

BC PSYCHOLOGIST

SPRING 2012

A Special Focus:
PSYCHOLOGICAL SERVICES FOR
FIRST NATIONS

The background of the cover features a close-up, abstract view of layered, reddish-brown rock formations, possibly sandstone, with sharp, angular edges and deep shadows, creating a dramatic and textured visual.

BC PSYCHOLOGIST

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The British Columbia Psychological Association provides leadership for the advancement and promotion of the profession and science of psychology in the service of our membership and the people of British Columbia.

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ASSOCIATION

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L E T T E R F R O M T H E P R E S I D E N T

This year both the College of Psychologists of BC and the BCPA have elected as chairs of their respective Boards rural psychologists, namely Dr. Henry Harder from Prince George and myself from Terrace. It is a credit to both organizations to give to BC rural psychologists the opportunity to serve on the boards of our College and Association, and indeed, to even serve as their Board Chairs. I believe that this is a historic first for Psychologists in B.C.

In a 1999 CPA survey the ratio of urban psychologists in BC serving their urban population was about one to 4,000 but the ratio of rural psychologists in BC serving their rural population was only about one psychologist for 24,000. These ratios have not changed significantly over the last twelve years and clearly, there is a desperate need for more rural psychologists.

Contrary to the popular myth that rural life is more pastoral and less stressful than urban life, it turns out that individuals in rural communities actually have shorter life expectancies largely due to higher infant mortality rates and higher rates of violence, substance abuse, suicide and poverty than their urban counterparts. For instance, youth suicide in rural Canada is 4 to 6 times higher (Armstrong, 2011). In spite of this greater need, rural BC is clearly very much underrepresented in the distribution of psychologists. “If there is two-tiered medicine in Canada, it’s not rich and poor, it’s urban versus rural” (Dr. Wooton quoted by Laurent, 2002).

Of course, over the last three decades, the poor and working poor have had increasingly less access to Psychological services and one of the goals of our strategic plan is to advocate for better access and availability of Psychological services for all British Columbians. It would be a grievous failure of historical purpose to become professionals that can only be readily hired by the wealthy. As your president I will speak for greater equity and access of service. Indeed, your Board of twelve directors met all day on Feb 25th/2012 to renew an agreement on key goals, review the strategic plan we have in hand, and achieve a better understanding

of how we are to best cooperate and divide the labours between us. We have an excellent Board of both fairly young and senior psychologists. It is gratifying to be working with both veteran Psychologists and the next generation of Psychologists, all of whom are giving generously of their time to serve both the present and the future of all practicing Psychologists in BC. Further details in our Strategic Plan regarding specific achievable goals and timelines will continue to be fleshed out over the next few months. These are exciting times, with new initiatives like Collaborative Care Models being discussed. We jointly sponsored with the College of Psychologists of British Columbia and Vancouver Coastal Health a workshop and presentation by Dr. Acton, Dr. Pusch and Dr. Oakander from Alberta on February 27th on Collaborative Shared Care. There is an opportunity here to again work closely with physicians and provide greater access to psychological services.

Also, I am pleased to report that the BCPA supported the CPA argument against an APA Council proposal to rescind the APA/CPA dues agreement and subsequently their proposal was defeated. This means that our affiliate status with the APA remains the same and the funding for the Council of Provincial Associations of Psychology received from APA remains intact. Our participation with the APA, and the subsequent support and resources received from them continue as well... We all thank Dr Sare Akdag, our Representative to Council, who was instrumental in securing this decision and made a very effective presentation at the Council meeting on the subject.

Regards,
Ted Altar

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TED ALTAR, Ph.D., R.Psych.

President of the BC Psychological Association

Contact for the Board of Directors: board@psychologists.bc.ca

LETTER FROM THE EXECUTIVE DIRECTOR

Well Hello Springtime! After what felt like the longest winter ever, we are finally beginning to see cherry blossoms and daffodils. Once again the season of renewal and growth is upon us and BCPA is also experiencing many changes with the season.

Having been very busy throughout the winter with Psychology Month and public outreach initiatives, our new Board of Directors is working hard to craft a clear strategic direction with measurable and achievable goals. Our committees have experienced growth with new members and renewed focus and we are busier than ever with outreach and advocacy efforts. If you have ever wondered what BCPA is doing for you and for psychology, now would be the time to attend a meeting and get involved! You don't even have to come to the office to attend a meeting as teleconferencing is always available!

As I mentioned, BCPA is experiencing many changes too. Our office is moving. As of May 1st, we will be located at #402 – 1177 West Broadway, where we will settle in to our new wheelchair accessible office, with a much bigger boardroom to accommodate our new twelve-person Board of Directors. The new space will also feature a resource section for members and a better archival space for the maintenance of association history. We will also be bidding adieu to our current staff: Alex Yip (who has already left us) and Eric Chu, who is leaving us at the end of April to pursue what I am sure will be a very successful career in photography. Please join me in wishing them a very happy future.

This edition is not only the largest *BC Psychologist* ever published, but also the first effort in our

new drive to produce a “journal” rather than a “newsletter”. We have a fantastic assortment of articles featuring different aspects of psychology and first nations people ranging from a historical perspective offered by Dr Ted Altar to therapeutic considerations discussed by Dr Sara David. I am sure that you will enjoy reading these valuable contributions and perhaps may even be moved to write yourself. Should you be interested in responding to an article or perhaps writing an article yourself please do not hesitate to contact me. I will be very happy to help you, and to ensure that your words are shared.

I want to also take this opportunity to acknowledge and thank all of you who have taken the time to volunteer with BCPA. Whether you have come to us as a member, as an affiliate or as a student your helping hands are the bedrock upon which BCPA stands. I thank you for your willingness to help, your enthusiasm and dedication to BCPA, to psychology and to the promotion of the mental health of all British Columbians.

At your service,
Rebecca Smith ■

REBECCA SMITH

Executive Director of the BC Psychological Association
Contact: exec@psychologists.bc.ca

Life can be Challenging.

Getting help from a
psychologist shouldn't be.

Did you know?

- ✓ 1 in 5 Canadians will face a psychological disorder in a given year
(Public Health Agency of Canada)
- ✓ Depression will be the second leading cause of disability, for all ages and both sexes by 2020
(World Health Organization)
- ✓ Mental disorders account for more of the global burden of disease than all cancers combined
(Mood Disorders Society of Canada)

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NEWS

UPCOMING EVENTS: *Workshops*

See page 45 for workshop details and registration.

Neuropsychological Principles in Assessment & Treatment of ADHD & Other Child Psychopathologies

James B. Hale, Ph.D., ABPdN
April 27th, 2012

Using Motivational Interviewing Strategies and Techniques to Help Patients Change Risky/ Problem Behaviours

Linda Carter Sobell, Ph.D., ABPP
May 11th, 2012

MISPRINT:

Please accept our apology for misprinting the credentials of board members Don Hutcheon and Cindy Weisbart in the masthead section in the last issue of the *BC Psychologist*. The credentials should have appeared as follows:

Don Hutcheon, Ed.D., R. Psych.
Cindy Weisbart, Psy.D., R. Psych.

SUBMIT ARTICLES:

Want to write for us? We are always looking for writers for the *BC Psychologist* or the BCPA blog. The theme for the upcoming Summer 2012 issue is: The Psychology of Gender. For further details contact us at: info@psychologists.bc.ca

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WE ARE MOVING:

As of May 1st, we will be located at #402 – 1177 West Broadway, where we will settle in to our new wheelchair accessible office and a much larger boardroom to accommodate our new twelve-person Board of Directors.

CONTACT US:

We publish notices regarding retirement, awards, and deaths of members. Please keep us informed about your career and life milestones. If you want a notice to be included (100 words maximum) contact us at: info@psychologists.bc.ca

B O A R D D I R E C T O R S

On January 20th, 2012, Dr. Jeanne LeBlanc and Dr. Michael Mandrusiak were appointed to fill the two vacancies on the Board of Directors. Both appointments will expire on November 30th, 2012 at the Annual General Meeting. Please join us in welcoming our two newest board members:

JEANNE LEBLANC, Ph.D., R.Psych. Board Member

Dr. Jeanne LeBlanc received her Ph.D. in Clinical Psychology from the University of Texas Southwestern Medical Center at Dallas in 1997, and then completed an internship and post-doctoral training in Rehabilitation Neuropsychology. She has also earned a Diplomate in Rehabilitation Psychology. Scopes of practice have included extensive work in the area of rehabilitation neuropsychology (hospital and private practice based), managing and providing clinical support to a rural community child and adolescent outpatient treatment clinic, working in the prison system in California, and years of teaching at the University and Graduate level. During the past number of years, Dr. LeBlanc has volunteered in a number of areas, including: 3-years of service to the Board of BCPA, participation in the DRN since 2004 -- becoming BC representative to APA's DRN in approximately 2006, and representative of psychology in the Ministry of Health's Disaster Psychosocial Services (also since about 2006). Areas of emphasis in regards to the role of psychology in BC includes (but are not limited to): advocating for greater availability of mental health services (including working towards MSP inclusion), providing opportunities and resources for our disaster response volunteers, and advocating for psychology to have a seat at the table in respect to provincial decisions made regarding mental health issues and the scope of our profession. Additionally, interests include continued efforts to promote the value of seeking help from psychologists, in our community, and to promote medical/psychological relationships.

MICHAEL MANDRUSIAK, Psy.D., R.Psych. Board Member

Dr. Michael Mandrusiak received his Psy.D. from Baylor University and completed pre-doctoral and post-doctoral internships in post-secondary mental health at the University of Manitoba and the University of British Columbia, respectively. He has been the co-chair of the Community Engagement Committee of the BCPA for the past three years and hopes to see BCPA strengthen its community partnerships with other mental health stakeholders, healthcare professionals and government. Michael belongs to a group clinical practice in the Burnaby area, where he treats conditions related to anxiety and mood disturbance, trauma, stress and career issues. In addition, he is the Director of Training and Community Service at the Adler School, which offers graduate level training in professional psychology. ■

COUNCIL OF REPRESENTATIVES

During its February 2012 meeting in Washington DC, the APA Council of Representatives voted to maintain the APA/CPA dues agreement, which allows CPA members to join APA at a 50% dues discount. A proposal to eliminate the dues agreement had been put forth to the Council in February 2011 by the APA Membership Board as a way of harmonizing the dues for all APA members. CPA and Canadian members of Council argued against this motion, highlighting the mutual benefit psychologists on both sides of the border receive from the collaborative relationship of CPA and APA. The Council decided to postpone the vote until February 2012 to give CPA and APA leaders time to come to a mutually-satisfactory solution.

Over the last year, CPA surveyed CPA/APA dual-members, engaged APA in numerous discussions, and solicited the opinion of the provincial psychological associations and Canadian representatives on the APA Council. CPA concluded that the preferred option was to maintain the dues agreement without changes; however, CPA also advocated that if APA eliminated the dues agreement, then Canadian psychologists should have the option of joining APA as International Affiliates. The APA Membership Board was in support of International Affiliate status for Canadians and agreed to make the elimination of the dues agreement contingent upon the successful change in APA by-laws regarding Canadians as International Affiliates.

During its February 2012 meeting, the APA Council was asked to vote on both a by-laws change regarding International Affiliate status for Canadians and the elimination of the APA/CPA dues agreement. As in February 2011, the Council expressed serious concerns about making any change that would affect Canadian membership in APA. Discussion on the Council floor highlighted the value of Canadian representation in APA governance and leadership, the mutual benefits of cross-border collaboration in advancing psychology in both countries, and recognized the shared history of North American psychologists. In the end, the Council voted to reject any change in the by-laws regarding the membership status of Canadian psychologists and by doing so, voted to maintain the APA/CPA dues agreement. The vote was decisive and affirmed the value of a Canadian perspective in the activities of APA and in the advancement of psychology in North America.

In addition to the APA/CPA Dues Agreement, the Council took many other actions during its February meeting. Please see APA ACCESS (a new e-newsletter for APA members) and/or an upcoming issue of the APA Monitor on Psychology for a summary of other Council activities. Highlights included the adoption of guidelines for psychology education, the approval of two new journals, and a half-day session examining the impact of technology on the science, practice, and education of psychology in the 21st century. ■

SARE AKDAG, Ph.D., R. Psych.

