

Exploring how Indigenous Healing Practices and a Western Treatment Model “Seeking Safety”
can Co-exist in Assisting Indigenous Peoples to Heal from Trauma and Addiction

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy (PhD) in Interdisciplinary Rural and Northern Health

Faculty of Graduate Studies,
Laurentian University
Sudbury, Ontario, Canada

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THESIS DEFENCE COMMITTEE/COMITÉ DE SOUTENANCE DE THÈSE
Laurentian Université/Université Laurentienne
Faculty of Graduate Studies/Faculté des études supérieures

Title of Thesis
Titre de la thèse Exploring How Traditional Healing Methods and a Western Treatment Model
“Seeking Safety” Can Co-exist in Assisting Aboriginal Peoples to Heal from
Trauma and Addiction

Name of Candidate
Nom du candidat Marsh, Teresa

Degree
Diplôme Doctor of Philosophy

Department/Program Rural and Northern Health Date of Defence
Département/Programme Date de la soutenance March 09, 2016

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Abstract

Background: Indigenous communities in Canada face significant challenges with trauma and substance use disorders (SUD). Most Elders, traditional healers and Indigenous scholars agree that connecting to culture, land, community, and spiritual practices is a pathway to healing trauma and SUD in Indigenous peoples. The purpose of this study was to explore whether the blending of Indigenous healing practices (IHP) and a mainstream treatment model, Seeking Safety (SS), resulted in a reduction of intergenerational trauma (IGT) symptoms and SUD. The SS model has been studied in other populations but there was no evidence of its effectiveness with Indigenous peoples. Some studies have shown the positive impact of Indigenous healing practices on SUD.

Methods: A mixed-methods design was used to evaluate the impact of a 13-week Indigenous healing practices and Seeking Safety (IHPSS) implementation project. This was a pilot study with one group of 12 Indigenous women and one group of 12 Indigenous men ($n = 24$) in Northern Ontario. Semi-structured interviews and focus groups were conducted at the end of treatment. The transcripts underwent qualitative thematic analysis to depict themes and understand the ways in which the program promoted healing. Data was collected pre- and post-implementation using the following assessment tools: the Trauma Symptom Checklist-40 (TSC-40), the Addiction Severity Index-Lite (ASI-Lite), the Historical Loss Scale (HLS), and the Historical Loss Associated Symptom Scale (HLASS). The effectiveness of the new program was assessed using paired t -tests, with the TSC-40 as the main outcome.

Results: A total of 17 participants completed the study. Four core themes emerged from the qualitative data that showed a positive impact on the symptoms and behaviors related to IGT and addiction in the participants. The benefits from both Indigenous healing practices and SS

were clearly depicted through the voices and viewpoints of all 17 participants. Participants demonstrated improvement in the trauma symptoms, as measured by the TSC-40, with a mean decrease of 23.9 (SD=6.4, $p=0.001$) points, represented a 55% improvement from baseline. Furthermore, all six TSC-40 subscales demonstrated a significant decrease: anxiety ($p = 0.001$); depression ($p=0.000$); sexual abuse trauma index ($p=0.0011$); sleep disturbance ($p=0.003$); dissociation ($p=0.027$); and sexual problems ($p=0.037$). Substance use did not increase as measured by the ASI-Lite alcohol composite score (mean difference = -0.011) and drug composite score (mean difference = 0.032).

Conclusion: Evidence from this mixed-methods pilot study indicates that blending IHP with the SS model was beneficial in reducing trauma symptoms. The combination of IHP and mainstream healing methods has the potential to enhance the health and well-being of Indigenous peoples.

Keywords: Post-traumatic Stress Disorder (PTSD), substance use disorder, IGT, blended implementation, Two-Eyed Seeing, Seeking Safety, Indigenous healing practices, decolonizing methodologies, Indigenous worldviews, sharing circles, Elders

Co-Authorship Statement

This thesis is presented in an integrated-article format as per the policy in the School of Rural and Northern Health Student Handbook 2014-15. Four papers are included in this thesis, and each paper includes co-authorship by members of my PhD Committee. As the principal investigator and first author on all four papers, I was responsible for the content of each paper. I was also primarily responsible for writing the initial draft manuscript and editing the final version after co-author contributions and feedback had been received. All the co-authors contributed in a variety of significant ways, including (1) the design of the study; (2) the analysis, synthesis, and interpretation of data; (3) the content of each paper; and (4) the editing drafts and revisions requested by journals. All four papers are included in the body of the thesis (Chapters 2, 3, 4, and 5) and all were submitted for publication in academic peer-reviewed journals. Chapter 2 was published in the *Harm Reduction Journal* in May 2015. For the purpose of consistency within the thesis, the reference style has been changed from the published version (Vancouver style) to APA within this thesis. Chapter 3 was published in the *International Journal of Qualitative Methods*. Chapter 4 was accepted by the *International Indigenous Policy Journal* and Chapter 5 has recently been submitted to the *Addiction Research and Therapy Journal*.

Acknowledgements

I thank the Creator and all my ancestors who walked with me during the years of working on this PhD. I am humbled and grateful for the wisdom, challenges, learning, growth and gifts received during these years.

I would like to thank the men and women who participated in the Indigenous Healing practices and Seeking Safety implementation project (IHPSS). All those who entered the program did so with dedication to their healing and made this research project possible.

I would like to thank my supervisors Dr. Sheila Cote-Meek, and Dr. Nancy Young. Gratitude also goes to Dr. Diana Coholic, who guided me through the first two years of my studies. Sheila and Nancy, I express my deepest gratitude for all the support and encouragement you provided throughout my time in the Interdisciplinary PhD program. I have learned a great deal about myself, the research process and the many facets of interdisciplinary health. This experience has been challenging and, at times, frightening, yet extremely rewarding. I will always look back on this experience, with all of you walking beside me.

I would also like to extend my grateful appreciation to my thesis committee members: Firstly, to Dr. Lisa Najavits, my mentor and heroine, gratitude and thanks for all the support and light you brought into my life and learning. When I approached you with the idea of using your model for this study you encouraged, inspired and supported me. Secondly, Dr. Pamela Toulouse, during my difficult first year and my struggles with discouragement, you sat and listened to me with your heart. You did not say a great deal, but your presence and love sustained me and made me want to become a better person. You told me as we parted one day, “Everyday was a good day.” Those words became my mantra.

I would like to acknowledge Elders Julie and Frank Ozawagosh, for all the wisdom and support they provided from the inception of this research idea, and their help with the writing of all the manuscripts, particularly in regards to the Indigenous healing practices content. Moreover, I thank them for the unending love, guidance, teachings, and encouragement they offered throughout. I also extend my gratitude to all the members of the Indigenous advisory group, Elders Julie & Frank Ozawagosh, Dr. David Marsh, Dr. Denise Gauthier-Frohlick, Bridget Elliot, Ann Marie Recollet, and Perry McLeod-Shabogesic. I could never have done this without your support, wisdom, encouragement and love. I have beautiful and joyful memories of meetings, feasts and gatherings and they live in me.

I am humbly grateful to the sharing circle facilitators, Lisa Osawamick, Eric Souliere, Dr. Denise Gauthier-Frohlick, Bridget Elliot, Natasha Contin and Lara Longo. You offered months of your time to support this research and all the participants from the beginning to the end. Your dedication, passion and compassion were evident as I read the qualitative transcripts. You have made a difference in the lives of the men and women who came for healing and light, bringing all the literature, ceremonies and teachings to life. Miigwetch!

The director, Marie Meawasige at the N'Swakamok Native Friendship Centre and Patricia Delea the director at Rockhaven Recovery Home for Men (now Monarch Recovery Services), accepted me with open arms and extended support throughout the research and beyond. All the staff at both organizations supported the program and gave of their time willingly and joyfully. I thank them all from the deepest part of my being.

Gratitude and thanks to you, David, my best friend and husband, for your unconditional love and support. Thank you my dear children, Shireen, Reon and Catherine, for believing in me,

and encouraging me to take this all the way. Ashley and Helen, my son and daughter-in-law, thank you for coming into my life and supporting me the way you did.

Thank you Maya, Jordan and Acacia, my beautiful grandchildren; this is my gift to you.

I thank my mother, father and grandmother, now in the spirit world, for all your love and teachings. I thank all my sisters and my late brother for all their love and support.

Thanks also to my father-in-law who always believed in and encouraged me. Thank you, Hannah, my healer, for always believing in me.

I thank all my spiritual teachers and healers who directed me over the years and those who encouraged me to follow the path.

Finally, thank you all my dear friends, yogis and yoginis who kept me on track and encouraged me to keep going.

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List of Abbreviations Used

CAS	Children's Aid Society
CHCH	Community Holistic Circle Healing
CIHR	Canadian Institutes of Health Research
CWB	Community Well-Being
DSM-V	Diagnostic and Statistical Manual-V
HIV	Human Immunodeficiency Virus
HLASS	Historical Loss Associated Symptom Scale
HLS	Historical Loss Scale
HT	Historical Trauma
HTT	Historic Trauma Transmission
IGT	Intergenerational Trauma
IHP	Indigenous Healing Practices
IHPSS	Indigenous Healing Practices and Seeking Safety
KT	Knowledge Transfer
NHS	National Household Survey
OATC	Ontario Addiction Treatment Centers
OCAP	Ownership, Control, Access, and Possession
PG	Pathological Gambling
PTSD	Post-Traumatic Stress Disorder
RHS	Regional Health Survey
RCT	Randomized Controlled Trials
SD	Standard Deviation
SS	Seeking Safety
SDOH	Social Determinants of Health
SPSS	SPSS® Statistical Software Version 20

SRT	Structured Writing Therapy
SUD	Substance Use Disorders
TAU	Treatment As Usual
TRC	Truth and Reconciliation Report
TREM	Trauma Recovery and Empowerment Model
TSC-40	Trauma Symptom Checklist-40
TSI	Trauma Symptom Inventory
WHO	World Health Organization

Chapter 1: Introduction

Indigenous peoples in Canada have experienced generations of traumatic events as a result of colonialism, which resulted in structural racism, residential school systems, oppression and misguided policies (Kirmayer, Tait, & Simpson, 2009; Menzies, 2014; Waldram, 2006). Two major consequences of these substantial challenges are intergenerational trauma (IGT) and substance use disorders (SUD). Unfortunately, there is no currently available, culturally appropriate, evidence-based, integrative treatment for both conditions (Kirmayer, et al., 2009; Menzies, 2014; Thatcher, 2004; Stewart, 2007).

This thesis reviews the relevant literature on IGT, SUD and treatment approaches (Chapter 1); describes the treatment approach based on blending Indigenous healing practices (IHP) with a mainstream treatment model for treating IGT and SUD (Chapter 2); and presents the methodology for understanding the nature and estimating the magnitude of the impact of the blended approach (Chapter 3). Qualitative and quantitative results of the implementation of this blended approach are described in detail in Chapters 4 and 5, followed by a discussion of these findings in the context of the broader literature (Chapter 6).

It is well known that Indigenous peoples are faced with the most serious health inequities in Canada; they have generally poorer physical and mental health; are less likely to complete primary, secondary, and tertiary education; and do not have the same employment opportunities as non-Indigenous Canadians (Chansonneuve, 2007; Hart, 2010; Kirmayer, et al., 2009). Indigenous communities in Canada also experience mental health problems, depression, anxiety, SUD and their consequences—such as violence, anger and suicide—at significantly higher rates than the general population. Within the Indigenous population, youth are the most dramatically affected. The disproportionately high prevalence of mental health problems and SUD in

Indigenous communities can be linked in part to a history of cultural disruption, oppression, marginalization and the impact of ongoing colonization (Hart, 2010; Menzies, 2014; Waldram, 2006). These factors have strongly contributed to the multigenerational grief and loss associated with IGT (Brant Castellano, 2004; Smith, 1999; Waldram, 2006; Wilson, 2008).

Despite the high frequency of issues related to mental health and substance use disorders, Duran (1990) and others (Brave Heart, 1998; Duran, 2006; Martin-Hill, 2003; Menzies, 2014) have noted substantial dropout rates from mainstream treatment and a general underutilization of Western services for mental health and SUD by Indigenous peoples. This has been attributed to the fact that many treatment programs for mental health and SUD lack culturally appropriate services (Bishop, 1999, 2003; Martin-Hill, 2003; Stewart, 2007). Western treatments and conventional psychology have failed to understand holistic Indigenous wellness, spirituality, and traditional healing methods (Cote & Schissel, 2008; Evans-Campbell, 2008; Poonwassie, 2005; Stewart, 2008). It is therefore necessary to investigate treatments that are more relevant and incorporate Indigenous ways of knowing and approaches to healing.

This research project was born out of the identified needs and challenges that exist in the current mental health status of Indigenous peoples. In addition, the project was inspired by the lack of traditional and culturally sensitive evidence-based treatment models available for treating IGT and SUD integratively. The study described in this thesis focused on conducting research with a group of Indigenous men and women in a mid-size city in Northeastern Ontario. The purpose of the study was to explore whether or not incorporating IHP into the SS model was a feasible, suitable, and beneficial approach for Indigenous women and men suffering from IGT and SUD. A Two-Eyed Seeing approach was utilized to honour the strengths of both Indigenous and Western knowledge, research techniques, knowledge translation, and program development

(Iwama, Marshall, Marshall & Bartlett, 2009). (See also Figure 1-1 on page 25).

Background

The Canadian Constitution (the Constitution Act, 1982) recognizes three groups of Indigenous peoples—First Nations, Métis and Inuit. These are three separate peoples with unique heritages, languages, cultural practices and spiritual beliefs.

Widely dispersed across the country, Indigenous populations comprise approximately 4.3% of the Canadian population (Statistics Canada, 2013a). The population of First Nations people forms 60.8% of all Indigenous people in Canada (Statistics Canada, 2013a).

Approximately half of First Nations peoples live on reserves, which are composed of distinct communities that are located in, or proximal to, their traditional territory. Many First Nations communities are located in rural and northern regions (Statistics Canada, 2013a). However, according to Statistics Canada, more than half (56%) of the Indigenous population in 2011 lived in urban areas—a number that rose from 49% in 1996 (Statistics Canada, 2013a).

In 2011, the National Household Survey (NHS) recorded 13,410 Indigenous individuals living in Greater Sudbury, the site of this research, representing 8.5% of the city's total population (Statistics Canada, 2013b). Of those, 48.4% (6,485) reported a First Nations identity, 48.2% (6,460) reported a Métis identity, and 0.3% (40) reported an Inuit identity. An additional 2.5% (330) reported other Indigenous identities and 0.7% (90) reported more than one Indigenous identity (Statistics Canada, 2013b). In general, the Indigenous population in Canada is younger than the non-Indigenous population. In Greater Sudbury, children aged 14 and under represented 21.1% of the total Indigenous population and 11.2% of all children in Greater Sudbury (Statistics Canada, 2013b). In 2011, the Indigenous language most frequently reported by Indigenous people was Ojibway (Statistics Canada, 2013b).

Literature Review

The impact of colonization on the health and well-being of Indigenous peoples, including the effects of IGT and SUD, was an initial focus of the literature review in order to find solutions to these long-standing challenges and guide the implementation of healing strategies.

Furthermore, IHP and the concept of Two-Eyed Seeing were explored, as many scholars and researchers agreed that both approaches could bring healing of IGT and SUD (Duran, 2006; McCormick, 2009; Waldram, 2006). Finally, it was necessary to review existing treatment options with the possibility of blending mainstream and IHP.

Colonization of Aboriginal Peoples

The negative health outcomes experienced by Indigenous peoples may be understood as direct consequences of colonization. Most notably, these effects are seen in the multi-generational effects of the residential school system (Cote & Schissel, 2008; McCormick, 2009). Residential schools operated in Canada from 1831 (pre-confederation) through to 1969, though a few remained in operation until 1996. During this period, more than 150,000 First Nations, Métis and Inuit children were taken to residential schools, oftentimes forcibly, and isolated from their families, with the purpose of assimilating them into the dominant culture (Cote and Schissel, 2008; McCormick, 2009). These schools were operated by Christian churches but were also encouraged and financed by the Canadian federal government (Cote & Schissel, 2008). Milloy (1999) recounts that in many instances, inspectors found raw sewage in the children's sleeping and eating quarters and that despite this being reported to the authorities, little change occurred. Reports of inadequate standards of clothing and food were also common and demands by parents to return their children home to live in better conditions went unanswered (Milloy, 1999; Minister of Supply and Services Canada, 1996). Poorly trained and underpaid staff used harsh

physical discipline on the children, often leading to physical abuse (Milloy, 1999; Minister of Supply and Services Canada, 1996). Furthermore, staff encouraged and forced children to abandon their Indigenous culture and practices. The resulting loss of culture and language meant that many children were unable to participate in traditional activities, finding themselves in a marginalized position as neither fully Indigenous nor part of the mainstream (Cote & Schissel, 2008; McCormick, 2009).

The brutal experiences lived by the children in these schools were a continued force that began to shape the lives and parenting styles of the survivors of the residential school system (Milloy, 1999; Wesley-Esquimaux, & Smolewski, 2004). Many survivors suffered and struggled with identity issues in the years that followed their time in the residential school system (MacLaurin, et al., 2008). Internalized oppression became pervasive as they expressed hatred toward themselves, their culture, and their traditional values and beliefs (Milloy, 1999; Troniak, 2011; Waldram, 2006). Chansonneuve (2007) explained that some residential school survivors express their grief as lateral violence directed toward family and community members, thereby creating intergenerational cycles of abuse that resemble many of the experiences at the residential schools. The residential school trauma caused a disconnection from traditional values and cultural morals that caused further pain, suffering, and loss of hope. As a result, some Indigenous peoples turned to drugs and alcohol to numb the pain and suffering they endured (McCormick, 2009; Milloy, 1999).

To date, internalized oppression remains present in many communities; survivors struggle to cope with the pain and suffering caused by the trauma of their experiences (Gone, 2009; Linklater, 2010; Menzies, 2014). The first National Residential School Conference took place in the early 1990's, hosted by Charlene Belleau with 900 people in attendance (Hodgson,

2008). In 1994, the Assembly of First Nations published *Breaking the Silence: An Interpretive Study of Residential School Impact and Healing as Illustrated by the Stories of First Nation Individuals* (Assembly of First Nations, 1994). With the support of the Assembly of First Nations and Inuit organizations, many former residential school students took the federal government and many churches to court. Their cases led to the Indian Residential Schools Settlement Agreement—the largest class-action settlement in Canadian history. The agreement sought to begin to acknowledge the harm caused by residential schools (Assembly of First Nations, 1994, 2007).

On January 7, 1998, the Honorable Jane Stewart delivered a formal apology in the House of Commons to former residential school survivors, their families, and their communities for Canada's role in the operation of the schools, on behalf of the Government of Canada (Younging, Dewar, & DeGagné, 2009). Along with providing compensation to former students, the agreement called for the establishment of The Truth and Reconciliation Commission of Canada (TRC) with a budget of \$60 million over five years. During the six years of the Commission's existence, three commissioners heard more than 6,750 survivor and witness statements from across Canada. On June 2, 2015, the TRC released their findings in the *Truth and Reconciliation Report*. The report's mission was to inform Canadians about the 150-year history of the residential schools through the voices of those who lived it (The Truth and Reconciliation Commission, 2015). The hope is that the TRC Report will encourage healing, hope, understanding, and renewed relationships based on trust and respect.

Phillips (2007), an Indigenous mental health consultant, notes: "There is no doubt that many treatment options presented for our peoples have been totally culturally inadequate.... Cultural appropriateness for our peoples in the helping professions means going right back to our

own beliefs about medicine, sickness, worldview, and re-discovering our own healing ways and beliefs” (p. 20). Duran (2006) agrees with this approach, and advocates for the inclusion of the historical context and IHP in the treatment of IGT. Furthermore, there appears to be a lack of research into the treatment of IGT and SUD in Indigenous peoples (Gone, 2009; Menzies, 2014). This pilot project is intended to begin to address this gap and to provide an example of a blended approach for IGT and SUD in Indigenous peoples.

Historical and Intergenerational Trauma

Many authors suggest that one of the key consequences of the colonial influence on Canada's Indigenous peoples has been IGT as well as high rates of illness, depression, alcoholism, suicide, and violence (Bombay, Matheson, & Anisman, 2009; Kirmayer, et al., 2000; Haskell & Randall, 2009). The term ‘historical trauma’ is also referred to as cumulative trauma (Brave Heart, 1998), soul wound (Duran, 2006), and IGT (Oliver, 1993; Whitbeck, Chen, Hoyt, & Adams, 2004). The term historical trauma originated from the psychoanalytic literature and from the work and experiences of Holocaust survivors and their families. Danieli (1989), Erikson (1963), Fogelman (1988, 1991), Krystal (1984), van der Kolk (1987), and Wardi (1992) conducted research in the Holocaust field. This group of researchers and trauma therapists contributed extensively to the literature and the concepts of historical trauma. According to these experts, historical trauma (HT) refers to cumulative emotional and psychological wounding over an individual’s lifespan and across generations, emanating from massive group trauma experiences. IGT is the most common term used to describe the systematic trauma suffered by Indigenous peoples in Canada (Evans-Campbell, 2008; Haskell, 2009; Palacios & Portillo, 2009). IGT and the impact on the health and wellness of Indigenous peoples are discussed in

detail later in this chapter as well as in Chapter 2 (p. 54), Chapter 4 (p. 125-129) and Chapter 5 (p.175).

People who have been traumatized often lose a sense of the meaning of life, perceive themselves as hopeless, and experience periods of time in which they feel de-humanized (Briere & Scott, 2006; Courtois & Ford, 2009; Duran, 2006; Herman, 1997; Marsh, 2010). In other words, trauma destroys the deep bonds and connections individuals have with themselves, others, and the world. Such disconnection, incoherence and compromised nervous systems have an even greater effect on the traumatized individual's sense of community and belonging, causing further feelings of isolation, shame, guilt, and self-blame (Courtois & Ford, 2009; Drake, 2003; Duran, 1995; Herman, 1992; Marsh, 2010). Many scholars and researchers describe how IGT led to spiritual bankruptcy in Indigenous peoples. IGT is now seen as a precursor to poor coping skills, re-enactment of trauma, violence, suicide, poor decision-making and SUD (Brave Heart, 1998; Duran, 2006; Menzies, 2014; Thatcher, 2004; Waldram, 2006). The same scholars and researchers concur that recovery must provide Indigenous people with the skills to heal from IGT. The skills required to heal from IGT and subsequent recovery of identity can be enhanced by cultural practices, IHP, and the presence of Elders, as well as through traditional ceremony (Brave Heart, 1998; Duran, 2006; Menzies, 2014; Thatcher, 2004; Waldram, 2006).

Challenges of SUD in Aboriginal Peoples

The debilitating effects associated with IGT (e.g. Post-Traumatic Stress Disorder (PTSD), depression, anxiety, self-harm, suicide, and SUD) are coping mechanisms prevalent in Indigenous peoples (Bombay, et al., 2009). In this study, the term IGT is used rather than PTSD. Brave Heart (2004) stated that although PTSD is adequate to describe the depth and effects of cumulative trauma, it has limitations. Indigenous communities have identified SUD as one of

their greatest health challenges (Kirmayer, et al., 2009; Menzies, 2014; Maté, 2009; Waldram, 2006). According to the results of the *First Nations and Inuit Regional Health Survey*, the majority of survey respondents saw no improvement in the reduction of SUD despite the many efforts that have been made (Svenson & LaFontaine, 1999). For example, according to a report from Health Canada (2003), 73% of First Nations community members considered alcohol use to be a problem in their community, and 59% considered drug use to be a problem in their community. Moreover, one in five Indigenous youth reported having used solvents; of these, one in three were under the age of 15 years and more than half started using solvents before the age of 11. Furthermore, these SUD also co-existed with behavioral addictions such as gambling, compulsive eating, shopping, and sex (Chansonneuve, 2007; Chrisjohn & Young, 1997; Corrado and Cohen, 2003; Linklater, 2010).

Maté (2009) defines addiction as “repeated behaviour, substance related or not, in which a person feels compelled to persist, regardless of its negative impact on his life or the lives of others. The distinguishing features are: compulsion, preoccupation, impaired control, persistence, relapse and craving” (p. 214). In getting to the root of SUD and their consequences, Maté (2009) agrees with other scholars and researchers that IGT and its associated pain and symptoms must be treated integratively (Brave Heart, 1998; Duran, 2006; Maté, 2009).

According to Whitbeck, et al. (2008), the prevalence of substance abuse, behavioral problems, and depression in 2002 were approximately two times greater for Indigenous children aged 10 to 12 years old than had been found in a previous study of Indigenous children. In the 2005 follow-up data from this cohort of 651 children and youth (tribally enrolled on four American and four Canadian reserves) showed significant and troubling increases in the prevalence rates of substance abuse, depressive disorders, and other mental health problems

(Whitbeck, et al., 2008). The challenges of substance use in Indigenous people are discussed in detail in Chapter 2 (p. 54) and Chapter 4 (p. 125-129).

The need to address SUD issues in Indigenous communities led to a study by Jiwa, Kelly, and St. Pierre-Hansen (2008) that examined the development of cultural and community-based programs for Indigenous people. They found that the key components of success in SUD treatment for this population appeared to be community engagement and strong leadership from Chief and Council. They noted the importance of viewing SUD through a sociocultural lens, and advocated for a traditional cultural component in the treatment of SUD. Along these lines, several researchers agreed that culturally sensitive assessment tools and interventions are needed to enhance healing from SUD in Indigenous people (Duran, 1995; Whitbeck, et al., 2004; Kirmayer et al., 2000). It is also important to consider treating SUD and the effects of trauma concurrently, since they are so closely connected (Kirmayer, et al., 2000; Whitbeck, et al., 2004).

In a recent study that reviewed the literature on the use of interventions to treat SUD in Indigenous populations, Rowan et al. (2014) found 19 studies in the United States (58%) and Canada (42%) that integrated Western and culturally based services in both residential and outpatient programs. The authors reported that the results showed benefits in all areas of wellness, as well as a reduction in substance use in 74 percent of the studies (Rowan et al. (2014). There was considerable heterogeneity in the study design and interventions described. 17 types of cultural interventions were found, with sweat lodge ceremonies the most commonly (68%) enacted. Study samples ranged from 11 to 2,685 participants. Just over half of the studies involved quasi-experimental designs (53%). As well, most articles (90%) measured physical wellness, with fewer (37%) examining spiritual health. While these studies support the effectiveness of blending Western and Indigenous approaches to healing from SUD, none

addressed the treatment of trauma and SUD integratively. Since the SUD emerged as a coping strategy for the debilitating symptoms of IGT, addressing both disorders in treatment is crucial for healing (Menzies, 2014; Whitbeck, et al., 2004).

Attention to culture and/or IHP has been reported as a successful element in substance use programs designed for Indigenous people (Menzies, 2014; Tousignant & Sioui, 2009; Whitbeck, et al., 2004). For example, a quantitative study of a self-identity-enhancing approach to preventing substance use stressed the importance of enhancing self-concept through cultural affiliation (Parker, Jamous, Marek & Camacho, 1991). These authors found that urban Indigenous youth (14 to 19 years of age) who were engaged in cultural activities reported lower rates of substance use compared with a control group who did not engage in cultural practices (Parker, et al., 1991).

