Athabasca University Master of Arts - Integrated Studies

WHAT DO MENTAL HEALTH PRACTIONERS NEED TO KNOW WHEN WORKING WITH ABORIGINAL CLIENTS TO ENSURE INTERCULTURAL COMPETENCE AND SAFE PRACTICE?

By

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Integrated Studies Project

submitted to Dr. NANCY ARTHUR

in partial fulfillment of the requirements for the degree of

Master of Arts – Integrated Studies

Athabasca, Alberta

APRIL, 2010

Abstract

What do mental health therapists need to know when working with Aboriginal people? In order to answer this question I will explore literature on intercultural counselling and safe practice for mental health practitioners working with this population. To support literature claims I will also explore real life practical examples. The first step in creating an open environment in intercultural counselling is to challenge personal and systemic assumptions. Listening to the voice of Aboriginal people is essential and I will explore the voice of Aboriginal people through a lens of research paradigms such as Positivist, Interpretive and Critical theory. I will discuss the value for professionals to be visible in Aboriginal communities. Through exploration of the dilemmas in cross cultural counselling and therapeutic interventions I will highlight what mental health professionals need to know when working with Aboriginal people.

Background

I began a journey to learn more about Aboriginal people and their culture 25 years ago when I started to work as a community mental health therapist. This process involved participating in cultural ceremonies, traveling to reserves and personal examination and reflection. I befriended an Aboriginal Elder and participated in the sweat lodge ceremony on a monthly basis for 20 years. I was honoured by receiving a prayer pipe and with this gift certain responsibilities and obligations were bestowed on me. At the sweat lodge ceremony I am asked to explain the ceremony and protocols to participants both Aboriginal and non aboriginal. During the sweat lodge ceremony I sit to the Elders left, a position designated usually for Elders and with this appointment instructed to lead two of the rounds singing sacred Sun Dance songs. I do not take this designation lightly and engage in the ceremony with sincerity and respect. The more I learned about Aboriginal culture, the more I learned about myself. I realized that a parallel process was happening. The personal openness and reflection was also illustrated in my professional practice as I gained a reputation at work as the "Aboriginal expert".

I have worked from an intercultural perspective as a therapist since the mid 1980's and when I became a manager for the mental health program in 1999, I had the opportunity to draw from my experience and organize Aboriginal Awareness workshops for the mental health program. The challenge was to develop an opportunity for mental health staff to gain an awareness of Aboriginal culture, explore their own assumptions, and challenge them to shift their preconceived ideas about Aboriginal people. For health

care providers, their personal development and growth promotes a professional practice change.

Through my academic studies I have learned the language of several adult education theorists who follow the principles of adult education. Some of the adult education principles include using relevant, practical information, and incorporating meaningful life experiences. My challenge therefore is to bring about a relevant learning experience for professionals who might benefit, not only from personal development, but also from enhancing their professional practice in the mindset of inter cultural counselling.

In this essay, I identify what mental health therapists need to know to be safe practicing intercultural counsellors. Real life practical experiences will augment the literature review. The literature, personal experiences and the workshops that I facilitate are opportunities to promote a paradigm shift for mental health staff, through reflective practice exploring knowledge, skills, and affective change. The end result will be to provide mental health therapists some ideas on what they need to know to facilitate working with Aboriginal clients.

Personal Reflections

The process of developing intercultural and safe practice competence needs to start with a personal reflection. There are several assumptions associated with transformation theory (Mezirow 2000). The first assumption is that we learn about our environment through our associations and social interactions from those around us. The society in which we grow up in has such a large impact on us. Elements of culture, language, family, religious beliefs, formalized education, and family dynamics will all influence how we understand and internalize meaning about the world around ourselves. According

to Mezirow (2000), learning perspectives are "structures of assumptions within which one's past experience assimilates and transforms new experience" (p.42). We use these assumptions or beliefs to evaluate, test, or make sense of each experience we have. These learning perspectives are broken down into three categories.

The three categories are epistemic, sociolinguistic, and psychological perspectives. The epistemic perspective includes developmental stage perspectives, learning styles, sensory learning preferences, scope of awareness, as well as global focus, reflectivity and others. The second perspective is sociolinguistic perspectives and this includes social order examples. A few of these perspectives include norms, language, ethnocentrism, philosophies and other factors such as common sense. The third category is the internal psychological perspective. Factors here include self-concept, locus of control, lost functioning as a result of adult anxiety, psychological defence mechanisms, neurosis, and other character preferences.

Mezirow's assumption is that we draw our understanding from our own unique learning perspectives, and this can be linked to the first domain in Arthur and Collins (2005) Cultural Infused Counselling model. This model uses three core cultural competency domains: cultural awareness including personal assumptions, values, and biases, awareness of other or understanding the world views of the client; and finally the developing a working alliance or agreement on goal and tasks in the context of a trusting relationship.

One of the exercises in the Aboriginal Awareness workshop explores each participant's unique cultural background. In this exercise participants are asked to reflect on family, community including ethnicity, education, expectations, customs and

language, work, socio-economic, and religion. Participants may volunteer to the large group their personal discoveries on how their learning perspectives have shaped them to be the people they are today.