Sare Akdag is the BCPA Representative to the APA's Council of Representatives. She is also on staff at BC Children's Hospital and has a private practice in Vancouver. If you would like to contact Dr. Akdag directly, you may email her at sakdag@cw.bc.ca.

PSYCHOLOGICAL SERVICES/THERAPY IN FIRST NATIONS POPULATIONS:

A CRITICAL PERSPECTIVE

MIKE WEBSTER, Ph.D., R. Psych.

Dr. Webster has practiced as a police psychologist for over 35 years. He specializes in Crisis Management and works with law enforcement agencies both domestically and internationally. He has consulted on a number of high profile crises including Waco Texas, Jordan Montana, Lima Peru, and Gustafsen Lake British Columbia.

My interest in this topic springs from two sources. The first is the nature of my work as a (police) psychologist; with a specialty in crisis management, I have consulted with the principle parties involved in conflicts between various police services and Aboriginal groups including Gustafsen Lake, Apex Alpine, and the Six Nations Stand-offs in Ontario. As a result of these experiences, I have developed an interest in Aboriginal Culture and spirituality. The second is my discomfort with mainstream psychology's focus on individuals, and its almost total disregard of the impact of power differentials, and sexual, social, organizational and racial influences on psychopathology.

With regard to terminology, I think it may be more respectful, and more inclusive, to use the terms Aboriginal or Indigenous rather than "First Nations". The Aboriginal peoples of Canada may all request psychological services, and include First Nations, Inuit and Metis regardless of their status under the Indian Act. This combined group makes up approximately 4.4 – 5% of the population of the country; it is comprised of 11 major language groups, including 58 dialects and 596 bands and lives on 2,284 reserves, or in urban and rural communities (Statistics Canada, 2006). The Aboriginal peoples are richly diverse in their cultures, lifestyles, and languages. It can be argued that even the terms Aboriginal and Indigenous are inaccurate as the people being described are far from a homogenous group. They do share, however, similar historical experiences that have influenced similar perspectives; and they are welded together through the experience of colonization that has led to a similar body politic and collective identity.

Aboriginal Mental Health:

There is much historical evidence (e.g., the current Truth and Reconciliation Commission) to suggest that the mental health issues of the Aboriginal peoples originate with "their being victims of colonization." Much of what they present in a therapeutic encounter can be viewed

as symptomatic of an "historic trauma response" (Yellow Horse Brave Heart and DeBruyn, 1998; Duran and Duran 1995). When this "soul wound" becomes unbearable an Aboriginal person can experience what appear to be mainstream "mental disorders".

It is unfortunate that Aboriginal knowledge systems, in the fields of mental health and treatment, have been underestimated. These systems when recognized and empowered will be able to take their place in a mainstream that enforces silence and conformity to a single dominant theoretical view of "mental disorders". The strength of these knowledge systems is not merely theoretical, but practical, and present in the experiences and lived realities of the Aboriginal peoples. For example, the genocidal treatment of their ancestors has left many present day Aboriginal people with a kind of "survivor guilt". This unresolved guilt remains, as Aboriginal peoples have not been afforded the opportunity to adequately grieve and heal. Many of the Aboriginal traditions and ceremonies around death have been erased through colonization. The generations of trauma experienced by their ancestors now live in the collective consciousness of the present day Aboriginal peoples. It is this "gut wrenching" emotional response that is passed down from generation to generation that fuels the blaze consuming interactions and relationships within communities, families, and individuals. Aboriginal/Indigenous health frameworks view the consequences of disenfranchised grief, masquerading as mainstream "mental disorders", as a shame-like response within the Aboriginal peoples; and this shame about one's identity, culture, and community has given rise to a destructive introjected racism and hatred. The end product then, of this unattended grief, may be a community at war within itself as it struggles for a place in Canadian society.

Psychological Services/Therapy:

Psychological interventions into Aboriginal communities are best born from decolonization. Decolonizing means assisting the Aboriginal

peoples in questioning the conventional notions of mainstream psychology/psychiatry. It means assisting in the assertion of Aboriginal/Indigenous healing systems and the confrontation of a single perspective as the definitive way of understanding psychological issues. It means assisting the Aboriginal peoples in understanding who they are, gaining confidence in what they know, and deciding for themselves which mainstream ideas they can work with and which they can't.

Decolonization embraces the politics of identity, and its construction. In order to rationally challenge the domination of mainstream psychology/psychiatry, Aboriginal people must be in charge of defining their own aboriginality. Only then will they be able to abandon the role of passive victims and actively participate in the restoration of their own health. New truths must be established to overcome the "soul wounds" inflicted by governmental policies like "kill the Indian in the child". And as mainstream psychological methods have been less than successful, there is little to be lost in the recognition of traditional healing and cultural methods. For example, preliminary steps on the path to healing require mourning and dreaming/visioning (Laenui, 2000). Aboriginal perspectives posit that in order to break free of paralyzing emotion, people must mourn what has been taken from them. Moreover, the chances of healing are increased by dreaming/visioning what the Aboriginal people want in their futures, and how to utilize resources toward that end for the entire community.

Finally, and in harmony with decolonization, the mental health of Aboriginal communities seems to lie in their degree of autonomy. Those communities with more local control and cultural continuity appear to thrive, whereas those with less psychological and spiritual connection with their past, present and future don't. Those communities with more control of local government, renewed cultural practices, and successful land claims, boast overall improved mental health for their constituents. Chandler and Lalonde (1998) demonstrated the benefits of this alternate perspective by discovering a strong

relationship between the degree of community autonomy and suicide rates in British Columbia Aboriginal communities. They found that of the 196 Aboriginal communities in the province, those with greater independence and cultural continuity were also those with significantly lower suicide rates among their youth.

Conclusion:

An alternate perspective on the provision of psychological services to Aboriginal peoples recognizes how power differentials between opposing views on healing and well-being are often ignored, resulting in hegemonies that are oppressive and insensitive to historical and local needs. By questioning the conventional notion that mainstream psychology is the only "story", a more critical approach provides the impetus to empower the marginalized to evaluate their participation in health frameworks that do not recognize indigenous knowledge systems, or meet their needs.

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(Mood Disorders Society of Canada)

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HEALING AND EMPOWERING

FIRST NATIONS CLIENTS

SARA JOY DAVID, Ph.D., R. Psych.

Sara Joy David, is a clinical psychologist practising in B.C. since 1972. She has been a sessional lecturer at Antioch University and the University of Victoria. Social justice, diversity, empowerment, and health care as self-care is her focus as a therapist, writer, supervisor, and consultant to other health care professionals.

Whenever possible it is preferable for First Nations clients to work with First Nations resource people. Sometimes this is not possible. A psychologist who is not Native would do well to suggest secondary resources such as the community wide healing groups available on many reserves, sweat lodges, Native women's sweet grass ceremonies, and Native Friendship centres. It is, however, important for therapists to bear in mind that some Native women have been violated by their

Native partners, relatives and/or even Native elders; in which case they may feel safer outside their Native communities. Such clients who have faced double oppression and multiple betrayals must be treated with added sensitivity, patience, nurturing and support.

While I am not Native, I have had the opportunity to consult with a number of individuals who are Native. I have done my utmost to incorporate Native history and



Native processes when facilitating their healing and empowerment. I have also made every effort to include in sessions with First Nations clients, my understanding of the role of the internalized psychological oppression suffered by all populations that are not part of the dominant, white, North American, male, traditional mainstream.

First and foremost, it is critical to understand the extent and depth of the racism experienced historically and currently by First Nations peoples. Centuries of domination by whites, together with

Christianization and the systematic indoctrination as well as abuse of Native children in residential schools has led to profound humiliation, disentitlement and, for a disproportionate number of Natives, severe problems in establishing functional relationships, gaining and maintaining meaningful employment and overcoming the debilitating impact of troubled memories. The chairman of Canada's Truth and Reconciliation Commission, Justice Murray Sinclair, has gone so far as to state that Canada's treatment of aboriginal children meets the United Nations definition of "an act of genocide".

The native peoples of Canada have suffered generations of extermination through assimilation and brutality. This horrific legacy has been exacerbated by the violence and continuing cycle of abuse often experienced within Native communities. Therapists must know the extent of the “buckskin curtain of indifference, ignorance and, all too often, plain bigotry” (Cardinal, 1999).

In a first session with Native clients, I draw out their own views about how systemic oppression has affected them. I take great care to impart that I do not view myself as an “expert”, and that I will discourage them from treating me as an “expert,” nor will I diminish them in any way by regarding them as passive recipients of my expertise. Rather I will facilitate a dialogue in which they arrive

“Reclaiming the self, one’s own authority, and one’s connectedness to and trust in one’s own inner wisdom is as important as any of the more specific goals and objectives the Native client brings to the consultation process.”

With all clients, there is discussion and decisions as to whether we both (or “all” in the case of couple and family counselling) sense there is a good match between the services I offer, and the clients’ needs, desires and expectations. I state my beliefs that guide me as a person and a therapist.

- I consider that all the emotional turmoil and difficulties that we experience in living have both internal and external causes. Often we have incorrectly blamed ourselves for events that are, in fact, a result of external factors such as bullying in the workplace, family of origin dysfunction, trauma, or systemic oppression such as racism, sexism, classism, ageism and other divisive ‘isms’. At other times we have failed to consider our own contribution to the problems that repetitively challenge us.
- I also indicate that the process we will engage in will involve re-evaluating what created the problems we are currently facing so as to increase the accuracy and clarity of the causes of our difficulties. This, in turn, will increase the effectiveness of our ability to restore choice where we have felt we had no choice, and to reclaim our power where a sense of powerlessness has set in.

at or reclaim their own authority in telling their own stories, making sense of their suffering, and acquiring knowledge and skills that will enable them to succeed in areas where they have felt defeated or blocked. Finally, I communicate that I will not label as “pathological” intense anger, grief and fear that are appropriate reactions to poverty, brutality, and trauma.

Counselling that is entirely verbal and analytic might be unhelpful to some Native clients, and it may be necessary to pay more attention to nonverbal communication, to use art therapy, imagery and metaphor, somatic experiencing, gestalt therapy, focusing, EMDR, EFT, and biofeedback in addition to insight-oriented therapies.

As in working with all severe trauma clients, the psychologist must teach Native clients two sets of emotional self-care skills:

- 1) Emotionally expressive skills that access intense grief, fear, rage enabling the client to release and transform these safely
- 2) Emotional regulation skills that assist in calming, centering, and regaining equilibrium when conditions are not conducive to catharsis.

Clients must also be assisted to develop their intuition and follow a set of guidelines about when to express and when to control their feelings. Finally, Native clients must be encouraged to develop a sense of entitlement, self-confidence, boundary setting skills and, when appropriate, political organizing skills so as to demand respect, equality and justice as they go forward to replace the exploitation, poverty and injustice they have been subjected to all too frequently in the past.

It is critical that the non-Native psychologist be hyper-vigilant about any interaction or intervention that could be experienced by a Native client as condescending or intrusive. Therapists must avoid inflicting further injury through any inadvertent betrayal of trust, overlooking the political roots of the clients' current reality, or failing to take into consideration cherished native values and ways of being that may clash with white European/North American ways of living. The task is to draw on both Native and non-Native frames of reference, freeing the imprisoned or damaged self of Native clients and strengthening all that contributes to their emotional, financial and spiritual resilience. To this end, seeking regular feedback and encouraging clients to speak up when uncomfortable with a particular technique or particular response is essential. Care must be exercised by the therapist to ensure that Native clients are not merely accommodating a suggestion that is not a fit. More important than any attachment to particular paradigms, techniques, or approaches is the flexibility to adapt to Native values and processes and to the validation of the particular client's needs in each given moment.

The cumulative effect of generations of oppression is a loss of identity. This is a form of identity theft that must be dealt with. Reclaiming the self, one's own authority, and one's connectedness to and trust in one's own inner wisdom is as important as any of the more specific goals and objectives the Native client brings to the consultation process.