Boyd-Ball, Dishion, Myers, and Light (2011) examined the effects of psychopathological, peer, family, and cultural predictors of American Indian adolescents' drug use following inpatient treatment. Data regarding lifetime, 90 days prior to treatment, and one-year post-treatment substance use were collected using interviews, questionnaires, and observations of 57 American Indian adolescents and their families. Findings provided insight into the unique and shared risk and protective factors relevant to American Indian adolescents' substance use outcomes. This study suggests that a combination of family management and American Indian traditional cultural practices in families serves as a potential target for interventions to reduce substance use in adolescence (Boyd-Ball et al., 2011).

Indigenous Healing Practices and Models for the Treatment of IGT and SUD

The provision of effective treatments that incorporate IHP and Western treatments can be challenging. Some Western treatments focus mainly on the individual and exclude the holistic

view of mind, body and spirit. On the other hand, IHP emphasize connection, holism and spirituality (Duran, 2006; Hill, 2009; Voss, Douville, Little & Twiss, 1999). Some studies and scholars have shown that for Indigenous peoples, the most successful SUD treatment utilise IHP (Brave Heart 1998; Duran, 2006; Hill, 2009; La Framboise, Trimble, & Mohatt, 1990; Spicer, 2001).

IHP and philosophies are often utilized by Elders and traditional healers via the Medicine Wheel and the Seven Grandfather Teachings (Hill, 2009; Lavallée, 2009; McCormick, 2009; Menzies, 2014; Nabigon, 2006). Traditional ways of healing include sweat lodge ceremonies, smudging, drumming, sharing circles, and prayer (Duran, 2006; Lavallée, 2009; McCormick, 2009; Menzies, 2014). The use and effects of culturally based approaches are discussed in greater detail in Chapter 3 (p. 95-101) and Chapter 4 (p. 136-144). Furthermore, Indigenous Elders teach that well-being is achieved through the balance of the four main components of human existence. These include the physical, emotional, spiritual and mental and are often depicted in the Medicine Wheel (Lavallée, 2008; Nabigon, 2006; Vickers, 1993).

Some researchers have suggested that the key to healing, following the experience of residential school abuse and its intergenerational effects, lies in the area of reclaiming identity (Smith, 1999; Waldram, 1997; Warry, 2008). Furthermore, some authors concur that reclaiming Indigenous identity means recovering traditional values, language, beliefs, philosophies, ideologies and approaches and adapting them to the needs of today (Duran, 1995; Gagne, 1998; McCormick, 1996; Proulx & Perrault, 2000). Recovering the traditional aspects of Indigenous identity cannot be divorced from Indigenous spirituality, which is premised on the principles of trust, sharing, respect, honour, and acceptance. Spirituality has sustained Indigenous people throughout their existence, including the period prior to colonization and the introduction of

residential schools (Brasfield, 2001; Grant, 1996). When discussing Indigenous knowledge systems and spirituality, a focus on IHP is paramount because of the large-scale suppression of Indigenous cultural and spiritual expression during the colonization process (Duran, 2006; Porsanger, 2004; Rice, 2005; Tousignant & Sioui, 2009).

Indigenous cultures and communities carry many spiritual and IHP to help traumatized people heal (Duran, 2006; Linklater, 2010; Mehl-Madrona, 1998). The challenges Indigenous communities face to date with SUD and the new opioid addiction epidemic has devastated many families (Grand Chief Metatawabin, 2012; Menzies, 2014; Stewart, 2008; Whitbeck, 2004). In spite of these challenges, there are many communities that have created sustaining programs in their communities. One such example is the Alkali Lake (Esketemc), a Shuswap First Nation with over 35 years experience in addictions prevention and intervention programming. Their long experience in effective prevention and intervention demonstrates the crucial importance of getting at underlying issues such as child abuse in order to stop intergenerational patterns of addictive behaviours. Prior to 1940, this community of 400 in North-central British Columbia did not have an addictions problem. The introduction of alcohol by colonizers and the traumatic impacts of residential school abuse created this crisis. “By the 1960s, the community was immersed in the culture of alcoholism” (Four Worlds International Institute, 1998; p4).

In response to this challenge, Alkali Lake First Nation established a comprehensive community healing model to address SUD and the sexual abuse challenges. Actions taken by this community’s members included: stopping all liquor sales on reserve; arresting bootleggers; and the creation of a system where food vouchers were distributed to members who spent their welfare money on alcohol. Community members who committed alcohol-related crimes could choose between jail or residential treatment (Chansonneuve, 2007). Traditional healers were

brought in from different Indigenous communities and offered traditional healing to help with the IGT, loss of identity and the recovery of spirituality. The community also started sweat lodge and pipe ceremonies, which had been lost for many years. Other supports included healing circles and Alcoholics Anonymous (AA) meetings. New employment initiatives were created for members who went to treatment. In two years, 30 community members in Alkali Lake First Nation had received treatment. After three years, 40 percent of the community was substance free. After seven years, 98 percent of the community members were substance free, and after 13 years, the community achieved full employment (Four Worlds International Institute, 1998).

The Community Holistic Circle Healing (CHCH) process in Hollow Water, established in 1985 provides another example of successful community-based treatment. Arguably, this community has, the most mature healing process in Canada and addresses the needs of both sexual assault victims and victimizers (Buller, 2013). Buller, 2013 writes, “Valdie Seymour and Berma Bushie are two of the founders from a First Nation of 700 people on the Eastern shore of Lake Winnipeg. In the mid-1980s, Hollow Water discovered a solution to sexual assault in the power of healing circles. They began with a resource team of 24, wherein the members of which openly shared their painful personal stories with each other” (p. 293).

Phelan (1998) writes, “In search of help, 20 community members travelled to Alkali Lake, B.C. in 1988. By this time, Alkali Lake was renowned for having turned around an adult population of which 95 per cent were said to be abusing alcohol to the point where 95 per cent were considered "recovering" alcoholics. When the Hollow Water group returned from Alkali Lake, it conducted a week-long stretch of workshops to share personal stories about victimization. Soon, there was a flood of 17 disclosures from children of current abuse cases” (p. 15). Phelan (1998) claims, “Hollow Water concentrated on setting up an alternative as opposed

to reporting all of the community members. Restorative justice such as this has immense power over an offender because the truth is part of healing” (p. 15). In the Western world, the justice system does not operate at the spiritual, emotional, or social levels. The evaluation of CHCH approach has shown that community healing processes have real potential to use traditional values, culture, and spiritual practices to improve treatment for offenders, their victims, families and the community. For example, substance use has almost stopped in the older population and this has encouraged the community in addressing drug abuse among youth to heal from their SUD. Also the overall health of individuals fares well against the average Manitoban. In addition, community awareness has been heightened about proper nutrition and life expectancy has risen from 63 to 70 years (Buller, 2013).

In 1975 the National Alcohol and Drug Abuse Program (NNADAP) was established as a pilot project. This program was created because of the “urgent and visible nature of alcohol and drug abuse among First Nations and Inuit people” (NNAPF, 2000; p11). Seven years later the program received permanent funding from the Federal government. This program has been extremely successful and, through the NNADAP renewal framework report, many communities have also implemented the harm reduction approach to SUD. This shift was especially important in programming for clients whose physical and mental health was badly compromised due to SUD. According to NNADAP, the advantage of this approach is that, “Small gains can save lives in the short run and serve as the point of departure on a new, less risky and more healthy path through the future” (NNAPF, 2000; p30). The abstinence orientation of many decision-makers and treatment staff has been identified as a major barrier in moving towards a harm reduction model for SUD (NNAPF, 2000).

Gone (2009) conducted a study with eight staff and 11 clients in a Native American

healing lodge. He interviewed participants regarding the therapeutic approach used to address the legacy of Native American historical trauma. On the basis of thematic content analysis of interviews, four components of healing discourse emerged from these interviews. Gone (2009) claims;

“First, clients were understood by their counsellors to carry pain, leading to adult dysfunction, including substance use. Counsellors believed in confession of pain in order to discharge the trauma and remove the influence. Third, the cathartic expression of this pain was said by counsellors to enhance lifelong changes of self-examination and self-improvement. And finally, the counsellors’ inclusion of Indigenous heritage, identity, and spirituality was believed to relieve and heal the pathogenic effects of colonization” (p19).

It was concluded that this healing intervention was one profound way for psychologists to bridge evidence-based and culturally sensitive treatment paradigms. Also, that it was important for Western and Indigenous researchers to partner with Indigenous programs to measure culturally sensitive interventions (Gone, 2009).

A few case studies report the incorporation of healing rituals into conventional counselling and treatment interventions (Brave Heart, 1998; Duran, 2006; Outanova & Moodley, 2010; Robbins & Dewar, 2011). Scholars, traditional healers, and Elders encourage and utilize integration; however, some feel that these approaches require additional scientific evidence to support their use (Martin-Hill, 2003; Poonwassie, 2006; Rojas & Stunley, 2014). Currently, Indigenous people and communities are challenged by the substantial service gaps in areas such as withdrawal management, trauma treatment, aftercare, and psychiatric care (Hart, 2010; Menzies, 2014; Spittal, et al., 2007). Given the fact that Indigenous people experience significantly higher rates of mental health problems than the general population, the need for

appropriate services is crucial.

Mainstream Treatment of IGT and SUD

It has been estimated that a history of traumatic experiences is very common among people with SUD, being present in as many as 55 to 99 percent (Driessen, et al., 2008; Hien, et al., 2009; Najavits & Hein, 2013). Furthermore, high rates of PTSD have been found among SUD patients (Hien et al., 2009; Spittal, et al., 2007). These high rates of co-morbidity suggest that there is a connection between the two disorders (Driessen et al., 2008; Hien et al., 2009; Najavits & Hien, 2013; Spittal, et al., 2007). Some studies describe pathways that are related to both disorders such as the “self-medication hypothesis” in which PTSD precedes SUD (Bremner, Darnell & Charney, 1996; Cottler, Compton, Mager, Spitznagel, & Janca, 1992). It is now evident that both disorders share the same neurobiological systems and that SUD could increase the chances of developing PTSD and vice versa, that PTSD increases the likelihood of SUD (Brady, Back & Coffey, 2004). There appears to be a link between re-traumatization and SUD (Driessen et al., 2008; Haskell, 2009; Spittal, et al., 2007). For example, an intoxicated person would not be able and alert enough to detect any danger signs from the brain and would therefore be more vulnerable to re-traumatization (Chilcoat, & Menard, 2003; Krystal, 1984).

In a recent study that reviewed the literature on the use of interventions to treat PTSD in various populations, Forneris, et al. (2013) explored 19 studies that covered various populations, traumas, and interventions. They found that in a meta-analysis of three trials (from the same team) for people with acute stress disorder, brief trauma-focused cognitive behavioral therapy was more effective than supportive counselling in reducing the severity of PTSD symptoms (moderate strength); these two interventions had similar results for incidence of PTSD (low strength); depression severity (low strength); and anxiety severity (moderate strength). PTSD

symptom severity after injury decreased more with collaborative care than with usual care (single study; low strength). The authors also reported that debriefing did not reduce incidence or severity of PTSD or psychological symptoms in civilian traumas (low strength). They found that evidence about relevant outcomes was unavailable for many interventions or was insufficient owing to methodological shortcomings. Furthermore, they concluded that evidence is very limited regarding best practices to treat trauma-exposed individuals. They stated that brief cognitive behavioral therapy may reduce PTSD symptom severity in people with acute stress disorder and that collaborative care could help decrease symptom severity post-injury (Forneris et al., 2013). The literature for co-occurring PTSD and SUD is, however, quite limited (Chilcoat, & Menard, 2003; Forneris, et al., 2013; Gatz, et al., 2007).

Several trauma-specific treatments have been developed or adapted for women with co-occurring SUD and PTSD. One such model is the Trauma Recovery and Empowerment Model (TREM). In a quasi-experimental study, Troussant, VanDerMark, Borneman and Groeber (2007) used the modified TREM model to treat women (n=170) in an existing residential SUD program. 190 women were recruited and 64 were assigned to TREM and 106 to treatment-as-usual (TAU). A total of 170 women completed the study. The results showed that the women in the TREM arm showed significantly better outcomes than those in the TAU arm on trauma-related symptoms (Toussaint, et al., 2007).

In a randomized controlled trial (RCT), van Dam, Ehring, Vedel and Emmelkamp (2013) investigated the effectiveness of a combined treatment for co-morbid PTSD and SUD. Structured Writing Therapy (SWT) for PTSD, an evidence-based trauma focused intervention, was added on to treatment-as-usual (TAU), consisting of an intensive cognitive behavioral inpatient or day-group treatment for SUD. The outcomes of the combined treatment (TAU and SWT) were

compared to TAU alone in a sample of 34 patients. Results showed a general reduction of SUD symptoms for both TAU and SWT, and TAU. The authors concluded that even with this small sample size and the indirect nature of findings, the outcomes of this study support continued investigations on trauma-focused treatment for patients with concurrent PTSD and SUD (van Dam et al., 2013).

Lenz, Henesy & Callendar (2016), in a recent study, evaluated the effectiveness of the SS program for the treatment of SUD and PTSD. In this meta-analysis their search of the literature identified 47 candidate articles, dissertations and theses that needed further review. Through an inclusion and exclusion criteria they selected 12 (10 peer-review publications, and two doctoral dissertations). The number of participants yielded was 1,997; of this number, 846 participants received SS as the primary treatment, 995 participants received alternative treatment and 196 received no treatment and were assigned to a waiting list. Participants were predominantly adults ($n = 1,965$, 98%) who were ethnic minorities ($n = 1,174$, 59%) and were receiving treatment for symptoms related to multiple types of traumatic experiences ($n = 1,763$, 88%) (Lenz, et al., 2016). In this meta-analysis it was found that the SS intervention was more effective for the treatment of both SUD and PTSD than the alternative treatments. Mainstream SUD and PTSD treatment programs such as SS have been found to be effective in a variety of settings, but had not been previously evaluated with Indigenous clients.

SS is a manualized psycho-educational counselling program that targets the unique problems resulting from struggling with SUD or trauma. The program aims to increase the coping skills of participants with the goal of reducing the chance of relapse by emphasizing values such as respect, care, integration, and healing of self (Najavits, 2007). In this program, participants work to reduce suicidal and self-harming thoughts and behaviours, including the

urge to use substances and engage in other unsafe behaviours. They also work to remove themselves from unhealthful relationships to gain a sense of control and healing (Najavits, 2002a). Participants develop skills such as grounding, joining the present, and changing what can be changed to reduce the severity of their urge to self-harm (Najavits, 2009). The primary goals of treatment are abstinence from substances and acquiring coping skills to obtain personal safety (Najavits, 2002a).

SS has been used successfully among many minority populations, including African-Americans, Hispanics, and Asian Americans, as well as challenging populations (e.g., the homeless, prisoners, adolescents, public-sector clients, and veterans). The model has also been translated into numerous languages with international implementation (Najavits 2002a, 2007, 2009; Najavits & Hein, 2013).

The SS model includes spiritual discussions through the offering of a philosophical quote at the beginning of the group sessions (Najavits, 2007; Najavits & Hein, 2013), as well as discussions about safety, cultural continuity, gentle language, and teachings about the genesis of IGT and SUD (Najavits, 2002a; Najavits & Hein, 2013). SS incorporates the inclusion of the mind, body, spirit, and self-awareness during treatment, as well as connection to community through emphasis on the utilization of community resources. Specifically, this model was chosen because it offered an individually empowering approach to the treatment of trauma and SUD (Najavits, 2002). This empowering approach and inclusion of spirituality suggested the feasibility of combining SS and IHP.

Effectiveness of Seeking Safety

Research shows that multiple forms of SS have been effective when delivered in a group or with individuals, with individuals from marginalized populations, or via inpatient or outpatient

services (Hien, et al., 2010; Hien, et al., 2015). The International Society for Traumatic Stress Studies (ISTSS) Practice Guidelines (2009) recognized SS as an effective treatment model currently available for PTSD and SUD. This recommendation was based on 12 studies ranked as Level A to C in the ISTSS expert review process (International Society for Traumatic Stress Studies Practice Guidelines, 2009). These studies included a range of participant groups from adolescents, homeless, veterans, prisoners and others (Cook, et al., 2006; Hien et al., 2009; Hein, et al., 2015; Najavits, Schmitz, Gotthardt, & Weiss, 2005; Najavits, Weiss, Shaw & Muenz, 1998; Weller, 2005; Zlotnick, Johnson, Najavits, 2009). The flexibility of SS to be adapted to different settings, populations and delivery methods suggested the feasibility of combining SS and IHP.

The perspective of SS is convergent with Indigenous traditional methods. Because of the content and delivery method of SS, the program complements traditional teachings such as holism, relational connection, spirituality, cultural presence, honesty, and respect (Gone, 2008; Lavallée, 2009; Menzies, 2014). Specifically, this model was chosen, over other Western approaches, because it offered an individually empowering approach to the treatment of trauma and SUD, allowed for open discussion of spirituality, could be delivered in an outpatient setting and had previously been shown to be effective after adaptation for different populations (Najavits, 2002a).

Why a Blended Approach for this Pilot Implementation Project?

Many substance use measures are currently in use in Indigenous communities, including restricted and dry communities, IHP, counselling services, AA self-help groups and residential treatment programs. Despite these measures, the challenges with SUD in many Indigenous communities persist. These problems include overdose deaths, accidents, violence, injuries,

kidney and liver failure, fractures etc. (Grand Chief Mike Metatawabin, 2012). On February 6, 2012, Matawa First Nations reported that almost 2000 people have an opioid addiction in Matawa First Nation communities alone. On January 23, 2012, Chief Matthew Keewaykapow of Cat Lake First Nation declared a State of emergency due to widespread opioid addiction reaching 70 percent of his community members, ranging in age as young as 11 years to over 60 years. With a total population of 25,000 in Sioux Lookout Zone alone, at least 9,000 community members were impacted (Grand Chief Mike Metatawabin, 2012).

There is also a direct link between SUD and suicide in these communities (Chandler & Lalonde, 1998; Menzies, 2014). Many Indigenous Elders, leaders and traditional healers concur that it is important to blend Western and Indigenous treatment programs to resolve these challenges (Duran, 2006; Gone, 2009; Hill, 2009; Menzies). The new drug epidemic with prescription opioids, such as OxyContin, is causing even greater devastation to communities. This epidemic is claiming the lives of many Indigenous young people (Grand Chief Mike Metatawabin, 2012). Traditional healer Jennifer Ashawasegai from Henvey Inlet First Nations agrees that the traditional healers and Elders are working diligently to support healing in their communities, but they also need the help of the Western treatments such as Methadone, Suboxone, counselling, education and other forms of harm reduction strategies to help people heal. She said that the time has come that Western and Indigenous treatment programs work side-by-side with respect for each other. Furthermore, she concurred that Elders and teachers need to be updated with new knowledge and wisdom about the physiological effects of IGT and SUD (J. Ashawasegai; J. Ozawagosh & F. Ozawagosh, personal conversation, March 9, 2016).

Given that the literature suggests that IHP are the most effective treatments for Indigenous people with SUD and IGT (Brave Heart 1998; Duran, 2006; Hill, 2009; La

Framboise, Trimble, & Mohatt, 1990; Spicer, 2001; Lavallée, 2009; McCormick, 2009; Menzies, 2014; Nabigon, 2006) and that SS has been demonstrated to be effective in a range of other populations, the idea to blend the two approaches, IHP and SS, was considered as an option for this thesis. SS was chosen because of the integration of SUD and trauma treatment, the demonstrated flexibility to adapt the model, the inclusion of spirituality, the empowerment focus and the range of previous research (Najavits, et al., 1998; Najavits, 2002; Najavits & Hien, 2013). Moreover, the delivery model of a set number, frequency and length of outpatient sessions of SS was seen as a feasible structure within which to deliver significant quantity and quality of IHP in a structured intervention that could reasonably be assessed during the timeframe of this thesis project. Finally, the researcher had a familiarity with the SS and felt it was worthy of exploring the blending of IHP and SS.

Frameworks and Research Questions

The Indigenous theoretical framework that guided and informed the development of this research was the Medicine Wheel. The Medicine Wheel has many different meanings and uses (Nabigon, 2006; Menzies, 2014). For example, The Medicine Wheel teachings are based on a circular pattern and cyclical set of four: the four Seasons, the four stages of Life, the four Biopsychosocial and spiritual aspects of a person and the four directions. The circle also depicts balance, and illustrates that everything is interconnected and part of one cosmic whole. Throughout this project, the Elders encouraged the use of the Medicine Wheel to outline the research process as well as to depict the concept of Two-Eyed Seeing (J. Ozawagosh & F. Ozawagosh, personal conversation, January 5, 2013) (See Figures 1-1, p. 29 and Figure 1, p. 170). Used by many Indigenous communities, the Medicine Wheel also describes health, wellness, and balance (Nabigon, 2006; Menzies, 2014). The application of the concept of Two-

Eyed Seeing advocates for inclusion, trust, respect, collaboration, understanding, and acceptance of the strengths that reside in both Western and Indigenous worldviews (Iwama et al., 2009).

Two-Eyed Seeing encourages Indigenous people, health-care providers, and researchers to develop a relationship of mutual cultural respect, wherein the benefits of both worldviews are acknowledged as beneficial in the healing processes (Bartlett, 2009; Iwama, et al., 2009). The Two-Eyed Seeing approach supports Indigenous and decolonizing methodologies utilized in this study.

The decolonization process encourages Indigenous people to reclaim their Indigeneity and, in doing so, regain their power (Hart, 2010; Kovach, 2009; Wilson, 2008). Decolonization is further described as Indigenous people embracing an understanding of the history of colonization and rediscovering their ancestral traditions and cultural values (Duran, 2006; Hart, 2010; Wilson, 2008). The decolonization process consists of a healing journey that may involve grief, anger, rage, growth, and empowerment, coupled with the realization that bondage still exists today (Liamputting, 2010; Smith, 1999; Wilson, 2008). Decolonization encourages Indigenous people to regain their right to self-determination, not only from an economic or political viewpoint, but also with respect to research (Bombay, et al., 2009; Crazy Bull, 1997a; Duran, 2006; Smith, 1999; Wilson, 2008).

During this project, the Elders and advisory group sought reassurance that the Western treatment would not dominate the traditional approaches in the blended approach. The teachings that emerged from this for me as an Indigenous student and researcher were that I was doing research with the people for the people and that, in itself, is decolonizing. Working with Western researchers and Elders together could bring teachings to the Western researchers as to how Indigenous peoples need to be treated and respected. The Elders and traditional healers agreed

throughout this project that this respect was maintained, as demonstrated in subsequent chapters. Traditional healer Heather MacDonald clearly taught me that traditional knowledge and ways of knowing already are present in the Indigenous people. Therefore, bringing in Western wisdom to enhance the healing of peoples was positive as long as it is done with respect and kindness. She also indicated that this process could be a movement toward decolonization because the inclusion of others brings back connection that was lost. She further stated that the Elders taught that Indigenous peoples must be inclusive and respectful to all people on this earth. Furthermore, she concurred that decolonization is a process that needs to unfold gently (H. MacDonald, personal conversation, March 10, 2016).

The review of literature and the decision to use an Indigenous decolonizing methodology led to the research question: Can IHP incorporated into Najavits' (2002a) SS integrative substance use and PTSD treatment model be a feasible, suitable, and beneficial group treatment for trauma and SUD in Indigenous women and men in Northeastern Ontario, Canada? The comprehensive development, implementation, and evaluation of this research was initiated in 2012 through to 2014. This process was guided by a comprehensive methodology and research design.

Research Design Overview

Adherence to cultural ethics and protocols guided this mixed-methods approach, utilizing both quantitative and qualitative inquiry. It was also critical to conduct this research in an honorable, honest, respectful and humble manner. Cultural informants (Elders, an Indigenous advisory group, Indigenous scholars and clinicians) were invited into this process as consultants and experts. The teachings, wisdom, guidance and feedback of these experts were critical to the success of this research. Following is a brief overview of the methodological process of this

project; further design features and details relevant to each phase are provided in subsequent chapters:

1. Consultation with cultural informants and collaboration with Elders
2. Establishment of an Indigenous advisory group
3. Incorporation of IHP throughout the research process (See also Chapter 3, p. 95-101).

These included:

- a. Training of Indigenous facilitators in the application of the IHPSS implementation project
- b. Recruitment of participants
- c. Implementation of the blended project through 25 sharing circles over three months (September 2013 to December 2013)
- d. Collection of qualitative data via semi-structured interviews and end-of-treatment focus groups
- e. Collection of quantitative data pre- and post-implementation using the following assessment tools: the Addiction Severity Index-Lite (ASI-Lite), the Trauma Symptom Checklist-40 (TSC-40), the Historical Loss Scale (HLS) and the Historical Loss Associated Symptom Scale (HLASS). (See also Chapter 3, p. 95-101). (See also Chapter 5, p. 183-188).

The Two Program Delivery Sites

This research took place at two sites in downtown Sudbury. The N'Swakamok Native Friendship provides programs and services to assist with meeting the social, cultural, and recreational needs of the urban Indigenous community. The second site, the Rockhaven Recovery Home for Men, delivers a residential/in-patient recovery program that aims to

empower Indigenous and non-Indigenous men to develop a personal program of recovery from substance use disorders. Forty percent of the men Rockhaven serves are of Indigenous ancestry (Patricia Delyea, personal conversation, April 15, 2013). These sites were chosen because they serve Indigenous people struggling with IGT and SUD challenges; in addition, both sites employed mental health and addiction counsellors as well as offering social support. Furthermore, The Elders, Indigenous advisory group and community members agreed that these sites would attract the people who needed the culturally relevant programming.

Participants

A convenience sampling approach was used to recruit 24 participants (12 women and 12 men) who self-identified as Indigenous and were seeking treatment for SUD. All participants resided off reserve in Northern Ontario and were between the ages of 24 and 68 years (with an average age of 35 years). Of the 24 participants, 16 identified as Ojibway, two as Cree, and six as Métis. A mixed-methods design was used to evaluate the impact of a 13-week IHPSS implementation project with one group of 12 Indigenous women and one group of 12 Indigenous men ($n = 24$) in Northern Ontario. Details relevant to each phase are provided in subsequent chapters.

Ethical Considerations

This research was in keeping with the Canadian Institutes of Health Research (2011) *Guidelines for Research Involving Aboriginal People* and the *Tri-Council Policy Statement for Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, et al., 2011). The study received approval from Laurentian University's Ethics Board in May 2013. Appendices A, B, C, D, and E contain copies of the Research Information and Consent Form

used for the sharing circles, the written (signed) Research Information and Consent Form, Research Ethics Approval and the letter sent to the participants.

Over the past four years, I connected with many Indigenous professionals, clinicians, Elders, Traditional healers, community members and the director of N'Swakamok Native Friendship Centre. They providing step-by-step guidance during this research project and they made sure that all pertinent traditional protocols were followed. Furthermore, during the initial stages of the research process, the cultural informants informed me that I had their full support for this project and that they accepted the above ethics approval.