It is apparent to me that personal development and self reflection is critical for a therapist to be an effective counsellor. In conversations with elders Joseph Couture, a Cree elder, and Art Calling Last a Blood Elder, that in the view of Aboriginal people; personal and professional development are the same (personal communications 1990, 2009). According to Couture (personal conversations, 1990), the degree of success of an educational experience, be it classroom, sweat lodge, or personal journaling is dependant upon an emotional impact with the increase in knowledge and skill development. Therefore, from an Aboriginal point of view, personal and professional development is enmeshed and it is imperative that the mental health therapist seriously reflects on previous academic training in order to become an intercultural counsellor encourage mental health professionals to reflect on their education and training as part of the safe practice training. "It is timely for counsellors to examine their professional beliefs about the delivery of counselling services" (Arthur and Collins., 2005, p. 151). In today's world, mental health therapists arrive at their jobs following years of training and practice in varying perspectives and techniques. Through their disciplines they are educated and promoted to follow best practice evidence. Evidence practice is "(a) fact or body of facts on which a proof, belief or judgment is based. Evidence does not mean certainty. Rather, it represents an available proof with varying degree of certainty" (Jenicek, 2006, p. 142). It is important in the arena of science to establish, replicate and value reliable consistency. Evidence offers others the opportunity to utilize similar approaches to gain

similar results. These perspectives and practices are used to create like mindedness for people of the same profession. Disciplines are closed systems as they are self contained and self monitored basing the criteria of a discipline by definition "the training of people to obey rules or a code of behavior" (Soanes, 2001). The advantage of a recognizable profession through best practice provides support in the areas of self regulation, monitoring, and with collegial association and peer review. The disadvantage is that reaching beyond the discipline to explore knew learning's may not be accepted by the discipline and may even be discouraged. However, disciplines can be more fluid in development as Palys (2003) states, "a discipline is defined by what members of that discipline do, are interested in, and write about," as we determined that "a discipline's boundaries are ultimately defined by the actions of its practitioners" (p. 33). Therefore practitioners are able to challenge previous main stream educational and best practice leanings and seek out new opportunities and new cultural experiences. By achieving awareness from outside their current disciplines, the mental health therapist may develop openness to new learning's and therefore available to become safe intercultural practitioners.

How are we as disciplined professionals able to challenge years of education and training? I suggest that we are shaped by our training and education based on three different research paradigms. The paradigms are Positivists, Interpretive and Critical theory. I would encourage mental health therapists who are embarking on an intercultural counselling process to challenge, through critical theory, the previous learning's of their discipline. As an intercultural therapist, it is important to recognize and challenge whose voice is being presented through the research, education and training we have received as

professionals. It is essential for the practitioner to understand authoritarian power and control messages presented to students and readers of research paradigm documentation.

Research Paradigms

The positivist paradigm refers to a scientific model and is deterministic in nature. A recent movement in post positivism theory suggests it is the likelihood that phenomena will occur between variables rather than the guarantee of the event happening (Gephart, 1999: Heath, 1997). The research design is to minimize influencing factors and discover a truth based on quantitative review with the expectation of being able to reproduce test results. This verifies the reliability of the event and predicts the likelihood of being true. An example is Adelson's (2005) article titled, The Embodiment of Inequity Helps Disparities in Aboriginal Canada. A major part of this article is from a scientific paradigm. There are several pages of statistical information on demographics of population, life expectancy, housing, education, income, unemployment, social problems, health issues and rates of death. The scientific paradigm approach implies or focuses on the social and medical concerns as a source to disenfranchise Aboriginal people rather than historical and political decisions that maintains the status quo. The bio-medical language used promotes an authoritarian power and control message to the reader. Adelson herself states that the article has a scientific model focus and critiques it for lacking its critical theory approach and thereby limits the whole story.

The Interpretivism research paradigm involves the interplay of people or social construction (Gephart, 1999). This research approach is qualitative and the researcher is

an active participant in the process. In this paradigm, research is always influenced by people. The truth varies, therefore, with each individual's point of view and involvement or perspective. Often focus groups or case studies may validate a more generalized truth or at least uncovering experiences of that person. One example is the Alberta Government's (2006) document produced by the Wisdom Committee of the Alberta Mental Health Board. This document titled Aboriginal Research Protocols was authored by twenty-three individuals, twenty who were Aboriginal. This article establishes recommendations for researchers who study Aboriginal people. An interpretive paradigm is the focus. Knowledge for the articles is based on interviews by Aboriginal elders. The construction of the truth is shared between authors who were Aboriginal and Aboriginal interviewees. By construction of a shared truth non Aboriginal therapist will have an opportunity to learn from the other perspective. Developing empathy enhances the therapeutic relationship and supports collaboration in developing therapeutic goals. The critical postmodern theory paradigm confronts the disparities in the world. The assumption is that disparities and inequities are the result of a power based, capitalistic approach. Society is a social construct and is influenced by governmental policies and reinforced through the institutions of education, social support services, and health (Gephart, 1999). The societal truth is an accepted norm to maintain the status quo. A postmodern view to deconstruct the power based system and address the disparities of society is the underlying focus. Critical theory is also used to examine research in health related research (Smith, 2007). Smith challenges the way written discourse restricts nursing practice in Australian medical practice and encourages disciplines to use critical discourse analysis to identify scope of practice. An example of critical theory by an

Aboriginal writer is Thira's (n.d.) article, The Fourth Wave of Colonization: Western Healing. The accusation is made that Western medicine is a continuation of colonization and genocide. The article starts with an historical account with the primary focus of North American governments' power structures. Thira promotes social welfare programs, medical and mental health programs as responsible institutions of maintaining the power structure and enabling the status quo of hierarchal oppression. Thira claims that governmental institutions have only shifted their mindset of Aboriginal people from "savages" to "sick" people. Another example of critical theory is provided by the Maori people of New Zealand titled Cultural Safety: Module II/People's Experiences of Oppression (n.d.). In this article examples of power imbalances are mentioned in relation to racism, sexism, classism, ageism, and more. The article comments on how the imbalances of power are reinforced through shame-based experiences of Aboriginal people. An example of critical theory discourse is given at the end of this article.