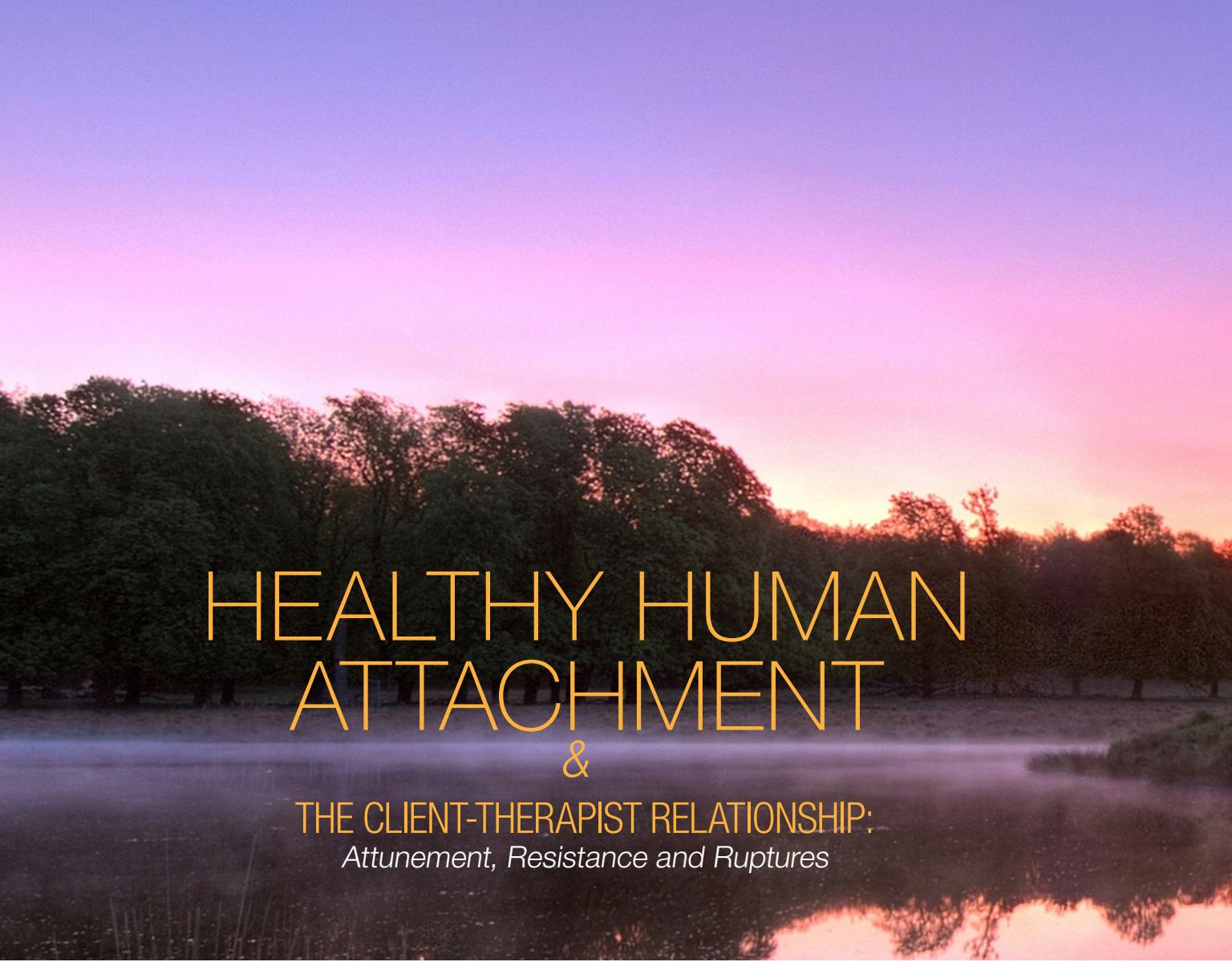
Sometimes it is the feeling of being genuinely cared for that has the greatest impact with survivors of psychological oppression. One former client touchingly stated when terminating therapy: "I have waited 45 years to hear another express outrage at how I was treated". The client, of course, had to deal with her own hurt and rage. The support she felt at knowing another felt outrage on her behalf was the ingredient that created the felt safety that allowed her own repressed feelings to surface with a greater intensity than ever before. Any therapist working with a Native population must be prepared to share the deepest recesses of the client's pain. It requires considerable skill and empathy to create the conditions that allow that pain to surface in its full intensity. There must be no felt pressure to face feelings that could be overwhelming, only permission and support when they emerge.

Ritual plays an important role in Native culture and making room for it in the therapeutic process can be experienced as an honouring of Native practices. Inviting a client to share aspects of her/his Nation's traditions, history, and rituals can assist in the process of creating appropriate healing and completion rituals.

Therapists working with a Native population would do well to consider expanding their role by joining with the many advocates demanding justice for Canada's Aboriginal Peoples. Only significant political advances, marked improvements in Aboriginal living conditions, and shifting the persisting discriminatory attitudes of all too many Canadians will reduce the psychological trauma experienced by future generations of First Nations citizens.

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HEALTHY HUMAN ATTACHMENT

&

THE CLIENT-THERAPIST RELATIONSHIP:

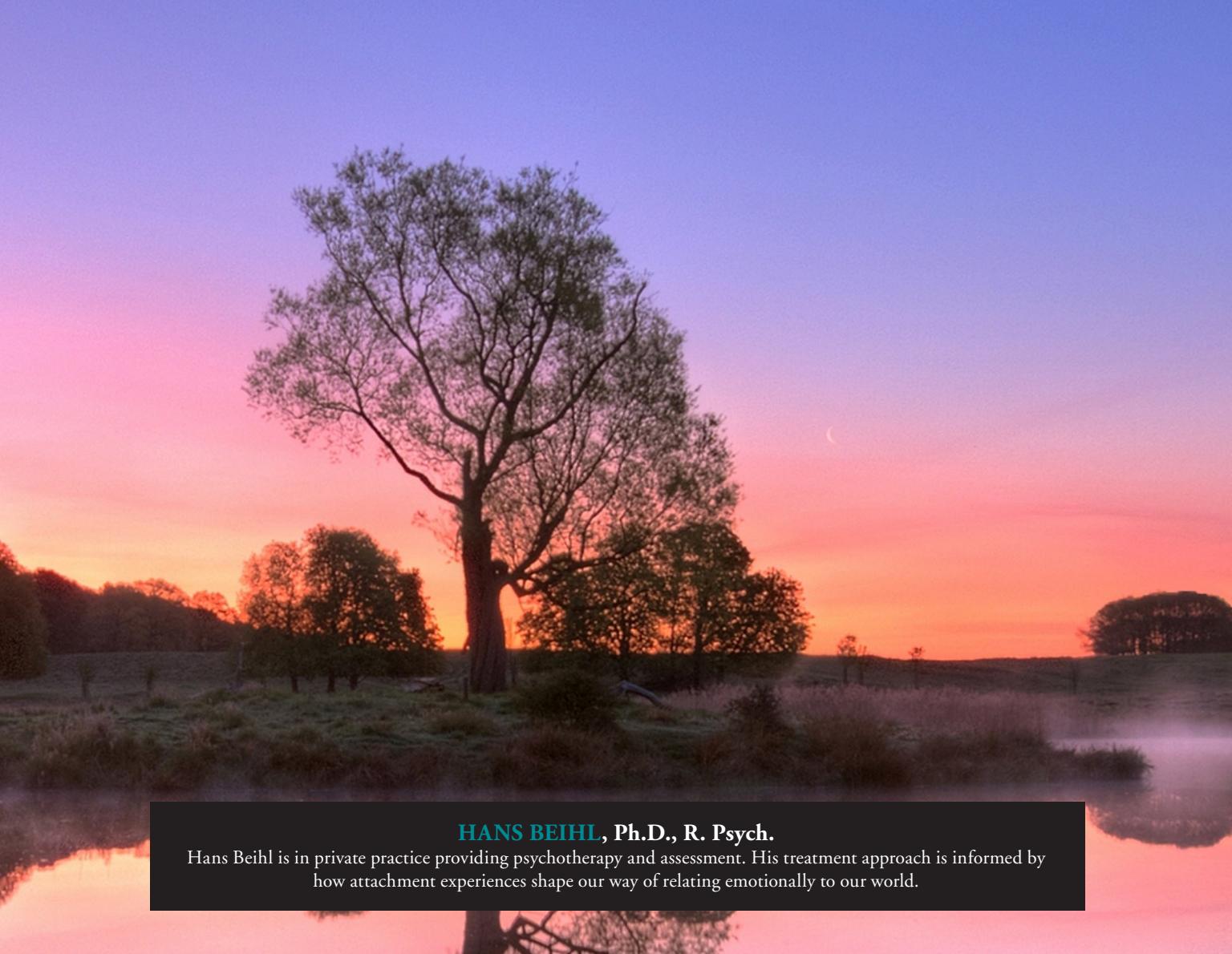
Attunement, Resistance and Ruptures

As a result of chronic exposure to social and economic deprivation, great stresses have long been brought to bear on the family unit in many First Nations communities, leading to high rates of violence, drug and alcohol abuse, and suicide. Tragically, the emotional damage that results from being raised in a broken family is passed on from generation to generation. Experiencing healthy, positive social supports is crucial to one's mental health and emotional well-being—even more so in the midst of economic and political hopelessness.

Human beings have a basic need for closeness and attachment. Strong communities are built on the bedrock of healthy interpersonal bonds. Psychologists, in their role as healers, can help individuals, couples, and families rediscover nurturing emotional ties. To be effective healers in working with the emotionally

abused and deprived, psychologists need to be sensitively attuned to the needs of their clients, whose repeated experience has been one of not feeling valued and listened to.

Whether one's preferred treatment model is technique focused, experiential, psychodynamic, or interpersonal, the client is faced with the task of changing behaviors, perceptions and modes of thinking and being that originally emerged to protect the self. There is a lot at stake in giving up familiar, safe patterns of interacting with one's world, no matter how self-defeating. What we as therapists regard as *resistance* to change, from the client's vantage is just an automatic, natural act of self-preservation. Resistance to change is a defensive survival process that guards against the threat of that dreaded experience of loss of self, of psychological annihilation—that deep, visceral



HANS BEIHL, Ph.D., R. Psych.

Hans Beihl is in private practice providing psychotherapy and assessment. His treatment approach is informed by how attachment experiences shape our way of relating emotionally to our world.

experience not obedient to intellectual reasoning. The client's self-protective ways of relating to the world have served to shield him or her from vulnerability to harm or attack. To give up one's only known way of being for something uncertain or unknown—no matter how motivated one is to change—is counterintuitive and akin to walking down a dark, foreboding trail, with danger lurking at every corner. Not surprisingly, then, helping clients overcome their fear of change is one of the most challenging aspects of therapy. It is this challenge that makes the psychotherapeutic relationship so important.

Although we still have little knowledge of how or why psychotherapy works to produce change (Kazdin, 2007), research over the past few decades has recognized that the therapeutic

alliance is in some way important in bringing about change (Beihl, 2011). As well, processes of implicit learning and emotion regulating systems of the brain shaped by early attachment experiences in the parent-child relationship have been conceptualized as intrinsic to the process of change in psychotherapy (Schore, 2003). It is dubious that people change merely by changing thoughts. Whenever we experience ourselves in new ways, it is a multidimensional emotional experience.

In the domain of self-psychology and interpersonal psychology, concepts of *attunement* and *resonance* have been given much attention and are viewed as key to understanding the change process (Summers, 1994, pp. 304-328). These concepts refer to the attentiveness, sensitivity and

responsiveness of the therapist to the client's fluctuating mental state and emotional needs in the moment to moment dynamic of client-therapist interactions. Both conscious and unconscious processes are brought into play, as the therapist makes fine-tuned adjustments in his own mental state to the client's fluctuating mental state. Authentic engagement involves more than nurturing or cool intellectual insight. It is a complex, synchronized emotional exchange between client and therapist in which the client is actively "engaged and experienced and responded to" (Levenson, 1982, p. 100).

Ruptures in attunement occur when we fail to be sensitive to the client's needs, anxieties, and negative emotional reactions to our verbal and non-verbal behaviors. What may cause a rupture in the relationship with one client, may not in another. A passing comment, a turn of phrase, a wisp of insensitivity may be enough to cause a breach in the alliance. In the psychotherapeutic milieu in which the client is encouraged to face what is new and threatening, there is always the risk of overstepping the client's tolerance for change, regardless of the therapist's dedication to being present and attuned. As skilled and caring professionals, motivated to prevent harm and alleviate distress, our commitment and good intent may at times contribute to our unawareness of those subtle moments when we err and cross the line with the person sitting across from us.