Two-Eyed Seeing Blended Approach as Conceptualized in the Medicine Wheel

The Elders and Indigenous advisory group recommended the use of the Medicine Wheel to depict the concept of Two-Eyed Seeing (see Figure 1-1 on page 32). The Medicine Wheel was adapted by adding a SS circle to depict how the Western knowledge was blended with an already strengths-based IHP framework. Traditional healers and Elders agree that the support of the Western knowledge to treat IGT and SUD can help bring resolution and strength to people that are struggling with both disorders or who are trapped in the substance use cycle (J. Ozawagosh & F. Ozawagosh; J. Ashawasegai; H. MacDonald personal conversations, March 9, 2016). The second outer circle embraces IHP and shows how they can be applied to all people with the guidance of teachers, Elders, and the Seven Grandfather Teachings.

The four quadrants in the Medicine Wheel represent wisdom, the stages of life, Indigenous teachings, and connectedness (Vickers, 1993). Furthermore, the researcher or clinician can utilize the knowledge of each quadrant as a guide for the Two-Eyed Seeing approach. For example, the east quadrant represents spring, new beginnings, childhood, and a time for new ideas. When beginning a research project involving Indigenous people, the

researcher must be guided by the teachings of Elders, an Indigenous advisory group, and the community. Indigenous facilitators and community members must be included in the process from beginning to end.

The south quadrant represents summer, maturing, growing into adulthood, transformation and integration, and accepting knowledge and change. This quadrant could guide the researcher or clinician to begin the preparation for the implementation of the Two-Eyed Seeing and SS sharing circles.

The west quadrant represents spring, adulthood, sunset, a new awareness, and a time of preparation, as well as family and responsibility. The west can serve as a guide for the Elders, Indigenous advisory groups, researchers, and facilitators during data analysis and drafting the research papers.

The north quadrant represents winter, old age, purity, wisdom, a great place for healing and the wisdom that was given. This quadrant could guide the researcher or clinician to write and talk and teach about the outcome and gains of this research project.

Another adaptation was the adding of two inner circles. The first one depicts the research process. Finally, the inner circle represents Indigenous people, the community, and the Elders as the most important reason for this integration and blending of Indigenous and Western knowledge. This also honours Elder Albert, who taught that Two-Eyed Seeing is the gift of multiple perspectives treasured and respected by many Indigenous people.

Article and Chapter Overview

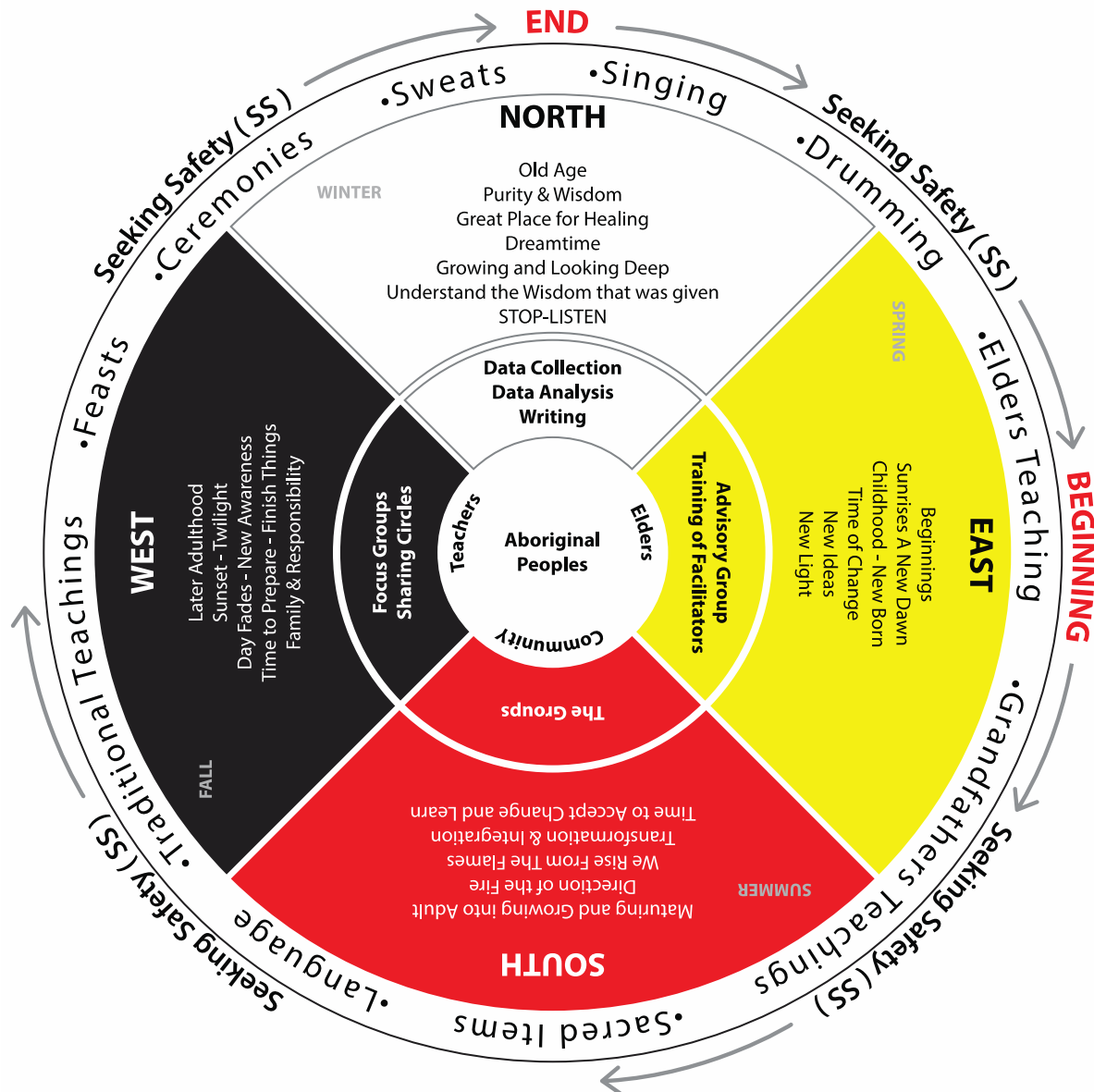
This thesis has presented the findings of a single coordinated research effort, which has been prepared for publication in the peer-reviewed press. Chapters 2 to 5 represent discrete manuscripts, which were written for publication in the peer-reviewed literature. As each chapter

was written to the length and content requirements of different journals, there is some variation in style; however, they are presented in a common format including approach to reference citation for inclusion in the thesis. Table 1-1 provides a summary of the content of each chapter and the relationship to the individual papers. The research presented here was conducted over four years (2012-2015). This introductory chapter has presented the thesis overview and a literature review (Chapter 1). Chapter 2 explores the feasibility of blending Indigenous healing practices with a Western treatment model SS. Chapter 3 focuses on the methodological approach including Two-Eyed Seeing, an Indigenous methodology and decolonizing approach (Chapter 3; Appendices A, B, C, D, E). This is followed by the key qualitative findings (Chapter 4). The quantitative findings of the research appear in (Chapter 5). Chapter 6 presents an overall discussion of the research process and findings that allows a deeper exploration of the relationship between this research and previous published studies as well as comments on knowledge translation and study limitations, future research directions, and a conclusion summarizing the significance and relevance of the findings.

Table 1-1: Overview of Thesis Chapters and Corresponding Integrated Articles

Chapter 1	Introduction to thesis & Literature Review
Chapter 2	Explores the feasibility of blending IHP with a Western treatment model SS.
Chapter 3	Presents the methods used to conduct this IHPSS pilot project.
Chapter 4	Presents the qualitative results of IHPSS pilot project.
Chapter 5	Presents the quantitative results of IHPSS pilot project.
Chapter 6	Discussion and conclusion of thesis

Figure 1-1: Two-Eyed Seeing Blended Approach to Delivering the IHPSS Implementation Project Conceptualized in the Medicine Wheel



Adapted from J. R. Vickers. Medicine Wheels: A Mystery in Stone. *Alberta Past* 8 (3): 6-7, Winter 1992-93.

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Chapter 2: Blending Aboriginal and Western Healing Methods to Treat Intergenerational Trauma with Substance Use Disorders in Aboriginal Peoples Who Live in Northeastern Ontario, Canada

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Marsh, T.N., Coholic, D., Cote-Meek, S., Najavits, L.M., (2015). Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in northeastern Ontario, Canada. *Harm Reduction Journal*, 12 (1), 1-12.

Context for the Article:

This chapter is the first integrated article (with reference style changed from Vancouver to APA), and it explores the feasibility of blending Aboriginal healing practices with a Western treatment model called “Seeking Safety” to address issues of self-identified intergenerational trauma with substance use disorders in Aboriginal peoples, utilizing the concept of “Two-Eyed Seeing.” Two-Eyed Seeing is a philosophical, theoretical, and/or methodological approach that recognizes the need for both Western and Indigenous ways of knowing in research, knowledge translation, and program development. Considering the particular health needs of Aboriginal peoples, this chapter explores Aboriginal and Western treatments that address both intergenerational trauma and addiction, and the practicality of using the Seeking Safety group intervention as a part of a Two-Eyed Seeing approach to treatment. Figure 1-1 depicts this Two-Eyed Seeing concept and provides a description of Seeking Safety conceptualized in the Medicine Wheel.

Abstract

As with many Indigenous groups around the world, Aboriginal communities in Canada face significant challenges with trauma and substance use. The complexity of symptoms that accompanies intergenerational trauma and substance use disorders represent major challenges in the treatment of both. There appears to be an underutilization of substance use and mental health services, substantial client dropout rates, and an increase in HIV infections in Aboriginal communities in Canada. The aim of this paper is to explore and evaluate current literature to explore whether or not traditional Aboriginal healing methods and the Western treatment model “Seeking Safety” could be blended to help Aboriginal peoples heal from intergenerational trauma and substance use disorders. A literature search was conducted using the key words intergenerational trauma, historical trauma, Seeking Safety, substance use, Two-Eyed Seeing, Aboriginal spirituality, and Aboriginal traditional healing practices. In the literature review of Indigenous knowledge, most Indigenous scholars proposed that the wellness of an Aboriginal community can be adequately measured only from within an Indigenous knowledge framework that is holistic, inclusive, and respectful of the balance between the spiritual, emotional, physical, and social realms. Their findings indicate that treatment interventions must honour the historical context and history of all Indigenous peoples. Furthermore, there appears to be sufficient evidence that strengthening cultural identity, community integration, and political empowerment can enhance and improve mental health and substance use disorders in Aboriginal populations. In addition, Seeking Safety was highlighted as a well-studied model with most populations, resulting in excellent healing. The recommendations provided seek to improve the treatment and healing of Aboriginal peoples presenting with intergenerational trauma and addiction. Other recommendations include the input of qualitative and quantitative research as well as studies

encouraging Aboriginal peoples to explore treatments that could specifically enhance health in their respective communities.

Keywords: PTSD, substance abuse, intergenerational trauma, historical trauma, Two-Eyed Seeing, Seeking Safety, Aboriginal traditional healing practices, residential school, healing, Aboriginal care.

Introduction

Research with Aboriginal peoples is based on relational responsibility, as well as how the researcher relates to the participants. Relational accountability implies that all parts of the research process are related, from inspiration to expiration, and that the researcher is not only responsible for nurturing and maintaining this relationship, but also for “all your relations” (Steinhauer, 2002). As an Indigenous woman and not Aboriginal, the first author consulted with a number of Aboriginal researchers and scholars throughout this project—at inception, during research, and while writing this manuscript. She met with several Elders on a weekly basis for one year at the Atikameksheng Anishnawbek (Whitefish Lake) reserve in Sudbury with the goal of learning more about Aboriginal communities. She learned that Elders were the carriers of knowledge of both physical and spiritual reality and that they have been educated through the oral tradition. Elders carry credentials that are recognizable in Aboriginal society, especially regarding ethics and proper protocols (Brant Castellano, 2004). On the advice given to her by the Elders, she established an Aboriginal advisory group to help guide her through the research process and teachings about doing research with Aboriginal peoples as well as writing this review paper. She continued to meet with the advisory group on a monthly basis. In addition, the first author worked with an Aboriginal supervisor and one Aboriginal committee member who both reside in Sudbury and are members of Aboriginal communities.

While Aboriginal peoples in Canada share the experiences of colonization and the destruction of their cultural practices, it is important to avoid generalizations, as there are three distinct groups of Aboriginal peoples in Canada with unique geographic and linguistic heritages, many subcultures, cultural practices, and spiritual beliefs (Macaulay, 2009). There are currently 1.2 million Aboriginal people residing in Canada, of whom 61% are First Nations, 34% are

Métis, and 5% are Inuit (Statistics Canada, 2008). In this paper, the term “Aboriginal” refers to First Nations (status and non-status Indians), Métis, and Inuit people as referenced in the Canadian Constitution. The term “Indigenous” is used interchangeably with “Aboriginal,” particularly in international contexts. We use the term “Aboriginal peoples” as a way to respect and acknowledge their shared values, historical residential school experiences, and contemporary struggles with the aftermath of colonization and oppression. In doing so, we also acknowledge the strength and resilience of the Aboriginal peoples in Canada.

Many Aboriginal peoples suffer from intergenerational trauma caused by more than 400 years of systematic marginalization. According to Gagne (1998), intergenerational trauma is the transmission of historical oppression and its negative consequences across generations. Brave Heart (1998) explored the concept of intergenerational trauma in her study of the Lakota people. She concluded that most participants in the study displayed many symptoms related to trauma, and she agreed with other researchers that trauma experienced by more than one generation becomes institutionalized within the family and community (Brave Heart, 1998). This type of group trauma, both cumulative and psychological, can have a profound impact on health and has been proven to affect the lifespan of not only an individual but the lifespans of generations that follow (Brave Heart-Jordan & DeBruyn, 1995).

According to Duran (1990) (see also Martin-Hill, 2003; Smylie, 2011), Aboriginal peoples underutilize available mental health and addiction services. There are also significant treatment dropout rates for those who do seek care and support. Concern has been raised that Western treatments and conventional psychology have failed to address the needs of Aboriginal peoples because they do not understand traditional spiritual and healing methods that continue to persist in many Aboriginal communities (Cote & Schissel, 2008; Poonwassie & Charter, 2005).

In response to this underutilization of health services, health-care professionals have moved toward more holistic, culturally sensitive approaches, and have endeavoured to blend Western health-care practices with traditional Aboriginal healing practices (Martin-Hill, 2003; Poonwassie & Charter, 2005; Rojas & Stunley, 2014). The blending of Aboriginal and Western research methods, knowledge translation, and program development has been called Two-Eyed Seeing (Iwama, et al., 2009). Two-Eyed Seeing refers to learning to see from one eye with the strengths of Indigenous knowledge and ways of knowing, and from the other eye with the strengths of Western knowledge and ways of knowing and to use both these eyes together, for the benefit of all (Iwama, et al., 2009). For many practitioners, care incorporates sweat ceremonies, a cultural practice performed in a heated, dome-shaped lodge that uses heat and steam to cleanse toxins from the mind, body, and spirit; smudging, the burning of sacred herbs in a small bowl to purify people and places; drumming, the use of ceremonial drums and songs as a way to connect with the Creator and spirit; sharing circles, a healing method in which all participants, including the Elders, are viewed as equal and information, spirituality, and emotionality are shared; traditional healers, who use a wide range of activities, from physical cures using herbal medicines and other remedies to the promotion of psychological and spiritual healing using ceremony; and Elder teachings (Duran, 2006; McCormick, 1996; Poonwassie & Charter, 2005). This holistic view of mental health and addiction not only ensures that care is culturally relevant but also encourages connection to the community (Cote & Schissel, 2008; Poonwassie & Charter, 2005).

In a recent scoping study that reviewed the literature on the use of interventions to treat substance use disorders in Indigenous populations, Rowan et al., (2014) found nineteen studies in United States (58%) and Canada (42%) that integrated Western and culturally based services in

both residential and outpatient programs. The authors reported that the results showed benefits in all areas of wellness, as well as the reduction in substance use in 74% of the studies (Rowan et al., 2014).

In another study, Jiwa, Kelly & St Pierre-Hansen (2008) reviewed 19 opinion, review, and program description articles from six quantitative, three qualitative, and two mixed-methods studies. They identified that the literature on community-based, substance use programs emphasizes the importance of viewing substance use disorders through a sociocultural, spiritual lens. In other words, the incorporation of sociocultural, traditional practices, and community-based models proved more successful. The authors also agreed that there is a paucity of evaluation, research, and outcome data for these programs.

Historical Overview of Intergenerational Trauma

The term historical trauma also referred to as cumulative trauma (Brave Heart, 1998), soul wound (Duran, 2006), and intergenerational trauma originated from research into the experiences of Holocaust survivors and their families (Oliver, 2003; Whitbeck, et al., 2004). It refers to the cumulative emotional and psychological harm experienced throughout an individual's lifespan and through subsequent generations.

An important distinction should be made between intergenerational trauma and post-traumatic stress disorder, which is a psychological disorder also caused by exposure to trauma. Brave Heart (2003) stated that although post-traumatic stress disorder (PTSD) is adequate to describe the depth and effects of cumulative trauma, it is too narrow in scope and therefore fails to adequately address complex Aboriginal experiences. She further stated that the theories of historical intergenerational trauma and historical trauma response accurately describe and can help others to understand and acknowledge massive cumulative trauma.

It is well documented that the intergenerational trauma experienced by Aboriginal peoples is linked to experiences at residential schools (Kirmayer, et al., 2000; Gagne, 1998; Menzies, 2010; Waldram, 2008). The Government of Canada implemented Indian Residential Schools from 1831 to 1996 (Kelly, 2011). These schools were operated by Christian churches and were encouraged and financed by the Canadian federal government (Cote & Schissel, 2008). Aboriginal parents believed that their children would receive education, but in truth, the Canadian government implemented the schools to solve “the Indian problem” (Chrisjohn, Young & Maraun, 2006; Fournier & Crey, 1997). These schools encouraged and forced students to repress their Aboriginal culture and practices. Many scholars have researched the impacts of residential schooling on Aboriginal peoples and shed light on why so many Aboriginal peoples suffer from trauma, violence, self-harming behaviour, and addictions (Reading, 2014; Health Council of Canada, 2012). The brutal experiences in these schools were reported by survivors as a force that shaped their lives and future parenting styles. Internalized oppression and neo-colonialism became the hallmark of many as they expressed hatred toward themselves, their culture, and traditional values and beliefs (Cote & Schissel, 2008; Waldram, 2008), leading many to later struggle with identity issues. Chansonneuve (2007) explained that some residential school survivors express their grief as lateral violence directed toward family and community members, thereby creating intergenerational cycles of abuse, which can resemble many of the experiences at the residential schools (McCormick, 2009).

Duran (2006), an Apache/Pueblo Native American psychologist, concluded that the Aboriginal patient suffered a “soul wound” through multiple losses sustained from colonization, particularly from forced attendance at English-speaking boarding schools. Duran (2006) and Brave Heart (1998) connected the idea of a soul wound with historical trauma and observed

success in using culturally based workshops and interventions when treating Aboriginal clients: “Intervention strategies that have been useful in dealing with the soul wound have been effective in many ways. People have engaged in the healing process and have made use of traditional forms of healing” (p.352). They agreed that drawing on Indigenous knowledge and worldviews offered therapists, healers, and health-care practitioners a valuable way to assist clients to work through their traumatic experiences. Similarly, many Aboriginal Elders referred to the symptoms of trauma as spiritual injuries, soul sickness, soul wounding or ancestral hurt, and encouraged clients through their teachings to use traditional medicines and healing to heal the soul (J. Ozawagosh & F. Ozawagosh, personal conversation, January 5, 2013)

Intergenerational trauma is the most common term used to describe the systematic trauma suffered by Aboriginal peoples (Evans-Campbell, 2008; Palacios & Portillo, 2009). Wesley-Esquimaux and Smolewski (2004) introduced the Historical Trauma Transmission model, describing it as a system in which:

trauma memories are passed to next generations through different channels, including biological (in hereditary predispositions to PTSD), cultural (through storytelling, culturally sanctioned behaviors), social (through inadequate parenting, lateral violence, acting out of abuse), and psychological (through memory processes). (Wesley-Esquimaux & Smolewski, 2004, p. 76).

Challenges of Treating Substance Use Disorders in Aboriginal People

There is no doubt that addictive behaviours and substance abuse have taken a terrible toll on Aboriginal populations in Canada, contributing to far greater incidences of accidents, disease and illness, violence, and death compared to the rates typically found in the general population (Kirmayer, et al., 2000). Corrado and Cohen (2003) completed a review of case files of former

Aboriginal residential school pupils who had undergone clinical assessments in British Columbia. Of 127 case files reviewed, 82% reported that their substance use disorder behaviours began after attending residential schools. In addition, 78.8% of the former Aboriginal residential school pupils had substance use disorders. This coincides with research that shows a link between post-traumatic stress disorder and alcoholism (Chansonneuve, 2007; Kirmayer, Fletcher, & Watt, 2009), as well as a link between discrimination and the likelihood of American-Indian adults meeting criteria for substance use disorder (Whitbeck, et al., 2004). Corrado and Cohen (2003) noted that “alcohol abuse is strongly associated with historical loss” (p. 413), and Haskell and Randall (2009) agreed that “this is a very significant finding because it delineates a connection between the use of alcohol as a form of coping or numbing feelings by people attempting to deal with overwhelming current and/or historical traumas” (p. 71). This research concurs with the findings of Whitbeck, Yu, Johnson, Hoyt, & Walls, (2008), which stated that the prevalence of substance use disorder, behavioral problems, and depression were approximately two times greater for Aboriginal children aged 10 to 12 years old (Whitbeck, et al., 2004).

While it is clear that intergenerational trauma has affected the mental health of Aboriginal peoples, it is important to identify that the impacts vary from community to community (Chandler & Lalonde, 1998; Hill, 2003). For example, Chandler & Lalonde (1998) presented in their research data that while certain Indigenous or First Nations groups do in fact suffer dramatically elevated suicide rates, such rates vary widely across British Columbia’s nearly 200 Aboriginal groups. Some communities showed rates 800 times the national average, while in others suicide is essentially unknown. Finally, they demonstrated that these variable incidence rates were strongly associated with the degree to which British Columbia’s 196 bands

are engaged in community practices that are employed as markers of a collective effort to rehabilitate the cultural continuity of these groups.

Along these lines, several researchers agreed that culturally sensitive assessment tools and interventions are needed to enhance healing from substance use disorders in Aboriginal peoples (Duran & Duran, 1999; Kirmayer, et al., 2000; Whitbeck, et al., 2004). Importantly, there is also a need to consider treating substance use disorders and the effects of trauma concurrently since they are so closely connected (Kirmayer, et al., 2000; Whitbeck, et al., 2004).

Treatments that Address Intergenerational Trauma with Substance Use Disorders

Aboriginal Spirituality and Healing Practices

The key to healing following the experience of residential school abuse and its intergenerational effects lies in the area of reclaiming identity (Smith, 1999; Waldram, 1997). Many authors have argued that reclaiming Aboriginal identity means recovering traditional values, beliefs, philosophies, ideologies, and approaches, and adapting them to the needs of today (Duran, 1995; Gagne, 1998; McCormick, 1996; Proulx & Perrault, 2000). This reclamation of traditional culture can encompass both individual and collective identities, and can be sought by way of traditional health methods. According to the World Health Organization (2008), traditional medicine is:

The sum total of knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness. (p. 59)

The *Report of the Royal Commission on Aboriginal Peoples* defined traditional healing as:

Practices designed to promote mental, physical, and spiritual well-being that are based on beliefs which go back to the time before the spread of Western 'scientific' bio-medicine. When Aboriginal Peoples in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counselling and the accumulated wisdom of Elders. (p. 348)

Thus, there appears to be a consensus among researchers and practitioners that restoring traditional healing practices and knowledge is a pathway to both empowerment and health for Aboriginal peoples and communities. Aboriginal spirituality, premised on the principles of trust, sharing, respect, honour, and acceptance, cannot be divorced from traditional healing methods. This spirituality has sustained Aboriginal peoples throughout their existence, including the period prior to the introduction of residential schools (Brasfield, 2001; Grant, 1996). However, in order to achieve this goal, the traditional knowledge once practiced in historical Aboriginal societies must be revived as a treatment philosophy when treating substance use disorders and trauma in Aboriginal peoples (Duran, 2006; Thatcher, 2004).

Duran and Duran (1995) suggested that culture-based approaches to the treatment of trauma and addiction should have many facets and must include multidimensional approaches with an emphasis on both intervention and prevention strategies, which are essential for improving the mental health status of Aboriginal peoples. Duran and Duran (1995) also emphasized the need to restore balance in all areas of life for Aboriginal peoples by providing bilingual education and encouraging Aboriginal traditions, customs, and spiritual teachings as a means of increasing self-esteem.

Attention to culture and/or traditional healing has been reported as a successful element

in substance abuse programs designed for Aboriginal peoples (Menzies, 2014; Tousignant & Sioui, 2009; Whitbeck, et al., 2004). For example, a quantitative study of a self-identity enhancing approach to preventing substance abuse stressed the importance of enhancing self-concept through cultural affiliation (Parker, et al., 1991). Through surveys and self-reported data, these authors found that engaging off-reserve Aboriginal youth aged 14-19 years in cultural activities yielded lower rates of substance use disorders use compared with the control group that had not participated in cultural activities (Parker, et al., 1991). Similarly, the Round Lake Treatment Centre in British Columbia implemented a program that emphasized cultural awareness through healing circles and family involvement. Evaluation of results from this program from 1991 to 1995 indicated that most participants were no longer struggling with substance use two years after completing the program (Parker, et al., 1991). Also, between 1999 and 2003, about half the adult population (200 people) from the Montagnais-Innu village of Nutashkuan in Labrador participated in nature camps located on their ancestral hunting territory. This program, which was strongly influenced by traditional Aboriginal spirituality and led by Montagnais-Innu healers and non-Innu psychologists, resulted in a subjective assertion by these leaders of a “steep drop in the rate of consultations for domestic violence” (Tousignant & Sioui, 2009, p. 52) which is often exacerbated by substance use disorders.

Blending Aboriginal and Western Healing Methods Through Two-Eyed Seeing

One way of incorporating Aboriginal traditional healing practices into treatment for substance use and intergenerational trauma is through the concept of Two-Eyed Seeing. Two-Eyed Seeing recognizes Indigenous knowledge as a distinct and whole knowledge system that can exist side by side with mainstream (Western) science (Bartlett, et al., 2008). Two-Eyed

Seeing asks us, in a very respectful and passionate way, to bring together our different ways of knowing and to use our understanding and wisdom to bring about healing (Bartlett, et al., 2008).

The application of the concept of Two-Eyed Seeing advocates for inclusion, trust, respect, collaboration, understanding, and acceptance of the strengths that reside in both Western and Aboriginal worldviews (Iwama, et al., 2009). Through collaboration and the demonstration of mutual respect in worldviews, Two-Eyed Seeing encourages Aboriginal peoples and health-care providers to develop a relationship of mutual cultural respect, wherein the benefits of both worldviews are acknowledged as beneficial in the healing processes. As well, the incorporation of traditional healing and cultural involvement can further develop a sense of identity in individuals suffering from intergenerational trauma and substance abuse, which is extremely important for recovery.