> "Aboriginal peoples are commonly assumed to experience a higher incidence of diabetes due to poor lifestyle and diet choice, caused, in part, by their culture. Missing from this analysis is the recognition, in terms of cultural safety, that life choice or life opportunity is closely linked to historical, social, political, and economic factors relating to our experiences. . . explaining health only in terms of our culture objectifies culture, making it something that can be seen, studied, or judged" (n.d).

This quotation illustrates the critical theory approach by challenging the medical field perspective, a Positivist's view. To suggest culture as a reason for illness, ignoring the power and control issues of an oppressed people is not an

acceptable view by the National Aboriginal Health Organization. For mental health practitioners it is important to reflect on how medical field education or discipline training may influence our practice.

Hearing the Voices of Aboriginal People

It is a common assumption that "talk therapy" is useful in the field of mental health. Telling one's story is part of the healing process. Some authors indicate that disclosure of past traumas through a writing process improve long-term health (Pennebaker, 1995). Specialists who focus work on re-traumatization do caution therapists that a re-traumatization may occur (Arendt, M., Elklit, A., 2001). Other authors suggest that writing is an effective method in dealing with grief and loss (Zimmerman, 2002). The founder of narrative therapy promotes listening as an important technique in helping a client relate their perceived events and personal story as well as open up alternative stories and focus on traits that the client views as "preferred" scripts (White, 1997). Needless to say hearing a client's story is essential for the mental health professional.

I co-facilitate Aboriginal Awareness workshops for mental health staff at my place of employment. Participants are able to view the discourse of Aboriginal speakers from varying perspectives. Commonly the critical theory perspective and the interpretive research paradigm perspectives are often illustrated through the voice of the presenters. Several Aboriginal presenters share their story on the first day of the workshop. Some presenters promote a critical theory perspective when discussing residential schools and the acculturation process. The discourse continues, with a key message to understand the

impact colonization has had on Aboriginal people. Although there is some historical and scientific knowledge presented by speakers, a true understanding from critical analysis position involving the oppression, power control issues from a historical perspective must be acknowledged.

Numerous times when the critical analysis approach is presented by an Aboriginal speaker, the emotional content, especially anger, presents an interesting dynamic. During the debriefing segment of the workshop, staffs often express a range of emotions from grief, anger, quilt, sadness and denial. It is important for mental health workers to realize that due to historical events, anger is a predominant emotion and mental health workers need to be aware that this anger will be directed towards them (Bittker, 1973, Hammerschlag, 1988). If mental health workers do not accept this dynamic, the process of cross cultural counselling is stalled.

Other Aboriginal presenters offer an interpretive view as they share knowledge about traditions and custom of Aboriginal people. Speakers share their stories involving extended family issues, ethics and values, language and other epistemic factors such as life experiences, psychological make up, and cultural practices such as traditional versus mainstream (Mezirow, 1991). One example at the workshop is the Aboriginal caterer who tells her story from an interpretive approach and even provides a positive spin to her experience in the boarding home school. Despite the hardships and trauma of being removed from her family as a young child, the caterer speaks positively about learning the value of reading and writing, as well as learning how to sew and cook, and for

her, this provided the necessary tools to become a successful caterer at the age of eighty-five. The caterer's interpretive paradigm discourse is often met with warm, genuine, supportive feedback and hugs from the mental health staff. However, staff must also be careful not to over value the friendly warm presentations and discard presentations that use the critical theory approach that might evoke less warm feeling.

At the Aboriginal Awareness workshop a presentation is also given on the Elder in Residence Program sponsored by the Health Authority. In this program a Blackfoot elder conducts a sweat lodge ceremony once a month. The purpose of the program is to initiate a repatriation effort for Aboriginal clients of the two treatment facilities in that community, to allow them to experience the traditional Aboriginal healing process. It is also an opportunity for staff members in the region to participate in a cross cultural experience as well as to "role take" (Canales, 2000). Staffs are able to view Aboriginal people in a variety of roles. During this ceremony the authoritarian power structure is based on an Aboriginal world view. The elder is open to sharing his perspective of the Aboriginal healing process through the actions of the ceremony and the discourse in an interpretive paradigm perspective. An example is the dialogue of sharing customs and explanations from an Aboriginal point of view as well as cultural stories that are told in the lodge. There is also the critical theory perspective and the deconstruction of the power and control perspective such as the residential schools and the banning of sweat lodge ceremonies in the past.

There is also a role reversal of the critical theory perspective as the elder is now in control of the ceremony. A restructuring from a power and control view is demonstrated as the elder is in charge. An example is the starting time of the ceremony. Starting time occurs only when the elder indicates that the "time is right". The ceremony and protocols are strictly adhered to according to historical Aboriginal practice. There is no room for a mainstream domination during the ceremony. When the sweat lodge door is closed the ceremony begins and a new learning can occur. "Effective learning in relationships is facilitated when coming from a place of not knowing. Abandoning a desire for certainty, closure, and control in relationships and replacing it with efforts to be tentative, experimental, and open ended is useful in community practice" (Racher & Annis, 2007, p. 265). The sweat lodge ceremony provides an opportunity for patients and mental health staff to experience the Aboriginal world view as the dominant power structure. The information about the sweat lodge is provided verbally as workshop participants are encouraged to participate in this regular occurring practice.