Such ruptures or failures in attunement are a potential threat to successful treatment, as the client withdraws emotionally, feeling unheard, manipulated, minimized, or misunderstood. The client may then reveal only what he or she thinks the therapist wants to hear. When a rupture occurs, the client's sense of emotional disconnection from the therapist may be masked or hidden due to underlying feelings of shame—shame born out of exposure in early life to parental challenges that resulted in feelings of humiliation, rejection or negation. If the therapist is not vigilant, such ruptures may fester below the surface, while on the surface the client goes through the motions of maintaining a false bond.

When clients fail to get better, or when they suddenly stop coming, we conjure up explanations, but have missed opportunities to test our hypotheses. Without a process in place to explicitly obtain feedback from the client we may be remiss in identifying and mending breaches in the alliance.

In order to increase the likelihood of recognizing ruptures, one needs to explicitly seek feedback from the client. In my own practice, at the end of each treatment session, I obtain feedback from the client about the alliance, using the Session Rating Scale (SRS) (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). I explain to clients that it is very important for me to know how I performed in the session to ensure that I am addressing their needs and doing what is helpful. Through this process, the message I strive to convey is that I care about the client and value his or her input. The process empowers the client. After the client completes the SRS, I ask these questions: "Is there anything I did today that you disliked or found upsetting or unhelpful? Is there anything I could have done that would have been more helpful?" By the end of the second session, clients become accustomed to this routine. It is not unusual for clients to give positive feedback, but every now and then, clients will voice dissatisfaction or discomfort with what transpired in the session—alliance issues that otherwise might have gone unnoticed, potentially resulting in barriers to effective treatment.

The following example is illustrative of what can happen if one fails to explicitly focus on the client's emotional experience of the rupture during the alliance repair process. At the end of a treatment session with one of my clients, I invited her to talk about the low score she had given me on the SRS. She revealed somewhat hesitantly that she had not liked the questions I had asked her about her mother's way of dealing with her father's verbal abuse. She did not feel this line of questioning was helpful. I explained to the client that perhaps what she observed in the home might have shaped her own way of dealing with emotional intimacy and trust. The client listened and seemed accepting of my explanation, but made little further comment. Another appointment was arranged. The client's husband phoned me several days later, letting me know that his wife wished to cancel her appointment, since she had other pressing matters to attend to. I never heard from her again.

Although I made an attempt to address the rupture at the time of the feedback discussion, I felt afterwards that I had missed the mark. What I had failed to do at the time was discuss *process*—that is, the negative *emotional experience* the client had on being questioned about her mother. Instead, I had only focused on explaining my rationale, probably with a degree of defensive self-justification. I should have explored

how my comments had affected her emotionally, and clearly acknowledged my contribution to her discomfort. I suspect that in some way she had taken my line of questioning as criticism of her mother—the one person who had been an important support in her early life. A central issue for this client involved dealing with conflict in her interpersonal relationships, typically withdrawing when hurt or offended. I had erred in taking advantage of that moment in therapy to explore how difficult it probably was for her to give me negative feedback. In effect, I had reinforced the client's withdrawal pattern by overlooking the underlying emotional issues reflected in her feedback. While I cannot be sure why she suddenly left treatment, if I had not asked for feedback at all from the client, I would probably have more easily convinced myself that the client had merely lost interest in treatment.

No matter how well -attuned a therapist may be, ruptures will inevitably occur in the alliance. No one can be attuned perfectly all the time. By acknowledging ruptures, the therapist models the repair of bonds in relationships. "It is in the repairing of the misattunement and subsequent re-attunement that healing takes place" (Mann, 2010, p. 200). The client learns that ruptures are not life and death events in a relationship, but a normal aspect of interpersonal contact, and can be bridged.

When the therapist realizes that a rupture in the alliance has occurred, attention needs to be immediately directed to examining the process that resulted in the misattunement. Greenberg and Johnson (2010, pp. 180-1) provide a useful list of steps to address ruptures in the alliance. In the repair process, the therapist needs to probe the client's emotional experience of the rupture, and validate the client's experience. The therapist needs to acknowledge any pain that may have been caused, determine if the client has been reassured of the therapist's concern for the client, and should ask the client what additional support may be helpful.

Even the most vigilant therapist may sometimes say the wrong thing and fail to notice every rupture in the alliance, especially if the client says nothing, or pretends all is well due to worries about rejection, or a need to save face. It is incumbent on the therapist to explicitly invite the client to provide feedback.

Having this feedback increases the likelihood of uncovering ruptures and then proceeding with repair work. When feedback is obtained from clients, the likelihood of improvement increases (Lambert & Shimokawa, 2011). These research findings may well reflect the enhanced attunement and alliance building that comes out of the process of acknowledging and repairing hidden ruptures in the client-therapist relationship—ruptures that would otherwise go unnoticed.

When we acknowledge our failure in attunement with the client, we face our imperfection. We are not all knowing nor all powerful, despite what fantasies some clients may have about us, or distortions we may have fallen victim to about ourselves. Acknowledging ruptures requires a degree of courage. By virtue of the unequal power balance between therapist and client, and our professionally established role as "experts" in human behavior—a role that can be weighty and emotionally insulating—opening oneself to the client and acknowledging one's contribution to the breach in attunement can be humbling, perhaps even threatening to one's self-image. But clients typically respect such honesty and humanness, with the result that the therapeutic bond becomes strengthened.

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A T H O U G H T E X P E R I M E N T :

THE ALPHA CENTAURIANS

H A V E L A N D E D



With due respect, permit me to offer a thought experiment that you may find instructive regarding the psychology of oppression and dislocation.

Let us engage in a very fanciful thought experiment where Von Däniken is right and our human ancestors were actually space explorers from another star, say Alpha Centauri. They return and have started colonizing Canada. It turns out that even though they are genetically human (or should we say that we are genetically Alpha Centauri), they have a very bright orange skin. They have emigrated in mass and have become the dominant population of Canada. Unfortunately they brought some new diseases that over time reduced our population by around 80%. They control the governances and given their superior technology, particularly their weaponry, resistance has proven futile. We all must now forbear and submit to their control, including their laws, and attempt to assimilate into their culture. There has been some progress in that the earlier abuses of their invasion no longer occur and their rule of law more readily applies to all, including themselves when it comes to us. The Centaurians look at us with a paternalist outlook and believe that

they are a benefit to the planet and that they are sincerely helping us out of our earlier primitive existence. They have provided small areas for us to remain together and have provided housing made of metal. For the last 400 years we have even been allowed greater participation in their governance by being given a vote fifty years ago. Given that their population is 30 times larger than our own, this vote really makes little difference. Unemployment for us Canadians in our major communities remains chronically static at 50% to 80%. The Centaurian communities are markedly wealthier than ours and their employment is at 93%.

- At this point, what do you think would be status of our mental health in our now marginalized Canadian communities?
- Would there be more depression among Canadians?
- Would the suicide rate rise?
- Would there be a loss of belief in ourselves and diminished expectations?
- Would the rate of substance abuse likely rise?
- It is likely that among the Canadian population these problems would markedly increase, but by how much?

DR. TED ALTAR, R.Psych.
President of the BC Psychological Association

Let us continue further. The best jobs and all the positions of power are held by Alpha Centaurians and the official language is Centarese, the sounds of which are very difficult to learn for Canadians. Your kids are sent to boarding schools until the age of 16. They get an education but it is inferior to that received by the Centaurians. Grade 12, for instance, is not offered at many of these schools in BC. At the boarding schools your kids are forbidden to speak English or French and severely punished if they do so. Not only must they learn Centarese but also a new religion which teaches them that your cultural traditions and beliefs are outdated and primitive. Your kids could get more education but now they must go to the schools of the Centaurians and compete with their kids in a very different educational milieu than that of the Boarding schools where there were no Centaurian children. Your kids visit during the summer holidays and Centmas (their Christmas) but otherwise you have little contact with them. This has resulted in your kids not fitting in with the remnants of our Canadian society contained on reserves, but they also don't fit in very well with the Centaurians. Their skin is not orange enough and some behavioural mannerisms and core values set them apart. The Centaurians speak faster with a more elaborate sentence structure and vocabulary and we can't seem to get a word in edgewise and so we forbear and remain quiet as they rapidly and very assertively speak. They won't learn English and good spoken English is disappearing as our grandparents die off. Our kids are leaving our communities and are trying to fit in as best they can in the Centaurian communities.

- Again, how would these added circumstances affect our mental health?
- How marginalized would we feel from such dislocations?
- How could we believe in ourselves sufficiently to compete in such a new world?

Finally, consider that there is both overt and subtle racism by the Centaurians towards us. They see us as being too dependent on their wealth, that we are

too undisciplined and lack self-efficacy. In fact, they earlier had banned many of our key cultural practices, burned our great literature and took down our art and placed it in their museums. The Centaurian laws forbidding us of our culture were repealed and some of our art works have recently even been returned but much has been lost with the rewriting of our history. Instead of some of our own teaching from our traditions we now learn second hand from their anthropologists and even some of their "Centaurian healers". A paternalistic attitude still lingers and takes the form of lower expectations for us Canadians.

Of course, this thought experiment would have been more effective if you did not know that analogy was about the history of our First Nations Peoples in Canada. If you didn't know the parallel being made, you might have felt indignation and even anger about such an unjust, oppressive and paternalistic colonization by the Centaurians. You may have even reflected that after decades and even generations of being denied, as a separate and worthy identity, full acceptance, partnership and inclusion as Canadians in their own place and residence there might be a resignation and resentment, along with some feelings of possible despair. Maybe you would also have felt some pride in resisting in any manner you could, whether it be through the Courts, civic protest or simply individually through holding onto as much of your identity as possible.

We must acclaim the forbearance, fairness and generosity of the spirit of First Nations peoples as they have very ably asserted their voice and remained remarkably robust in preserving as best as they could their unique identity under such a sad and appalling history of systematic intrusion, racism and institutional de-acculturation. Although First Nations have maintained their voice in spite of historical oppression and a persistent subtle racism, it still behooves us to listen. First Nations are in a process of revitalizing their communities and affirming their identity. They need our support and understanding and we need to earn their forgiveness. ■



W O R K I N G W I T H

FIRST NATIONS:

THE MOST DISADVANTAGED GROUP IN NEED OF THE BEST SERVICES
PSYCHOLOGISTS CAN OFFER

DR. TED ALTAR, R.Psych.
President of the BC Psychological Association

It is with pride in our profession of Psychology, and I hope with personal humility, that I submit this article about working with First Nations Peoples. I have been fortunate indeed to have had the honour of providing services to First Nations people both on and off various Reserves for the last fifteen years. I don't claim to be an expert but at best simply one who has learned to know that one must always learn more, listen with great respect, act with caution, and be mindful of one's own privileged perspective as a professional who is to be identified with the dominant and domineering society. There are far too few First Nations Psychologists and this really needs to be addressed and rectified. Ted Palys wrote in his Canadian book on research methods:



. . . a non-Aboriginal social scientist should be able to do research dealing with Aboriginal issues--indeed, not doing research on so important a topic seems a tacit acceptance of injustice--but the person who does so without seeking diverse and critical Aboriginal input at every stage of the process, from the design and conception of research to the final act of writing and interpretation, risks a myopic and potentially hurtful result. (Palys, 2008, p. 214)

The same need for listening and acceptance of First Nations input applies even more pointedly to us as providers of psychological services to First Nations individuals, families or communities.

THE CONTRIBUTIONS OF FIRST NATIONS TO CANADIAN NATION BUILDING

In working with First Nations people one must really learn some of the history of First Nations and this includes also knowing something of the positive history. We need to be informed about the contributions First Nations have made to the richness and diversity of Canada. Permit me to ask which group do you think were the first to receive welfare in Canada? Many, when pressed, will often answer that it was the First Nations peoples. Even First Nations themselves may answer incorrectly. In point of fact, it was the French and English. The Vikings are thought to be the first Europeans to attempt to colonize

Canada and they did in fact have communities in Newfoundland and Labrador. Why did this Northern European people, who were excellent farmers and the best explorers of their day and hardened to Northern European winter living, not survive in Canada? Besides harsh weather (the onset of the “little ice age”), another possible reason is that they made war on Native populations and therefore did not seek aid from the local Native populations. The French and English, who were used to more temperate climates did seek help and were given aid in the form of knowledge and even material help. In fact, many were actually adopted by the First Nations communities.

