health and healing processes within counselling. The elements of counselling in this illustration were provided by participants, all of whom gave specific examples of how counsellors can bring each factor to life for individual clients through the counselling process. What is most important about the relationship among concepts in this illustration is that there is one, and it is one that is strong and overlapping, one that strengthens each concept without detracting from its importance as a single factor.

I created this illustration of Indigenous healing and counselling to employ the metathemes resulting from this study in an active and meaningful way. Counsellors who are not educated in a Western approach to counselling will not be able to effectively employ this illustration because it is designed to work in concert with a foundation of skills in Western counselling approaches that give a basis to a sound therapeutic alliance. Duran (2006) writes that counselling that employs a “hybrid approach”, which involves “two or more ways of knowing and this can be a harmonious process” is one way to view successful Indigenous counselling practices today (p.14). The illustration I have created is intended to **complement** aspects of Western counselling, not deny or delegitimize it, with Indigenous concepts and elements in order to successfully meet helping and healing for Native peoples in current contexts, which requires negotiations between Western and traditional Native worlds.

Summary of Chapter Five

The metathemes of community, cultural identity, holistic approach, and interdependence were consistently apparent across the participants’ and other data depicting Indigenous mental health and healing. These four metathemes represent what should be in place for mental health in an Indigenous context. I have discussed in-depth each theme as related to currently existing literature, the participant interviews, my field notes, and my field journal. I have also extended the meaning of my findings by suggesting specific implications and highlighting the gaps in preexisting information on this topic.

An illustration for Indigenous healing and counselling practice was presented. How each core concept is applied in a counselling relationship in Native contexts will be

different because in each Native culture, and often within particular cultures, practices are different. However, the use of some general elements has been voiced by all participants as necessary to promoting mental health and healing. What remains consistent is that these factors must be present in terms of philosophy and general counselling practices, though, again, it is important to note that the specific practices will differ from helper to helper and from community to community.

The next chapter contains my concluding statements and implications of the research.

Chapter Six: Concluding Statements and Implications

In this chapter I present my concluding comments. Included are a summary of the dissertation, boundaries of the study, implications of the study, and researcher reflections.

Summary

How do Native counsellors understand the intersection of traditional Indigenous cultural conceptions of mental health and contemporary counselling practice? Through this dissertation, I attempted to answer this research question by articulating Indigenous perspectives on mental health and healing. I structured and conducted a qualitative study using a narrative methodology that was based on a conceptual framework of Indigenous ways of knowing and social constructivism. I interviewed five Native counsellors to get their stories about the intersection of Indigenous mental health and healing with their counselling practices. A narrative analysis of the interviews, using a story map yielded within and across participant results. Core concepts of cultural identity, community, holistic approach, and interdependence were presented as the final results to construct an illustration for Indigenous healing and counselling. This counselling illustration epitomizes the goal of this study, in that it is a concrete articulation that can be used to influence education, counselling and other mental health services, and, importantly, government policy. From an Indigenous perspective, these core concepts of community, cultural identity, holistic approach, and interdependence must be actively present in the process of counselling and healing. It has been suggested in the literature that elements such as these are present in the context of Native mental health; the voices of the participants in this study carry these statements one step further by asserting their necessity and integrity to mental health and healing. The counsellors interviewed in this

study had knowledge and experience in the practice of helping relationships, and by virtue of their own cultural identities as diverse Indigenous peoples. Their stories represent authentic experiences of mental health and healing in their work as professional helpers over past and present experiences and future intentions and by extension give relevance and strength to this research.

Boundaries of the Study

These are boundaries of this study in that there are limits to what I can assert in its results and what I cannot assert. As in all qualitative studies, there are particular limits a study can have regarding the degree of generalizations and interpretations that can be drawn from it.

Bias

Researcher bias can arise as a concern for qualitative researchers. Since qualitative research is based on intersubjectivity, researchers must put research protocols into place to address this concern. According to Schwandt (1997) there are four types of bias in research:

1. Bias resulting from over-reliance on accessible or key informants.
2. Selective attention to dramatic events and/or statements.
3. Biasing effects of the presence of the inquirer in the site of investigation.
4. Biases stemming from the effects of the respondents and the site on the inquirer (p. 9).

However, much of the critique of qualitative research in terms of bias does not take into account qualitative research's nature as intersubjectivity and its methods, such as purposeful sampling or the principle that the researcher is a primary instrument of the

research (Denzin & Lincoln, 2000; Taylor & Bogden, 1984). Also ignored by critics of qualitative research is the political and social discourses involved in the theory and practice of social science that questions research objectivity in research practice (Schwandt, 1997).