Blue and Darou (2005) also identify the importance of ceremonial practice as a healing process. They identify ceremonies such as sweat lodges, smudging with sweet grass or cedar, the vision quest, drumming and the sun dance as healing practices. There are documented examples of mainstream academia collaborating with Aboriginal spiritual practices for therapeutic interventions. Young, Ingram, and Swartz (1989) wrote about a Cree Elder and a research project in conjunction with the University of Alberta to incorporate sweat lodge

ceremonies and the treatment of psoriasis. The intercultural therapist must recognize the importance of ceremony. If an Aboriginal client requests support in attendance of such activities the intercultural therapist needs to encourage the clients' participation. If the counsellor were to accompany their client, then they might be seen as moving one step closer to intercultural safe practicing counsellor. For the mental health therapist, openness to a new way of thinking is required. The sweat lodge ceremony and other Aboriginal spiritual practices are opportunities for mental health therapists to experience directly the effectiveness of Aboriginal ceremony. To be an effective intercultural counsellor with Aboriginal people the therapist must shift away from the view that mainstream medicine is the only method of treatment for their clients.

Critical Theory and Advocating

The Maori people of New Zealand have provided a specific view of cultural awareness and safe practice. Influenced by Irihapeti Ramsden, a doctorate graduate of Philosophy in Nursing, the National Aboriginal Health Organization paraphrases Ramsden,

> "(C)ultural awareness is the beginning step in a learning process, which involves understanding difference, while cultural sensitivity is an immediate step where a self-exploration of a student begins. Cultural safety is the final outcome of the learning process" (NAHO, n.d.).

The article reinforces a need to teach people about economic, social political, health, and education issues and the impact the dominant society has had on

these issues. The power structure of a dominant society has had a direct role in marginalizing Aboriginal people. In order to be an effective, culturally safe practitioner, understanding of the power issues is paramount. Therefore, staff who understand the power and control issues of the dominant society are then able to demonstrate safe cultural practice.

At the Aboriginal Awareness workshop for mental health therapists, participants are presented with the historical information of the residential schools, colonization, and disenfranchised political movement of the federal government. This process is often presented at this course by Aboriginal people. Participants of the workshop have an opportunity through group discussion and consciousness-raising to explore discrimination and systemic racism. Through this process the group is moved to a commitment to work towards recognizing Aboriginal injustice and commit themselves to create a more "just and fair world".

Intercultural Counselling Approaches

During the Aboriginal Awareness workshops we explore several approaches to intercultural counselling. Arthur and Collins' (2005) Cultural Infused Counselling is a model that uses three core cultural competencies domains: cultural awareness including personal assumptions, values, and biases, awareness of other or understanding the world views of the client, and finally the developing of a working alliance or agreeing to work on therapeutic goals within the context of that trusting relationship. A concerted effort to explore this model

is implemented in the Aboriginal Awareness workshop by role playing the first two domains. Exploring one's own cultural background and beliefs and then interviewing each other from a cultural perspective, provides a practical opportunity for therapists to learn from the other. In the third domain of an agreed working alliance consultation with an Elder is an option. In my role as a manger I encourage staff members to use this option and as a manager can support this process with an honorarium for the Elder.

There are similarities between Ramsden and N.A.H.O.'s view of cultural sensitivity and cultural awareness and Cultural Infused Counselling. Similarities include the concept that cultural awareness is a learning process and that it involves understanding one's own cultural background as well as differences in another's cultural background. There are differences however from the research paradigm view.

The major difference is that, in Cultural Infused Counselling, a more interpretive paradigm exists in which a negotiated process occurs between therapist and client. For Ramsden, the relationship requires the critical theory view and a paramount need to recognize and understand historic and current authoritarian power structures that maintain the status quo of marginalizing Aboriginal people (n.d). In Arthur and Collins' (2005) Cultural Infused Counselling Process, thirteen steps are identified to work to that goal of engagement with a client. The effort to equalize the power between therapist and client is identified in stage 2 of developing trust and respect. It is important for the therapist to realize that a therapist enters into the counselling relationship

with more power than the client. An effective intercultural counsellor must actively work to restore a power balance with clients and this may be done through shared collaborative interpretive discourse.

I recognise that there are some professionals who engage in intercultural counselling but are not be able to participate in Aboriginal ceremonies. For primary care physicians and Behavioural Health Consultants who work in a primary care settings, a model exists to utilize a shared collaborative experience for clients. Hunter et. al., (2009) uses the explanatory model of health and illness to engage with minority clients. In this model cultural factors are elicited from the following questions, "What do you think caused your problem?", "Why do you think it started when it did?", "How does it affect you?", "What worries you most?", "What kind of treatment do you think you should receive?" (p. 58). Other supportive questions such as "Have you tried any other treatment?" and "Have you seen any spiritual leaders or healers for this illness?" are augmented questions provided by Kleinman's illness narrative, as suggested by Blunt, (2008). The purpose of such questionings helps the therapist enable the client to reveal their story from their own cultural background and places the expertise of the problem and possible solutions with the client and not solely dependant on the expertise of the therapist.

Social and Cultural Influences

It is paramount for a mental health therapist to accept that social and cultural influences influence mental health beliefs and behaviours (Hunter at al, 2002). Knowledge of social practices and cultural beliefs can be acquired cognitively through studying and reading. To have this knowledge is a very important awareness for the

mental health therapist. Blue and Darou (2005) cover Rules of Behaviour for Aboriginal people using Claire Brandt's (1990) information:

> "- Noninterference: Discouragement of coercion of any type
> - Noncompetitiveness: Management of intergroup dynamics to suppress rivalry and possible embarrassment
> -Emotional restraint: Promotion of strong self control and discouragement of strong or violent feelings…
> -Sharing: Generosity that discourages hoarding, again a valuable trait…in an egalitarian community
> -Suppression of ambition: Related to above
> -Flexibility to the concept of time:
> -Not expressing gratitude and approval: The intrinsic reward …sufficient
> -Native protocol: …rules are everywhere
> -Teaching by Modelling:
> -Correction by teasing:
> conflict to enemies or hypothetical or religious third party"(p.314)

It is imperative for mental health therapists to have a solid understanding of Aboriginal codes of behaviour. There is always a risk however if information is gained only from a book. This can create further distancing from your client and may lead to categorizing and stereotyping of ethnic groups (Sutherland, 2002). Therefore, I encourage mental health therapists to supplement their readings with engagement with Aboriginal clients to glean important facts about Aboriginal rules of Behaviour.