One of the many advantages that have been forgotten is that during the 16th century First Nations medicine was superior to European medicine. Stitching of wounds, for example, was practiced by the ancient Egyptians but was forgotten. First Nations actually taught this medical technique to the English and French. They also knew of effective medicinal plants that we know

canoe which is actually a highly engineered vessel light enough to portage through heavy woods where no roads existed. The European cart or even row boat were ineffective for such unspoiled wilderness. Other influences in the realm of ideas include the Iroquoian League of Nations federalist system which served to help inspire and support the idea of American and Canadian federalism. Indeed, if it were not for the support of First Nations against the American invasion of 1812, we Canadians may well now be American. Unfortunately, the Native allies were the war’s worst victims losing land and power and the British Plan of a semi-independent sanctuary for Natives in the US was abandoned.

The contributions of First Nations art, music and literature are probably better known. It is clear that we owe much to First Nations but we have forgotten about or minimized their immense contributions to the making of Canada, and even to ourselves as Canadians.

2001	Canadian Reference Population	First Nations in Canada
Life Expectancy at Birth in Years.	78.7	73
Life Expectancy Index*	.90	.80
Proportion Completed High School or Higher	.75	.57
Educational Attainment Index	.85	.74
Average Annual Income	22,489	10,094
Income Index	.89	.76
HDI Score	.88	.77

[table adapted from Cooke, Beavon & McHardy, 2004, p. 54]

*The UN index is a value between 0 and 1.

contained aspirin and digitalis. In contrast, for example, the standard treatment for syphilis in 16-century Europe was mercury administered with a urethral syringe and the common treatment for practically all ills was blood-letting. New foods like potatoes, beans, corn, peanuts, pumpkins, tomatoes, squash, peppers, nuts, melons, cranberries, fourteen varieties of beans, wild rice, sunflower seeds, etc. were shared and how to farm them was taught to Europeans. What was the most advanced technology of communication in North America during early colonization? It turns out to be the

THE CURRENT PLIGHT OF FIRST NATIONS

Since 1990, the United Nations has been using a revised “Human Development Index” (HDI) which, based on various measures (education, health, life span, living standards, income per capita), has demonstrated that Canada scores near the top (ranking of 6th) in quality of life. This high average of well-being, however, clearly is not shared by all Canadians. The group that historically deserves arguably the most benefit but nevertheless has received the least continues to be our First Nation peoples.

An HDI index score of .77 for First Nations would rank them along with citizens of a country like Romania or Thailand. First Nations on reserves in BC were at a HDI of .75 which would rank them 86th between the level of the Philippines and Turkmenistan. Many individual First Nations communities in Canada stand even lower than these averages. For example, using the “community well-being index” for individuals,

“nearly 50% of First Nations communities occupied the lower half of the index range (between 0.30 and 0.65) while less than 3% of other Canadian communities fell within this range.” (INAC, 2004)

We all hope that education will improve the conditions of First Nations. However, Stats Canada in 2006 still reported a gap between Native and non-natives of some 18% to 25% (depending on the age group) in obtaining just high school. Also in 2006 some 26% of the Canadian population obtained a university degree but only 8% of First Nations. It is clear that First Nations are at a considerable disadvantage and this is an insult to us all. There are many factors for this past and current inequity and permit me to list some of the salient factors:

- **Racism:** Aboriginal people in general have been the victims of discrimination and racism. Marginalization, a loss of language and culture, low self-efficacy and a felt inferiority effectively segregates native peoples from participating in Canadian society. Discrimination can be both blatant and subtle.

- **Unemployment or underemployment:** The unemployment rate of First Nations people off reserve in 2006 was 13% as compared to 5% for non-natives. This rate is higher on reserve at 22% but these rates don't reflect the underemployment involving seasonal or part-time work. Those Native individuals who are employed often work in lower paid positions, disproportionately work in more dangerous occupations (forestry or fishing), and are relegated to the more repetitive and high stress jobs.

- **Physical Environment:** Disproportionate numbers of First Nations must live in crowded homes or apartments. Many on reserve homes are also crowded with multiple generations sharing a

house that often is of poor or cheap construction where there may be severe problems of mould and deterioration.

- **Health:** First Nations people suffer disproportionate rates of diabetes, heart disease, infant mortality, obesity, accidental deaths, alcohol abuse, etc. In addition, there is a lack of health resources in most communities and very often the resources that do exist are limited and downgraded.

- **Health Services:** There is an egregious lack of health care services both in quantity and quality in Native communities. There is also an ethnocentric disregard for traditional healers and healing practices. For instance the Coast Salish tried to maintain a practice of cultural rehabilitation where they would ask, or even physically force (but not hurt) a wayward member to come to the longhouse for purification and instruction. Unfortunately, this practice was deemed kidnapping in the BC Courts and so this important option to save their own son and daughter from the downtown streets of Vancouver was denied to Salish families. Instead, Native parents must lament their children being degraded, exploited and even killed in urban areas far from family and tradition.

- **Education:** Native children obtain lower levels of education and very often the quality of education is lower on reserves. The children are more likely to be born and raised in poverty with one or both parents absent physically or emotionally distressed. This affects their ability to learn and to believe in themselves and have a future self through higher education. Ask native youth what they see themselves doing in five years and the common answer is simply, “don’t know”. A low self-efficacy and diminished future self is murderous to any aspiration and interest in higher education.

- **Gender:** Native women are at a distinct disadvantage due to being more subjected to family violence, diabetes, and substance abuse, as well as being lured into prostitution, suffering from mental health issues and on average being even poorer than aboriginal men.

- **Geography:** The location of a community is related to overall health outcomes. Many First

Nations communities are located in rural and/or remote areas, where health care is less available and the cost is much higher and “Native speed bumps” is native humour for the fact that the unpaved roads to many reserves are in poor conditions and can become at times highly hazardous during winter conditions.

• **External Images:** The incessant exposure of external images in movies, magazines, and TV of who is successful and deserves to be successful is constant denigration of all us for being average and ordinary. It is worse for First Nations. Imagine being a Native youth on an isolated reserve and how your limited experience of non-Native people in and outside of your community would shape your own self-perceptions of who you are. For too long, this young person would experience his or her teachers as predominantly non-Native. The same would apply to his or her experience of all other professionals like doctors, lawyers, dentists, engineers, administrators, store owners, car salesmen, and so on. Seeing the large homes in non-Native communities along with the expensive cars and material possessions of the successful and prominent would also give a tacit message of how being Native means that you are different in an invidious way. Repeat this experience in the movies and TV where First Nations are very rarely seen in professional roles succeeding in the dominant society at large.

THE SAD HISTORY OF COLONIZATION AND OPPRESSION

There is a psychology of oppressed groups but it is not usually part of the curriculum or training of Psychologists. It is a psychological truism that everyone needs a sense of significance, belonging and mastery. Understanding something of the history of First Nation peoples is essential for understanding why helping to develop a person’s sense of individual and collective significance, individual and collective belonging and individual and collective mastery are especially important developmental goals in providing any psychotherapy to a First Nations person.

First Nations have suffered at least six fundamental and profound dislocations:

1. The severe **reduction of the populations** through the new diseases brought over by the Europeans

2. The **loss of self-governance** and local autonomy through the reserve system and Indian agents (Dussault & Erasmus 2009)

3. The **loss of their lands** and traditional means of livelihood through outright takeover or broken treaties. (Wallis et al., 2010)

4. The political and cultural **denigrations of their cultures** and communities through discriminatory laws and assimilation policies of the Department of Indian Affairs (Smith, 1995)

5. The disruption of their very dignity and intimate lives as family through **separation of the children** sent to Residential schools (Annett, 2002; Chrisjohn & Young, 2006; Fontaine, 2010; Milloy, 1999; Nuu-Chah-Nulth Tribal Council, 1996)

Dislocation of the cultural integrity of First Nations peoples has been severe and incessant (Bruce Alexander, 2010) over the years of colonization and to the present time. The loss of land, the loss of autonomy and a consequential loss of dignity is a grievous wound that few can even imagine let alone understand. The first dislocations that occurred on a continental scale were the new diseases brought over by Europeans and a decrease of some forty to eighty percent of the First Nations population after post-contact. Since disease kills more of the young and old, an unimaginable disruption and loss occurred where adults had to grieve their children and their elders. Losing so many elders meant losing their oral libraries, losing their teachers, losing their politicians, losing their healers and leaders. Much was lost by disease alone and the reasons for this unilateral kill is maybe best explained by Jared Diamond (2005) who argued for simply the dumb luck of geography that best explains why intelligent and industrious peoples around the world did not have the same opportunities of industrial development as did Europe.

DATES OF SOME POLITICAL CULTURAL DISLOCATIONS:

Space here does not permit me to summarize all of the dislocations such as Residential school, but I would like to list just a few of the political/legal dislocations that have occurred.

1763 Royal Proclamation by King George III required the negotiation of treaties before lands west of the Appalachian divide, then considered “Indian Lands” could be transferred to European colonists. In spite of this proclamation in reward for First Nations helping the British against the French and to stabilize British relations with First Nations, vast areas of land were already claimed prior to the treaties. Many areas promised were not given and later large amounts of established treaty land were expropriated without any negotiation, compensation or even consultation. The reserves across Canada are nowhere near the land area that was first negotiated when negotiations did occur. The total number of reserves in BC is 1,701 and these reserves amount to only .36 percent of all land.

1829 The last surviving Beothuk dies, a female in her late twenties, and this group First Nations become officially extinct due to disease, competition for food from other tribes and Europeans, and violent encounters with other tribes and Europeans.

1850 -1854 The Governor of the colony on Vancouver Island signed 14 treaties with Native peoples on southern Vancouver Island for the creation of reserves. Lack of funds to compensate for Native lands and resistance of recognition by the British colonists of the Nuu-Chah-Nulth Tribal Council defeated this effort and later the authorities granted only very small reserves that could not sustain the Native population and this initiated a forced dependency on the government.

1871 British Columbia enters Confederation but in spite of some pressure from the federal Nuu-Chah-Nulth Tribal Council government to enlarge the reserves, British Columbia refused. Except for some land on Southern Vancouver Island from the Douglas Treaties and South-eastern BC (Treaty 8), there is no treaty covering most native land in British Columbia.

1857 In Upper Canada the *Act to Encourage the Gradual Civilization of the Indian Tribes in this Province* was used to

provide for the voluntary ‘enfranchisement’ — freedom from Indian status — of individuals of good character as determined by a board of examiners. Upon enfranchisement, they would no longer be considered ‘Indians’ and would acquire instead the rights common to

ordinary, non-Aboriginal settlers. In addition, however, they would take a portion of tribal land with them. They and such property would no longer be ‘Indian’ in the eyes of the law. Reformers saw enfranchisement as a ‘privilege.’ (Report on the Royal Commission on Aboriginal Peoples [1996], accessed online at <http://www.aadnc-aandc.gc.ca/eng/1307458586498>, March 8, 2012) This act also served to fractionate and divide First Nations communities further.

1874 Intoxication by a Native person became punishable by one month in jail. While intended to protect First Nations from this vice, it has arguably delayed the development of social drinking for First Nations people and may have actually reinforced the idea that the sole purpose of drinking alcohol is to become intoxicated.

1876 Native women who married non-Native men would lose Native status, along with their children. This policy was maintained until Bill C-31 in 1985. Many bands, however, refused to reinstate many of these women. This policy did not apply to Native men, and their non-Native wives could obtain native status. Today, some 32% of residents on Native reserves have no Aboriginal ancestry. (General B.C. and Canada First Nations Statistics, 2012, p 1)

1881 Non-native “justice” was imposed on reserves by officers of the Indian department along with Indian agents, with no requirement of any legal training, and *ex officio* Justices of the Peace.

1881 Under the pretext of protecting natives from exploitation, the purchase of Native farm produce without a permit carried a penalty of a fine or up to three months in jail. Non-Native farmers had complained about unfair competition from Native farmers on the grounds of government assistance to reserves. The permit system was also used a means of control by Indian agents to favour or punish individuals. The end result greatly inhibited the development of commercial farming and made farming inefficient and even unviable for many Native individuals.