Gadamer (1994) writes that bias cannot be eliminated or placed aside in any research method. No researcher can avoid bias through selection of method; all people interact with some level of bias as a matter of natural human thinking and behaviour. Gadamer asserts that bias is an inseparable part of the human condition. Schwandt (1997) agrees with this view of bias by stating, "In fact, our understanding of ourselves and our world depends on having prejudgment. What we must do to achieve understanding is to reflect on prejudice [as bias] and distinguish enabling from disabling prejudice" (p. 10).

I am aware of my biases and in order to understand and reflect on these, I have framed them as assumptions. The following three assumptions underpinned the present study.

1. Indigenous health research should reflect the needs and benefits of the participants and their community as well as academic and applied interests. It is my view that contemporary researcher practices should be constantly evolving, and that despite theoretical limitations, all should seek breaks with traditional-colonial theorizing about participants and communities, particularly Indigenous communities. The research relationship is one of a co-constructed nature (Peavy, 1998), but this nature often goes unrecognized because it is confined by the edges of a Western paradigm of ethical research and design practices (Piquemal, 2001). Alternatives and critiques of the current Western system of research must, in my opinion, come from First Nation's

conceptualizations and philosophies, such as Indigenous ways of knowing and Indigenous protocols.

2. An important assumption is that the participants would be willing to engage in honest and meaningful conversation with me about their experiences of mental health and healing in counselling contexts. Trust is the foundation of an ethical and authentic research relationship (Piquemal, 2001), and this notion of trust assumes that all parties involved will be honest in their interactions. It is my belief that trust was established between myself and the participants and other community members who gave input throughout the research process.

3. I assume that there are differences between Indigenous and Western ways of helping and healing. As an Indigenous person, my worldview is very much biased from my experiences as a marginalized person in a Western world. It is valuable for me to remember, particularly in the context of research, that despite specific and cultural differences, we are all human beings that have the same goal of wellness and survival.

Further, despite varying epistemologies and paradigms, most peoples, regardless of cultural differences, share values of family, faith, belonging, and health. My assumptions that Indigenous views of health or Indigenous ways of knowing are radically different from Western ways must be kept in the context of my experience and that of specific research questions posed for this study.

Generalizability. Generalizability is a concept from a quantitative paradigm that does not directly apply to qualitative research (Creswell, 2005). In contrast, the utility of qualitative results are intended to allow the reader to understand the findings both within the context of the study itself and beyond. There are within and between group cultural

differences amongst Indigenous Nations, individuals, and communities (McCormick, 1997). The issues and implications of this study were designed to enhance academic knowledge about cultural differences and to guide researchers to be sensitive to the mental health and healing needs of Indigenous peoples. The intent is to provide academic researchers with direction for cross-cultural sensitivities about mental health and healing that are respectful, synergetic, and aimed to benefit Indigenous communities at various levels. My methods of following local protocol, spending time in the community with the participants, consultants, Elders, and other community members, and my follow-through with give back to the community through dissemination and on-going relationship reflects a depth to this research.

Lincoln and Guba (1985) propose qualitative research as "naturalistic inquiry" for studies in the social and behavioural sciences because this type of inquiry would take into account the lack of predictability of human interactions and the unique lives outside of lab settings, and establish a separate set of criteria more appropriate to life outside the laboratory. Silverman (2001) found that in social contexts, qualitative research methods are believed to "provide a 'deeper' understanding of social phenomena than would be obtained from purely quantitative data" (p. 32). Qualitative methods usually devote large amounts of time to participants during the data-gathering phase, thus important and substantive information is obtained from those who are most affected by the issue of study (Schwandt, 1997). In Native communities, "people always do have ideas about what is best for their community" (Erasmus & Ensign 1998, p. 46). The direct input of Indigenous peoples regarding research in their own communities has been argued to be

crucial in designing and implementing research that yield authentic results because it is ethical in that it follows local protocol (Piquemal, 2001).

Qualitative research can include the opportunity to involve the participants' community at all stages of the research process. Partnerships can be developed with the community through their input in the planning, designing, data gathering and even analysis of the results (Hudson & Taylor-Henley, 2001). This process allows for meaningful input. Thus, the community becomes an important part of the research, rather than simply providing the data for research. Community members become invested in research activities and respond in a different way that has been viewed as deeper and more meaningful than in other research projects that may see them as subjects or objects of the research (Hudson & Taylor Henley, 2001). Participants can feel that the research belongs to them and their community. In fact, most Indigenous researchers consider participants as co-researchers and co-owners in the research results (Kenny, 2002). Given the history of misappropriation of Indigenous knowledge by researchers (Piquemal, 2001; Smith 1999), this approach helps to create a more respectful and receptive research context for all involved, as well as strengthen the internal validity of the study.