Two-Eyed Seeing emerged from the teachings of the late spiritual leader and healer Chief Charles Labrador of Acadia First Nation in Nova Scotia. In his words: “Go into the forest, you see the birch, maple, pine. Look underground and all those trees are holding hands. We as people must do the same” (Iwama, et al., 2009). Chief Charles Labrador’s concept of Two-Eyed Seeing was first discussed in the literature in 2004 by Elder Albert Marshall from the Eskasoni Mik’maw Nation in Nova Scotia (Bartlett, et al., 2008). Elder Albert spent most of his childhood and teenage years in Indian Residential School in Shubenacadie, Nova Scotia. He was profoundly affected by this experience and it led him on a life-long quest to connect with and understand both cultures as an integral part of his own healing from intergenerational trauma (Bartlett, et al., 2008). Marshall felt that students in the Integrative Science co-learning journey at Cape Breton University would benefit from meaningful collaboration and communication with Elders and teachers in Aboriginal communities (Iwama, et al., 2009).

According to Stewart (2008), blending Aboriginal and Western treatment methods involves: the incorporation of Aboriginal traditional healing practices and traditional healers; the presence of Elders in treatment programs; the involvement of local communities, drumming, smudging, and sweat ceremonies; and the participation of non-Aboriginal treatment providers in community events and ceremonies (Gone, 2008; Menzies, 2014; Stewart, 2007). This blended model of care has the potential to increase the rate at which Aboriginal peoples access mental health services and decrease program dropout rates. Furthermore, a blended approach could strengthen relationships between Aboriginal and non-Aboriginal service providers and can encourage cultural understanding (Gone, 2008; Menzies, 2014; Poonwassie & Charter, 2005; Robbins & Dewar, 2011).

Blending these two approaches can be challenging, yet is a worthwhile task when done in an ethical and culturally safe way. Western approaches to knowledge are characterized by the individualized ownership of knowledge and efforts to quantify for the purposes of generalizability. Aboriginal approaches to knowledge are contextualized, relational, and owned by the community (Cajete, 2000). In the Aboriginal worldview, knowledge and the knowers or learners are intimately connected, meaning that they are connected to everything and everyone around them, casually referred to as “all our relations, be it air, water, rocks, trees, animals, insects, humans, and so forth” (Aikenhead & Michell, 2011). In the Western sciences, this is usually not the case. Because of this connection, Aboriginal knowledge is more accurately described as a way of living in nature (Aikenhead & Michell, 2011) that is strongly place-based. The goal of Aboriginal knowledge is to become open to the natural world in body and spirit (Cajete, 2000).

Limitations for blending Aboriginal and Western treatments could include the risk of

continuing to oppress Aboriginal peoples and knowledge. Historically, Aboriginal communities were forced by academics or government agents to participate in research with little or no understanding of the purpose or practice that would be undertaken. The outcomes of these research projects were often disrespectful, misguided, and harmful (Brant Castellano, 2004). Thus, the way in which approaches are blended and facilitated must take into account the values, practices, and beliefs of Aboriginal peoples in a way that is respectful and inclusive. In addition, many researchers and treatment providers made statistical generalizations by treating Aboriginal peoples as if they were one large group without recognizing their diversities (Duran, 2006; Goforth, 2009). In order to avoid this risk, clinicians and researchers must recognise that each group of Indigenous peoples have cultural concepts that are specific to that particular group (Kovach, 2009; Smith, 1999; Smith, 2000; Waldram, Herring, & Young, 1995).

Other potential limitations of blending approaches include the reality that many Aboriginal communities lack the resources to recover and revitalize their language and culture. Policy should acknowledge traditional knowledge as a critical component to success of preventative and intervention strategies for Aboriginal communities, yet currently this is not the case (Smith, 1999; Smith, 2000; Waldram, et al., 1995). In addition, another barrier to the implementation of blended research and interventions is the awareness of rural and northern issues across provincial government organizations, including the social determinants of health; Aboriginal health; existing policies, programs, and services; and the shortage of Aboriginal doctors, researchers and other health-care professionals in the north. There may be substantial issues implementing Two-Eyed Seeing Indigenous decolonizing methodology without these vital resources and systems of support (Brascoupé & Waters, 2009; Hill, 2009; Menzies, 2014).

The Seeking Safety Group Counselling Program

The Seeking Safety program aims to increase the coping skills of participants with the goal of reducing the chance of relapse by emphasizing values such as respect, care, integration, and healing of self (Najavits, 2007). Participants work to reduce suicidal and self-harming thoughts and behaviours, including the urge and desire to use substances and other unsafe behaviours. They also work to remove themselves from unhealthy relationships in order to gain a sense of control and healing (Najavits, 2002a). Group participants develop skills such as: grounding, an act of mentally (and sometimes physically) linking oneself with the earth or another source of power like the moon, stars, another element, or any other natural source of energy to calm the mind and thoughts; joining the present; making sure you are present in the group or circle; and changing what can be changed to reduce the severity of their urge to self-harm (Najavits, 2007). Seeking Safety is considered a first-stage therapy, and as such, the primary goals of treatment are abstinence from substances and acquiring coping skills to obtain personal safety (Najavits, 2002a; Zlotnick, et al., 2009).

Hien and colleagues (2004) compared the effectiveness of Seeking Safety and relapse prevention with non-standardized community-care treatment for 107 urban, low-income, treatment-seeking women. Participants' substance use and PTSD symptoms improved during the Seeking Safety and relapse prevention program, but did not in the community care treatment. Seeking Safety has also been assessed in two pilot studies as an intervention for women in correctional settings (Zlotnick, Najavits, Rohsenow, & Johnson, 2003; Zlotnick, et al., 2009). Although the recidivism rate (return to prison) was 33% at three-month follow-up, a rate typical of this population, a significant decrease in drug and alcohol use and legal problems was found from pre-treatment to both six weeks after release and three months after release. The Seeking

Safety treatment model was rated equally helpful for PTSD and substance abuse by the participants (Zlotnick, et al., 2009).

What makes the Seeking Safety model unique is that, unlike traditional Western treatment programs that emphasize more of a medical model or exclude the aspects of treatment, Seeking Safety encourages spiritual discussions by offering a philosophical quote at the beginning of the treatment's group sessions (Najavits, 2007; Najavits & Hien, 2013). Seeking Safety also bridges this gap by including discussions about safety, cultural continuity, gentle language, and teachings about the genesis of intergenerational trauma and addiction (Najavits, 2002a, 2007). Furthermore, the Seeking Safety treatment model encourages the treatment of trauma and addiction in an integrative way. Rather than treating these conditions separately, Seeking Safety emphasizes a holistic and integrative approach that addresses trauma and addiction simultaneously. Seeking Safety incorporates the inclusion of the mind, body, spirit, and self-awareness during treatment, as well as connection to community through emphasis of the utilization of community resources. Thus, the perspective of Seeking Safety is convergent with Aboriginal traditional methods because traditional methods include the values and concepts of holism, relational connection, spirituality, cultural presence, honesty, respect, and connection to land and all of creation (Gone, 2008).

An Example of Seeking Safety from an Aboriginal Traditional Healing Approach

As an Indigenous woman from South Africa, when the first author first read the Seeking Safety manual, the method captured her attention due to the culturally sensitive, empowering, and understanding language that addressed the needs of the clients (Najavits, 2002a). She found Seeking Safety to be positive, strengths-based, respectful, supportive, and collaborative (Najavits, 2007). These elements constitute what may have been missing from other mainstream

treatment models that led to large attrition rates with Aboriginal participants (Gone, 2008; Rojas & Stubbley, 2014; Whitbeck, et al., 2008).

Furthermore, the first author was touched by the detailed attention that was paid to safety and self-care, not just for the client, but for the clinician as well. These two factors are often closely monitored within Aboriginal communities, particularly when traditional healing practices are utilized. For instance, each time the first author attended a sweat lodge ceremony, the Elders explained and taught about the entire process before anyone entered the lodge, advocating that the teachings were for the safety of everyone. Another example of the collaborative nature of Aboriginal healing is that the Elders never entered the lodge alone. There were always helpers present to help the Elders and to make sure that the participants were kept safe during the ceremony. In sharing her experiences with the Elders and Aboriginal communities, she was encouraged to write this manuscript to explore whether it would be possible to utilize the model in Aboriginal communities (J. Ozawagosh & F. Ozawagosh, personal conversation, January 5, 2013).

Aboriginal traditional healing practices could be blended with Seeking Safety in order to treat intergenerational trauma and substance use disorders simultaneously. A visual conceptual model of the blended approach and explanation is provided in Figure 1-1 (see p. 83). The Seeking Safety program can be offered in a group format in one- or two-hour group sessions (Najavits, 2002). Sharing circles can replace these groups, because sharing circles are a method that is familiar and comforting for some Aboriginal peoples in Canada, who have knowledge of this practice (Restoule, 2004). Healing circles and learning circles are also sometimes used to describe sharing circles. They are used as part of ceremony as a way of healing (Stevenson, 1999) and are increasingly used by Indigenous researchers (Restoule, 2004).

Also, the presence of an Elder in the sharing circles would be an important healing practice to add to Seeking Safety, as Aboriginal people have long recognized the role of the Elder as integral in the healing process. Elders' skills, knowledge, and ability to help individuals restore balance in their lives have earned them significant roles within Aboriginal communities (Menzies, Bodnar, & Harper, 2010). The Elder's role in the sharing circle is to focus on the positive identity of each and every one in the circle and to help develop the connection to the spiritual world through his/her teachings.

The Seeking Safety manualized program also provides information about topics through handouts that aim to teach participants a variety of skills. The majority of topics address the cognitive, behavioral, interpersonal, and case-management needs of persons with substance abuse and PTSD (Najavits, 2002a). To adhere to cultural sensitivity, the material could be conveyed verbally. Aboriginal facilitators are encouraged to use language that respects their cultural values and beliefs. For example, a session on anger can be explained through the role of the sacred fire. Some Aboriginal peoples believe that we are all our own fire keepers and must make sure that our fire is taken care of so that it does not destroy us (J. Ozawagosh & F. Ozawagosh, personal conversation, January 5, 2013). This would be an appropriate parallel to the Seeking Safety material, which explains anger as constructive or destructive (Najavits, 2007).

In the Seeking Safety program an inspiring quotation is used to start each session (Najavits, 2002). The use of smudging and drumming with singing to open up the sharing circles can be used in conjunction with the Seeking Safety quotation. Smudging is a sacred act that is a part of many rituals. Traditional medicines such as sweetgrass, sage, cedar, and tobacco encompass the four sacred plants. Burning these is a sign of deep spirituality in Aboriginal practices. The cleansing smoke from smudging can be used to purify people and places, and

calms the central nervous system. A feather or hand-held fan can be used to help spread the smoke around, but the hand can be used as well. Drums, on the other hand, represent the heartbeat of the nation and the pulse of the universe. Drums are sacred objects and are often used in healing ceremonies. All songs are seen as honour songs, as their name implies, and are sung to honour the Creator, the ancestors, and particular individuals. Songs can have a profound healing effect (Menzies, Bodnar, & Harper, 2010).

Moreover, making regular sweat ceremonies available to all participants can be a powerful way to bring forth Aboriginal traditional healing and the Seeking Safety topics, which focus on cognitive, behavioural, or interpersonal aspects of healing. Sweat lodge ceremonies involve the heating of a sweat lodge to help repair damage done to the spirits of people, their minds, and their bodies. In order to warm the lodge, rocks are heated in a fire outside the lodge, then brought into the centre of the lodge with a shovel and placed in a pit dug into the ground. Sweat lodge participants sit in a circle at a safe distance from the pit. Sweat ceremonies are led by a properly trained and authorized ceremonial traditional spiritual leader. The sweat lodge is a place of spiritual refuge and mental and physical healing. It is a place to receive answers and guidance by asking spiritual entities, totem helpers, the Creator, and Mother Earth for needed wisdom and power (Duran, 2006; Hart, 2010; Hill, 2009). Therefore, the integration of any aspect of the topics can be useful during the sweat ceremony.

The Seeking Safety program ends each session with a ‘checkout’ or closing activity. During a checkout, participants provide feedback about their experience during the sharing circle (Najavits, 2002). They can report what they liked or disliked, what community resources they will use and what commitment they will make in order to continue their healing. In addition to this, a Grandfather teaching and Aboriginal spiritual and traditional sayings, smudging, and/or

prayer could be offered. The Teachings of the Seven Grandfathers, also known simply as either the Seven Teachings or Seven Grandfathers, are a set of teachings on human conduct toward others, and include the concepts of wisdom, love, honesty, respect, bravery, humility, and truth. These teachings could blend well with the Seeking Safety topics on honesty, respecting one's time, and commitment. These topics encourage the clients to apply these concepts to themselves, their families, and their helpers. For example, clients are encouraged to be honest about their substance use when asked by a child, family member, or Elder. In addition, taking the time to go to the ceremonies and keep appointments with counsellors are all ways of commitment and respecting one's time in recovery.

Furthermore, Elders, facilitators, and/or participants can introduce the utilization of sacred items and sacred bundles. The sacred bundle is considered a very precious possession, which represents a person's spiritual life and may be placed in the centre of the circle. A sacred bundle can consist of one or many items. It can be the little tobacco or medicine pouch that someone wears around their neck, or it can be items such as a sacred pipe or rattle that the spirits have given to a person to carry for the people (Lavallée, 2008; Menzies, 2014). Many Seeking Safety topics can be integrated the sacred bundle. For example, the topic about when substances control a person and keep him/her away from recovery can easily be linked to a traditional teaching about carrying a sacred bundle to help climb the recovery mountain (Hart, 2010; Menzies, et al., 2010; Najavits, 2007). The sacred pipe is also a sacred item that could be used as part of the Seeking Safety Program. Sacred pipes are used during both private and group ceremonies. An offered prayer is believed to be carried to the Creator through the smoke of the pipe. The pipe ceremony and the Seeking Safety topics of having compassion and taking good care of oneself (Najavits, 2002) converge, as both practices encourage gentleness and kindness to

self. Participants who follow their traditional teachings will be encouraged to bring their sacred items to the sharing circle to help guide and connect them to their culture and traditions and integrate the Seeking Safety topics (Lavallée, 2008; Menzies, 2014).

Seeking Safety also uses grounding and centering techniques; these are often used together to help traumatized individuals connect with their bodies and elements around them to calm the mind in the group sessions (Najavits, 2002). The facilitator can guide the participants through an exercise encouraging them to focus on different body parts, rooting their feet to the ground or feeling the contours of the chair and connecting to the breath. These could be practiced with spirituality and traditional teachings in all of the sharing circles. For example, a sacred song with drumming and the burning of sweetgrass could be used during the grounding session. The burning of sweetgrass represents kindness and stillness.

Lastly, holding a traditional feast at the onset of the sharing circles and at the end of the program would be another traditional practice that is honoured by most Aboriginal peoples. A traditional feast symbolizes and celebrates the gifts from Mother Earth. This is a way of recognizing the spirits and Creator and giving thanks. It also symbolizes renewing the earth by prayers, chants, and dances (Kovach, 2009; Lavallée, 2008).

Conclusion

Because of the complexity of the symptoms that accompany historical, intergenerational trauma and substance use disorders, paired with the chaotic and poor social conditions these clients endure, many clinicians and treatment agencies experience challenges in attracting, retaining, and supporting patients for treatment (Evans-Campbell, 2008; Marsh, 2010; Menzies, 2014; Brave Heart, 2003 & Duran, 2006). Therefore, research into the treatment of intergenerational trauma and substance use disorders is required so that the challenges that both

disorders present can be adequately addressed in treatment modalities. In addition to gaining a better understanding of the issues around the treatment of intergenerational trauma and substance use disorders, there is a continued need to consider treatment and healing programs that focus on Aboriginal people and are able to blend Western knowledge and Aboriginal healing practices to better reach and affect those in need. One example of how this can be achieved is through the Seeking Safety treatment program. The Seeking Safety program is based on well-respected Western treatment methods, such as an integrative, interpersonal, and an educational approach that is very close to Aboriginal healing practices, such as holistic approaches and the use of Elders to bring the teachings about the struggles that people face when dealing with both disorders (Brave Heart, 2003 & Duran, 2006).

In terms of future directions, community-based feasibility studies could be implemented to explore the use of Seeking Safety with Aboriginal people. Such studies could shed light on this subject and contribute to a better understanding of effective healing modalities in Aboriginal populations. Also, studies where community members are asked how Aboriginal traditional healing practices and Western models could be integrated in their communities could be a valuable contribution to research. The wisdom and teachings from Elders and community members from different geographical areas could be a valuable endeavour in the field of research on this topic.

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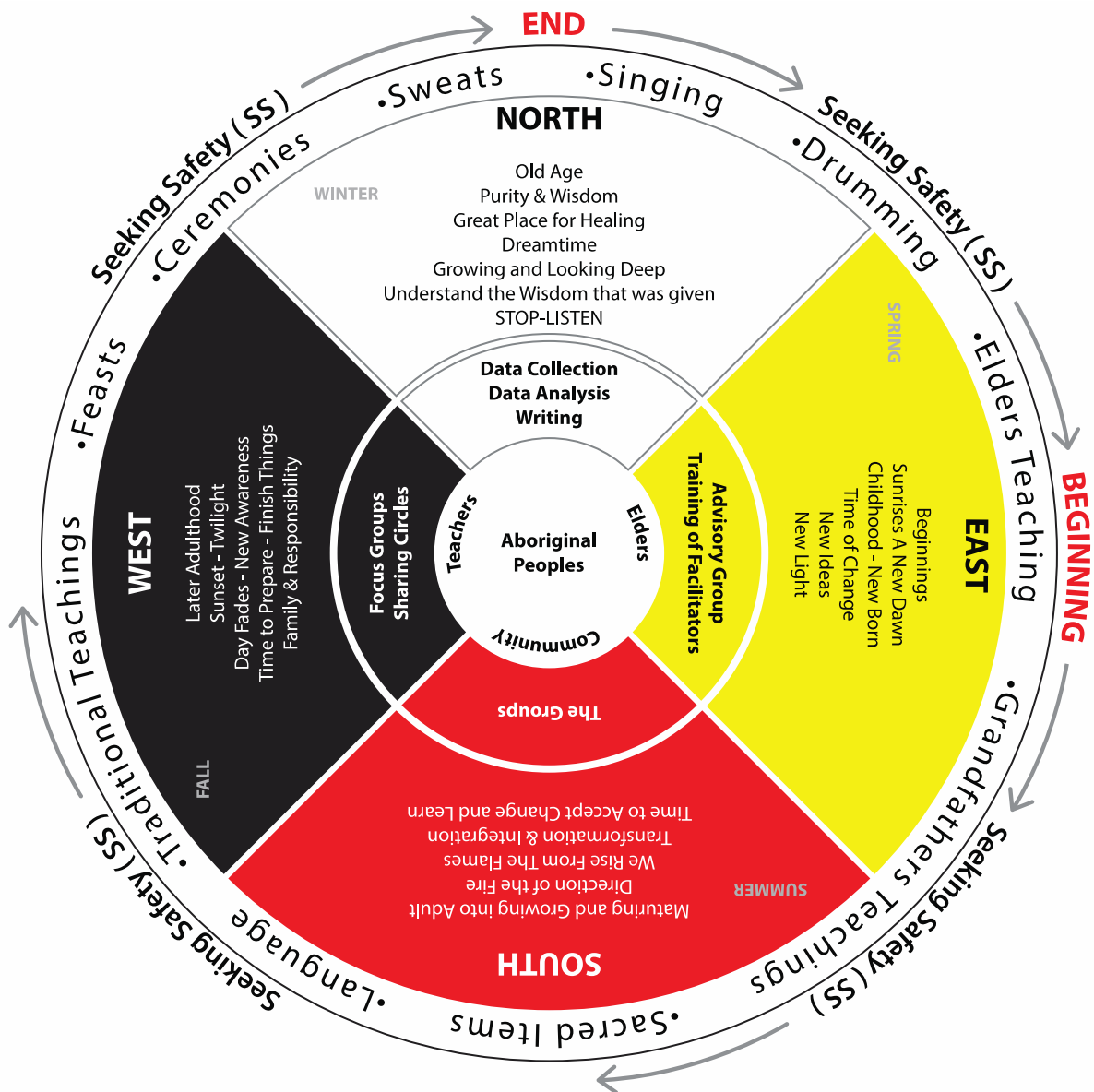
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Figure 1-1: Two-Eyed Seeing Blended Approach to Delivering the Seeking Safety

Implementation Project Conceptualized in the Medicine Wheel

Adapted from an article, "Medicine Wheels: A Mystery in Stone," written by J. Rod Vickers that appeared in *Alberta Past* 8 (3): 6-7, Winter 1992-93.



Description of Seeking Safety Conceptualized in the Medicine Wheel

Adapted from an article, "Medicine Wheels: A Mystery in Stone," written by J. Rod Vickers, that appeared in *Alberta Past*, 8 (3): 6-7, Winter 1992.

The Elders and Aboriginal advisory group, when presented with possibility of utilizing a Western model, Seeking Safety, with Aboriginal traditional healing practices by the first author, advised that the Medicine Wheel should be used to depict this Two-Eyed Seeing concept. The outer circle embraces Aboriginal traditional healing practices and Seeking Safety, and shows how it can be applied to all people with the guidance of teachers, Elders, and the Seven Grandfather Teachings.

The four quadrants in the Medicine Wheel represent wisdom, the stages of life, Aboriginal teachings, and connectedness (Vickers, 1993). Furthermore, the researcher or clinician can utilize the knowledge of each quadrant as a guide for the Two-Eyed Seeing model. For example, the east quadrant represents spring, new beginnings, childhood, and a time for new ideas. When beginning a research project involving Indigenous peoples, the researcher must be guided by the teachings of Elders, an Aboriginal advisory group, and the community. Indigenous facilitators and community members must all be included in the process from inspiration to expiration.

The south quadrant represents summer, maturing, growing into adulthood, transformation and integration, and accepting knowledge and change. This quadrant could guide the researcher or clinician to begin the preparation for the implementation of the Two-Eyed Seeing and Seeking Safety sharing circles.

The west quadrant represents spring, adulthood, sunset, a new awareness, a time of preparation, as well as family and responsibility. The west can serve as a guide for the Elders, researcher, the Aboriginal advisory group, and facilitators during the data analysis and drafting the research papers.

Finally, the inner circle represents the Aboriginal peoples, the community, and the Elders as the most important reason for this integration and blending of Aboriginal and Western knowledge. This would also honour Elder Albert, who taught that Two-Eyed Seeing is the gift of multiple perspectives treasured and respected by many Aboriginal peoples. After all, Elder Albert stated that Two-Eyed Seeing refers to learning to see from one eye with the strengths of Indigenous knowledge and ways of knowing, and from the other eye with the strengths of Western knowledge and ways of knowing, and to use both these eyes together, for the benefit of all.

Chapter 3: The Application of Two-Eyed Seeing Decolonizing Methodology in Qualitative and Quantitative Research for the Treatment of Intergenerational Trauma and Substance Use Disorders

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Marsh, T.N., Cote-Meek, S., Toulouse, P., Najavits, L.M., Young, N.L., (2015b). The application of Two-Eyed Seeing decolonizing methodology in qualitative and quantitative research for the treatment of intergenerational trauma and substance use disorders. *International Journal of Qualitative Methods*, 14(4), 1-13.

Context for this Article:

This chapter is the second integrated article and it explains the methodological process used while conducting this research study. Central to the research process was the application of the Two-Eyed Seeing approach, an Indigenous methodology and a decolonizing framework, along with the utilization of cultural ethics and protocols that are essential practices in Indigenous research. This chapter also details the ways in which Elders, Indigenous health-care workers, Aboriginal community members, research participants, and the research committee participated in this research. Finally, the blending of Aboriginal traditional healing practices and a Western treatment program, Seeking Safety, is discussed in detail.

Introduction

This paper describes the methodological process used while conducting research with a group of Aboriginal men and women in a mid-sized city in Northeastern Ontario. The study explored whether or not incorporating Aboriginal traditional healing practices into Najavits' (2002a) Seeking Safety treatment model was a feasible, suitable, and beneficial approach for Aboriginal women and men suffering from intergenerational trauma and substance use disorders. Also, the authors demonstrated the application of Two-Eyed Seeing, an Indigenous decolonizing methodology, to both qualitative and quantitative inquiry. An Indigenous research framework and several qualitative Indigenous methods were used, including sharing circles, Elders teachings and establishment of an Aboriginal advisory group. These elements will be discussed in detail. Furthermore, Two-Eyed Seeing was used to honor the strengths of both Aboriginal and Western knowledge, research techniques, knowledge translation, and program development (Iwama, et al., 2009). The focus of this paper is on the methodological process itself. The results will be discussed in a separate paper. Briefly, a mixed-method inquiry incorporated a 13-week Seeking Safety treatment sharing circles program with 24 Aboriginal peoples in Northern Ontario. Data was collected from research sharing circle sessions, semi-structured interviews, the Trauma Symptom Checklist-40, Addiction Severity Index (Lite), and the Historical Loss Scale & Historical Losses Associated Symptom Scale.

For the purposes of this paper, the term "Aboriginal" refers to First Nations (status and non-status Indians), Métis, and Inuit people as referenced in the Canadian Constitution. The term Aboriginal is used as a way to respect and acknowledge their shared: values, historical residential school experiences, and contemporary struggles in the aftermath of colonization and oppression. The word "Indigenous" will also be used interchangeably with Aboriginal. The

preceding term is often most recognizable within international contexts.

This research project was initiated to examine the efficacy of a new culturally-relevant treatment model to support the healing of First Nations adults who suffer from the combination of intergenerational trauma and substance use disorders. These conditions are frequent among Aboriginal adults in Canada and yet there is a lack of traditional and culturally sensitive treatment models available (Braveheart, 2003; Macaulay, 2009; Nabigon, 2006; Waldram, 2006).

It is well known that Aboriginal peoples are the most disadvantaged group in Canada. Aboriginal peoples in Canada have generally poorer physical and mental health, are less likely to complete primary, secondary, and tertiary education, and do not have the same employment opportunities as non-Aboriginal Canadians (Chansonneuve, 2007; Hart, 2010; Kirmayer, et al., 2009). Furthermore, Aboriginal peoples are affected by high rates of suicide, homicide, substance use disorders, accidental deaths, community/domestic violence, child abuse/neglect, poverty, as well as other complex social problems. Most, if not all, of these issues have been attributed to the impact of ongoing colonization (Waldram, 2006). These factors have strongly contributed to the multigenerational grief and loss associated with intergenerational trauma (Brant Castellano, 2004; Smith, 1999; Waldram, 2006; Wilson, 2008).

Despite the high rate of issues related to mental health and substance use disorders, Duran (1990) and others (Martin-Hill, 2003; Smylie, 2011) have noted that Aboriginal peoples underutilize treatment services for mental health and substance use disorders. When Aboriginal peoples do access these services, they have high dropout rates. This has been attributed to the fact that many treatment programs for mental health and substance use disorders lack an understanding of the cultural needs of Aboriginal peoples (Bishop, 1999; Bishop & Glynn, 2003;

Martin-Hill, 2003). Stewart (2008) suggested that these contemporary treatment issues exist for Aboriginal peoples because Western treatments and conventional psychology have failed to understand holistic Indigenous wellness, spirituality, and traditional healing methods (Cote & Schissel, 2008; Evans-Campbell, 2008; Poonwassie & Charter, 2005; Stewart, 2008). Therefore, it is necessary to investigate more relevant treatment that incorporates Indigenous ways of knowing and approaches to healing.