Being Visible in the Aboriginal World

In today's world the mental health therapist has many roles. Direct counselling is only one role as a therapist is often asked to sit on committees and involve themselves in program planning. I suggest that working collaboratively with Aboriginal committee members enhances intercultural practice. It creates visibility especially if the meeting is

on the reserve. Visibility demonstrates interest and willingness to meet Aboriginal people where they are the experts. It offers cultural exposure to new learnings.

The Aboriginal Steering Committee

I sit on such a committee titled the Aboriginal Steering committee. It started about two years ago following Populations Health's focus groups Inclusion Lens survey (Shookner, 2002). A series of focus groups were held and were facilitated by population health staff and Aboriginal community members. One of the outcomes for the health region was to establish a working group comprised of managers with decision making ability and Aboriginal employees of the region.

The steering committee consists of the Population Health manager, a health region vice president, and four Aboriginal staff representing mental health, Children's Care Services, a rural emergency department, and home care, along with mangers from several departments including myself. At any given point in time there were 50 % representations of Aboriginal staff. The power, however, resides with the managers and being fully aware of this phenomenon, efforts were made to employ an interpretive paradigm in the discourse. For example, any decisions are made based upon an agreement where each member of the committee has a say.

There were interesting discourses, however, and it was brought to the attention of the committee, by the mental health Aboriginal staff, that each Aboriginal person tended to speak from a territorial perspective only. Each spoke for their own program. There was difficulty in expanding discussion to the second reserve or to move from a children's perspective to a senior's perspective and vice versa. A silo of power was presented by

each of the Aboriginal staff member. An understanding of the Aboriginal political world provided learning for all group participants. A critical theory approach was presented by each staff member in their discourse. One example was the home care staff that focused on the residential school and the disruption of parenting skills that lead to many seniors who were now unable to organize their health care. Her solution was employing cultural brokers to resolve the issue. Although there is merit to her argument, through critical theory, building another silo of authority with out interpretive basis may lead to a replaying of the original problem of power and control and thereby becoming an exclusive rather than inclusive process.

The committee did arrive at consensus on two items. They were to establish a regional Aboriginal awareness program and a targeted Aboriginal recruitment. The voice of the Aboriginal staff members tended to focus on a critical discourse paradigm. In order to gain consensus between all committee participants an interpretive collaborative discourse proved successful.

The Kainai Wellness and Mental Health Committee

The Joint Kainai Wellness and Mental Health committee meeting was established in 1988. The purpose of the group has shifted over time from a consultation model, based on positivist theory, to a more interpretive collaborative focus today. This committee consists of the Blood Reserve's mental health program of all Aboriginal staff and two local provincial mental health clinics staff who are mostly non Aboriginal. The location and host of the committee meetings rotates between the sites as per requested by the Kainai Wellness staff.

The major accomplishment, to this point in time, was the development of a culturally sensitive suicide assessment tool. Kainai Wellness staff felt a series of misdiagnosed admissions at a local community's Emergency Department occurred and as a result a young Aboriginal male committed suicide. The Aboriginal community felt an inadequate assessment was done by the ER nurses and physicians. Our goal was to work collaboratively with the local emergency department and develop a new assessment tool.

The committee met every two weeks to develop a culturally sensitive suicide risk assessment tool. A variety of paradigms were implemented in the accomplishment of the task. The process started with a positivist view as we invited a local Emergency Department nurse and analyzed current literature. After receiving copyright permission to alter one of the present tools a collaborative/ interpretive process resulted in the development of the new tool. We highlighted the importance for emergency staff to dialogue with their Aboriginal patients. We expanded the categories of risk factors involving life events, emotional/behavioural factors, and social support areas from the patient's perspective. We then returned to a positivist approach by developing guidelines for managing risk levels that include clear instructions on how to provide safe care for the patient and when to transfer to the urban site for specialized care. These were based on best practise research from previous assessment tools. Finally, we highlighted a number of questions that the ER nurses could ask to help with their interview. This assessment tool was adopted by the entire health region and implemented at each Emergency department in the region.

I feel that the non Aboriginal staff members were open to new learning opportunities and were able to see the Aboriginal staff from a different perspective.

ER staffs from across the region were also able to see Aboriginal staff from a new perspective as a result of the success that the new tool provided. It is an example of Canales' "role taking" (2000, p.8) as many ER staff were more accustomed to Aboriginal people being their clients and not their peers. Many forms of discourse are implemented in the joint committee; however the overall successfulness can be attributed to the interpretive paradigm with the intent of inclusionary practise.

Provincial Working Group on Mental Health and Addictions

Integration in the Primary Care Setting

The last practice setting and discourse I will review is the provincial working group on mental health and addictions integration in the primary care setting. On the table for discussion at this group is how to integrate Aboriginal mental health and addictions issues into the primary care setting. Unfortunately there were no Aboriginal staff members on the committee. This does provide an opportunity for non Aboriginal staff to advocate on behalf of Aboriginal people. We did review a provincial document written by Aboriginal staff members.