Qualitative research has also been described as seeking to understand how things happen, rather than what happens (Schwandt, 1997). Thus it is concerned with process. In this way, qualitative research is particularly suited to Indigenous communities, because in unearthing processes, there exists a possibility that the devastating results of colonization can be deconstructed (Kenny, 2000). The dilemmas of integrating traditional Indigenous and modern Western paradigms can be revealed. The setting of priorities of meaning could be accomplished. And practical life and quality of life can be addressed. Thus

qualitative research goes beyond the surface and studies substance, which I believe can be valuable and meaningful beyond generalizable results.

Indigenous Ways of Knowing

Debates concerning competing knowledge claims will be continuous. In Indigenous policy research, for example, the research is holistic and balanced, and the diverse positions on knowledge claims must all be considered in the context of ethical research practice (Erasmus & Ensign, 1998). Knowledge claims must be scrutinized for how they can best represent an Indigenous world view, Indigenous systems of knowledge, and balance in a holistic perspective on policy research. It is critical to be aware that all sources of data derived from research in Native communities are ethically questionable if their methodology does not include appropriate attention to a Native cultural and social approach to contemporary research (Hudson & Taylor-Henley, 2001).

Traditional knowledge hinges on respect for all life forms as literally conscious and intrinsically interdependent and valuable (Corsiglia & Snively, 1997). Indigenous peoples' lives are characterized by a lengthy history of relations between community members, nonhumans (wild animals, insects, trees, rivers, grass, etc.), and lands (Gadgil, Berkes, & Folke, 1993). Escobar (1998) writes that "unlike modern constructions, with their strict separation between biophysical, human and supernatural worlds, local models in many non-Western contexts [like traditional ways of knowing] are often predicated on links of continuity between the three spheres and embedded in social relations that cannot be reduced to modern, capitalistic terms" (p. 61).

Each culture throughout the world has a set of paradigms, which are a collective set of values and knowledge of the way to live and be in the world (Lee, 1995). A

distinction that may be made about Indigenous values is that they inform a body of knowledge about specific environments that span several thousands of years, in many cases since time immemorial (Alfred, 1999). Chief Wavey (1993, p. 11–12) notes that "we spend a great deal of our time, through all seasons of the year, traveling over, drinking, eating, smelling and living with the ecological system, which surrounds us" (p. 11). Indigenous peoples are characterized as having, for example, intimate knowledge of trap lines, waterways, spiritual/traditional lands as well as knowing their relationship to earth, which is expressed in cultural values such as sharing and caring (Escobar, 1998).

Colonization has interrupted many traditional ways of living and knowing for Natives throughout the world (Mussell et al., 1993). However, many Natives today are presently undergoing a profound spiritual renaissance of traditional ecological value renewal and Indigenous ways of knowing (Wenzel, 1997). The present study reflects this return to traditional ways of knowing by its incorporation of community protocol and community consultation as part of its methodology, and the use of an Indigenous paradigm of health and healing. This study concludes with no suggestion of a definitive answer to general knowledge claims, as this was not a goal of the research, as discussed in earlier in Chapter One. My belief and intent is to offer alternative methods of legitimate researching and writing about Indigenous mental health and healing that is based in an Indigenous paradigm, or Indigenous ways of knowing.

Implications

Government Health Policy

Perhaps one of the most far reaching implications of this dissertation is how it could impact settler and Indigenous government health policy. Articulating an

understanding of mental health and healing that is grounded in an Indigenous paradigm could effectively provide the means for rewriting some of Canada's federal and regional health systems to include Indigenous conceptions of mental health and healing in health policies. Appropriately and effectively addressing the mental health needs of Native peoples today could be described as an imminent necessity, as it has been established through the literature that there is currently a health crisis for many Indigenous peoples that endangers not only their standard of health but their very existence. Therefore, dealing with this health crisis in a way that works, in a way that takes into account a cultural conception of health and healing, such as that which resulted from the present study, could in effect improve the health status and survival of Native groups in Canada and serve as a model to international Indigenous groups facing similar problems.