Background

Historically, some Aboriginal peoples in Canada have been treated unethically in the research process. In some instances, Canadian Aboriginal peoples have not been provided with clear information about research projects that concerned them, have been excluded from the research process, and have been forced to participate in research projects by government agents and academics (Brant Castellano, 2004). Prior to the colonization and oppression of Aboriginal peoples, they were sovereign independent nations who conducted their own program evaluations. They had established traditional systems of solving conflicts and rectifying issues. These methods of investigation and problem solving involved everyone in the community, and were specifically guided by Elders (Battiste, 2000; Crazy Bull, 1997; Kovach, 2005; Smith, 1999; Waldram, 1997).

According to Brant Castellano (2004), Aboriginal research is:

Research that touches the life and well-being of Aboriginal peoples. It may involve Aboriginal peoples and their communities directly. It may assemble data that describes or claims to describe Aboriginal peoples and their heritage. Or, it may affect the human or natural environment in which Aboriginal peoples live. (p. 99)

When Aboriginal leaders, Elders, and researchers began a much needed critical discourse about proper research protocols with Aboriginal peoples, they identified the need for research guidelines (inclusive of ethics) to guide non-Aboriginal scholars when conducting research with Indigenous peoples (Brant Castellano, 2004; Smith, 1999). For example, in Canada there are guidelines that have been prepared by the Ethics Office of the Canadian Institutes of Health Research (CIHR), in conjunction with its Institute of Aboriginal Peoples' Health, to assist researchers and institutions in conducting ethical and culturally competent research pertaining to Aboriginal peoples. These guidelines promote health research practices that are in keeping with Aboriginal values and traditions. The guidelines also assist in developing research partnerships that encourage culturally competent research processes that benefit Aboriginal communities (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010). Many Indigenous researchers are now actively working to ensure Indigenous research is not only respectful and culturally sensitive, but also reflective of the values of Indigenous communities (Brant Castellano, 2004; Kovach, 2009; Smith, 1999; Smith, 2009; Steinhauer, 2001; Wilson, 2008).

Currently, various organizations, universities, colleges, and some governmental agencies are actively transforming Aboriginal research into a positive instrument of reciprocal knowledge dissemination. In this way, Aboriginal research should represent Aboriginal peoples' strength, resilience, wisdom, and understanding of the world (Brant Castellano, 2004; Wilson, 2001; Waldram, 2006). This change has been a powerful and positive step toward the establishment of principles and guidelines for academics, universities, governmental institutions, partners in research, and communities doing research with Aboriginal peoples (Bishop, 2003; Brant

Castellano, 2004; Canadian Institutes of Health Research et al., 2010; Wilson, 2008).

Understanding Decolonizing Methodology

All research is embedded with elements of power and control, and some Indigenous researchers have begun to interrogate these practices (Duran, 2006; Liamputting, 2010; Smith, 1999; Smith, 2000). The decolonization of research has become one of the most discussed issues in Indigenous research. Some researchers believe that it is critical to confront particular epistemologies in the academic and research world to ensure they are respectful, inclusive, or culturally sensitive (Bishop, 2003; Cote-Meek, 2010; Gone, 2004; Kovach, 2009; Smith, 1999; Wilson, 2008). Decolonization is a process where Indigenous peoples—particularly those severely affected by colonial expansion, genocide, and cultural assimilation—recover their power by reclaiming their Indigeneity (Hart, 2010; Kovach, 2005; Wilson, 2008). The process of decolonization requires critically evaluated methodologies, as well as ethically and culturally acceptable approaches to the study of issues involving Indigenous peoples (Smith, 1999).

Decolonization is further described as Indigenous peoples embracing an understanding of the history of colonization and rediscovering their ancestral traditions and cultural values (Duran, 2006; Hart, 2010; Wilson, 2008). Furthermore, decolonization has been described as a healing journey that may involve grief, anger, rage, growth, and empowerment, coupled with the realization that bondage still exists today (Liamputting, 2010; Smith, 1999; Wilson, 2008). In this process, there is a commitment to Indigenous peoples and their right to self-determination, not only from an economic or political viewpoint, but also with respect to research (Abdullah & Stringer, 1999; Bombay, et al., 2009; Crazy Bull, 1997a; Duran, 2006; Smith, 1999; Wilson, 2008).

Another goal of decolonizing research is to break free from the Western paradigm of research that is often more focused on the discovery and interpretation of facts. From an Indigenous perspective, the research process is also inclusive of Aboriginal peoples' views, feelings, and experiences with nature, culture, and spirit (Porsanger, 2004; Smith, 1999; Wilson, 2008).

Indigenous research approaches and the development of Indigenous methodologies guide the research agenda. For example, the Alaskan Yupiaq scholar George Kanaqluk has shown in his studies that Westernized theoretical, ready-to-use methods must be reconsidered and reworked in Indigenous research. According to Kanaqluk, the researcher should not start from a theoretical perspective, but rather, with Indigenous ethical protocols at the forefront, and the development of methods that will respectfully represent the Indigenous population (Duran, 2006; Grieves, 2009; Liamputting, 2010).

The search for a respectful research paradigm for this project led to Two-Eyed Seeing, an Indigenous decolonizing methodology that provides an inclusive philosophical, theoretical, and methodological approach. Two-Eyed Seeing was first discussed in the literature in 2004 by Elder Albert Marshall from the Eskasoni Mik'maw Nation in Nova Scotia (Bartlett, 2009). Marshall felt that students in the Integrative Science co-learning journey at Cape Breton University would benefit from meaningful collaboration and communication with Elders and teachers in Aboriginal communities (Iwama, et al., 2009).

Two-Eyed Seeing is the blending of Aboriginal and Western research methods, knowledge translation, and program development (Bartlett, Marshall, & Marshall, 2012; Bartlett, 2009; Iwama et al., 2009). According to Stewart (2007), blending Aboriginal and Western treatment methods involves the incorporation of Aboriginal traditional healing practices and

traditional healers; the presence of Elders in treatment programs; the involvement of local communities, drumming, smudging, and sweat ceremonies; and the participation of non-Aboriginal treatment providers in community events and ceremonies (Stewart, 2007; Gone, 2008; Menzies, 2014). Creating a blended model of care has the potential to increase the rate at which Aboriginal peoples access mental health services and decrease program dropout rates. Furthermore, a blended approach could encourage cultural understanding and strengthen relationships between Aboriginal and non-Aboriginal service providers (Gone, 2008; Menzies, 2014; Poonwassie & Charter, 2005; Robbins & Dewar, 2011).

Two-Eyed Seeing framework recognizes Indigenous knowledge as a distinct epistemological system that can exist side by side with mainstream (Western) science (Bartlett, Marshall, & Marshall, 2012; Bartlett, et al., 2009; Iwama, et al., 2009). The application of the concept of Two-Eyed Seeing advocates for inclusion, trust, respect, collaboration, understanding, and acceptance of the strengths that reside in both Western and Aboriginal worldviews (Iwama, et al., 2009). Two-Eyed Seeing encourages Aboriginal peoples, health-care providers, and researchers to develop a relationship of mutual cultural respect, wherein the benefits of both worldviews are acknowledged as beneficial in the healing processes (Bartlett, et al., 2012; Bartlett, 2009; Iwama, et al., 2009).

Applying Two-Eyed Seeing to research methodology requires a keen understanding of Indigenous epistemologies, which embody the cosmologies, values, cultural beliefs, and relationships that can vary from one community to another. In most Indigenous epistemologies, knowledge is acquired through revelation, such as dreams, visions, and intuition. Knowledge can also be passed down by Elders and knowledge keepers through teachings and is regarded as spiritual, derived from ancestors and the spirit world. This spiritual knowledge cannot be

observed by physical means; therefore, it cannot be measured or quantified (Hart, 2010; Linklater, 2010).

The Two-Eyed Seeing framework resonated with the first author's background and experience as an Indigenous woman from Cape Town, South Africa. She grew up with both Indigenous and Western influences, and was taught first hand by her parents, grandparents, and ancestors that Indigenous knowledge has been passed down through generations. Furthermore, they taught her how to respect, embrace, and understand the different worldviews of the people of South Africa. Her Elders and research committee also emphasized that decolonizing was the act of getting rid of colonization by an oppressing nation. In this paper, the concept of decolonizing research methods is interpreted as the possibility for research to be designed in a way that empowers, liberates, and respects Aboriginal peoples.

In the next section, the authors explore the practical application of an Indigenous research framework using decolonizing methods. These include the application of Two-Eyed Seeing; consultation and collaboration with Elders; the development of an ethical relationship; the establishment of an advisory group with committee members; and the training of the sharing circle facilitators.

The Application of Two-Eyed Seeing, an Indigenous Decolonizing Approach

Situating oneself as a researcher is important, particularly within an Aboriginal research framework (Absolon & Willett, 2004; Baskin, 2005; Restoule, 2004). Situating oneself provides an opportunity for the researcher to demonstrate that he or she is committed to open and honest communication, inclusion, community connectedness, and respect. It demonstrates that the researcher encourages authenticity in relationships at all levels. Situating ourselves also helps to define the worldview from which we speak. Within most Indigenous communities, researchers

identify themselves at the beginning of the research. They name: who we are by: name, where we are from/place of origin, and who their ancestors are (Lavallée, 2007a, 2008). This transparency helps to establish trust (Absolon & Willett, 2004). As the first author was Indigenous but not from Aboriginal ancestry, the guidance, teachings, and wisdom from Elders, the Aboriginal advisory group, and Aboriginal committee members was important to support this process. By respectfully sharing their perspectives from the Ojibway, Algonquin, and Cree Nations of Canada, they encouraged the integration of their knowledge, morals, and beliefs into transparent research.

The methodology of situating oneself is framed by the insider/outsider debate. When conducting research with Aboriginal peoples, one must have an applied awareness of being an outsider within the community. Critiques of insider/outsider roles originated with African American scholars in the early 1960s and lead to the emergence of what Robert Merton described as the insider doctrine (Innes, 2009). In the insider doctrine, insiders are defined as members of a particular group research their own group (Innes, 2009). The insider/outsider debates create awareness about the differences in cultural values, research processes, and protocols required when doing research with Aboriginal peoples. It raises complex questions and issues; for example, a cultural insider could also be an outsider in some Aboriginal communities. Aboriginal Elders teach that even though a cultural insider may have an easier time connecting with Aboriginal communities, the responsibility of the cultural insider is much greater because he or she is familiar with the culture and required protocols (Brant Castellano, 2004; Crazy Bull, 1997a; Hill, 2009). Some outsiders in the Aboriginal context are also bound by principles of cooperation and respect, as well as additional protocols that must be observed. For example, most Aboriginal communities expect any outside researcher to be accompanied by a community

member or helper. The helper can provide the outsider with guidance regarding the cultural beliefs, values, and protocols. The helper's role is also to ensure that these practices are observed and respected by the researcher.

The insider/outsider debate has also created discussion regarding Aboriginal involvement in research that pertains to Aboriginal communities. Importantly, the community or Aboriginal persons engaged in the project need to be involved from the design phase of the research through to implementation (Brant Castellano, 2004; Crazy Bull, 1997a; Hill, 2009). This ensures that traditional cultural protocols are followed from inception to completion of the project.

The first author recognized that she comes from a similar history with differences of colonization and oppression, including the loss of land, language, and culture. She grew up in South Africa and the generations before her suffered multiple losses. Thus, she explicitly states that her own life experiences, bias, and personal views will influence the findings. Her bias stems from personal experience with colonization and oppression and the similarities she shares with Aboriginal peoples. Furthermore, her experiences with apartheid, poverty, and poor living and health conditions have placed her in a position of understanding Aboriginal peoples in their suffering. Throughout the research, strategies were implemented to enrich the research process and the credibility of the findings. These six distinct strategies will be further discussed, and include (a) consultation and collaboration with Elders; (b) the development of ethical relationships; (c) the establishment of an Aboriginal advisory group with community members; (d) training of the sharing circle facilitators; (e) settings and demographics of participants; and, (f) conducting Seeking Safety sharing circles.

Consultation and Collaboration with the Elders

Since pre-colonial times, Elders have been the gatekeepers of Indigenous wisdom, knowledge, and history. Elders traditionally hold crucial roles in supporting both formal and informal education in Aboriginal communities. They impart tradition, knowledge, culture, values, and lessons using orality and role modeling traditional practices (Bishop, Higgins, Casella & Contos, 2002; Menzies, et al., 2010). For research to be based on Aboriginal knowledge, Elders must be involved (Lavallée, 2008). An Elder is someone who is considered exceptionally wise in the ways of their culture and teachings (AHF, 2005). They are recognized for their wisdom, their stability, their humour, and their ability to know what is appropriate in a particular situation. Elders are the carriers of knowledge in both physical and spiritual realities. They have been educated through the oral tradition, and carry credentials that are recognizable in Aboriginal society. The insights of the Elders were especially critical to ethical protocols when conducting research with Aboriginal peoples (Brant Castellano, 2004).

The first author consulted with a number of Aboriginal researchers and scholars throughout this project—at inception, during research, and while writing this manuscript. She met with several Elders on a weekly basis for one year at the Atikameksheng Anishnawbek (Whitefish Lake) reserve in Sudbury with the goal of learning more about Aboriginal communities. Two Elders, Frank and Julie Ozawagosh of Atikameksheng Anishnawbek (Whitefish Lake First Nation), guided the traditional and spiritual healing practices of this research. In their community, Elders Julie and Frank Ozawagosh are recognized as spiritual people. They are regularly approached by members of their community for healing. By providing step-by-step guidance during this project, they made sure that all pertinent traditional protocols were followed. They modeled what it meant to be respectful and honest, and were vital in

ensuring that this project with Aboriginal peoples was conducted appropriately. They also had many other roles in this research project that included: advisors, guides, committee members, and teachers of the traditional knowledge in the Seeking Safety sharing circles. They performed sweat lodge ceremonies for the participants and the first author in a lodge situated on their land.

Development of an Ethical Relationship

Within a decolonizing methodology, research with Aboriginal peoples is based on relational accountability. Relational accountability implies that all parts of the research process are related, from inspiration to expiration. In the Aboriginal worldview, knowledge and the knowers or learners are intimately connected, meaning that they are connected to everything and everyone around them. This means that the researcher is connected to “all our relations, be it air, water, rocks, trees, animals, insects, humans, and so forth” (Steinhauer, 2002, p. 72). In this way, relational accountability suggests that while you are conducting research, the researcher is not only responsible for nurturing and maintaining relationships, he or she is also responsible for everything and everyone that is connected to the research process.

Inspired by the concept of relational accountability, the authors took various steps to consider the impact of this research on those connected to it. First, a number of Aboriginal scholars were consulted to provide insight into choosing the community. They provided guidance regarding community protocols of carrying out Aboriginal research in this geographical area. Second, several Elders were consulted once a week for one year at Atikameksheng Anishnawbek (Whitefish Lake First Nation) with the goal of learning more about the communities. On the advice provided by the Elders, an Aboriginal advisory group was established to guide the research process with the appropriate teachings and protocols. Third, for 90 minutes each week, the first author volunteered to teach yoga at the N'Swakamok Native

Friendship Centre and Rockhaven Recovery Home for Men in Sudbury. This was foundational to her commitment to relational accountability to the participants. The experience also provided her with a respectful space to get to know them. Finally, one Aboriginal supervisor and one Aboriginal committee member were chosen to advise the first author on the Aboriginal content of the research.

Tobacco was offered as a gift to all research participants as a gesture of respect and gratitude, which are suggested as culturally appropriate practices in this region. The Elders and members of the Aboriginal advisory group recommended that these traditions be followed and respected.

The Western part of this study also required that the research plan undergo an ethical review by the Laurentian University Research Ethics Board. This research was in keeping with the Canadian Institutes of Health Research (2011) *Guidelines for Research Involving Aboriginal People* and the *Tri-Council Policy Statement for Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research et al., 2011). The ethics committee asked about the offering of gifts. It was explained that gifting was an integral part of Aboriginal traditional methods and this satisfied their inquiry (Menzies, et al., 2010). Furthermore, the ethics committee asked questions about the involvement of Elders. It was adequately explained that the Elders are the knowledge keepers of Aboriginal communities, and that their presence in this project was an integral part of bringing Aboriginal traditional healing methods into the treatment of intergenerational trauma and addiction. Soon after this meeting, the project was approved.

Establishment of an Advisory Group with Community Members

As a non-Aboriginal woman joining the community as an outsider, the first author was not an expert in Aboriginal ethics, rights, principles and protocols. The research supervisors,

Elders, and community members provided invaluable guidance regarding the ethics, rights, and protocols lived daily by Aboriginal peoples. In addition, an Aboriginal advisory group was established to ensure that the research adhered to the rights, protocols, and principles that are integral to Aboriginal communities. The first author met with the advisory group and her supervisor on a monthly basis and consulted with them regarding the research process. Part of the discussions included the two research sites, the recruitment process, and the use of appropriate language.

This research generated knowledge that could affect the health and wellbeing of Aboriginal peoples, and therefore the advisory group was pivotal in maintaining this critical focus. Members of the advisory group consisted of two Elders from Atikameksheng Anishnawbek (Whitefish Lake First Nation); an Aboriginal physician and specialist in addiction medicine from the Northern Ontario School of Medicine; an Aboriginal Ph.D. researcher from Laurentian University; an Aboriginal translation worker from N'Swakamok Native Friendship Centre; an Aboriginal translation worker and wellness worker from N'Swakamok Native Friendship Centre; and an Elder and community healer from Shkagamik-Kwe Health Centre.

The Aboriginal advisory group helped guide every process. They became the sounding board and consultation voice to further enhance cultural sensitivity and Aboriginal traditional healing methods. Their involvement increased the authenticity of this research process through their demonstration of the importance of respect for individuals and community. They explained that researchers both seek and hold the knowledge of a community. Moreover, they provided guidance regarding the principles of reciprocity, responsibility and non-intrusive observation. The Aboriginal advisory group explained that researchers should be present without interfering with the individual and community

processes. Many teachings were about deep listening and hearing with more than the ears. This meant that one should carefully listen and pay attention to how the heart and sense of being are emotionally and spiritually moved. Called upon regularly for guidance and advice, the advisory committee was pivotal to the research throughout the entire process.

Training of the Sharing Circle Facilitators

With the help and guidance of the Elders and Aboriginal community members, the facilitators were recruited. The Elders advised that the facilitators and two undergraduate social work students should be Indigenous with experience of working with this population. All facilitators had previous experience working with individuals who have experienced trauma and suffer from substance use disorders. Most of the facilitators had an excellent understanding and knowledge of Aboriginal traditional healing practices. Facilitators understood that they were expected to use an Indigenous decolonizing methodology and teach cultural practices. The first author, who had received her training in the Seeking Safety approach, trained all the facilitators over a period of six days, eight hours per day. The training consisted of didactic, experiential, and small-group learning. The training included the implementation of the Seeking Safety model, inclusive of traditional healing methods. Much time was spent on facilitation of group discussion and sharing circles.

Practice sessions were set up to encourage the facilitators to explore their strengths and weaknesses in facilitation. These sessions were captured by video. With respect to Two-Eyed Seeing, the training was done in a way that included Aboriginal traditional methods. For example, sometimes the content on intergenerational trauma brought up past painful experiences. All facilitators were encouraged to burn sacred medicines and to place it at the feet of the participant to offer strength. The facilitators understood and valued the ritual of burning sacred

medicines as essential to this approach. During every session, Elders were invited into the Circle to bring teachings and guidance on all traditional healing practices. Discourse on group methods, group processes, therapeutic use of self, and expectations were practiced during these sessions.

A unique outcome of facilitator training was the formation of a community built upon trust, laughter, and feasting. These are respectfully consistent with the Aboriginal cultures in this area. While the study took place during September, October, and December 2013, ongoing bi-weekly supervision was provided to the facilitators. One-on-one consultations were also available on an *ad hoc* basis. This was a very powerful learning time for the facilitators and the first author, as the Seeking Safety content informed them in ways that supported Indigenous ways and teachings.

Setting and Demographics of Participants

The Elders, community members, and the advisory group recommended that this program should take place in an urban Aboriginal community and not on a First Nation reserve. They explained that most of the clients who needed this Seeking Safety sharing circle intervention had left their communities. This was due in part to perceived shame and guilt about continuing to use substances while seeking help. The Elders identified that many people on reserves believed in the abstinence model, but many clients needed information on how to stop using drugs and alcohol. Furthermore, they encouraged an urban location because most of the substance use treatment agencies, mental health programs, and Friendship centres are located in these settings.

All twenty-four of the participants in this research project lived off-reserve. The female sharing circles took place at the N'Swakamok Native Friendship Centre located in Sudbury, Ontario. This centre assists Aboriginal peoples by providing program activities that serve the

social, cultural, and recreational needs of the urban Aboriginal community. The men's sharing circle took place at the Rockhaven Recovery Home for Men, which was located in the same city. This home delivers a residential/in-patient recovery program that empowers Aboriginal and non-Aboriginal men to develop a personal program of recovery from substance use disorders. Forty percent of the men Rockhaven serves are of Aboriginal ancestry.

Most of the participants in this research were of Ojibway, Cree, and Métis heritage. They ranged in age from 24 to 68 with an average age of 35. The sharing circles were co-facilitated by two students and two Aboriginal health-care workers. The facilitators and the students worked and volunteered at the N'Swakamok Native Friendship Centre and the Rockhaven Recovery Home for Men. The facilitators organized and facilitated these sharing circles twice a week for 13 weeks. Each weekly sharing circle was two hours long.

Conducting the Seeking Safety Sharing Circles

To ensure that the Seeking Safety model included both Aboriginal and Western knowledges, the various culturally-specific and culturally-sensitive practices were integrated into the program. The fidelity of the Seeking Safety model was retained in that the model is inherently flexible and clinicians are encouraged to use language, examples, and practices relevant to their population. The model has also been used successfully among many other minority populations, including African-Americans, Hispanics, and Asian-Americans, as well as translated into numerous languages with implementation in various countries (Najavits, 2002a, 2007, 2009; Najavits, & Hien, 2013). Najavits (2002b) refers to this as an adaptation within the model, which maintains fidelity to it, rather than an adaptation outside the model, which would involve changing essential elements or adding material that is at odds with the model. The developer is the fourth author on this paper and was consulted on the use of the cultural practices

described here.

Seeking Safety can be offered to groups or individuals. In the current project, it was offered in group modality to benefit from the positive convergence with sharing circles. In Aboriginal culture, sharing circles are used as part of ceremony and as a way of healing (Stevenson, 1999). They are familiar and comforting for some Aboriginal peoples in Canada and reflective of the traditions of the area (Restoule, 2004). All participants in the sharing circle, including the facilitator, are viewed as equal, and information, spirituality, and emotionality are shared. For these reasons, they have been increasingly used by Indigenous researchers. This project incorporated Aboriginal protocols including ceremonial openings and closings, offering of tobacco to participants, having an Elder present at each session, offering participants sweat lodge ceremonies, opening the circles with drumming, sacred songs, and smudging. Over a period of three months, two sharing circles were carried out each week. The number of participants who attended varied. During the 25 sharing circles, an average of nine participants out of the 12 registered participants attended. The Circles were scheduled at a time agreed upon by the facilitators and participants during the recruitment process. Beverages and a light snack were offered during every circle.

The facilitators offered tobacco bundles to participants, which had been prepared ahead of time. The facilitators took time to explain the respectful rules for the sharing circles. The first author remained mainly in the background, but was always present to help and support. Since the first author interviewed all the participants, they welcomed her presence and at times would invite her into the Circle to give a teaching. During the sharing circles, the participants talked about themselves, their families, and their challenges with trauma and substance use. Participants were not expected to share detailed stories about their trauma. Rather, discussions focused on the

unique problems that have resulted from struggling with internalized oppression and substance use.

The Seeking Safety treatment model in the sharing circles included topics such as: when substances control you, dealing with anger, setting boundaries in relationships, and taking good care of yourself. In addition, facilitators offered a Grandfather teaching, Aboriginal spiritual and traditional sayings, smudging, and/or prayers during the sessions. The teachings of the Seven Grandfathers, also known as either the Seven Teachings or Seven Grandfathers, are a set of teachings on human conduct toward others. They include the concepts of wisdom, love, honesty, respect, bravery, humility, and truth (Benton-Banai, 1988). These teachings blended well with the Seeking Safety topics on honesty, respecting one's time, and commitment. The topics encouraged participants to apply these concepts to themselves, their families, and their helpers. For example, participants were encouraged to be honest about their substance use when asked by a child, family member, or Elder. In addition, taking the time to go to the ceremonies and keep appointments with counsellors were all ways of blending traditional practices with Seeking Safety topics. These actions supported the Seeking Safety teachings on commitment and respecting one's time in recovery. The facilitators also used traditional healing methods, such as storytelling, inviting the presence of Elders, smudging, drumming, sweats, bringing of sacred bundles to the circle, and teachings about the history of the Aboriginal people. Participants were told that they did not have to participate in anything with which they were not comfortable. For example, some of the participants initially preferred to remain quiet and just observe until they felt more comfortable to talk and share. The facilitators respected this and let the participants know that this was acceptable.

The presence of an Elder in the sharing circles was an important healing practice in using

a Two-Eyed Seeing, an Indigenous decolonizing methodology. Aboriginal peoples have long recognized the role of the Elder as integral in the healing process. Elders' skills, knowledge, and their ability to help individuals restore balance in their lives have earned them significant roles within Aboriginal communities (Menzies, et al., 2010). The Elder's presence in the sharing circles was reflexive and culturally adaptive. They taught about Two-Eyed Seeing, while also focusing on the positive identity of each person in the circle. They also helped to develop a connection to the spiritual world through their teachings.

Furthermore, Elders, facilitators, and participants introduced their sacred items and sacred bundles during the sharing circles. A sacred bundle can consist of one or many items. It can be a tobacco or sacred medicine pouch worn around the neck, or it can be an item such as a sacred pipe that the spirits have given to a person to carry for the people. The sacred bundle is considered a very precious possession that represents a person's spiritual life (Hart, 2010; Menzies, 2010). All the participants were invited to bring their bundles, and were encouraged to place their sacred bundles or items at the center of the circle.

The Seeking Safety program consists of up to 25 treatment topics that aim to teach participants a variety of skills. The majority of topics address the cognitive, behavioral, interpersonal, and case management needs of persons with substance use and post-traumatic stress disorders (PTSD) (Najavits, 2002a). To adhere to Two-Eyed Seeing and cultural sensitivity, the material was conveyed verbally. The facilitators encouraged language that respected the participants' cultural values and beliefs. For example, the session on boundaries was explained through the role of the Seven Grandfather Teachings (Benton-Banai, 1988).

In the Seeking Safety program, a holistic and philosophical quotation is used to start each session. Each sharing circle was opened with smudging, drumming and singing. Smudging is a

sacred act that is recognized by many Aboriginal peoples as respecting the Great Spirit and the ancestors. Sacred medicines such as sweetgrass, sage, cedar, and tobacco were used during each sharing circle. Drumming was used in the circles to represent the heartbeat of the Nation and the pulse of the universe. Some songs are honor songs and were sung to honor the Creator, the ancestors, and particular individuals. These songs can have a profound healing effect on participants (Menzies, et al., 2010).