The provincial document reviewed was the Aboriginal Mental Health: A Framework for Alberta Healthy Aboriginal People in Healthy Communities (2004), the primary paradigm used is critical analysis. The authors are Alberta Mental Health Board's Aboriginal Service staff and the Wisdom committee. After explaining historical issues of colonization the document focuses on power and control issues. The language is challenging. For example, Aboriginal health must be viewed in an Holistic manner

because the bio medical model does not meet the Aboriginal people's needs. Even the language, in promoting cultural trained professionals is strong, "Failure to grasp the significance of these contextual factors often leads to stigmatization, misdiagnosis, and inappropriate treatment" (p. 28). Based from the critical analysis paradigm the document then focuses on a new framework moving away from the bio medical model. Even in the absence of Aboriginal people at this committee an opportunity to advocate for equality and justice can occur through written discourse and verbal discourse by mental health staff.

The Walk About

In order for a mental health therapist to be an effective cross cultural counsellor, they need to be visible in the Aboriginal world. An extreme example is Morgan's Walk About (1994). Morgan had identified she had established an ethnocentric belief system in setting up work programs for Aborigine' youth of Australia. Upon realizing her personal disconnect between her professional career and reaching out to the Australian Aborigine youth, she was invited to a Walk About. She spent four months in the desert of Australia with an Aborigine troop with no connection to the outside world. In her own words she believed she had lived in a world of left brained functioning. As part of her Walk About she was forced to think in a right brained world. She talked about her frustrations as she had the opportunity to lead the troop through their walk in a challenging environment and how she was able to shed off old learning's and embrace the communication of her troop (telepathically). Through her book, Morgan is able to identify her course of action,

acquisition of knowledge and skills as seen in her new role. As a result, self-confidence and competence were demonstrated as examples towards the end of her story. Her book and subsequent lectures explaining her experience were all part of a promotion to improve world conditions and efforts for social change for the Aborigine of Australia. For Morgan, by placing herself in the environment, sharing the feelings and world view from the perspective of the other, created the truest sense of understanding and engagement. Although Morgan's example is extreme, it does bear witness to the importance of engaging with aboriginal people in their world view. The popular and powerful example is the participation in spiritual ceremonies.

One of the programs I participate in a monthly basis is a health region sponsored sweat lodge ceremony. I openly encourage all mental health staff to attend and the management group have supported the learning process by providing a staff development day to attend. By participating at a sweat lodge ceremony staffs have an opportunity to role take (Canales, 2000) and witness Aboriginal people in roles of authority and expertise. It also reinforces the wisdom and connection to an elder. The stories and story telling reflect unique learning opportunities for mental health therapists. It also provides a new and exciting learning when a therapist attends with their clients.

One of the greatest learning experiences I have had was when I was invited to a Beaver Bundle opening by the Elder that I regularly sweat with. During the 8 hour ceremony I was one of three non Aboriginal people in a ceremony of about three hundred people. Putting yourself in a minority environment event can be a growing experience. To accept the vulnerability that many minority groups may feel in a mainstream environment is risky. I was approached by a young man from Montana who had mistaken

me for the museum curator who had brought the Beaver Bundle to the ceremonial site. Unable to reassure the man that I was not who he thought I was, it created tension and concern on my part. The Elder came to my rescue scolding the fellow from Montana explaining to him that I was a person who worked and sweated along side him for the past 18 years and he should not be concerned with my presence there. Although I am not suggesting that mental health staff commit to the same extent as I have; being risk takers, attending ceremonies and simply being visible in the Aboriginal community is important to be a successful intercultural counsellor with Aboriginal people.

A more pragmatic approach is to present an open curiosity, a listening to Aboriginal stories, risk making mistakes, learn to be an ally, respectful of the opinions for others, share honestly from one's own experience, and be open-minded (Sutherland, 2002). Although these skills are often required in the therapy sessions I feel that the intercultural counsellor needs to travel out to Aboriginal communities and learn through their experiences.

Dilemmas in Cross Cultural Counselling

There are numerous barriers to cross cultural counselling. The meeting of the "other" often evokes numerous reactions within individuals. The world view of mainstream culture differs from a minority group and specifically Aboriginal world view (Rank, 1982). There are a number of options to cross cultural counselling.

One perspective is to utilize strictly Aboriginal counsellors when working with Aboriginal clients. However, practitioners from a minority culture may not be the best to practice mental health therapy for that culture as often these practitioners are seen as identifying more with the dominant culture (Rank, 1982). I have been told by Aboriginal clients that when an Aboriginal person leaves the reserve to acquire an education they are often derogatively referred to as an “apple”. The reference is to someone who is red on the outside and white in the middle. When I worked as a mental health therapist, Aboriginal clients reported to me that they choose non-Aboriginal therapists for reasons of anonymity and confidentiality. Their concern was that by presenting themselves in a waiting room for a counsellor on the Reserve then everyone would know their business. I believe it is important to maintain options for clients when they choose counselling support.

A popular solution is the utilization of a cultural brokerage program or having para-professional Aboriginal staff supports the voice of Aboriginal people. It has been longstanding and utilized both in Canada and New Zealand (n.d.). A cultural brokerage program uses Aboriginal liaison workers to provide a cultural perspective for Aboriginal clients in terms of an advocate in the arena of schools or in the arena of mental health counselling. Kirmayer (2003) proposes a cultural consultation team of trained professional staff rather than use of para professional lay people. This team would be readily accessed for consultation and would be comprised of psychiatrist, interpreters, therapists and outreach staff. The importance of staff members from the same culture should

not be understated. If the professional is from the same cultural background as their client a connection exists. This process can be very successful.