Two Dimensions to Mental Health

The results from this study imply that Indigenous mental health possesses two dimensions, one that views mental health as wellness or strength, and one that views mental health as healing. The view of mental health as wellness or strength comes from a view of a person in positive balance that is grounded in the holistic approach. An Indigenous holistic approach to health is based on a view that mental health occurs when there is balance between the four parts of the self, (spiritual, emotional, physical, and mental) (Mussell et al., 2003). When equal attention is not paid by the individual or community to the needs of whole person, i.e., the four parts of self, then imbalance occurs. Thus balance is equated with wellness or strength.

Indigenous mental health as healing is rooted in the colonial experience. This study has shown that within the scope of the experiences of these participants, healing

from colonialism is a major mental health issue for Native clients today. The historical experiences of Native populations continue to leave a legacy in the form of trauma that must be healed in today's mental health contexts. Viewing mental health as dealing with historical trauma from colonization has implications that go far beyond this dissertation to influence both social and health government policy. In terms of Indigenous communities, the implication here is that each community must deal with the unique and particular ways that trauma has impacted its members. This would involve addressing the symptomology present in communities that is associated with this trauma and taking action to heal this trauma in ways that are appropriate and effective for that community. The results from this dissertation suggest that this process of healing will vary from community to community due to within and between group cultural differences and that the necessity to heal from the trauma of colonization is ever present. This need to heal will change only when Native communities take action to deal with the reality and non-Native communities support them in doing so.

Counselling programmes could be developed from the results of this study that reflect the two dimensions of mental health as wellness or strength and healing. These counselling programmes would be grounded in an Indigenous paradigm of health and wellness that came from the inclusion of four metathemes of community, cultural identity, holistic approach, and interdependence into all aspects of the helping relationship. These programmes would be different to many currently existing counselling and therapy programmes currently being used in Native contexts that do not take into account these integral aspects of mental health and healing.

Research Methodology

As discussed in an above section, it is my own personal belief, or bias, that research should be an evolving practice and that this practice develops through a process of praxis. Community-based research shares this view of being based on a process of praxis, where research methodology is refined and improved each time is implemented. This study contributed to the evolution of Indigenous community health research by giving a voice to Indigenous mental health workers in an academic context about their needs to be effective counsellors and the needs of their clients. Mental health services are largely delivered to Native communities by non-community members and from a non-Native paradigm. Giving voice to participants in terms of the topic of research, the analysis of results and the dissemination process strengthens the authenticity of the results and the methodology employed. Barton (2004) wrote of narrative inquiry as a relational methodology for use with health research in Native communities. The present study employed a narrative methodology in the spirit of a collaborative relationship with an Indigenous community. Narratives have been shown in the literature to be an important part of traditional Native culture in term of its oral storytelling tradition. Further to this, it may now be possible to incorporate other Native traditions, such as Indigenous traditional ecological knowledge, which is based on a holistic conception of the world, into research methodologies.

Also in terms of research methodologies, this study shows how community based research can be both ethical in terms of community protocols and rigorous in terms of academic standard. Training opportunities can be provided for communities involved in research, such as interviewing skills, developing questionnaires, surveys, or open-ended

questions, setting up meeting schedules and presentation skills for dissemination.

Community-driven research promotes the use of Indigenous expertise, both academic and traditional Native experts, throughout the research process (Whitmore, 1994).

Education

Counsellor training programmes could incorporate the Indigenous paradigm of mental health and healing into its curriculum. For example, traditional teachings in Native communities based on the medicine wheel create an epistemological paradigm that employs a holistic foundation for human behaviour and interaction; it informs a framework for mental health through a discussion of its four quadrants, each one a separate representation of an aspect of the self (Thunderbird, 2005).

Other Indigenous practices mentioned by participants included:

- Storytelling
- Advice from Elders
- Interconnectedness with family and community
- Healing circles (round robin, usually started by an Elder)
- Ceremony (sweet grass use, vision quest, sweat lodge, prayer, drumming, sundance, and more)

These practices usually include involvement with local community, including Elders, traditional helpers, and those who wish to share traditional forms of helping with counsellors who make the invitation to incorporate Native methods (See Blue & Darou, 2005; Duran, 2006; McCormick, 1996).

As described previously, Duran (2006) writes that the Western paradigm of mental health is marked by beliefs in logical positivism, linear thinking, and

individualism that promote illness instead of Indigenous wellness: “Western trained therapists are trained to think within a prescribed paradigm that targets pathology” p. 19. Instead, counsellor training programmes could employ a pedagogy that targets mental health as wellness, as articulated in this dissertation.