Sweat lodge ceremonies were available to the group. Sweat lodge ceremonies provided a powerful way to bring forth a Two-Eyed Seeing as an Indigenous decolonizing methodology. The sweat ceremonies helped repair the damage done to the spirits, mind, and bodies of the participants. During the sweat ceremonies, the Elders gave teachings about Aboriginal traditional healing and its restorative power. Participants were also invited to share their stories and experiences. Three sweats were offered for both male and female groups over the period of three months. Not all participants were able to attend the ceremonies; on average, eight participants were present. All the facilitators, including the first author, attended the ceremonies.

The Seeking Safety program ends each session with a checkout activity where clients can give feedback about their experiences, report on what they liked or disliked, identify community resources that they may use, and discuss how they will continue their healing (Najavits, 2009). In addition to this, each session closed with a Grandfather Teaching, Aboriginal insight, prayer, or smudge. Seeking Safety uses grounding and centering techniques in the group sessions. These techniques help traumatized individuals connect to the present, calm the nervous system, and help with difficult memories. In sharing circles, grounding and centering is an important part of the healing process. During the ceremonies, the Elders and facilitators encouraged participants to connect with Mother Earth and her elements. They taught participants to be aware of their feet

connected to the Mother Earth, to feel Mother Earth's support, and to honor this feeling of connection. Moreover, during the grounding, participants were encouraged to drum, sing a sacred song, or burn a sacred medicine. Sometimes this was accompanied by a teaching from the Elder about how energy or sacred medicine in the circle can bring forth comfort and healing.

In conclusion, as food is an integral part of Aboriginal culture, a traditional feast was held at the onset of the sharing circles and at the end of the program. A traditional feast symbolizes and celebrates the harvest from the field and forest. This is a way of recognizing the spirits and Creator and giving thanks. It also symbolizes renewing the earth by prayers, chants, and dances (Kovach, 2009; Lavallée, 2007a, 2008). The feasts were held as a way of honoring the healing, research, and teachings.

Data Collection

Choice of Outcome Tools: Qualitative and Quantitative

The Indigenous decolonizing approach of Two-Eyed Seeing was interwoven through the selection of tools and during the data collection phase. Numerous discussions were had with the advisory group, Elders, and the research committee about appropriate quantitative and qualitative methods. The instruments were presented and teachings were provided about how to make this process culturally safe. The following data collection methods were applied over a period of seven months as a respectful means to include participants' viewpoints and experiences.

Initial 90-minute meetings were conducted with the participants in their place and time of choice. During these meetings, participants received information about Seeking Safety, traditional healing, sharing circles, the process, and the program details. They had lots of time to ask questions and tell their stories; for example, some participants would start off the interview through story telling about their families, communities, ceremonies and culture. Some sessions

spanned multiple hours, as respect and listening to stories are part of the decolonizing approach in Two-Eyed Seeing. Also, during this period, participants shared many painful stories about trauma and the impact of the substances on their lives. Listening with the heart is a form of respect in Indigenous cultures, because respect is not just about being polite and saying ‘please’ or ‘thank you,’ but rather refers to the willingness to listen intently to others (Steinhauer, 2002). Furthermore, many of the women were highly emotional as they reported losing their families to the Children’s Aid Society (CAS). Smudging, the burning of sacred herbs in a small bowl that help to calm and purify people and places, was offered during these emotional times. As part of these meetings, the following was administered: Addiction Severity Index Lite (ASI-Lite), Trauma Symptom Checklist-40 (TSC-40), the Historical Loss Scale (HLS), and Historical Losses Associated Symptom Scale (HLASS).

At these meetings, participants completed questions related to their age, gender, level of education, occupation, marital status, and tribal affiliation (see Appendix I). Participants were also asked questions about the types of schools they attended, the types of communities they had lived in, who raised them during their childhood, and the number of siblings in their family. They were asked a few questions about their identification with traditional Aboriginal culture. Most of the participants stated that no one had ever asked them these types of questions. They reported that, until this time, they had not realized how much these losses affected them. Participants were touched and expressed that they wanted to heal and claim back their identities. Most participants became excited about the program and reported that they could not wait for it to begin.

The Seeking Safety sharing circles followed these initial meetings. At the end of every Seeking Safety sharing circle, the participants completed an end-of-session questionnaire. These

end-of-session questionnaires were designed to capture the immediate reaction of participants to the content and traditional healing techniques in each session. This data was then analyzed for common themes and emerging trends. At the end of the 25 Seeking Safety sharing circles, a 90-minute sharing circle was held with all participants (one for each gender circle, within two weeks of the last sharing circle). Gender division was maintained throughout the intervention, as requested by the Elders and Aboriginal advisory group. They indicated that the hallmark of this treatment was safety and healing, therefore both men and women would feel safer this way. During these sharing circles, participants were asked to talk about their experience (see Appendix F). Individual sessions with all the participants and facilitators in an end-of-program, semi-structured individual interview were also conducted. These lasted approximately 75 minutes (see Appendices B and C).

During the 25 sharing circles and at the completion of the program, the participants were advised about aftercare. They were all encouraged to return to their referring treatment agencies and to continue to apply the strategies and knowledge they received. They were encouraged to use the resource list that they received at the beginning of the project. Participants were also encouraged to continue their relationship with the Elders. During the final feast, all participants received a certificate of completion, a book about healing from trauma, and a Medicine Wheel. Participants were excited about their growth and the insights that they had experienced in these sharing circles.

Qualitative and Quantitative Data Analysis

Transparency and member checking are very important elements of Indigenous decolonizing approaches such as Two-Eyed Seeing. Therefore, the discussions from the sharing circles and the semi-structured interviews were transcribed verbatim. Each participant was

assigned a number to maintain participant confidentiality. The Elders, Aboriginal advisory group, and research committee provided input into the cultural components of the data to gain more accurate meaning to the analysis. Feedback from participants was essential to Two-Eyed Seeing and the Indigenous decolonizing methodology; thus all participants received a copy of their transcripts and were encouraged to make additions and deletions. No changes were made by any of the participants.

The results of the baseline questionnaire were analyzed using frequency data from all participants (n=24). Participant retention was addressed by the number of sessions attended (10 sessions). The post intervention number of participants was sixteen (n=17). The treatment outcomes were defined as change in current (i.e., past 30 days) PTSD trauma symptoms severity (measured by the composite score of the TSC) and change in drug and alcohol problems (measured by the ASI Lite). These levels were compared to the level of symptom severity one month prior to treatment. As a general data analysis approach for the third set of outcomes listed above, bivariate comparisons were performed using a paired sample *t*-test. The paired sample *t*-test was used to identify the difference in mean change in a continuous variable (composite TSC or ASI Lite score) within a group using paired data, such as pre-treatment and post-treatment data of a single group. SPSS® statistical software version 20 was used to assist in the analysis of the data (SPSS, 2007).

All discussions from the sharing circles and the semi-structured interviews were audiotaped and transcribed verbatim in Microsoft Word using numbers to maintain participant confidentiality. After transcription, a qualitative thematic analysis was performed to search for themes that emerged from the text of each individual post-treatment semi-structured interview, and the end-of-treatment sharing circles. Themes were identified via careful reading and re-

reading of the data by the primary author (Rice & Ezzy, 1999). The identified themes were then categorized as pattern recognition occurred. The following four core themes were identified: (a) healing through traditional Aboriginal healing methods, (b) education and knowledge about Seeking Safety and material, (c) awareness, understanding, and the link between trauma, substance use, and the impact of colonization, and (d) integration and application of knowledge. The results of each of these themes will be described in detail in a separate paper. During data analysis, the Elders explored the four core themes and decided that these themes connected with the teachings in the Medicine Wheel. Based on the recommendation of the Elders, the results were depicted through the lens of the Medicine Wheel in order to authenticate Indigenous decolonizing methodology of Two-Eyed Seeing (personal conversation with Elder Julie and Frank Ozawagosh January 5, 2013). Next, member statements that corresponded to a specific theme were identified and transformed into meaningful units, and then coded into subthemes (Boyatzis, 1998).

Conclusion

The use of Two-Eyed Seeing and an Indigenous decolonizing methodology encourages authenticity in our relations, both personal and in the research process (Bartlett, 2009). This methodology suggests that knowledge is relational, shared with creation, and deeply rooted in everything (Wilson, 2001). Researchers are not only part of the creation of knowledge, but also part of the transformation that takes place during the research process. The principles of this methodology—such as the open and honest communication, inclusion, community connectedness, and the involvement of the Elders, the Aboriginal advisory group, and the research committee—enhanced respect and encouraged equality in relationships. Throughout the entire research process, the Elders, Aboriginal advisory group, research committee, community

members, stakeholders, and participants provided valuable input into the Indigenous research process. This support network helped the first author in the multiple roles she held as researcher, clinician, woman, supervisor, mentor, and student doing research with Aboriginal peoples. Such self-reflection and openness are an integral requirement in the Indigenous research (Kovach, 2009).

Restoule (2004) described Indigenous research methods as incorporating experiential learning where participants are fully engaged. This research project was a challenging, powerful, and revealing journey of growth and discovery. As a student, the first author learned many transformative lessons through using Two-Eyed Seeing and an Indigenous decolonizing research framework and methodology. As an Indigenous researcher and professional, she also became a respectful co-creator of wisdom, understanding, and healing that may benefit others. Lavallée (2008) stated that researchers experience growth and personal transformation from the research undertaken, and in keeping with this, the first author saw her involvement in this process as a privilege and honor.

In conclusion, this paper highlights treatment and research methods that honor the strengths of both Indigenous and Western knowledge's and shed light on the potential and healing of integrated approaches used by treatment centres, and for learning by researchers and clinicians. The research methodologies emerging from these communities and the helping/health practices demonstrate how Two-Eyed Seeing and other forms of Indigenous decolonizing research can occur. We must always remember and respect the strength and resiliency of the Aboriginal peoples. Our hope is that this research will further inspire trauma and substance use treatment facilities (and society) to become more compassionate and understanding toward these Nations.

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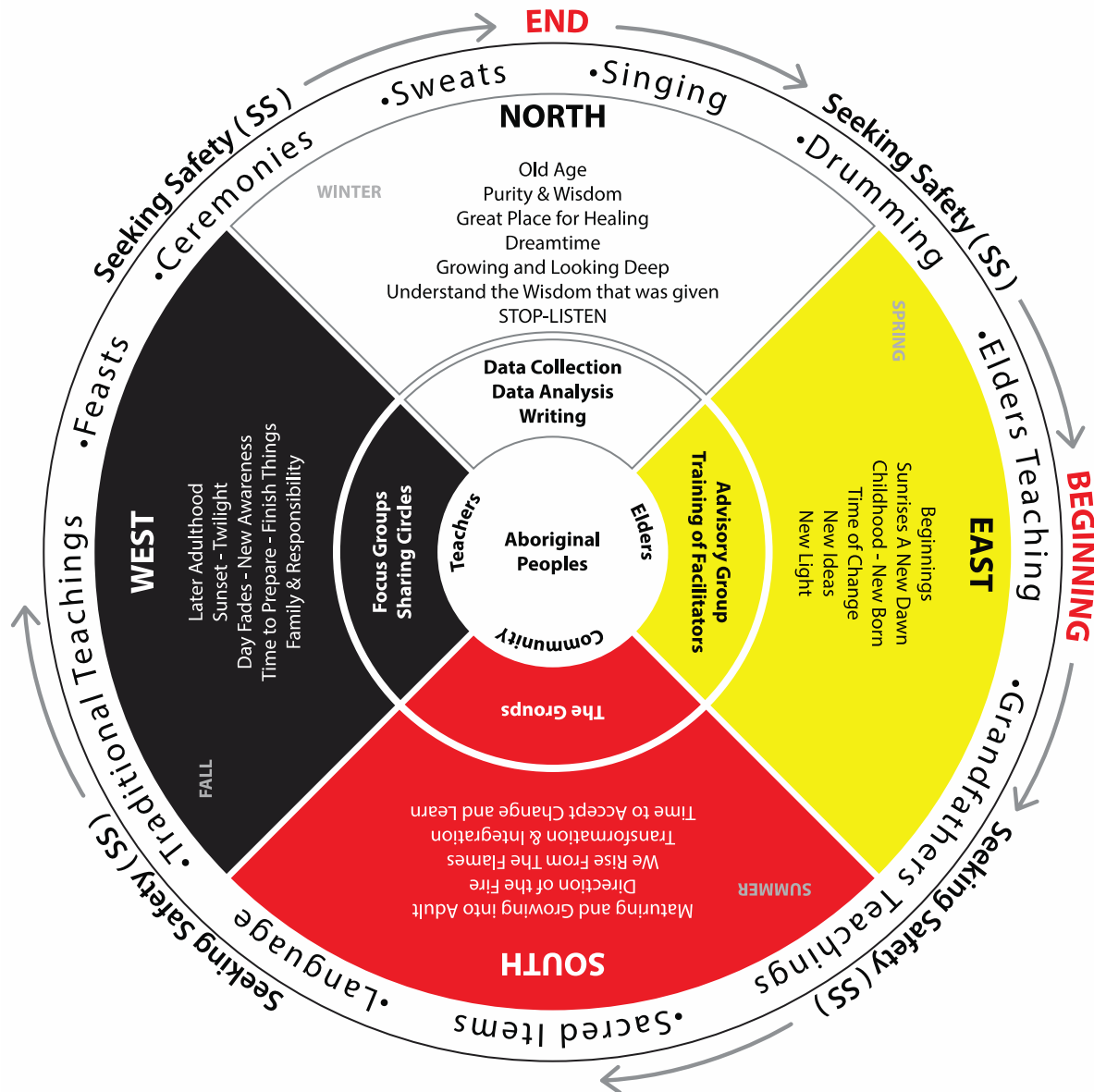
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Figure 1-1: Two-Eyed Seeing Blended Approach to Delivering the Seeking Safety Implementation Project Conceptualized in the Medicine Wheel



Chapter 4: Indigenous Healing and Seeking Safety: A Blended Implementation Project for Intergenerational Trauma and Substance Use Disorders

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Paper in Press

Marsh, T.N., Cote-Meek, S., Young, N.L., Najavits, L.M., Toulouse, P., (2015c). Indigenous healing and Seeking Safety: A blended implementation project for intergenerational trauma and substance use disorders. *The International Indigenous Policy Journal*. In Press.

Context for the Article:

This chapter is the third integrated article, and was submitted to the International Indigenous Policy Journal, was accepted for publication and under further review. This paper it explains and discusses the qualitative methods, results, discussion of study limitations and future research. Also, The findings from this phase helped address the research question: Is the integration of Aboriginal traditional healing practices into the Seeking Safety model effective for group treatment for intergenerational trauma and SUD in Aboriginal women and men?

Introduction

Many Indigenous researchers, traditional healers, and Elders agree that interventions that treat intergenerational trauma and substance use disorder in Aboriginal peoples should involve cultural interventions. This approach is critical in facilitating healing and fostering positive identity for Aboriginal peoples (Gone, 2009; Hill, 2009; Kovach, 2009; Mehl-Madrona, 2009). In this paper, the term Aboriginal refers to First Nations (status and non-status Indians), Métis, and Inuit peoples. This term is consistent with the legal definition in the Canadian Constitution. The word Indigenous will also be used interchangeably as it is the most identifiable within international contexts.

Indigenous peoples currently face many challenges, such as substance use and high rates of mental illness, which are directly related to the social determinants of health (SDOH) (Atleo, 2011; Brascoupe & Waters, 2009; Menzies, 2014). These SDOH include poverty, unemployment, poor education, poor nutrition, poor housing, and unclean water (Atleo, 2011). In the report “Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,” The World Health Organization’s (WHO) Commission on Social Determinants of Health highlights that social justice is a matter of life and death. Social injustice affects the way people live, their chance of illness, and their risk of premature death (WHO, 2008).

It is imperative that health-care professionals, universities, medical schools, hospitals, clinics, schools, Aboriginal organizations and communities advocate for changes in policy to address these substantial disparities in Indigenous and non-Indigenous peoples (Abdullah & Stringer, 1999; Armitage, 1995; Atleo, 2011; Cornell, 2006; Fast, 2010). Disparities between Indigenous and non-Indigenous peoples are well documented. According to the United Nations’

Human Development Report, Aboriginal peoples in Canada rank 48 out of 174 countries for their level of overall development, and 71 for education. In contrast, the rest of Canada ranks in the top five (UN, 2006). Furthermore, the Community Well-Being (CWB) gap between First Nations and non-Aboriginal communities is substantial. In 2011, the average CWB score for First Nations communities was 20 points lower than the average score for non-Aboriginal communities. This gap is the same size as it was in 1981 (Aboriginal Affairs and Northern Development Canada, 2015), an indication that there has been no progress in the well-being of First Nations communities in more than two decades. In addition to these more commonly used measures of well-being, Aboriginal peoples in Canada are currently struggling with very high rates of suicide and substance use disorders (Assembly of First Nations, 2007; Kirmayer, 1994). For example, the 2010 Regional Health Survey (RHS) identified that almost two thirds of First Nations adults who drink meet the criteria for heavy drinking. In addition, First Nations males appear to be at higher risk of heavy drinking (and related harms) compared to females. Heavy drinking is associated with a range of harmful effects, including a variety of health conditions and traumatic injury. Therefore, greater efforts are needed to encourage moderate drinking among First Nations adults who choose to consume alcohol, and abstinence among those who have developed alcohol dependence (FNIGC, 2012).

This study was created in response to the difficulties that exist in the current health status of Aboriginal peoples, and the lack of treatment models that address intergenerational trauma and substance use disorders. The purpose of this study was to explore whether the blending of Aboriginal traditional healing practices and a Western treatment model Seeking Safety could a feasible way to address both disorders (Marsh, Coholic, Cote-Meek, Najavits, 2015a; Najavits, 2002a).

Literature Review

Many Aboriginal leaders and communities in Canada are currently expressing worrisome messages about the increase in substance use, and the spread of human immunodeficiency virus (HIV) and hepatitis C virus among young Aboriginal people (Spittal, et al., 2007). For example, the Cedar Project (2003-2007), a prospective cohort study involving Aboriginal people in Vancouver and Prince George, British Columbia, found that injection drug use accounts for the majority (70%-80%) of hepatitis C infections in young Aboriginal people in Canada under the age of 24 years. In addition, the same study found that over half (59%) of HIV infections in Aboriginal peoples are also caused from injection drug use (Spittal, et al., 2007). Aboriginal and non-Aboriginal scholars agree that the high rate of substance use, suicide and self-harm are related to the impact of residential school abuse and the resultant intergenerational trauma on Aboriginal peoples (Duran, 2006; Evans-Campbell, 2008; Gone, 2008; Kirmayer, et al., 2009; Waldram, 1997; Wesley-Esquimaux & Smolewski, 2004).

The term “historical trauma,” also referred to as cumulative trauma (Brave Heart, 1998), soul wound (Duran, 2006), and intergenerational trauma (Oliver, 2003; Whitbeck, et al., 2004) originated from research into the experiences of Holocaust survivors and their families (Danieli, 1989; Erikson 1963; Fogelman 1991; van der Kolk, 1987). Intergenerational trauma refers to the cumulative emotional and psychological harm experienced throughout an individual’s lifespan and through subsequent generations (Brave Heart & DeBruyn, 1995; Gagne, 1998). Brave Heart and DeBruyn (1998), Gagne (1998), and Menzies (2014) agree that intergenerational trauma occurs when the impact and damaging effects are left untreated in one generation. The term was identified to have significance for Aboriginal populations when Brave Heart (1998) applied the concept of intergenerational trauma in her study of the Lakota people. She concluded that most

participants in the study displayed symptoms related to trauma, such as depression and anxiety. Brave Heart (1998) agreed with other researchers that trauma experienced by more than one generation becomes internalized within the family and community (Brave Heart, 1998). Many Aboriginal peoples suffer from intergenerational trauma, which is associated with more than 400 years of systematic marginalization (Abdullah & Stringer, 1999; Armitage, 1995; Couture, 2000). It is well understood that the core of Aboriginal family and community issues—including multiple mental health challenges, suicide, and substance use disorders—are the result of the impact of colonization and in particular, experiences at residential schools in Canada (Chansonneuve, 2007; Fontaine, 2010; Menzies, 2014).

Inspired by the work of Judith Herman (1997), Wesley-Esquimaux and Smolewski (2004) introduced a new model for trauma transmission and healing. They suggest the presence of complex or endemic post-traumatic stress disorder (PTSD) in Aboriginal culture originated as a direct result of historic trauma transmission (HTT). They described their model of trauma transmission as follows:

The trauma memories are passed to next generations through different channels, including biological (in hereditary predispositions to post-traumatic stress disorder), cultural (through story-telling, culturally sanctioned behaviors), social (through inadequate parenting, lateral violence, acting out of abuse), and psychological (through memory processes) channels. (p. 76)

Haskell and Randall (2009) state that Wesley-Esquimaux and Smolewski's finding is very significant because it "delineates a connection between the use of alcohol as a form of coping or numbing feelings by people attempting to deal with overwhelming current and/or historical traumas" (p. 71).

According to the literature, the key to healing from intergenerational trauma lies in reclaiming identity (Gone, 2008; Kirmayer, 2009; Tuhiwai Smith, 1999; Waldram, 1997). Reclaiming Aboriginal identity means recovering traditional values, beliefs, philosophies, ideologies and approaches, and adapting them to the needs of today (Menzies 2014; Proulx and Perrault, 2000). This reclamation process encompasses both individual and collective identity, and can be sought by way of traditional healing methods. To encourage reclamation of identity, Aboriginal Health Access Centres and Friendship Centres were established across the country (Blum, 2005; Couture, 2000). These centres revived traditional healing practices through the teachings of Elders and traditional healers. They also offered physical, emotional, mental, spiritual, language and educational support to Aboriginal peoples (Blum, 2005; Couture, 2000). These efforts have been employed to encourage resiliency (the capacity of an individual/culture to cope successfully in the face of significant adversity or risk), a characteristic that many Aboriginal communities (both rural and urban) agree must become a central strategy to reclaim Aboriginal identity (Frideres and Gadacz, 2008; Norris, 2000).

In response to this Aboriginal identity renaissance, many health-care professionals have moved toward more holistic, culturally sensitive approaches to care. In addition, many health-care professionals have endeavored to blend mainstream health-care practices with traditional Aboriginal healing practices (Martin-Hill, 2003; Poonwassie & Charter, 2005; Rojas & Stunley, 2014). The blending of Aboriginal and Western research methods, knowledge translation, and program development is a concept called Two-Eyed Seeing (Iwama, et al., 2009). Two-Eyed Seeing recognizes Indigenous knowledge as a distinct and whole knowledge system that exists side by side with mainstream (Western) science (Iwama, Marshall, Marshall, & Bartlett, 2009). In a recent literature review, Rowan et al. (2014) agreed with other researchers (Duran, 2006;

Hill, 2009; Kovach, 2009; Menzies, 2014) that the utilization of the Two-Eyed Seeing in treatment and research was a useful approach to supporting healing in Aboriginal communities. The search for a respectful research paradigm for this project led to the selection of a Two-Eyed Seeing approach. Two-Eyed Seeing guides this work and is an example of the application of an Indigenous decolonizing lens. Therefore, Two-Eyed Seeing provided valuable guidance in the blending of Seeking Safety with Aboriginal healing practices (Iwama, et al., 2009).

Two-Eyed Seeing has been integrated into some forms of research and clinical practice and appears to be well suited to substance abuse treatment for First Nations adults. It is important to note that a thorough review of the literature did not identify any examples of the integration of Aboriginal traditional healing practices and mainstream treatments with for substance use and intergenerational trauma—a critical gap in both practice and research. This research sought to explore the potential of such an approach in the treatment of intergenerational trauma and substance use disorders in an Aboriginal population.

The mainstream intervention chosen for this research was the Seeking Safety model, which has been found to be effective in a variety of settings (Najavits & Hien, 2013). The perspective of Seeking Safety is convergent with Aboriginal traditional methods. Due to the content and delivery method of Seeking Safety, the program complements traditional teachings such as holism, relational connection, spirituality, cultural presence, honesty, and respect (Gone, 2008; Lavallée, 2008; Menzies, 2014). Specifically, this model was chosen because it offered an individually empowering approach to the treatment of trauma and SUD (Najavits, 2002a).

The Seeking Safety program is a well-researched, psycho-educational individual or group counselling intervention that targets the unique problems that result from substance use and post-traumatic stress disorder (PTSD). The model has been translated into numerous languages with

implementation internationally (Najavits, 2002a, 2007, 2009; Najavits, & Hein, 2013). In addition, it has been used successfully among many minority populations, including African-Americans, Hispanics, and Asian-Americans, as well as women and men in prison, adolescents, and men returning from combat (Najavits, 2009). Gatz et al., (2007) reported that adult women who participated in Seeking Safety (in the context of additional substance use disorder and mental health services) demonstrated greater reduction of PTSD symptoms and improved coping skills compared to women participating in traditional residential treatment programs for substance use. Hien, et al., (2004) compared the effectiveness of Seeking Safety and relapse prevention with non-standardized community care treatment for 107 urban, low-income, treatment-seeking women. Participants' substance use and PTSD symptoms improved in Seeking Safety and relapse prevention, but not in the community care treatment. In their review of the literature on treatment studies for co-morbid substance use disorder and PTSD, Najavits and Hein (2013) showed positive outcomes on multiple domains. They found that the Seeking Safety program was the only treatment outperforming a control on both PTSD and substance use disorder (Najavits and Hien, 2013).

Indigenous research framework, methodology and approaches were applied throughout the entirety of this project. These included:

- the application of Two-Eyed Seeing;
- consultation and collaboration with Elders;
- the establishment of an Aboriginal advisory group; and
- the incorporation of Aboriginal traditional healing practices (Marsh et al., 2015a,b).

The use of the Seeking Safety treatment model in combination with Aboriginal healing practices

was explored in this paper. This implementation project was co-created with Aboriginal Elders, who also collaborated on the development of the Medicine Wheel (See Figure 1). Various Aboriginal, culturally based methods were used during the application process and during the traditional ceremonies. These ceremonies included:

- Sweat lodge ceremonies, a cultural practice performed in a heated, dome-shaped shelter that uses heat and steam to cleanse toxins from the mind, body, and spirit;
- Smudging, the burning of sacred herbs in a small bowl to purify people and places;
- Drumming, the use of ceremonial drums and songs as a way to connect with the Creator and spirit;
- Sharing circles, a healing method in which all participants, including the Elders, are viewed as equal and information, spirituality, and emotionality are shared;
- Sacred bundle, a very precious possession that represents a person's spiritual life;
- Traditional healers, who use a wide range of activities for the promotion of psychological and spiritual healing, such as herbal medicines;
- and Elder teachings (Marsh et al., 2015a,b; Menzies, 2010; Robbins & Dewar, 2011).

Methods

This study seeks to address the question: Can the integration of Aboriginal traditional healing practices into Najavits' (2002a) Seeking Safety model produce a feasible, suitable, and beneficial group treatment for Intergenerational trauma and SUD in Aboriginal women and men? A qualitative Indigenous decolonizing methodology was used during this project.