1884 The Indian Act was amended from a policy intending to protect treaty lands to one denying First Nations their own culture. That year the potlatch and Tamanawas dance was made illegal with a jail

sentence of two to six months . This continued for about 75 years. Other changes included creating a new offence for inciting “*three or more Indians, non-treaty Indians, or halfbreeds*” to breach the peace or to make “*riotous*” or “*threatening demands*” on a civil servant. (RRCAP, vol 1, part II, chp 9).

1885. The PASS system was attempted to restrict the mobility of First Nations individuals. Native individuals had to obtain a written pass from their local Indian agent if they wished to leave the reserve. This was difficult to enforce and in the 1890s it was rarely enforced but it continued to be occasionally used into the twentieth century. Trespass under the Indian Act or vagrancy under the Criminal Code was more frequently employed to restrict movement and mobility.

1909 Dr. Peter Bryce as medical superintendent for the Department of Indian Affairs officially reported that between 1894 and 1908 some 30% to 50% of children in Residential schools died (a 6% to 12% yearly death rate). This report did not become public until 1922 after he was removed from his position and he published, “*The Story of a National Crime: Being a Record of the Health Conditions of the Indians of Canada from 1904 to 1921*”. He further courageously reports that these mortality rates were effectively deliberate by having healthy children exposed to sick children with tuberculosis when quarantining was the only effective control of the disease before the arrival of streptomycin in 1946.

When church and government officials were not blaming each other for the condition of native residential schools, they often sought solace in the belief that tuberculosis was hereditary and incurable.
(Sproule-Jones, 1996, p. 212)

1914 Western natives had to obtain official permission to wear traditional dress in any “*dance, show, exhibition, stampede or pageant*.” (ibid.) Additional bans continued to be added over the years, such as the ban in the 1950s pertaining to traditional Native marriage ceremonies.

1918 Deputy Superintendent Duncan Campbell Scott vigorously sponsored amendment to the Indian Act that gave government agents the addition powers to prosecute the anti-potlatching and anti-dancing laws.

1927 Indian affairs are given more powers to control Native leisure time by regulating the “*operation of pool rooms, dance halls and other places of amusement on reserves across Canada*.” (ibid.). In 1930 this was extended for First Nations to include off reserve pool rooms where they could be banned from entry with penalties for the proprietor of a fine or a maximum one month jail sentence.

1951 Revisions of the Indian Act started to weaken the powers of Indian agents and the department of Indian Affairs and this process continues today.

1960 First Nations individuals were given the vote in Federal elections without restriction. British Columbia was the first Province in 1949 to give voting rights in Provincial elections and Quebec was the last in 1969. There were no status Natives in Newfoundland until the Miawpukek Band of Conne River was recognized 1984.

Even today there is a lack of understanding and history of the importance of First Nations to the Canadian polity and culture. Many Canadians even today would agree with the following statement made in 1920 by the then deputy superintendent general of Indian Affairs:

I want to get rid of the Indian problem. I do not think as a matter of fact, that the country ought to continuously protect a class of people who are able to stand alone...Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian Department, that is the whole object of this Bill. (Duncan Campbell Scott, 1920, quoted in RRCAP)

There are still examples of this unkind and prejudicial attitude that one can find in the comments of some Canadians in newspapers or on radio talk shows. One explanation of why the maple leaf on the Canadian flag has three points was that it represents the three pillars or foundations of Canada: Native, French and English. It is unfortunate that this is not the official understanding of what is being symbolized by our flag.

SOME DIFFERENCES TO UNDERSTAND

Therapy is not value neutral and we need to be mindful of what may be implied by our therapeutic interventions or our therapeutic relationship. Consider the following table of some possible comparisons of First Nations people with non-Native Canadians:

It is, however, to be remembered that these differences in degree are generalities and do not apply to all First Nations individuals or even groups. Urbanization and television have greatly influenced traditional ways of being and many differences that existed historically are rapidly disappearing. Nevertheless, it may be helpful to be prepared for

First Nations Canadians	Non-Native Canadians
Children & adults respect and value their elders	Less reverential attitudes towards elders
Children are expected to learn through stories, communal events and shared activities (experiential & practical)	Children's learning is more focused on schoolbooks and educational media (presentational and propositional)
Children will learn when they are ready to learn.	There are stages and ages where learning different things is expected.
Sharing of material goods is more emphasized. Status is displayed by how much one gives.	Personal ownership is strongly affirmed. Status is displayed by how much one accumulates.
Collectivist orientation towards others	Individualist orientation towards others
Immediate and extended family come first	Personal interest and individual development is more strongly valued
Less emphasis on being precise with time keeping	More aware of time and how it is to be apportioned
More cooperative and modest	More competitive and self-affirming
More bound by family and group expectations	More bound by general rules
Affirms the person and their relationships with family and community	Value placed on material possessions is high
History of greater respect and status for women in spite of a greater emphasis on specific sex roles	History of severe sexual discrimination with a current stress on the equality of the sexes
Women were empowered	History of woman being devalued and objectified
Value loyalty and group contributions	Value individual achievements and personal success
Encourage non-interference with others	Greater interference in the form of asserting one's rights and wants as they conflict with another's
Tradition and past history is important	Looking forward towards the future is important
Talk about other members is high but tends to be more accepting	Less concern with others but more critical of each other
Emphasis on the spiritual and a communal vision	Emphasis on scientific and technological advances.
Justified scepticism towards, and mistrust of, the dominant society and its institutions	Identification with and some pride in the dominant society and its institutions
Self identity in terms of collectivist connections and group belonging	Self-identity in terms of personal attributes and individual achievement.
A wry and subtle humour is very present and employed to cope with difficult stressors.	Irony, satire and the structured joke is more prevalent and employed for entertainment
A respect and concern for place and traditional lands	Maximum exploitation of place and land is worshipped
Interconnectedness and interrelatedness of things and people	Separateness and uniqueness of things and people

(Adapted in part from Baruth & Manning, 1991)

such differences to be overtly or covertly present and which may make for a conflict with one's own emphasis in values or with rapport. With this caveat in mind, consider the following differences that may or may not exist in social behaviours:

Notwithstanding large variations of such behaviours, it can be useful to be aware of such potential differences that may lead to faulty attributions. For instance, a native youth may be incorrectly judged as inattentive and disinterested in talking with a non-Native professional when in fact this youth is showing

Nations, another First Nations woman remembered hurtful words from her non-Native therapist: "They did the right thing. You would still be sleeping in huts and using bows and arrows." This insensitivity is pretty blatant but there is a more insidious insensitivity that comes from not accepting that one cannot really understand the experiences of First Nation clients but then presuming that one can by telling one's own story of disappointment and being treated unfairly as if there is a real parallel when in fact the analogy is remote and offensive.

First Nations Peoples	Non Native Canadians
Staring can be disrespectful. Avoidance of some eye contact is signalling respect.	More direct eye contact indicates listening and being attentive
Turn taking in conversations signalled by longer pauses. Silence is communication.	Shorter pauses between turn-taking. Silence is awkward and must be filled
May speak slower and softer, and lower their voices to emphasize a point	Speak faster and louder, and will raise their voices to emphasize a point
Spatial distance is greater, particularly between the sexes and being too close is intrusive and rude	The closer the spatial distance to a certain point, the greater the intimacy between the sexes
Handshake is soft and passive	Handshake is firm and assertive
Patient and willing to wait	Demanding of more immediate attention
First attempt to understand the other in terms of which culture or tribe they come from and their place in the group or origin.	First attempt to understand the other in terms of occupation, wealth and social status.
Value how many people and the quality of the people you know that they also know	Value how much you earn in comparison with what they earn.
Sensitive towards discrimination	Sensitive to role or status challenge

respect and cautious guardedness towards this non-Native adult.

IMPLICATIONS FOR SERVING FIRST NATION CLIENTS

Not knowing something of the history of oppression and not appreciating it effects will greatly reduce one's ability to establish rapport and understanding. One First Nations person told me of how one non-native therapist was dismissive and argumentative about their claim for Residential reparation, asserting to her that it was simply "history repeating itself". She felt that it was her fault for bringing up the negative aspects of her history but then she felt that this counsellor was also trying to cover up and justify the government and the churches. With respect to how colonization has affected First

1. Self-awareness. Take the implicit associations test on the web (go to <https://implicit.harvard.edu/implicit>). Our culturally learned bias is also partly unconscious and it is sobering indeed to take this test to find out how biased one might be at this automatic level in cognitive responsiveness. I would insist that this is a necessary prerequisite for working with any minority group, or with any group that has historically been subjected to prejudice and discrimination. If one does not understand one's unreflective biases and stereotypes one cannot properly correct for them.

2. Respect. I would suggest that we evince respect in the form of sensitive and chastened listening to another whose life experiences are likely to be very different from and less fortunate than one's own. Of course we have learned not to say, "I understand

what you must have gone through” but with First Nations one must go further and admit that one cannot even hope to imagine the kinds of disregard, marginalization and racism that First Nations people must experience and forebear. One can evince empathy but not ever presume direct or indirect understanding.

3. Sensitivity. What is required for a people whose history is one of being and feeling oppressed and undermined is that we show sensitivity and care in the form of opting for the more non-directive interventions and techniques over the more domineering and highly directive techniques.

4. Know about and compensate for stereotype threat. Claude Steele has done some very good work on stereotype threat and the effect size of believing that you cannot do as well as another person due to either your ethnicity or your gender is not to be underestimated. Decreased performance on tests can occur if, for example, students know that they are being asked to complete a test of intelligence.

5. Be mindful of who owns the needs we address. I have characterised the mental health needs of First Nations as being largely unmet and greatly ignored. We must, however, also note that with the “*cultural revitalization that is occurring within first nation communities will have a profound effect on defining need.*” (Project IN4M: Roundtable report, page 6). Are we, for example, really dealing with biological dysthymia or frustrated expectations, racism and a historically oppressive social disenfranchisement? If it is a combination of all of these things, then what is the relative importance of each? Let us remember that the biopsychosocial model does not denote that all three factors are of equal weight and that we are to be faulted for minimizing and even glibly dismissing the relevance of the historical, but still present to some degree, cultural denigration of First Nations peoples.

6. Healing and not punishment. It is important to encourage empowerment by giving clients themselves the knowledge and tools to help themselves and their families. Therapeutic techniques that involve confrontation or possible shaming and embarrassment must be avoided. Techniques that create or foster dependency must be avoided. Even using techniques

in which the person is strongly manipulated or made passive to an intervention can also be counter-therapeutic.

IF YOU WORK ON RESERVE

1. If you work on Reserve, know the community and try to remain unaligned. As one female First Nations matriarch told me, “*I admire non-Natives coming to work on reserve because it is a war zone.*” What she meant is that the community politics over particular concerns, issues or historical grievances can be quite intense and the variegated and shifting factions over those issues are complex. For example, it is a great honor and compliment to be invited for adoption with a particular house or clan, but then you may be seen as being aligned and not somebody to whom one can fully disclose private matters pertaining to historical antagonisms between individuals, clans or other groupings. It will take a few years to know more than the surface of what you see.

2. Do not provoke or aggravate conflicts. Just as physicians have the directive to “do no harm,” you similarly must not carelessly add to or foment existing divisions and historical conflicts. The people in these communities likely will have to live together for all of their lives and certain techniques or assumptions of therapy can aggravate, and maybe create, needless internecine conflicts. For example, one therapist used the two chair technique to encourage a youth to express his anger towards his parents. After the therapy session the youth returned home and continued with the ventilation at his parents, but this time in vivo, much to the distress and bewilderment of the two parents. These were not bad parents and the youth’s anger was only magnified by this manipulative and unsuitable technique.

3. Remember that you are a guest. Reserves are private property and these communities are struggling to develop their own economy, autonomy and identity. Unemployment on many reserves is appallingly high and can be as high as 50% to 80%. It is sobering to remember that during the great depression in Canada during the “dirty 30’s”, the unemployment rate was about 23%. Clearly, this rate of unemployment is far less than what First Nations communities must suffer and not just for half a decade, but for all of their lives

on reserve. As noted by Judge Reilly, some residents themselves have referred to one particular reserve as “a prison without bars” and a “welfare ghetto” (Reilly, 2010). Of course, this does not apply to all reserves and great improvements have been made. Depending on the reserve, conditions may be good or very impoverished.