Students training to be counsellors should also learn to enhance the cultural sensitivity of their own personal style of helping, as suggested by the participants who felt that the support of non-native communities is necessary. Native and non-Native students training to become counsellors could begin this process by acknowledging, exploring, and clarifying their own values, worldviews, and beliefs related to their own culture and that of those who are different to them (Arthur & Collins, 2005). How could this be done in concrete terms in a learning environment?

- Through cultural self awareness exercises (see Arthur & Collins, 2005; Johannes & Erwin, 2004).
 - Journaling exercises.
 - Interacting with others from own culture and other cultures (individual and group field trips).
 - Actively seeking knowledge and learning about diverse cultures (endless possibilities).
 - Introduction of an Indigenous paradigm of mental health and healing as articulated in the results of this dissertation, including illustrations and practices as cited above.
-

Future Research

A next step for this research would be to expand and deepen the internal validity of the results by replicating the study in different regions across Canada. Asking the same or a similar research question in different Indigenous communities across Canada could be useful in terms of broadening results that could satisfy broad health questions that are often posed by federal governments who administer funding for local and national Indigenous mental health programmes. Also looking at the location of such community studies in terms of reserve or non-reserve, urban or rural, could be an important way to implement further research by comparing results across these contexts.

Studies could also be conducted using the same research question but employing different instruments such as survey and questionnaires. These types of studies could effectively access larger sample sizes and complement the existing qualitative data of this study with quantitative information that could further deepen results. In fact, the results of this study could be used to design quantitative interview material such as inventories, checklists, surveys, and questionnaires.

Another direction for research could be to implement and evaluate the tentative illustration of counselling proposed in this study with specific Indigenous communities both where this study was conducted and in other Native territories. This illustration of Indigenous healing and counselling could be implemented and evaluated both qualitatively and quantitatively in various Native communities (reserve, non-reserve, urban, or rural) in order to strengthen the results of this study. It might also be interesting to evaluate the results of this study in non-Native communities by implementing and then

evaluating the counselling illustration in non-Native, mixed Native and non-Native, and Native communities, and comparing the results across settings.

Research Reflections

This study has been significant for me as a researcher in at least two ways. Firstly, I have learned that it is not always easy to go between the two worlds of academia and Indigenous communities. Secondly, carrying out research that benefits all involved is satisfying to me both personally and as a researcher.

In the course of my short academic career, going between the two worlds has been relatively smooth; however there have been some inevitable ups and downs. A negative aspect of this journey involves me being directly involved in academic research. When I am in a Native community, carrying out the process of research as a graduate student representing the university, I am continually concerned about the ethical dimensions of the project—*am I being respectful enough? Am I following local protocol enough? Will any future aspect of this project that I may not currently foresee be harmful to the community?* The list of questions that echoes in my internal dialogue is endless. There is a constant feeling within me that I must prove not only my research, but myself as an Indigenous person, to the community with whom I am working. Based on my interactions with community people involved in this project, there is little evidence to substantiate this feeling that I have -- it is perhaps more my own self-talk and personal history of experience that informs these emotions of self-doubt and fear. Oddly, the same emotions come over me when I am the other world of academe. In a university environment I also feel that I must prove not only my research but myself as Indigenous person with a legitimate identity as such. The university is concerned with the rigour of

my study, and this I anticipate. I often even enjoy the challenge of meeting this demand. Yet I have always felt somewhat emotional about justifying my identity as a Native person in the context of my research projects. Again, perhaps this fear and doubt comes from my personal history that is amply littered with experiences of racism, prejudice, and exclusion from the dominant Western society. However it is also true that some of these oppressive experiences have occurred within the context of post secondary education. What has been positive for me in the current research is the support and encouragement of my committee members, each of whom has inspired me to stay true to my voice as a Native person, and has fostered a sense of ability to incorporate this into my research in a way that is both systematic and true.

Carrying out research that is beneficial to both scholarship and to the community in which the research has occurred is satisfying. There have been times when my faith in the goodness of research has wavered, and this has disconcerted me, as I have been committed to seeking out and conducting ethical and successful scholarship since I began my studies. Having participant and other community members experience benefit from each stage of the research and from the results gives me a sense of pride and accomplishment in the work. I have not simply fulfilled part of doctoral requirements but I have done something that was of greater good for people within the context of the greater society. Further, I have addressed my own personal need to work toward healing and health in native communities because my own family and personal history has been fraught with issues of unbalance and unmet healing needs due to the colonial experience. Contributing to the mental health and healing needs of Native communities is healing for me as a person who has been impacted by this history. Helping others is a strong value

that I was taught by my grandparents and extended family that raised me from infancy. This project has strengthened my resolve to continue my effort to conduct ethical and appropriate community based mental health research with Native peoples. It inspires me to continue to seek out other people, both academics and native community members, to walk this path with me so we can continue to meet our peoples' health and healing needs.