The pitfalls with the utilization of cultural brokers or lay people to provide support have been identified as possible issues with confidentiality. Brokers have not been trained in the particular field of expertise such as schools with education and/or counselling with mental health therefore, may not have the insight or awareness of their own particular issues which may inhibit providing counselling or support to others. The other criticism is that these individuals are not trained interpreters and therefore may not understand the specific nuances of the educational field and/or medical field (Kirmayer, 2003). Another difficulty often identified is "no one individual can speak for an entire group and that generalization can be detrimental" (Casanet, 2004). The other criticism on the utilization of the cultural brokerage comes from the critical theory analyst's paradigm. If Aboriginal people are restricted to only see Aboriginal people, thereby limiting their own personal choice, does that not provide another silo of power and control which the authoritarian structure is simply redefined to an Aboriginal perspective. For me this speaks to an exclusionary system rather than an inclusionary system (Shookner, 2002). I believe it is important to promote an inclusionary process.

Another dilemma in intercultural counselling is cultural blindness or that culture really is not important in the counselling process. This view can be an individual or an organisational perspective (Racher & Annis, 2007). In this view, a dominating assumption is that the nursing profession can complete their

medical intervention and practice with any individual from any culture and therefore negating the value of the culture of the patient. Blue and Darou (2005) also point out that a counsellor can be over focused on the clients world view as to miss the significance of the problem. Minimizing, over-generalizing and color blindness are only one step away from ethnocentric stereotyping as individuals move through the continuum of ethnocentric to ethnosensitive practice.

At times a counsellor may over-value or over-emphasize culture (Arthur and Collins, 2005). A therapist from the dominant culture can over-value the client's culture and become intrigued by the minority culture. At times the therapist may "miss" the "real" problem or issue (Trimble, 1976, 1996). This issue becomes an over identification of the client's culture and becomes a barrier. In group discussions at the Aboriginal awareness workshop often the topic becomes an issue to try to sort out what are mental health problems, cultural issues, and even legal concerns. One example presented to me, was the use of a medicine pipe by an adolescent at a local high school to smoke marijuana. The native liaison worker insisted that the school cover up the issue and forward the pipe to the elder, who originally owned it. However by not notifying the police that a banned substance was in the schools the adolescent would not be held responsible for his behaviour.

In counselling a dilemma of counter transference (Arthur and Collins, 2005) may also occur. In counter transference the therapists projects their own personal feelings onto the client. In the Aboriginal Awareness workshop exercises are completed to challenge ones assumptions using specific assessment tools on

cultural competency and organizational acceptance (Sutherland, 2009). A reflective process to explore ones personal biases is essential for the cultural intercultural practising therapists. They need examine their own assumptions about Aboriginal people. Our preconceived assumptions about Aboriginal people are shaped by media and documented historical accounts often providing a negative construct. It therefore is imperative, as a safe practitioner, to evaluate both our personal understanding and professional learning.

Concluding Remarks

There are unique and interesting challenges that mental health therapist need to know and do to become safe practicing intercultural counsellors with Aboriginal people. The first challenge is to critically explore their personal and professional assumptions. From a system perspective of current learning organizations, authors Plumb and Welton reference Schon and Serge "(p)ost-modern organizations need workers capable of more than just reacting and adapting to changing circumstance… they need workers capable of thinking ahead, critically intervening in their environment and creating completely new ways of getting things done" (Plumb and Welton, p. 73). From this systemic view therapists need to re-evaluate where they do business and how they do business and this is even more applicable to the Aboriginal population.

Therapists need to seek out workshops that challenge preconceived assumptions about Aboriginal people. A need to make concerted efforts to stretch mental health therapists'

place of comfort to a place of not knowing and therefore to a place of receptive learning is essential. Mental health therapists need to be open to hear the voice of Aboriginal people who are Elders, professionals, colleagues and peers as well as from their clients. For therapists, they need to move away from the comfort of an office, and participate in ceremonies, committees and put themselves in places where Aboriginal people are located. Therapists need to be available to new opportunities to learn.

Blue and Darou quote Trimble (1996) in summarizing what a mental health counsellor needs to know:

> "Counsellors must be adaptive and flexible in their personal orientation and use of conventional counselling techniques. Commitment to understanding the cultural context and unique cultural characteristics of clients also is essential. This often requires counsellors to extend their efforts beyond what is typical in a conventional office" (p.320).

Therapists need to open themselves to new opportunities and a willingness to give up old assumptions. Engage in the therapeutic relationship with an open curiosity about Aboriginal people. There are several intercultural counselling models available. Through the workshops that I facilitate these models are presented and practiced. This on the job training can prove a valuable tool for the mental health practitioner. Practitioners need to actively seek out opportunities to learn and practice intercultural models of counselling.

I would add that the mental health counsellor must actively seek out their own understanding and bias's and actively explore the Aboriginal world view to become a safe practicing intercultural counsellor for Aboriginal clients.

References

Aboriginal and Islander Education Workers' Perception of Schooling (n.d.) Retrieved February 10/09 from

http://www.eddept.wa.edu.au/abled/quality/Aboriginal%20Ed%20Workers%20Ref%20ch

Adelson, Naomi (2005) The Embodiment of Inequity: Health Disparities in Aboriginal Canada, Canadian Journal of Public Health, ProQuest Nursing & Allied Health Source

Alberta Government (2004) Aboriginal Mental Health: A Framework for Alberta Healthy Aboriginal People in Healthy Communities Alberta Mental Health Board Retrieved February 10/09 From http://www.amhb.ab.ca/Initiatives/aboriginal/Documents/Aboriginal_%20%20Framework.pdf

Alberta Government (2006) Aboriginal Research Protocols, Alberta Mental Health Board Retrieved February 10/09 from

http://www.amhb.ab.ca/Initiatives/aboriginal/Documents/AMHB_ARP_ResearchPro.pdf

Arendt, M. and Elklit, A. (2001) Effectiveness of Psychological Debriefing, Acta Psychiatrica Scandinavica2001, vol. 104 pp.423-437 Blackwell, Oxford American Psychological Association