“To be effective with First Nation clients, it is important to become aware of the history of dislocation produced by disease, territorial loss, political oppression, cultural assimilation and residential school.”

4. Be prepared to commit. It may take five years to become accepted and it will take just as long to begin to understand some of the dynamics of the community and how the various families and individuals relate to each other. One of the common complaints is that each time another new counsellor or psychologist decides to work for a few months or a couple of years in a First Nations community, individuals must tell their story anew and educate yet another outsider to their community’s unique problems and stressors.

5. Don’t open up what you are not prepared to heal. The ‘dine and ditch’ approach weekend workshops by a facilitator can potentially do great harm. For example, suppression is a defense that many people have depended upon and which can actually work. When a Psychologist admonishes people for depending on this defence and pressures people to open up and share their individual stories and pain in a group, this then leaves people vulnerable with shame and old wounds again bleeding, and then feeling abandoned as the Psychologist leaves. It is presumptuous to think that a workshop that opens up wounds in a group of people can also heal them for all at the same time. We now know that critical incident debriefing and routine grief counselling may not only be ineffective but may actually make some people more symptomatic. Having individuals open up in manner that is not deeply personal but more about shared hurts and problems in the community can, however, be more

effective. Key problems are not to be ignored, but please give adequate time to provision and coaching of methods of coping and stress inoculation. Also, ensure that there are adequate counselling resources in place when you leave and have those local resources participate and also help guide your workshops.

6. Remember that you culturally live outside and are not embedded in the community you serve. For example, the people who are embedded in their First Nations community have strong loyalties first to their family and extended family, then to their clan and to their land and then to their communities. Such profound connections may conflict with our understanding of connectedness to country instead of community, to the present instead of the past, to the abstract instead of the immediacy of everyday life, to material things instead of known people. To take another example, in the language of the Gitxsan, non-native people were referred to as K'amksiiwa, meaning “*bleached driftwood*” due to the fact that non-Natives coming into their territories were fair skinned and were not rooted to one place but due to the labour market of late Capitalism have generations ago separated from ancestral homes to uproot almost routinely to go where jobs are to be obtained.

CONCLUSION

To be effective with First Nation clients, it is important to become aware of the history of dislocation produced by disease, territorial loss, political oppression, cultural assimilation and residential school. Obviously, one must not inadvertently add to that sense of dislocation by being perceived as overly controlling, domineering, patronizing or intrusive. It is also important to be aware of possible differences in expression, thinking

and disposition that may or may not be present. First Nation's historical guardedness and suspicion towards the dominant society is sometimes reflected on some psychopathology tests like the MMPI where there is a greater frequency of elevation on the F, 4 (Pd) and 8 (Sc) scales (Dana, 1993). Such elevations need to be interpreted very carefully and could easily mislead the naive Psychologist. It is therefore essential to understand the relevance of the social-political-cultural context both for diagnosis and treatment and to also keep in mind that cultural affirmation of First Nations is for some the best therapy.

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THE LEGACY OF RESIDENTIAL SCHOOL ABUSE

A disturbing legacy of British and French colonial occupation is its impact and profound imprint on First Nations culture and people. Various researchers have documented the far-reaching trauma, unresolved grief, and legacy of genocide among First Nations (e.g., Legters, 1988; Braveheart-Jordan & DeBruyn, 1994; McDonald, 1990; Washburn, 1998). In *Native American Postcolonial Psychology*, Duran and Duran (1995) summarize the effects of the colonization:

Native American people have been subjected to one of the most systematic attempts at genocide in the world's history. At the beginning of the colonization process in North America there were over 10 million Native American people living on the continent. By the year 1900, there were only 250,000 people left (Thornton 1986). For over five hundred years, Europeans have attempted to subjugate, exterminate, assimilate, and oppress Native American people. The effects of this subjugation and extermination have been devastating both physically and psychologically (p.28).

With this article, I argue that to provide effective psychological treatment for Aboriginal people, psychologists need to appreciate and understand the profound impact of this historical trauma and its ongoing legacy for the aboriginal people.

DR. DARIA SHEWCHUK, R. Psych.

Dr. Daria Shewchuk is an educator and clinician in private practice, specializing in trauma treatment. Over the last 35 years she has worked with First Nations people in a number of communities (primarily in Alberta and the Yukon). She continues to teach a graduate level course on trauma treatment. She is passionate about her work.

At the heart of the totality of the trauma to First Nations peoples and culture is the forced removal of First Nations children from their families to place them in “Indian boarding schools” or “residential schools.” In the late 1970’s, the author lived for two years in a remote northern community that was primarily native. There, the author witnessed first hand the frightened children who had reportedly been forcibly taken from their families in the wilderness and brought to town to attend boarding school. This was done in the name of “the law”, which stated that all children over the age of six years must attend school. None of these children spoke English, the language required in school. They were segregated according to age and this meant that they had little contact with siblings who could have helped them. During a storm, the nuns who ran the boarding school would force the children out of bed and herd them to the gymnasium, where they were required to kneel and pray (sometimes for several hours) to a Christian god that they had never heard of. In the morning, the children who were deemed to have acted out in some way were gathered and taken to see the priest. He made them adjust their clothing so that they could be spanked on their bare bottom. Some of the older children later told the author they could feel his erection as he spanked them.

Later, when I worked on multiple “Indian Reservations” (providing psychotherapy services on one of them for over twelve years), my adult clients spoke of being subjected to all kinds of abuse.

The frequency of the many types of abuse in these “residential schools” was great. While information regarding the nature of the abuse suffered by those living in these schools has been narratively documented (by, for example, Tafoya & Del Vecchio, 1996, and the current “Truth and Reconciliation Commission of Canada”), hard statistical information on the incidence of abuse has been kept confidential by the Canadian government, and the agencies that the government funded.

It is known that children suffered sexual, physical, and emotional abuse (Tafoya & DelVecchio, 1996). In addition, the children spoke of how horrible it

was to eat “white food”. They had no access to their usual diet. It is these types of situations that caused the United Nations to sanction Canada for its treatment of its First Nations people.

Tafoya and Del Vecchio (1996) note that as a result of the boarding school system, several generations of native peoples were raised without family ties. They further state that the children were subjected to hard physical labor and harsh discipline, and received no nurturing, the “most essential element of healthy development” (p. 52). They note that in order to survive, the children developed passive-aggressive behavior, learned helplessness, manipulation, alcohol and drug abuse, and other negative coping skills. Even worse, the children became strangers to their parents and alienated from their culture, unable to embrace the new culture. Not surprisingly, this often led to feelings of confusion, abandonment, low self-worth, powerlessness, and depression (Tafoya & DelVecchio, 1996).

Robin, Chester and Goldman (1996) write of the cumulative trauma and P.T.S.D. of First Nations peoples as contributing to the development of addictions and other psychiatric disorders. They note that P.T.S.D. appears to be strongly related to substance abuse, anxiety, and depression (p. 242). However, they also state “as a diagnostic category, P.T.S.D. fails to describe the nature and impact of severe, multiple, repeated, and cumulative aspects of trauma common to many [First Nations] communities” (p. 246). They suggest that “complex P.T.S.D.” or Disorders of Extreme Stress Not Otherwise Specified would be more accurate in describing the nature of stressor criteria for Native communities.

Carol Locust (1995), researcher from the University of Arizona, has examined the impact of colonization and degradation of the aboriginal peoples’ culture, lifestyles, social norms, spiritual beliefs, and so on. She refers to a condition similar to P.T.S.D., referred to as Post Colonization Stress Disorder (P.C.S.D.). She notes that the one major difference between the two conditions is that with P.T.S.D., the stress eventually stops. She states that for native people, there was “no relief from the

invasion". The intense suffering frequently results in substance abuse, suicide, motor vehicle accidents, and other unnatural deaths.

In terms of treatment, "white therapists" have historically not served First Nations clients well. Various researchers ("Assembly of First Nations", 1994; Duran, E. and Duran, B., 1995; McCormick, 1998) emphasize that in order to work effectively with First Nations people, counseling service providers must understand the historical context (as noted above) and have a genuine sensitivity to and appreciation of cultural differences.

This means that the service providers should have some understanding of the history and world view of Native people and how the concepts of First Nations health differ from the concept of health held by mainstream society. Jackson (1999) notes that,

A central focus of healing for many First Nations people is that of attaining and maintaining balance between the four aspects of the person, physical, mental, emotional, and spiritual. In contrast, Western therapeutic approaches can be seen as imbalanced and fragmented, as they over emphasize one aspect of the person by focusing, for example, on emotional or cognitive modification.

Another difference is the goals for treatment. Effective healing for many First Nations people focuses on interconnectedness, rather than autonomy, which is a more common goal for Western therapy. Connecting with family, community, nature, culture, and spirituality are all important dynamics in the recovery process of First Nations people (pp. 81, 82).

Jackson (1999) further notes that "spiritual wounding" is of special note when treating First Nations children. Jackson, the Assembly of First Nations (1994), McCormick (1998), and Mussell, Nicholls, and Adler (1993) note that for treatment to be successful, it needs to be more holistic, evolving around the being of each person. This includes treatment to address the physical being, the mental, emotional, and spiritual aspects of the person, as well as the harmony between each of these and the

environment. In addition, LaFramboise, Trimble, and Mohhat (1990) note that First Nations healing often requires individuals to transcend the ego, rather than strengthening it as Western therapies aim to do.

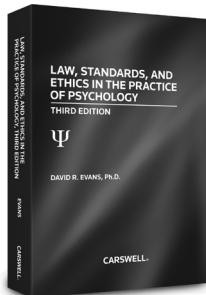
In fact, it is safe to say that "white therapists" and traditional (i.e., "white" or medical) approaches to mental health treatment have not been very effective in responding to the needs of First Nations clients. Treatment of the First Nations people is complicated by the fact that the Native world view is not something that can be generalized to all First Nations people. The worldview will vary depending on each client's tribal or band affiliation, personal characteristics, and level of acculturation to mainstream society.

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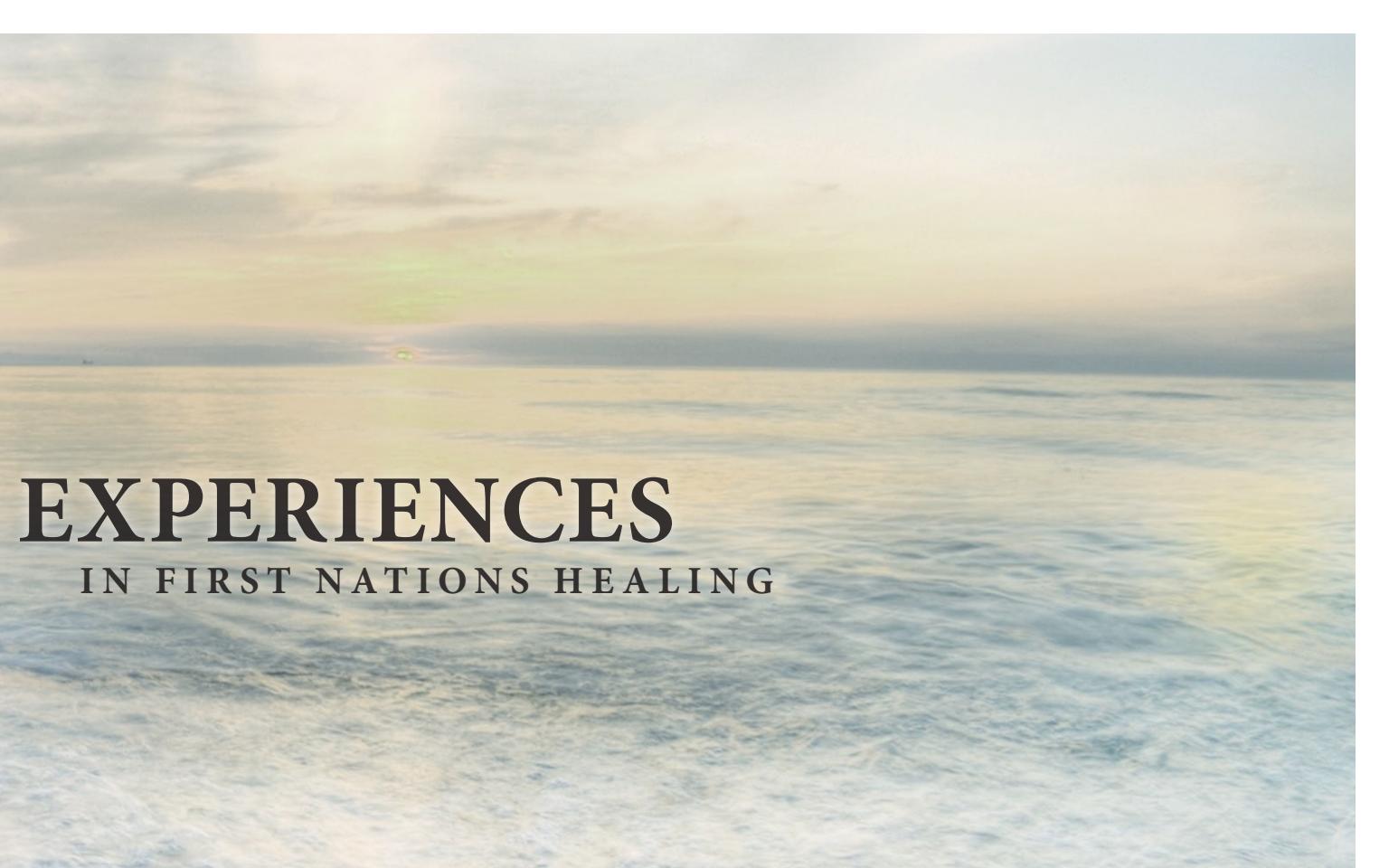
Dr. Daria Shewchuk is an educator and clinician in private practice, specializing in trauma treatment. Over the last 35 years she has worked with First Nations people in a number of communities (primarily in Alberta and the Yukon). She continues to teach a graduate level course on trauma treatment. She is passionate about her work.