There are many more ways in which the present research has impacted my development as a researcher, however, the two ways discussed in this section have had the greatest effect on me. I will continue to learn and develop as researcher in ways that can bring me close to my Native culture and identity and further the field of researching cultural health in ways that benefit all involved.

Conclusion

I believe that the results of this study form a basis from which to define and depict mental and healing from an Indigenous worldview. Conceptions of mental health and healing underpin our mental health services, such as counselling and therapy -- how do we define these from a specific cultural perspective? Likely we would be doing so from a unique perspective that was different across and sometimes within cultures. The dominant Western paradigm of mental health as practiced in most settings is not one of health, it is a model of illness and disease. An Indigenous paradigm of mental health and healing is focussed on restoring balance to the self through relationship with others and the environment. This illustration of health is not new or innovative, it has been in existence and successfully employed by Indigenous peoples in Canada for thousand of years. What is new is the articulation and validation of this definition as legitimate in and of its own right in the context of mental health research and practice. Since colonization,

Western paradigms of health have been forced on Native peoples in ways that invalidated and disregarded the only healing resources that had previously been available and were successful to Native peoples. As a result, many Native communities today flounder in attempts to deal with their health problems by utilizing the only resource currently available to them through the mental health care system, which is dominated by Western models of psychology. Yet at the same time we must acknowledge the reality that Native peoples today exist in a both Indigenous and Western worlds where a mental health approach that reflects this reality and serves to offer up both paradigms in a complementary way, rather than as dominating or subordinating, might help better serve Indigenous peoples' mental health needs.

Mental health within Native communities is increasingly considered vital for individuals in order for them to use their full resources to heal from the legacy of colonization and to survive as distinct cultural peoples. Although critical, developing and maintaining mental health within community can be challenging. In order to address this challenge, this study connected concepts of community, cultural identity, holistic health, and interdependence to suggest what factors underpin Indigenous mental health and healing. Yet again, the spirit of this research suggests that integrating these core concepts with Western counselling practices that are helpful in Native communities, such as sound therapeutic alliance, is how we can best apply the results of this study in an illustration of Indigenous healing and counselling practice. The intention in this study was never to deny the validity of the Western paradigm, but instead to find a way for it to be employed in a complementary way with an Indigenous paradigm in order to meet the current reality of Native peoples' mental health and healing needs.

Service providers and counsellor educators must make significant changes in order to address these mental health needs that are not currently being well met. Students training to become counsellors need to receive education about Indigenous peoples' mental health needs, including information about the historical experiences of Native peoples, the Indigenous paradigm on mental health and healing, and a comprehensive understanding of their own cultural sensitivities in the helping relationship. If non-Native institutions such as universities and settler governments are to support Native peoples in recovering from colonization, reexamining and modifying the paradigm of mental health to include Indigenous conceptions is one place to enact meaningful change and support the healing process for all.

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APPENDICES

APPENDIX A

PARTICIPANT RECRUITMENT LETTER

APPENDIX B
CERTIFICATE OF ETHICS APPROVAL

APPENDIX C

FIRST NATIONS BAND PERMISSION LETTERS

I am asking for similar permission from the Esquimalt Nation, whose people may be working as a counsellor and may enter as participants in this project. It is important for me to state that I have no intention of recruiting any Native participants from the greater Victoria area without first obtaining permission from both the Songhees and Esquimalt Nations.

Individual interviews with participants will require 2 to 4 hours of time, with a gift certificate to a book store offered to each participant at the end of the first interview as a token of my appreciation and respect for their time. There are no known risks to the interviews, and privacy and confidentiality will be ensured for each participant.

Below I have formulated some questions you might ask about this research project, and have provided detailed and non-technical answers:

What are the purposes and objectives of this research?

The purpose of this research project is to gain an in-depth understanding of the story of how Indigenous counsellors come to a conclusion of what Indigenous mental health is in today's counselling context. Objectives of the project are to gather information related to culturally-based mental health and healing in order to inform government policy in developing Indigenous paradigm-based training and programming for ministry of health initiatives in Canada, and contribute new information to the research literature on Indigenous mental health and healing from an Indigenous paradigm. Additionally, the methods used and data collected will be employed to develop teaching materials for community counsellors, support workers, psychologists, school counsellors, and other community members and health professionals who are supporting Indigenous peoples in mental health and healing.