Arthur, N. and Collins, S. (2005) *Culture- infused counselling: Celebrating the Canadian mosaic.* Calgary, AB: Counselling Concepts. pp.3-296

Bittker, Thomas E., (1973) Dilemmas of Mental Health Service Delivery to Off – Reservation Indians, Anthropological Quarterly, Vol. 46, (172-182)

Blount, Alexander (2008) Primary Care Behavioural Health Certificate Program, Department of Family Medicine and Community Health, University of Massachusetts Medical School, Worchester, MA approved by the American Psychological Association

Blue, A. and Darou, W.(2005) Counselling First Nations People, In *Culture- infused counselling: Celebrating the Canadian mosaic.* Calgary, AB: Counselling Concepts. pp.3-296

Canales, Mary (2000) Othering: Toward an Understanding of Difference, Advances In Nursing Science. Burlington, Vermont. Aspen Publishers, Inc.

CASAnet Resources (2005), National CASA Association, Cultural Awareness Training, Seattle, WA retrieved March, 2005 http:www.casanet.org/program-management/diversity/cultural-tra....

Gephart, Robert (1999) Paradigms and Research Methods, Research Methods Forum, Vol. 4 Academy of Management, Research Methods Division

Pennebaker, James W. (1995) *Emotion, Disclosure, and Health.* Washington, DC: American Psychological Association. Pp.4-45

Heath, H.(1997) Paradigm dialogues and dogma: finding a place for research, nursing models and reflective practice. Journal of Advanced Nursing 28 (2), P.288-294.

Fact Sheet: Cultural Safety (n.d.) National Aboriginal Health Organisation, Retrieved February 10/09 from www.haho.ca/english/documents/Culturalsafetyfactsheet.pdf

Hammerschlag, Carl (1988) *The Dancing Healers A doctors Journey of Healing with Native Americans,* Harper San Francisco a Division of Harper Collins Publishers, New York, N.Y., pp.37-47

Kirmayer, Laurence J. Groleau, Danielle. Guzder, Jaswant. Blake, Caminee. Jarvis, Eric, (2003) Cultural consultation: a model of mental health services for multicultural Societies in Canadian Journal of Psychiatry- Revue Canadienne de Psychiatrie. 48 (3), pp.145-53

Mezirow, J. (2000). Learning to think like an adult: Core concepts of transformation Theory. In J. Mezirow & Associates, *Learning as transformation: Critical Perspectives on a therapy in progress* (pp.3-43) San Francisco: Jossey-Bass Inc.

Morgan, M. (1994). *Mutant message down under.* New York: Harper Collins. pp. 99- 113

Palys, T. (2003). Research decisions: quantitative and qualitative perspectives. Ontario: Thomson Canada Limited.

Pennebaker, J. (Ed.). (1995) Emotion, *disclosure, and health*. 1st ed. Washington, DC: American Psychological Association pp1-30

Plumb, D. & Welton, M.(2001) Theory building in adult education: Questioning our grasp of the obvious. In D. Poonwassie & A. Poonwassie (Eds.) Fundamentals of Adult Education: Issues and practices for lifelong learning (pp. 63-75) Toronto: Thompson Publishers

Racher, Frances & Annis, Robert (2007) Respecting Culture and Honoring Diversity In Community Practice, Research and Theory for Nursing Practice: an International Journal, Springer Publishing Company

Shookner, Malcolm (2002) An Inclusion Lens Workbook for Looking at Social and Economic Exclusion and Inclusion, Population Health Research Unit, Dalhousie University and Social Inclusion reference Group Atlantic Region, Her Majesty the Queen in Right of Canada

Thira, Darien (n.d.) Beyond The Four Waves of Colonization, Retrieved February 10/09 From http://www.swaraj.org/fourwaves.htm

Soanes, Catherine (2001) *Oxford Dictionary of Current English,* third Ed. Oxford University Press, New York pp.253

Smith, JL. (2007) Critical discourse analysis for nursing research, Australian Health Policy Institute, the University of Sydney, Sydney Australia, Nursing Inquiry 2007:

14 p.60 -70

Sutherland, Edna (2000) Refugee Children and Families, Produced by Edna Sutherland And Associates in partnership with Calgary Catholic Immigration Society, Calgary Alberta, Canada

Trimble, Joseph E. (1976),Value Difference Among American Indians: Concerns for the Concerned Counselor In *Counseling Across Cultures,* Pederson, Paul; Lonner, Walter J.; Draguns, Juris G. , East-West Centre, The University Press of Hawaii, Honolulu, pp.65-81

Trimble, J. Fleming Beauvais, F. & Jumper-Thurman, P. (1996) Essential cultural and social strategies for counseling Native American Indians In P.B. Pedersen, J. G. Duguns, W. Lonner, & J. Trimble (Eds) *Counseling across cultures* (4th ed. pp.177-249) Thousand Oaks, CA: Sage

Weil, Susan Warner and McGill, Ian (1993) A Framework for Making Sense of Experiential Learning. *Making Sense of Experiential Learning diversity in theory and practice.* Open University Press, Bristol, Pa.

White, M (1997) *Narratives of Therapists' Lives,* South Australia: Dulwich Center Publications.

Young D., Ingram G., Swartz L.((1989) *Cry of the Eagle,* University of Toronto Press Toronto, Canada

Zimmermann, Susan (2002) *Writing to Heal the Soul: Transforming Grief and Loss through Writing.* New York: Three Rivers Press, New York, New York