The process of decolonization requires ethically and culturally acceptable approaches to the study of issues involving Indigenous peoples (Menzies, 2010; Smith, 1999; Wilson, 2008). Decolonization is further described as Indigenous peoples embracing an understanding of the

history of colonization and rediscovering their ancestral traditions and cultural values (Duran, 2006; Hart, 2010; Wilson, 2008). It is a healing journey that involves painful emotions such as grief, anger, rage, growth and empowerment (Liamputting, 2010; Smith, 1999; Wilson, 2008). To be consistent with a decolonization approach, the honoring of cultural informants and knowledge is important. Since this study incorporated Aboriginal traditional healing practices, the Elders, an Aboriginal advisory group, Aboriginal scholars and clinicians (also called cultural informants) were consulted throughout the entire research process.

Four facilitators and two students were selected to lead the Seeking Safety groups, which for our purposes were called “sharing circles.” The Elders advised that these individuals should be Indigenous and have experience working with Aboriginal peoples. All four facilitators had previous experience working with women and men who have experienced trauma and SUD. As a competent practitioner in the Western Seeking Safety model, the first author trained the facilitators in group facilitation and delivery of the sharing circles. The training lasted for one week, eight hours per day and consisted of didactical, experiential, small-group learning, and practice sessions. The training was video recorded so that facilitators could critically reflect on their techniques. Furthermore, discourse on group methods, group process, therapeutic use of self, and expectations were included.

Participants

Participants were recruited by counsellors and health-care workers from the following locations: N’Swakamok Native Friendship Centre, Iris Addiction Recovery for Women, Salvation Army Addiction Treatment Centre, Waters of Change Counseling Centre, Rockhaven Recovery Home for Men, Shkagamik-Kwe Health Centre, and Ontario Addiction Treatment Centers (OATC) Sudbury. In addition, participants were also recruited via workers on reserve in

the surrounding area of Sudbury. Referrals were sent to the first author who held appointments with prospective participants.

A convenience sampling approach was used to recruit 24 participants (12 women and 12 men) who self-identified as Aboriginal. All participants were willing to accept a method of treatment that incorporated Aboriginal traditional healing practices. In addition, all participants resided off reserve in Northern Ontario and were between the ages of 24 and 68 years (with an average age of 35 years). Of the 24 participants, 16 identified as Ojibway, two as Cree, and six as Métis. Furthermore, all participants self-reported that they had: intergenerational trauma and substance use (actively using or not); no active psychosis; no acute withdrawal; and no current suicidality or homocidality. The cultural informants deemed self-reporting culturally appropriate for identifying substance use and trauma symptoms. This study was approved by the Laurentian University Research Ethics Board in May 2013. Written informed consent was obtained from all participants.

The Application of Sharing Circles

The Seeking Safety model can be conducted as a group or individual treatment method. For the purposes of this project, it was offered as a group treatment. This choice was made deliberately to allow the sessions to be offered via sharing circles, a practice that is well known and comforting for some Aboriginal peoples in Canada. In Northern Ontario, sharing circles are often used in Aboriginal communities as part of ceremonies and a way of healing (Restoule, 2004; Stevenson, 1999).

In accordance with the recommendations of the Elders who guided this study, the sharing circles were offered separately to male and female participants. The Elders advised that gender division was important to ensure that participants felt comfortable and safe during the sharing

circle sessions. The men's sharing circles ($n = 12$) took place at the Rockhaven Recovery Home for Men, located in Sudbury, Ontario. Rockhaven delivers a recovery program that empowers Aboriginal and non-Aboriginal men to develop a personal program of recovery from substance use disorders. Forty percent of the men served by Rockhaven are of Aboriginal ancestry (Patricia Delyea, personal conversation, April 15, 2013). The female sharing circles ($n = 12$) took place at the N'Swakamok Native Friendship Centre in the same city. The N'Swakamok Native Friendship Centre assists Aboriginal peoples by providing programs that serve the social, cultural, and recreational needs of the urban Aboriginal community. Each of the sharing circles were co-facilitated by two Aboriginal health-care workers and one student (now called facilitators). These facilitators organized and led sharing circles twice a week for 13 weeks. Each weekly sharing circle was two hours long.

The facilitators, while covering the Seeking Safety topics (e.g. when substances control you, dealing with anger, setting boundaries in relationships, and taking good care of yourself), used the culturally relevant method of storytelling. They incorporated teachings about the history of the Aboriginal peoples, as well as the Seven Grandfather Teachings that discuss human conduct with an emphasis on wisdom, love, honesty, respect, bravery, humility, and truth (Benton-Banai, 1988). One Elder was also present at most sessions to help participants develop a connection to the spiritual world through traditional teachings (Menzies, et al., 2010). The Elders taught about Two-Eyed Seeing while also focusing on the positive identity of each person in the circle. Two of the facilitators were also traditional healers at the Friendship Centre. Therefore, their presence as both facilitators and healers was powerful in the sharing circles. Their skills included abilities to promote psychological and spiritual healing and complement the Elder teachings (Gone, 2008; Menzies, 2014; Najavits, 2002b; Restoule, 2004).

To encourage a holistic view of mental health and substance use (which includes connection to community), many Indigenous protocols were incorporated into the sharing circles. Each sharing circle was opened and closed with smudging, ceremonial drumming and singing. Tobacco, a herb recognized in Aboriginal culture for its healing powers, was prepared in bundles in advance of the sharing circles. It was offered to each participant for protection and healing. Participants were also invited to participate in sweat lodge ceremonies.

Data Collection

The first step in the data collection process was the initial meetings with the 24 participants, which were approximately 90 minutes in duration. Participants were briefed about the sharing circles, specifically regarding the process and how the program will be offered. Participants were given information about the duration of the program, the methods that would be used, and their role in the treatment. It was important and respectful for participants to know what to expect throughout their involvement in this research process.

In the second step of the data collection process, all 24 participants were given an end-of-session Seeking Safety questionnaire to complete at the end of each of the 25 sharing circles. This questionnaire was designed as part of the Seeking Safety program (2002a) to capture the immediate and specific reaction of participants to the Seeking Safety content (See Appendix F).

The third step of data collection involved conducting end-of-treatment sharing circles for each group (of the nine women and eight men who completed the program). This qualitative data was specifically collected via a 90-minute end-of-treatment sharing circle with participants. One end-of-treatment sharing circle was held for each of the two treatment groups. Both of the sharing circles were held within two weeks of the group's last treatment-related sharing circle (See Appendix G).

As the fourth step of the data collection process, 75-minute semi-structured interviews were conducted with each of the 17 participants who completed the program. These semi-structured interviews were also carried out with each of the two facilitators (See Appendix H).

Data Analysis

All discussions from the end-of-treatment sharing circles and the semi-structured interviews were audiotaped and transcribed verbatim using pseudonyms to maintain participant confidentiality. After transcription, a qualitative thematic analysis was initiated to examine the data. This method was selected to be consistent with cultural data analysis models that require more involvement and interpretation from the researcher (Bernard & Ryan, 1998; Denzin & Lincoln, 2005). First, the text was read and re-read to identify and describe implicit and explicit ideas within the data (Creswell, 2009). Next, codes were developed to represent the identified themes and link the raw data as summary markers. Code frequencies and code occurrences were then compared and the emerging relationships between the codes were graphically displayed. Finally, four emerging themes were identified (Bernard, 1998; Creswell, 2009) (see the Participant Medicine Wheel in Figure 1 on page 171). These themes were shared with the 17 participants and they all confirmed accurate depiction of their experiences during the implementation of the project.

During data analysis, the Elders who guided this research process explored the four core themes and confirmed that these themes connected with the teachings and four quadrants of the Medicine Wheel. The Elders recommended that the results be depicted through the lens of the Medicine Wheel in order to authenticate the Two-Eyed-Seeing and the Indigenous decolonizing methodology (J. Ozawagosh & F. Ozawagosh, personal conversation, January 5, 2014)

Results

The following four core themes were identified: (a) healing through traditional Aboriginal healing methods; (b) impact, education and knowledge through sharing circles; (c) awareness, understanding, and the link between trauma, substance use, and the impact of colonization; and (d) integration and application of knowledge. The participants will be identified as male or female participant 1, 2 or 3 and so forth (P1, P2, P3).

Healing Through Traditional Aboriginal Healing Methods

The sharing circles and the presence of Elders, Aboriginal facilitators, sacred bundles, sacred teachings, sacred medicines and ceremonies strengthened the experience of participants. Most participants reported that the inclusion of traditional healing approaches and the presence of Elders were helpful. Seven of the participants explained that they had lost their traditions by growing up off reserve, or that their families did not follow the traditional way. P4 of the female group noted that, “it was really good to be brought back to my own traditional ways; I have never attended an addiction program that included my cultural beliefs and values; I could see how it helped all of the women.” P16 of the male group reported that, “all the ceremonies helped me so much; it really grounded me when I felt scared; I could see how the spiritual and the presence of Creator was bringing the healing to others that really struggled.”

Many of the participants reported similar experiences during the sharing circles. Several participants said that all Aboriginal programs should include traditional practices because they facilitated culturally meaningful healing. P13 male explained, “I loved it when the Elders came [and brought all the sacred teachings and healing]; I wanted them to come to every session; the Elders facilitated the healing power of the smudging, drumming songs and the sacred Bundle; the Elders brought the spirituality to the circle; the Elders gave everyone and me in the circle that

connection [with the sacred medicine].” Participants also remarked on the benefit of the sweat lodge ceremonies. Most who attended the sweat ceremony claimed that they felt the healing happening in their bodies and minds. For example, one participant said:

As I was sitting with the Elders in the sweat ceremony, I could see my addiction and trauma pains melt away in the heat; the ceremony brought healing for us all and it is so powerful; I have not attended a sweat ceremony in many years.” [P19 male]

Similarly, P2 female said, “I really liked it when the facilitators brought in the traditional ways; they were so good to us and never judged us, even when we told them we used.” As the participants talked about their experiences with traditional healing practices, many of the participants said “Miigwetch” (which means “thank you” in Ojibway) to the facilitators and the Elders for respecting their tradition and bringing it to them in this treatment program. Also, most of the participants praised the fact that the treatment was offered in sharing circles. P8 female said, “it was good to come and sit in the circle every week; the circle is the way we do ceremony and I felt safe knowing I am in ceremony.”

All the participants affirmed that the Elders and facilitators helped them to heal and rediscover their identities. An example of this can be found in the female group when the facilitators decided to invite the women to take turns setting up the sacred bundle. This aspect of the treatment was highly praised by the female participants. P1 stated, “I felt so honored when I was asked by the facilitators to set up the sacred bundle and medicine; I felt valued, trusted, and respected, as I was never asked to do this before.” Several of the participants, both male and female, commented on the power of the singing and drumming. P15 male reported, “whenever I heard the song and drum, my pain would go away, my fear would leave my body; it was so powerful.”

Many of the participants shared their feelings about the loss of their land and tradition. These conversations emerged during the initial intake sessions and during the completion of the historical loss questionnaires. As P15 male stated, “nobody ever asked me this question about how I felt about losing my land; I did not even know that I thought about it so often; my grandfather took me hunting when I was a boy, and I feel that happiness now, in these circles with the Elders.” P4 female shared, “I love the bush; when I am in the bush I feel strong and whole; when I feel sad, I go to the bush.”

Impact of the Education and Knowledge through Sharing Circles

Most of the participants identified that the information in the Seeking Safety handouts was written in a way that they could understand. They also reported that the language was clear, sensitive, positive, and supportive. The participants thanked the facilitators for working through all the topics in such a systematic and gentle way, and described the facilitators as caring, compassionate, and kind. Several of the participants revealed that they now understand the role that their symptoms play in their lives, and how trauma and addiction impacts them daily. As some participants stated: “at this point in the program, I have been able to relate my experiences on PTSD and honoring myself through the culture and the support of people;” “today was a real eye opening experience realizing how substance abuse is connected to [my] trauma;” “it was such an eye opener to realize that all these symptoms I’ve had all my life are a normal result of my childhood trauma;” “I am very thankful.”

Furthermore, participants began to articulate how the growing knowledge of their symptoms empowered them. For example, most participants expressed how the sharing circles, handouts, and content brought a deeper understanding about the pain and suffering caused by trauma and substance use. P7 female stated:

I finally found my voice; I can be safe doing my healing work and I need not be re-traumatized; my workers understand that my addiction and trauma must be treated at the same time; I now know how to ask for help; I realized in this circle that I was never alone and I have all the resources that I need; I now understand how that addiction and trauma work together.

Most participants appreciated the binder of Seeking Safety materials that they received, which included all the Seeking Safety topics and highlighted the benefit of being able to go back to the material at any time. The information about safety in the Circle was taught through safe coping skills, a safe coping sheet, a safety plan, and a report of safe and unsafe behaviors at each session. Most of the participants expressed that these topics helped them to feel safe in the sharing circle and that they could begin to apply this safety in their daily lives. For example, P15 male explained:

I really like this Seeking Safety stuff; it's so easy to understand it; I leave the binder on my coffee table and I see how my 17 year-old son reads the handouts; it's so good for my children to know that I am healing.

Many participants reflected on how powerful it was to understand how they brought substances into their lives to help them deal with the pain and suffering of the trauma and abuse. They stated that this new knowledge helped them feel strong again, and confident that they could heal and get better. Others reflected on how difficult it was to hear some of the topics. P2 male reflected, "if only I knew this then, I could have been better already, because I hurt myself so much over the years." The facilitators always reminded the participants that they have to be in the present moment and to give thanks for the knowledge that they are receiving now. Some

participants reported that sitting in the circles was hard sometimes, but they were always there for each other and they bonded, connected, and became like a family.

Chansonneuve (2007) explained that some residential school survivors express their grief as lateral violence directed toward family and community members, thereby creating intergenerational cycles of abuse, which resemble many of the experiences at the residential schools (Chansonneuve, 2007; McCormick, 2009). One tangible example of lateral violence was that half of the women in this research had lost their children to the Children's Aid Society (CAS). They expressed how painful, shameful, and emotional this was for them to have lost their children due to their substance use. They also began to make the connection about how they have continued to numb themselves with substances to ease the pain of missing their children. P5 female stated:

I feel a pain deep here in my heart when I think of my babies; it is not right what they did; the residential school is just still here and now it's called CAS; I feel sometimes like just dying, but then I drink to stop the pain.

Five of the women gained custody of their children during the second and third months of the program. When the women reported this in the sharing circle, it was powerful and empowering for all the women in the Circle. For example, when the first woman regained custody of her two daughters, she shared the news in the sharing circle and encouraged the other women who lost their children not to give up. It was also an encouragement for the other women to embrace the program and the healing journey. During this time, the Elder gave the women a teaching about taking good care of their children and encouraged the women not to give up hope.

Most of the participants appreciated the fact that the facilitators handled substance use relapses compassionately. Participants knew that they could come back to the circle, be honest

about their use without judgment. This was extremely transformative for both men and women, who felt that the supportive nature of the facilitators helped them to heal. For example, one participant stated, “the facilitators, oh man they’re awesome; you can’t say a bad thing about them, it’s unreal; they helped us all; they never judged the ones that used; they always just welcome them back, man; they helped P18 quite a bit too because he had lots of problems.” [P1]

Participants also reported that they had received much wisdom from the Seeking Safety topics. For example, some participants said, “I experienced more peace; I am more peaceful, more joyful; That’s how much this program affected me; Just by hearing those others, with their problems, growing up and their childhood traumas, helped me a lot; and every one of those sessions I attended changed me somewhat; And after the sessions, it’s like a new you coming out of those sessions; that’s how much it affected me.” Frequently mentioned topics that were identified as particularly helpful to participants included: honesty; red and green flags; integrating the split self (where the person experiences different parts, for example the angry self or harsh self); and coping with triggers. Furthermore, most of the participants reported feeling safe, cared for, and empowered. Both male and female sharing circle participants reported how powerful it was to share their stories with others who had similar experiences. P8 female shared, “I am not alone; I am not the only one going through this; Seeking Safety taught me that I started to use alcohol because of my trauma and that I can heal from both [the trauma and the addiction concurrently].”

Most of the participants reflected on things that they internalized through learning about the Seeking Safety topics, including morals, values, culture, and language. For example, P17 male stated, “this program is amazing; I want to share it with my family because now I understand why I was so hard on myself and why I hurt my family; this is good stuff.” Others

shared the connections they made with why and how they had feelings of shame, guilt, pain, and disconnection, and why they hated themselves. P2 female noted, “Seeking Safety language is so soft and gentle, and it helped me to forgive myself for things I did in the past.” Many stated that the topic on commitment gave them knowledge about taking responsibility. Most participants reported that the language used in the Seeking Safety model was similar to the Seven Grandfathers teachings because it focused on respect, honesty, love and compassion for self and others.

Awareness, Understanding, and the Link between Substance Use, Trauma and the Impact of Colonization

This theme emerged very powerfully in both male and female sharing circles, as well as during the semi-structured interviews. Most of the participants stated that even though all the Seeking Safety topics were different, each of the sessions and topics helped them to understand trauma, the impact of colonization, substance use disorders and their interrelatedness. Participants expressed their learning and understanding through “a-ha” moments. They remained in awe of the new knowledge and understanding as they began to realize that they could control their self-destructive behaviors.

Both male and female participants began to understand their trauma and substance use as they began to identify when they needed to self-medicate with substances (triggers). They could feel their dependence during the times they craved substances. They also learned that they experienced physical changes in the body during these times. Because of this new insight into their behaviors and physical reactions, they learned to put words to the feelings. For example, P4 female stated: “I feel that same [wanting to drink when I am sad] feeling and hurt and I know exactly what you [the other participants] mean, because it [the cravings when I am sad] happens

to me all the time.” This confirms that P4 has a better understanding about her sadness and the need to remove the emotion by using substances.

Participants reported that when they began to understand the information and connection between substance use and their trauma, they could make healthier decisions in their lives. In both male and female sharing circles, the teachings about safety, self-care, and acknowledgment of their trauma and substances had a profound impact on their day-to-day lives. These teachings were reported in almost every circle through the participants’ statements. An illustrative example of this was depicted when P18 male explained:

When I completed that historical loss scale, I realized that I never thought about these losses in this way; yet now that I am asked about it, I realized that it had a profound effect on me and my family; I understand now why I get so very angry, because we are still living it [the historical trauma]; we live it every day.

P17 male also shared the impact of these realizations:

I can see now why it is so important for me to have compassion for my trauma and addiction; I witnessed how my parents used alcohol and how they hurt themselves; both my parents went to residential schools and they never talked about it; they only drank, and hurt us and themselves and they died when I was a boy.

Stories like the above often emerged during the circles. During the sharing of such a painful story, the facilitators would burn sacred medicine and place it at the feet of the participant to help with self-regulation of the pain. The presence and the teachings from the Elders assisted with bringing clarity and awareness to the participants. The knowledge and teachings also connected the participants to their tradition and spirit.

Integration and Application of Knowledge

When participants were asked about their experience in the sharing circles, both men and women discussed traditional healing elements and the Seeking Safety topics. These elements included smudging, drumming, teachings by the Elders, the Seven Grandfather Teachings, and the sweat lodge ceremonies. Participants discussed how the Seeking Safety topics informed them about trauma and the use of substances. They further stated they could use this new knowledge to continue the healing. For example, P11 female explained, “I realized that I was healing and that I can heal; as I heal, my children will heal also; as my children heal, my family will also heal; as my family heals, so will my community.” Other participants said, “When I was in the circle, I was held [feeling safe and supported] by all the ceremonies, the sacred medicine, the teachings by the Elders, and the love of the facilitators;” “Other aspects that I found helpful were that we were given tools to help us in our recovery; we were given topics that helped us with self-care; I thought that was important, as many people suffer with trauma and only know to cope using substances; the topics that were covered not only shed light on our illness, but also gave us tools to cope with it.” These statements continued throughout the transcripts and in the end-of-session questionnaires.

The words and stories of the participants provided a clear indication of the impact of sharing circles. Many of the participants reported that they felt they could connect with their identity through ceremony and understanding trauma, and their symptoms and behaviors. This acknowledgement from the participants of the impact of integrated implementation is further supported by the work of McCormick (2005), who confirms that, “one of the roles of therapy for traditional Aboriginal society has been to reaffirm cultural values” (p. 298). Therefore, the

integration of Aboriginal traditional healing practices and the Seeking Safety model encouraged participants to consider different core components of the healing process.

Discussion

This study set out to identify whether or not Aboriginal traditional healing practices incorporated into (2002a) Seeking Safety treatment model would be a feasible, suitable, and beneficial group implementation project for intergenerational trauma and substance use disorders in Aboriginal women and men. This blended implementation project profoundly affected the symptoms and behaviors related to intergenerational trauma and addiction in the participants, particularly for the seventeen completers.

Integration of the Core Themes into the Medicine Wheel

Brave Heart (1995), Duran (2006), Hill (2009), Marsh et al. (2015a) and Menzies, (2014) agree that restoring Aboriginal traditional healing practices and knowledge is a pathway to both empowerment and health for Aboriginal peoples and communities. However, to achieve this goal, the traditional knowledge once practiced in historical Aboriginal societies needs to be restored. In addition, traditional knowledge must be included in intervention measures aimed at substance use, trauma, and the epidemics facing Aboriginal peoples (Marsh et al., 2015a).

The proposed descriptive framework brought together the four core themes: (a) healing through traditional Aboriginal healing methods; (b) impact, education and knowledge through sharing circles; (c) awareness, understanding, and the link between trauma, substance use, and the impact of colonization; and (d) integration and application of knowledge. The Medicine Wheel was used as a visual tool to conceptualize the integrative process and the Two-Eyed Seeing approach. Figure 1 (see page 170) illustrates how the components of the Medicine Wheel and the sharing circles influenced the participants' learning, healing, and growth. This Medicine

Wheel was adapted from an article by Rod Vickers. In addition, the framework is based on the work of Duran (2006), Martin-Hill (2003), and Nabigon (1999 & 2006). There are many interpretations of the Medicine Wheel; however, for this research, an outer circle was added. This depicts the Seven Grandfather Teachings that contributed to the participants' learning, guidance, and growth throughout this implementation project.

The Medicine Wheel and the First Quadrant

The first quadrant is white and represents the North, winter, and the mental and intellectual mind. The Elders taught that the North in the Medicine Wheel represents purity and wisdom, healing, dreamtime, growing and reflection, understanding the wisdom, and listening (Menzies et al., 2010; 2003; Nabigon et al., 1999; Nabigon, 2006). This quadrant depicted the core theme of integration and application of knowledge. The themes that emerged via the quotes from the participants included connections to their children, the land, their culture and the Elders. For example, some participants reported, "we looked forward to seeing each other each week; we were worried about others, when they did not make it to the Circle; we would say a prayer, like we became connected like a family;" "I liked everything in the Circles; we became like a family, we were always thinking about the other person [the no shows]; to be dedicated two times a week for three months was a big thing, but we came, we made it and it was good;" "the women were all very helpful, being open to each other, trusting each other, and talking about their souls, because I can relate to a lot of these stories of theirs; I know now that I am not alone;" "I did not know that I was so affected by the loss of my land; I knew about the loss of my culture and now I see that I really miss being on the land and the Elders taught about this [connection to the land and culture]."

Traumatized people often lose the meaning of life, perceive that they are hopeless and have periods of time in which they feel de-humanized. Some authors refer to this condition as a spiritual crisis or soul wound (Duran & Duran, 1995). This disconnection has an even greater effect on their sense of community and belonging, moving them further into feelings of isolation, shame, guilt, and self-blame (Drake, 2003; Duran, 1995; Herman, 1997; Marsh, 2010). While participants reported these emotions and feelings often in the beginning, the symptoms lessened as the treatment progressed. Furthermore, it is well documented that connection to land, the physical environment, cultural practices, and spirituality enhance community well-being (Colomeda & Wenzel, 2005; Duran, 2006; Kirmayer, 2003; Menzies, 2014; Thatcher, 2004). The loss of land, culture, and language through colonization left many communities in turmoil with no strategies to enhance their healing (Brave Heart-Jordan and De Bruyn, 1995; Duran, 2006; Gone, 2009; Smith, 1999; Waldram, 2008; Warry, 2008). These connections and powerful moments of seeing and connecting came through clearly in all four themes.

The Medicine Wheel and the Second Quadrant

The color yellow is in the East. It represents Spring and the spiritual aspect of the mind. The Elders taught that the Spring in the Medicine Wheel represents beginnings, sunrise and a new dawn, children, change, new ideas, and a new light (Menzies et al., 2010; 2003; Nabigon et al., 1999; Nabigon, 2006). This quadrant depicted the core theme of healing through Aboriginal traditional practices. The evidence supporting this statement comes from the voices of the participants themselves who concluded that the below aspects supported their healing during the program.

- the teachings from the Elders and participants;
- the healing power of drumming;

- smudging;
- sweat lodge ceremonies;
- the sacred bundle; and
- the sacred medicines

Many participants discussed feeling a sense of freedom in themselves and feeling connected with others in the Circle. Some talked about the healing that took place during the sharing circles. For example, some participants stated, “it was nice to see that all the Spiritual stuff was incorporated, because growing up I never had that type of experience [with the traditional practices]; I enjoyed the Elders coming and teaching us; [the Elder’s] body language was warm; she would sing and pray and I felt moved by the Spirituality of it.” This sense of freedom is often discussed by trauma survivors (Duran & Duran, 1995; Herman, 1997). It is understood that trauma or PTSD takes away that connection to self, others, and the world. The activated nervous system is often experienced and described by survivors as a felt sense of living in a prison. When people finally begin to heal, this sense of safety and freedom returns (Haskell & Randall, 2009; Herman, 1997; Marsh, 2010).

Duran (2006) writes that Indigenous spirituality is closely linked with culture, connection to land, and ways of living in Indigenous communities (Duran et al., 1998; Duran, 2006). Loss of land, culture, and spirituality, as well as the effects of colonization and oppression negatively influenced the well-being, strength, and courage of Aboriginal peoples. It is therefore critical that reclaiming culture, employing traditional methods, and integrating spirituality is a necessary approach to promote community empowerment and healing (Brascoupe & Waters, 2009; Brave Heart, 1998; Crazy Bull, 1997a).

The Medicine Wheel and the Third Quadrant

The color red in the South represents Summer and the emotional mind. The Elders taught that the South in the Medicine Wheel represents maturing and growing into adulthood. It also reflects the direction of the fire, rising from the flames, transformation and integration, and a time to accept change and learn (Menzies et al., 2010; 2003; Nabigon et al., 1999; Nabigon, 2006). This quadrant depicted the core theme of the impact of education and knowledge through the sharing circles. The new, self-identified coping skills that emerged from the participants included: finding our voices, getting clarity about the role of the symptoms, knowing that we are not alone, and understanding trauma and substance use. Many participants expressed, “what I found most helpful was the grounding; I never knew anything about that; I would always think that it was real [the flashbacks]; it felt real to me; but then we got these tools from Seeking Safety; now I ground myself and tell myself it is not real [the flashbacks and nightmares]; that’s what I found most helpful.” Others stated, “the most rewarding thing in the sharing circle was being able to witness the changes in the women, from when they came the first time through the doors and when they left, their facial expressions, their body language; just seeing the transformation in them was so healing.”