Why is this research important? What contributions will it make?

Research of this type is important because there is a lack of empirical data in counselling psychology related to an Indigenous paradigm (or Indigenous conceptions) of mental health and healing, and because there is an under use of mental health services by Indigenous peoples due to cultural differences in conceptions of mental health and healing. This research could inform policy that will change mental health services so that they are culturally appropriate and thus more utilized by Aboriginal peoples.

Who are the participants I seek and how will participants be recruited?

Recruitment will take place in person and through a letter to possible participants from the researcher. A meeting will be set up with a community agency (Victoria Native Friendship Centre) contact person, who will suggest meeting possible participants in person and giving them the recruitment letter along with an oral invitation to participate in the research. If anyone agrees to meet for participation, the first interview will be set.

What will the interviews with the participants be like?

Each participant will be asked to do the following 2 interviews, each lasting about 1 to 2 hours.

Thank you very much for your time and willingness to consider my request for permission, and I offer my assurance and my word that you will remain informed of any developments changes, and results that occur within the context of this project, should you deem it acceptable for me to pursue.

In Spirit,

Suzanne Stewart
Dene First Nation
Doctoral Student, University of Victoria

APPENDIX D

PARTICIPANT CONSENT LETTER

APPENDIX E
INTERVIEW FORMATS

INTERVIEW FORMATS

Interview #1:

Each participant will be asked to do a first audio-taped interview using this format, which will be unstructured in nature. I will invite the participant to share his or her story using the following statements as a guide:

1. I would like to hear your story or stories of how you have come to be a helper.
2. I am particularly interested in how you understand mental health and healing for Indigenous clients.
3. Has this understanding changed from past to present, and how do you see it into the future?
4. How, in your past, present, and future experiences, does culture inform your story of mental health and healing and your story of counselling practice?

These statements posed to participants will be in an open-ended and unstructured manner. Prompts such as “Tell me more about that” will be used to encourage open-ended answers that will facilitate participants’ narratives.

Interview #2:

Each participant will be asked to do a second audio-taped interview using this format, which will be semi-structured in nature. I will use the following questions as a guide:

1. From your narratives in your interview I have constructed a story map...how does this map illustrate your views?
2. What is missing from your story map? What would you like to add?
3. Do you have anything else to say about your story map?

These statements posed to participants will be in an open-ended and manner. Prompts such as “Tell me more about that” will be used to encourage open-ended answers that will facilitate participants’ narratives.

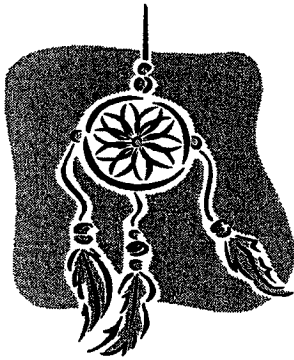
APPENDIX F
COMMUNITY NEWSLETTER

SUZANNE L. STEWART, DENE FIRST NATION, PHD CANDIDATE
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY & LEADERSHIP STUDIES - MAY 2007

Indigenous Helping and Healing

Email contact: slb@uvic.ca

Tel. 250-885-8225
University of Victoria



Benefits of the Study:

- Community healing
- Individual healing
- Community resiliency
- Partnerships
- Community capacity building
- Improving healthcare policy and programme delivery
- Legitimizing Indigenous worldviews in western society

Dissemination:

- Community newsletter
- Policy reports to Native and Settler governments
- Academic journals and conferences
- University curriculum
- Native community based education programming

Native Counsellors Tell Their Stories about Cultural Mental Health

For my dissertation research I sought to extend our understanding of mental health and healing from an Indigenous cultural perspective.

This project reflected my commitment to working with indigenous communities to identify healing strengths and positive aspects of our culture in order to resist colonialism and heal from its destruction.

Who is Suzanne Stewart?

I am from the Yellowknife Dene First Nation and completing my PhD in Counselling psychology at UVic, where I am a visitor to the traditional territories of the Coast Salish peoples. I have worked as a professional helper since 1998 and am currently registered clinical counsellor and come from a family of natural community helpers.

There are two main reasons for this study: 1) There is a

lack of empirical data in counselling psychology related to an indigenous paradigm of mental health and healing, 2) currently there is a health crisis in some Native communities, yet there is an under-use of mental health services by Indigenous peoples.

Research question: How do Native counsellors understand the intersection of traditional Indigenous cultural conceptions of mental health and contemporary counselling practice?