In this paper I discuss the healing potential of spiritual experiences for residential school survivors. I draw upon my experiences I have working with clientele, as well as personal (anecdotal) research among individuals in a native community in which I worked. I discuss how clients accessed, generated, and utilized spiritual experiences to process trauma, and to achieve better psychological and spiritual healing.

A starting point of this discussion is recognition of the legacy of residential schools: in particular, the far-reaching trauma, unresolved grief, and genocide. As noted in my other document printed in this edition, there are a number of researchers that speak to this

legacy (e.g., Legters, 1988; Braveheart-Jordan & DeBruyn, 1994 & 1995; McDonald, 1990; Washburn, 1998; Duran and Duran, 1995; Carol Locust, 1995; Truth and Reconciliation Commission of Canada (TRC) Website 2012), Assembly of First Nations, 1994.

The last federally run Indian residential school closed in 1996. Over much of the last 100 years, each September, government officials took school-aged children from their homes and communities to live at a residential school. Missionaries (either Roman Catholic or Anglican) often ran these schools. The children were segregated according to age, were not allowed to speak their language, and were forced to follow Christian teachings.



EXPERIENCES

IN FIRST NATIONS HEALING

Emotional abuse was pervasive at Indian residential schools, and a huge percentage of the children were physically and sexually abused. Needless to say the impact was profound and multigenerational: these children did not learn how to parent or how to cope, nor did they learn what constitutes normal human development.

Following from the above noted research, if one hopes to provide effective treatment for Native clients, it is also important to recognize differences between the concepts of health held by First Nations people and by ‘mainstream society.’ For example, Jackson (1999) notes that:

“A central focus of healing for many First Nations people is that of attaining and maintaining balance between the four aspects of the person; physical, mental, emotional, and spiritual. In contrast, Western therapeutic approaches can be

seen as imbalanced and fragmented, as they overemphasize one aspect of the person by focusing, for example, on emotional or cognitive modification.

Another difference is the goals for treatment. Effective healing for many First Nations people focuses on interconnectedness, rather than autonomy, which is a more common goal for Western therapy. Connecting with family, community, nature, culture, and spirituality are all important dynamics in the recovery process of First Nations people.” (pp. 81, 82).

In addition to considering differences between First Nations people and the mainstream Western treatment approaches and populations, one must avoid overgeneralization. One must appreciate that “the” Native worldview is not something that can be generalized to all First Nations people. Essentially, one’s worldview can vary depending on one’s tribal or band

affiliation, personal characteristics, and level of acculturation or accommodation to mainstream society.

Turning to my experiences working with First Nations people provides an opportunity to focus on firsthand and anecdotal accounts of the trauma and what individuals found helpful in healing. During the 1980s and 1990s, I was contracted to provide mental health services on one of the Indian Reservations in Northwestern Canada. I spent approximately 15 years there, seeing children from the ages of five through adolescence, as well as adults up to and including old age. The people I worked with described horrendous histories of sexual, physical, and emotional abuses, as well as outright murder at residential school. Their accounts led me to wonder at how they had healed themselves.

I set about asking the most functional members of the reserve if I could interview them; about 12 people agreed to participate. Upon meeting with these individuals, I asked about their background in order to confirm that they had also grown up with the residential school trauma that so many of my clients described. Without exception, these individuals had healed themselves and were considered strong models of health within the community. To illustrate factors essential to their healing, I describe two people's stories. (Life events are modified to protect confidentiality.)

The first is a woman who worked with abused children. She stated that initially she coped with the effects of abuse and trauma by becoming a chronic alcoholic. One day she and her husband (who was also alcoholic, and had also grown up in residential school) were driving with their two children in the backseat, and due to their drunkenness, they were in an accident. They managed to escape, but were too impaired to assist their children. They heard their children scream until they died. She indicated that this was a turning point for her; she knew that she needed to find some help for herself or she would commit suicide. Both she and her

husband found help within spirituality and religion. She attended counseling. She became a Christian. She also became a social worker. She is now considered a role model within the community. She and her husband became foster parents, and opened up their home to children within the community. In the context of professional work with this woman, I was always struck by the immense empathy she had towards the abusive parents with whom she works. It was when I inquired where her empathy came from that she told me the details of her story. She indicated that she used to be one of those abusive parents.

My second example is about a woman who was a survivor of residential school and incest. Her brother and her alcoholic father (also a survivor of residential school and sexual abuse) sexually abused her throughout her childhood until she ran away. She became a prostitute living on the streets. She described how she had coped with the pain of her life: with drinking and drug use. She was constantly exposed to the dangers of prostitution and violence. She attributes her turning point from this pain and lifestyle to finding her native spirituality.

For the most part, the other individuals I had interviewed also indicated that the turning point within their lives occurred as a result of a transformational spiritual experience that made them realize that 'if they don't find some meaning in life, they may as well die.' Jung speaks at great length on the topic of meaning and spirituality. In working with these individuals, I realized that their comments are in reminiscent of Jung's thinking on this topic.

"The individual who is not anchored in God can offer no resistance on his own resources to the physical and moral blandishment of the world. For this he needs the evidence of inner transcendent experience; which alone can protect him from the otherwise inevitable submersion in the mass." (Jung, 1958, p. 34).

On the Indian Reserve "the mass" experience has frequently been one of attempting to escape

the pain of abuse, trauma, and death. I was (and continue to be) amazed at the greater capacity of those who had significant spiritual experiences and had become grounded in a spiritual meaning. They seemed notably better at integrating their painful experiences in more productive ways than the clients lacking such spiritual experiences or meaning.

“I am constantly amazed by the human ability to heal from profound trauma (and all that can accompany that), and the positive role that one’s Personal Spiritual experiences can play in the healing.”

In his seminal work, *Man’s Search for Meaning* Victor Frankl (1984) speaks to the importance of spiritual experiences: that in the World War II concentration camps, spirituality and meaning were key factors in survivors’ will to live.

“What was really needed was a fundamental change in our attitude toward life. We had to learn ourselves and, furthermore, we had to teach the despairing men, that *it did not really matter what we expected from life, but rather what life expected from us*. We needed to stop asking about the meaning of life, and instead to think of ourselves as those who were being questioned by life/daily and hourly.” (pg. 57)

In the course of my therapeutic work and with what I learned with the interviews, I have consistently noticed how the most functional members on the reserve concerned themselves with “giving”. It seemed they had a sense of their purpose and tasks in life, and strove to fulfill them. They described their feelings: that they discovered their “purpose” through their Spiritual experiences and through personal healing.

Writings regarding the topic of spirituality and ‘ego’ are worth noting as they pertain to survivors’ experiences. Mykui’s (1995) describes

the self as embracing both the conscious and the unconscious and uses the term self-centered or self-centric to denote the ego functioning in the service of the self. He states: “In this manner the ego is replenished by assimilating the contents of the unconscious. The Ego, thus enriched and strengthened, can become stable enough to integrate even more unconscious

material” (p. 173). Dr. Lionel Corbett (1996) describes the transformative spiritual experiences that individuals can have, and how these experiences can contact a level of knowing that is beyond the ego.

For the survivors I met with, it seemed that their spirituality and meaning were enhanced with purpose and giving. To add to this, their ‘self’ description extended beyond ‘ego.’ Their ego in fact had become more stable and more able to integrate unconscious and disturbing material. To illustrate, the worker who I spoke about earlier, no longer thought of herself as just a victim needing to run away from the flashbacks of her life; rather she perceived herself as a worthwhile spiritual being. This woman told stories of how “God” was working with her to help her. She expressed a sense of humor about herself and her mistakes. She described how she views herself: with compassion and love. She examines her past experiences and integrates them in useful ways. She no longer fears flashbacks. Her views and behaviors were consistent with other interviewees: they all exhibit compassion and caring for themselves and others. They demonstrate the ability to look at their past experiences without fear, and exhibit humor, compassion, and a desire to understand. They attribute their change in

attitude to their spiritual experiences. A number of clients and interviewees defined which spiritual traditions (if any) they chose to follow, and why. Some recalled looking for, and ‘trying on’ various religious teachings and traditions in hopes of finding one that resonated with them and that provided satisfactory answers, especially the answers that would help them make sense of the experiences they had undergone. In essence, these people no longer searched for belief, but rather for spiritual experience. As a witness to their experiences and stories, I am reminded of Jung’s words “Belief is no adequate substitute for inner experience” (1958, p. 48). For the most part, individuals reported that they had found their answers within traditional spiritual teachings and practices. Some grounded this experience within a Christian tradition; others combined Christian and traditional native teachings to fit their needs.

The outcome of my experiences with clients and interviewees was appreciation for the importance of spirituality and meaning in one’s healing, especially with clients whose psychological work included processing horrific events they experienced in residential school. It has become my practice to ask clients if they had ever had a spiritual experience such as dreams, visions, synchronistic events, and/or experiences within nature. It has seemed that for many individuals, this question accessed some sort of transient function. Namely, that one’s attitude and outlook changed immediately, and one was able to speak from broader point of view. Jung (1989) captures the essence of such change. “If we understand and feel that here in this life we already have a link with the infinite, desires and attitudes change (325).”

Essentially, I found that in guiding clients through a process of accessing their own spiritual experiences, they came to feel their link with the Infinite. As well, they demonstrated and expressed miraculous shifts in attitudes and desires.

In closing, I want to emphasize the importance of spiritual experiences in one’s healing. Especially in the context of my work with First Nations persons, I am constantly amazed by the human ability to heal from profound trauma (and all that can accompany that), and the positive role that one’s Personal Spiritual experiences can play in the healing.

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Using Motivational Interviewing Strategies and Techniques To Help Patients Change Risky/Problems Behaviors

Workshop Presented by: Linda Carter Sobell, Ph.D., ABPP

About the Presenter

Dr. Linda Carter Sobell is Professor at the Center for Psychological Studies at Nova Southeastern University in Florida. She is nationally and internationally known for her research in the addictions field, particularly brief motivational interventions, the process of self-change, and the Timeline Followback. She is a Fellow in the American Psychological Association, a Motivational Interviewing Trainer, and holds a Diplomat in Cognitive and Behavioral Psychology from the American Board of Professional Psychology. She has given over 300 invited presentations/workshops, published over 275 articles and book chapters, serves on 9 editorial boards, and authored 8 books. Her most recent book, published in 2011 is titled Group therapy with substance use disorders: A motivational cognitive-behavioral approach (Guilford Press, NY). She has received several awards including the Betty Ford Award from the Association for Medical Education and Research in Substance Abuse, the Norman E. Zinberg.

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