Through this study, I attempted to answer this research question by articulating a valid Indigenous perspective on mental health and healing. I structured and conducted a qualitative study using a narrative methodology that was based on a conceptual framework of Indigenous ways of knowing and social constructivism. I interviewed 5 urban Native counsellors in a native

community agency to get their stories about the intersection of Indigenous mental health and healing with their counselling practices.

A narrative analysis of the interviews, using a story map, yielded within and across participant results. Core concepts of cultural identity, community, holistic approach, and interdependence were presented as the final results to construct a model for Indigenous healing and counselling (see page 2).

This counselling model epitomizes the goal of this study, in that it is a concrete articulation that can be used to influence education, counselling and other mental health services, and, importantly, government policy. From an Indigenous perspective, these core concepts of community, cultural identity, holistic approach, and interdependence must be

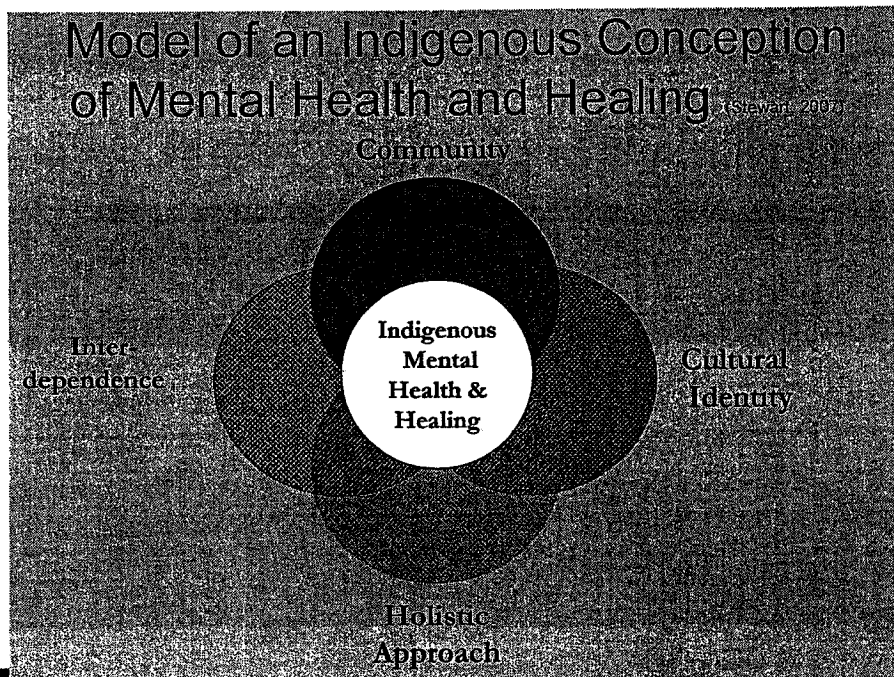
In order to find strengths and resources for healing

actively present in the process of counselling and healing. It has been suggested in the literature that elements such as these are present in the context of Native mental health; the voices of the participants in this study carry these statements one step further by

asserting their necessity and integrity to mental health and healing. The counsellors interviewed in this study had knowledge and experience in the practice of helping relationships, and by virtue of their own cultural identities as diverse Indigenous peo-

ples. Their stories represent authentic experiences of mental health and healing in their work as professional helpers over past and present experiences and future intentions and by extension give relevance and strength to this research.

Results of the Study



"I think that in mental health research, we cultural teaching, one of the seven teachings, as it wisdom, humility, bravery, and I think that you need all of those seven teachings to be with people as a support."

Quote from participant

Conclusions & Implications

Indigenous mental health for these counsellors in their work with Indigenous clients is about incorporating

Community

Cultural Identity

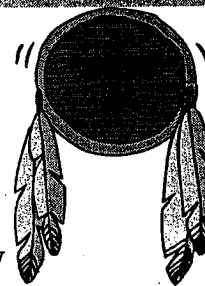
Holistic Approach

Interdependence

into the counselling relationship in active and helpful ways such as being in nature with clients, working with Elders, family, and community members, sharing food, using ceremony and prayer, and building the therapeutic alliance.

Five Implications:

1. A holistic conception of health and healing should be used by mental health practitioners and educators who are part of the **health promotion movement**.
2. **All counsellors in Canada should be educated** about an Indigenous paradigm of mental health and healing:
3. The results support the development of **culturally-based and holistic models**



of mental health and healing as a positive alternative to the deficit models of health.

4. To be effective, **counsellors should use Native approaches with Native clients**.

5. Popularizing **Indigenous models of mental health and healing could benefit everyone**.