Some of these participant responses are discussed in the literature on group psychotherapy. For example, Yalom and Leszez (2005) talk about the power of shared testimonies of traumatized individuals. They specifically refer to the moment when two people compassionately respond to the needs of the other. Yalom and Leszez agree with other scholars that trauma destroys faith, decency, courage and connection. The power of a group or sharing circles resulted in a reawakening that can occur through common altruism by others (Brave Heart, 2004; Drake, 2003; Duran, 2006; Herman, 2006; Marsh, 2010; Yalom and Leszez, 2005).

Yalom and Leszez (2005) also state that individuals in groups mirror the action of others. In this way, the survivor recognizes and claims a lost part of himself or herself. In that moment, the survivor begins to rejoin the human community (Marsh, 2010; Yalom and Leszez, 2005). Many traumatized individuals lose their sense of connection, and often move into isolation. Therefore, communal connection, as was displayed in the sharing circles, was highly effective for the participants' healing (Marsh, 2010).

The Medicine Wheel and the Fourth Quadrant

The color black is in the West. It represents Autumn and the physical body. Elders taught that the West in the Medicine Wheel represents later adulthood, sunset and twilight, new awareness, time to prepare and finish things, and family and responsibility (Menzies et al., 2010; 2003; Nabigon et al., 1999; Nabigon, 2006). The fourth quadrant represented the core themes of awareness, understanding, and the link between substance use, trauma, and the impact of colonization. Participants reflected upon healing stories, listening, laughter, and understanding the connection of body and mind. For example, some participants reported, "I liked the topics where we worked with emotion, especially anger, because in my journey, I got myself into trouble because I did not know how to express myself; I did not know there were other feelings under the anger and I learned that in the Circles;" "There was no hysterical screaming or yelling or vomiting or any of that violent stuff in this program, just gentle release of tears; I really loved that; so I have been able to use some of the stuff I learned in the groups; I have been able to be with my emotions and check in during the day."

All the themes reflected in the quotes from the participants refer to elements that contributed to learning, growth, insight, and healing. Furthermore, the blue arrows facing in both directions show the power of integration, connection to self, others and their identities. The

arrows also illustrate how well the learning and teaching were integrated by participants. The arrows also demonstrate the concept of the Two-Eyed Seeing decolonizing approach—Western and Aboriginal traditional healing practices are joined together in respect and acceptance in the sharing circles (Bartlett, 2005, 2012).

The Medicine Wheel and the Centre Circle

Finally, the center circle honors the resiliency of Aboriginal people (including the participants and facilitators). It represents how well they are doing in spite of all the losses they have endured. The Elders and the Aboriginal advisory group placed the self, family, community, Elders, and healers at the center. This represents that anything is possible when people are connected and united. Although Seeking Safety was originally developed to address the concurrent treatment needs of clients with both PTSD and SUD (Najavits, 2002a), it had never been combined with Aboriginal traditional healing practices. It is important to note that the Diagnostic and Statistical Manual-V (DSM-V) criteria for PTSD was not used here as this study focused on symptoms of intergenerational trauma. The reduction of these debilitating symptoms after the sharing circles implementation was remarkable, as reported by the participants. Most of the participants repeatedly described how powerful it was to experience a program that integrated both the teachings of Seeking Safety and traditional Aboriginal healing practices. Participants indicated that the Seeking Safety information helped them understand their behaviors with substances, while the traditional healing practices helped them to connect with their inner spiritual self. The traditional practices also helped them to restore their connection to their identities, their families, communities, their culture and the Elders. The participants stated that the presence of the Elders and the caring and supportive facilitators further enhanced their positive, healing experience.

Discussion and the Culturally Based Implementation Project

Over the three-month implementation period, 17 participants completed the implementation project. Participant retention was addressed by the number of sessions they attended (10). Seven participants did not complete the program. At the end of the implementation project, all 17 participants showed significant improvements in reported substance use and intergenerational trauma symptoms. Many experienced relief of symptoms such as feeling less angry, the ability to self-regulate, and being present in difficult emotions. All of these changes were experienced during the ceremonies, singing, drumming, the teachings of Elders and sharing circles. In a recent study, Patitz (2011) examined the efficacy of Seeking Safety by analyzing the historical records of 23 women who have completed the Seeking Safety program. The study found a reduction in the severity of trauma symptoms following the Seeking Safety treatment, and reported similar results to those reported in this paper. At the completion of the implementation project, all of the eight male participants who completed the study were substance free, as were six of the nine women. The three women who did not succeed in staying clean had mild slips back to alcohol and opiates. However, they reported being back on track after these brief slips.

A study done by Lowe et al. (2012) found that culturally based interventions with Native American adolescents were significantly more effective at reducing substance use and related problems than non-culturally based interventions. In a recent randomized controlled trial, Hein et al. (2015) tested the benefits of combining Seeking Safety with sertraline, a frontline medication for PTSD shown also to affect drinking outcomes. Both groups demonstrated significant improvements in PTSD symptoms (Hein et al., 2015).

A profound outcome of this implementation project included the five women who gained custody of their children. This took place within the third month of and some toward the end of the implementation project. To date, these women are substance free and fully engaged parents. During the early data collection period, six female participants shared many painful stories about trauma and the impact of the substances on their lives and their children. These six women were highly emotional as they reported losing their families to the Children's Aid Society (CAS). Furthermore, the women reported how they had numbed themselves with substances to ease the pain of missing their children. While they were in the program, the first author wrote letters to CAS to explain how the loss of their children impinged on their healing. The first author also explained the impact of intergenerational trauma on the women's well-being and how well they were doing in the sharing circles. This outcome speaks to the success of sharing circles in the implementation project. These women reported that the Two-Eyed Seeing approach for intergenerational trauma and substance use helped them to understand their pain and dependence. With the understanding of why they were using substances, coupled with support and healing ceremonies, they were on a journey of healing.

Participants perceived that Seeking Safety was enhanced with traditional teachings and methods. However, this study did not have a control condition for Seeking Safety alone (without the traditional teachings and methods). There is no way to draw conclusions about the relative impact of using these traditional methods. Various other projects affirm the positive impact of incorporating traditional healing methods, but those projects also did not have a control condition. Thus, further research is needed to evaluate the empirical impact with and without such methods. In a recent study, Oulanova & Moodley (2010) found that integrative efforts of mental health professionals in their practice proved extremely helpful for clients. Kirmayer,

Simpson, and Cargo (2003) further affirm the value in offering such access to traditional ways of healing. They stated that, “recuperating these traditions reconnects contemporary Aboriginal peoples to their historical traditions and mobilizes rituals and practices that may promote community solidarity. More broadly, the recovery of tradition itself may be viewed as healing” (p.16).

The teachings and healing that occurred in the sweat lodge proved the healing power of the blended implementation project. Sweat lodge ceremonies represent returning to the womb of Mother Earth. In doing so, participants were encouraged to release the pain of the past and present and claim back the Spirit. Through the presence of the Elders, the Creator, and the Ancestors, the healing was reported at a deep level by all of the participants. The hallmark of Seeking Safety is to encourage safety and self-care, so that a space can be created for healing from both intergenerational trauma and substance use (Najavits, 2007). All of the core content in the sharing circles was delivered to promote knowledge and understanding, so that the cause of the problem could be addressed. The sharing circles came from the same premise. They were implemented to encourage participants to heal from internalized oppression, which was causing participants to self-harm (Gone, 2009; Hill, 2009; Kovach, 2009; Najavits and Hein, 2013; Patitz, 2011).

During their time in the program, participants experienced growing support from their family, friends and community members. As the reputation of this research and implementation project spread in the Aboriginal communities and treatment agencies, the authors were not surprised when Health Sciences North, the regional hospital in Sudbury, started a Seeking Safety sharing circle in their healing Lodge. The Iris Addiction Recovery for Women Centre and the N’Swakamok Native Friendship Centre followed suit. Currently, six other agencies in Sudbury

are in the planning stages of implementing the sharing circles as an ongoing element of their treatment programs.

Limitations

The representativeness of participants in this study is of potential concern. The sample population was small and confined to two specific agencies in Northern Ontario. A future study with a larger sample size and a recruitment strategy design to generate a representative sample may increase the generalizability of these findings. However, it is important to keep in mind that qualitative research seeks to provide depth and breadth of understanding of an issue versus generalizability (Morse & Niehaus, 2009).

In addition, the data on substance use, mental health, and intergenerational trauma was self-reported. Therefore, variables such as lifetime diagnosis of a mental disability or disorder may be imprecise. In addition, there is a possibility that participants may under-report experiences and behaviors that are too painful to recall, or are absent as a memory. However, in light of the limitations, the key strengths to this study continue to be:

- the authenticity and cultural sensitivity of the Indigenous decolonizing methodology and the Two-Eyed Seeing approach;
- the academic rigor of the project, due to the inclusion of Elders, community informants, an Aboriginal advisory group, an Indigenous supervisor and an Aboriginal committee member;
- the voices of Indigenous peoples through the qualitative research approach;
- the historical lens used throughout the project;
- the presence of Indigenous facilitators and students in sharing circles.

Conclusion

This study provided the perspectives of Aboriginal peoples in Sudbury, Ontario, who reported several devastating symptoms of intergenerational trauma, substance abuse, and loss of culture that signify continuing intergenerational transmission of trauma. Aboriginal peoples continue to struggle with the compounding impact of intergenerational trauma, colonization, the stolen generations, racism, discrimination, and cultural dislocation (Brave Heart, 1998; Marsh et al., 2015a; Menzies, 2014). A dynamic, multilevel approach is needed to address historical trauma among Indigenous peoples at the individual, family, organizational, community, and policy levels (Spittal et al., 2007). In addition, collaboration with traditional helpers and Elders is integral to improving mental health care for Indigenous peoples (Duran, 2006; Hill, 2009; Mehl-Madrona, 2009; Menzies, 2014). In discussing the role of traditional practices in Canadian Aboriginal health, Waldram, Herring, and Young (1995) stated that, “at the heart of the matter is the need for increasing dialogue between healers and physicians, including the possibility of collaboration” (p. 247). The key to success for healing could come from changes in policy for the treatment of intergenerational trauma and substance use in Aboriginal peoples. Furthermore, through their resilience and hope, Aboriginal communities have proven that healing is possible through understanding decades of struggles.

This paper has presented qualitative findings that indicate the strong and positive impact of Seeking Safety when combined with traditional healing methods. Future research is encouraged to replicate this work in other Aboriginal populations to add evidence to the benefits of such an approach (Gone, 2009; Hill, 2009; Kovach, 2009; Mehl-Madrona, 2009; Menzies, et al., 2010). In addition, future studies could focus on the importance of collaboration between mainstream and Indigenous healer

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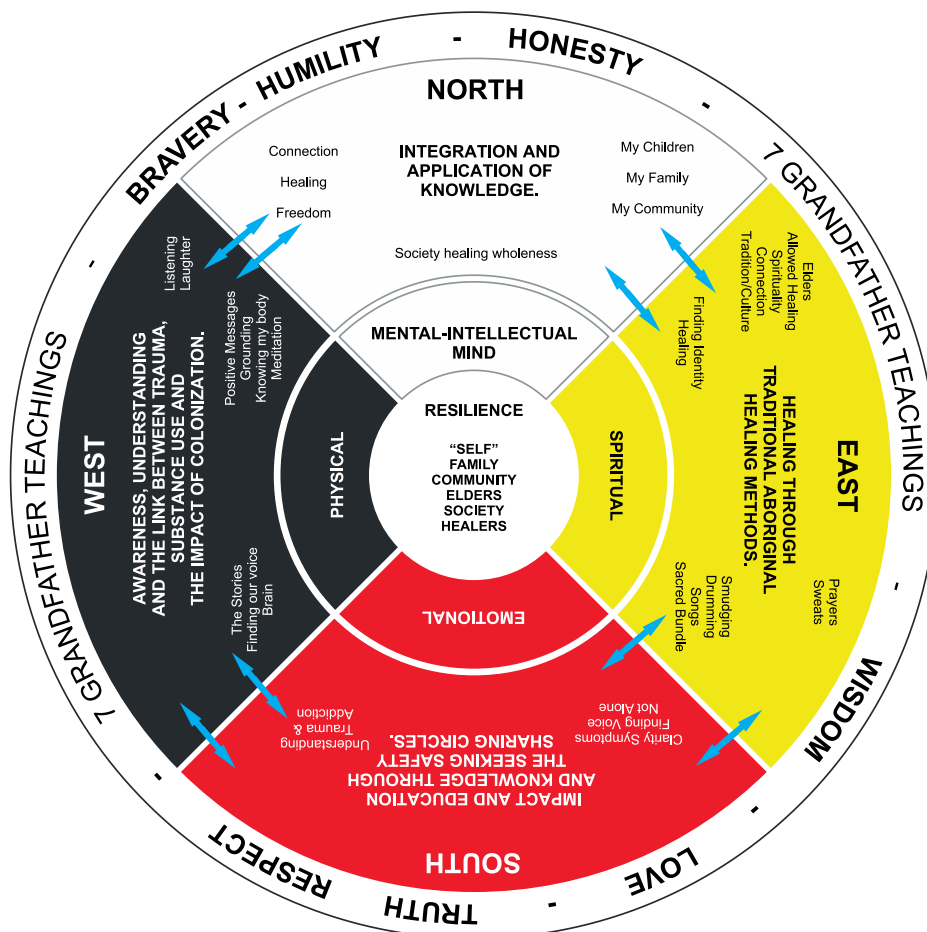
Figure 1: Qualitative Data Depicted in the Medicine Wheel

Adapted from an article, "Medicine Wheels: A Mystery in Stone", written by J. Rod Vickers that appeared in *Alberta Past* 8(3): 6-7, Winter 1992-93.

Research Title: Exploring How Traditional Healing Methods and a Western Treatment Model “Seeking Safety” Can Co-exist in Assisting Aboriginal Peoples Heal from Trauma and Addiction

Qualitative Data Depicted in the Medicine Wheel

PARTICIPANTS
n = 9 FEMALES
n = 8 MALES



Chapter 5: Impact of Indigenous Healing Practices and Seeking Safety on Intergenerational Trauma and Substance Use in an Indigenous Sample

Teresa Naseba Marsh, Nancy Young, Sheila Cote-Meek, Lisa M. Najavits and Pamela Toulouse

Context for the Article:

This chapter is the fourth integrated article and will be submitted to the Journal of Addiction Research and Therapy. This paper explains and discusses the quantitative methods, results, discussion of study limitations and future research. Also, the findings from this phase helped address the research question: Is the integration of Indigenous healing practices into the Seeking Safety model effective for group treatment for intergenerational trauma and SUD in Indigenous women and men?

Introduction

The impact of the colonization of Indigenous peoples in Canada has resulted in loss of traditional ways, culture, and land (Chansonneuve, 2007; Fontaine, 2010; Milloy, 1999). The impact of these losses has caused trauma that has been passed down over generations (Chansonneuve, 2007; Fontaine, 2010; Miller, 1996; Milloy, 1999). Many of those affected have turned to alcohol and substances to cope (Chansonneuve, 2007; Marsh et al., 2015 a, b; Menzies, 2014; Waldram, 2008). This paper reports on the evaluation of a relatively new treatment strategy to promote healing among Indigenous people in Northern Ontario who suffer from intergenerational trauma (IGT) and substance use disorder (SUD).

It is important to understand the larger context before embarking on the evaluation of treatment. Between 1831 and 1996 Indigenous children in Canada were forced to attend Indian residential schools, which restricted the practice of traditional ceremonies and hindered their ability to speak traditional languages. The impact of residential schools resulted in the devastation of a nation that was previously sovereign and independent, with established traditional systems to solve conflicts and rectify issues (Chansonneuve, 2007; Coté and Schissel, 2008; Chrisjohn et al., 2006; Waldram, 2008).

Survivors reported the brutal experiences in these schools as a force that shaped their lives and future parenting styles. Internalized oppression became the hallmark of many as they expressed hatred toward themselves, their culture, and traditional values and beliefs (Troniak, 2011; Waldram, 2008; Marsh et al., a, b; Marsh, Young, Cote-Meek, Najavits, & Toulouse, 2016), leading many to later struggle with identity issues. Chansonneuve (2007) explained that some residential school survivors express their grief as lateral violence directed toward family and community members, thereby creating intergenerational cycles of abuse that can resemble

many of the experiences at the residential schools (McCormick, 2009). As a result, many residential school survivors suffer from mental health challenges. They have also suffered shame, guilt, low self-esteem, and confusion from learning another culture and not knowing how to join the two cultures that they knew (Blackstock, 2006; Gone, 2008; Yazzie, 2000). Many of these Indigenous peoples turned to alcohol, drugs, gambling, crime or other methods to lessen their internalized hate, guilt, pain and trauma.

The internalization of oppression, shame and guilt created violence among and within Indigenous survivors. This led to deeper and more pervasive community-level mental health problems that continue today in many Indigenous communities (Gone, 2008; Stewart, 2008; Marsh et al., 2016). It is well-documented that people sexually abused as children are at increased risk for major psychiatric difficulties, including posttraumatic stress disorder (PTSD), major depression, SUD, self-harm, suicide, sexual problems, difficulties with self-soothing, difficulties with self-esteem, and perpetuating sexual acts against others (Haskell & Randall, 2009; Herman, 1997; Marsh, 2010; Marsh, et al., 2015b; Marsh, et al., 2016; Maté, 2009). Still, other effects on the mental health of Indigenous peoples have not been evaluated, such as loss of culture, languages, and loss of identity, including pride and a sense of connection with other Indigenous peoples. These consequences occur at the individual, family and community levels, all of which are connected and interrelated (Bombay et al., 2009). Considering the significant role that intergenerational trauma plays in the lives of Indigenous peoples, it was important to explore ways in which the cycle of trauma, stress and self-destructive behaviours could be halted (Bombay, et al., 2009; Brave Heart, 1998, 2006; Marsh, et al., 2015b; Marsh et al., 2016).

Many Indigenous researchers, traditional healers, and Elders agree that healing IGT and SUD in Indigenous peoples is rooted in cultural interventions and recovery of identities (Gone,

2009; Hill, 2009; Kovach, 2009; Mehl-Madrona, 2009). Stewart (2008), Duran (2006), Duran, Firehammer and Gonzalez (2008), Gone (2008), and McCabe (2008). All argue that therapy to heal mental health issues in Indigenous peoples must incorporate cultural practices.

The Seeking Safety (SS) treatment model is a psycho-educational group or individual counselling program that targets the unique problems that result from trauma and/or SUD. The program began in the United States in 1992 by Lisa Najavits, a clinical psychologist; it aims to increase the coping skills of participants with the goal of reducing relapse by emphasizing values such as respect, care, integration, and healing of self (Najavits, 2007; see also www.seekingsafety.org). It also incorporates the inclusion of the mind, body, spirit and self-awareness in the treatment of trauma and SUD, as well as connection to community through emphasis on the utilization of community resources (Najavits, 2002a, 2009). This model has been used successfully among many minority populations, including African-Americans, Hispanics, and Asian-Americans. It has also been translated into numerous languages with implementation in various countries (Najavits, 2002a, 2007, 2009; Najavits, & Hien, 2013). For these reasons, this model had potential relevance to Indigenous peoples.

The Two-Eyed Seeing approach was used to guide this research process. This approach was selected because it aligns with decolonizing and Indigenous research methodologies (Kovach, 2009; Smith, 1999; Wilson, 2008). Many Indigenous scholars agree that the process of decolonization requires ethically and culturally acceptable approaches when research involves Indigenous peoples (Menzies, et al., 2010; Smith, 1999; Wilson, 2008). The Two-Eyed Seeing approach is consistent with Indigenous governance, research as ceremony, and self-determination. In other words, it is consistent with the principles of ownership, control, access, and possession (OCAP) (First Nations Information Governance Centre, 2012; National

Aboriginal Health Organization [NAHO], 2005; Wilson, 2008).

Literature Review

In this paper, the term “Indigenous” refers to First Nations (status and non-status Indians), Métis and Inuit people as referenced in the Canadian Constitution; the term is used as a way to respect their status as the original peoples of Canada. In addition, the term Indigenous acknowledges the shared cultural values, historical residential school experiences, and contemporary struggles with the aftermath of colonization and oppression.

Today, many Indigenous peoples suffer from IGT caused by more than 400 years of systematic marginalization (Abdullah & Stringer, 1999; Armitage, 1995; Couture, 2000). According to Gagne (1998), IGT is the transmission of historical oppression and its negative consequences across generations. Brave Heart (1998) was the first to apply the concept of IGT to the Lakota people in the United States, naming it “historical trauma.” Brave Heart & DeBruyn, (1998) noted that the 1890 massacre (often referred to as the “Wounded Knee Massacre”), which occurred against the Lakota people and killed thousands, was the beginning of an over-reliance on alcohol and elevated rates of suicide, which were ways of coping with unresolved feelings of this loss. She tested her hypotheses on 45 service providers during a four-day psycho-educational intervention designed to initiate the resolution of grief, also employing a pre- and post-test using the Lakota Grief Experience questionnaire at the end of the intervention. The findings of the study indicated that education about historical trauma led to an increased awareness of the impact and associated grief of the traumatic Lakota history. Brave Heart’s study also showed that sharing the effects with other Lakota people in a traditional context provided them with catharsis. Lastly, the study demonstrated that participants experienced grief resolution, which led to a reduction in grief effects, the emerging of a more positive identity, and a commitment to

individual and community healing (Brave Heart, 1999).

Teresa Evans-Campbell (2008), a professor at the University of Washington School of Social Work and a citizen of the Snohomish Tribe of Indians, published an article delineating the nature and impact of historical trauma in Native American communities. Evans-Campbell (2008) argued that the events that give rise to historical trauma, though varied, could be viewed as sharing three broadly defining features. According to her report, the events (a) were widespread amongst the Indigenous community; (b) generated high levels of collective distress in contemporary communities; and (c) were perpetrated by outsiders, typically with destructive intent.

Inspired by the work of Judith Herman (1997; 2006), Wesley-Esquimaux and Smolewski (2004) introduced a new theoretical model for trauma transmission and healing, citing the presence of complex or endemic post-traumatic stress disorders in Indigenous cultures, which originated as a direct result of historic trauma transmission (HTT). In this new model, the authors made many observations about the nature and impact of historical trauma on Indigenous peoples of Canada (Wesley-Esquimaux & Smolewski, 2004). They described their model of trauma transmission as follows:

The trauma memories are passed to next generations through different channels, including biological (in hereditary predispositions to PTSD), cultural (through story-telling, culturally sanctioned behaviors), social (through inadequate parenting, lateral violence, acting out of abuse), and psychological channels (through memory processes) (Wesley-Esquimaux & Smolewski, 2004, p. 76).

Challenges of SUD in Indigenous Peoples

Most Indigenous communities struggle with substance use (Brave Heart, 2004; Chansonneuve, 2007; Kawamoto, 2001; Menzies, 2014; Mussell, 2005; Spittal, et al., 2007). Approximately one-third (35.3%) of First Nations adults were abstinent from alcohol in RHS 2008/10, a percentage higher than that observed in the general Canadian population (FNIGC, 2012). However, of First Nation adults who do drink, almost two-thirds met the criteria for heavy drinking. First Nations males appear to be at higher risk of heavy drinking (and related harms) compared to females (FNIGC, 2012). Heavy drinking is associated with a range of harmful effects, including various health conditions and traumatic injury. Greater efforts are needed to encourage moderate drinking among First Nations adults who choose to consume alcohol, and abstinence among those who have developed alcohol dependence (FNIGC, 2012). Maté (2009) defines addiction as “repeated behavior, substance related or not, in which a person feels compelled to persist, regardless of its negative impact on his life or the lives of others. The distinguishing features are: compulsion, preoccupation, impaired control, persistence, relapse and craving” (p. 214). In getting to the root of addiction and its consequences, Maté explains that the question is never “why the addiction?” but rather, “why the pain?” (Maté, 2009, p. 34).

The development of SUD is often associated with trauma and is thought to be an attempt to self-medicate in order to relieve the physical and emotional pain of the trauma (Marsh, et al., 2015b; Marsh, et al., 2016; Najavits, 2007, 2009). Substance use in response to stress is well documented, as many people have reported using alcohol after a traumatic event to relieve anxiety, irritability and depression (Volpicelli, Balaraman, Hahn, Wallace, & Bux, 1999). Many Indigenous communities have high rates of SUD that have been attributed to intergenerational impacts of trauma experienced by previous generations in residential schools (Chansonneuve,

2007). Substance use is described by many scholars and researchers as a coping strategy; it has been well documented in students of residential schools and continues to this day in many Indigenous communities (Chansonneuve, 2007; Duran, 2006; Marsh et al., 2015b; Menzies, 2014).

Corrado and Cohen (2003) completed a review of case files of former Indigenous residential school survivors who had undergone clinical assessments in British Columbia. Of the 127 case files reviewed, 82% reported that their substance abuse behaviors began after attending residential schools. In addition, 78.8% of these survivors had abused alcohol. This coincides with research that shows a connection between post-traumatic stress disorder and alcoholism in the Canadian Indigenous population (AHF, 2003; Bombay, et al., 2009; Kirmayer, et al., 2003).

Corrado and Cohen (2003) noted that “alcohol use disorder is strongly associated with historical loss” (p. 413), and Haskell and Randall (2009) agreed with this evidence. Many concerns have been raised by clinicians, healers and caregivers over difficulties in finding culturally appropriate help for Indigenous people in need of support for IGT and SUD (McCormick, 1995; Marsh et al., 2015b; Menzies, 2014). Indigenous people are often challenged by a lack of access to appropriate professional support after a trauma occurs or do not seek treatment, either because services are not available or due to a lack of trust, or the services offered are not socially or culturally relevant (Kirmayer, et al., 2000; Marsh et al., 2015a).

In response to the under-utilization of health services by Indigenous peoples, health-care professionals have moved toward more holistic, culturally sensitive approaches, and have endeavoured to blend mainstream health-care practices with traditional Indigenous healing practices (Martin-Hill, 2003; Rojas & Stunley, 2014). For many practitioners, care incorporates sweat lodges, smudging, drumming, sharing circles, traditional healers and Elder teachings. This

holistic view of mental health and addiction not only ensures that the care is culturally relevant, but also encourages connection to the community (Duran, 2006; McCormick, 1995, 2009; Poonwassie & Charter, 2005).

The Seeking Safety Treatment Model

Mainstream substance use and post-traumatic stress disorder (PTSD) treatment programs such as the SS model have not been previously applied to Indigenous populations, but have been found to be effective in a variety of other settings. For example, Gatz and colleagues (2007) reported that adult women who participated in SS in addition to integrated SUD and mental health services demonstrated greater reduction of PTSD symptoms and improved coping skills when compared to women participating in traditional residential treatment programs for substance use. In addition, there is research to support similar efficacy of the SS treatment in men (Boden, et al., 2012).

In several SS studies, the Trauma Symptom Check-list-40 (TSC-40) (Briere & Runtz, 1996) measure was used to evaluate changes in trauma symptoms, with findings consistently evidencing reductions (e.g., Ghee, et al., 2009; Patitz, Anderson & Najavits 2015; Najavits et al., 1998). For example a study done by Ghee, Bolling & Johnson (2009) examined the efficacy of a condensed version of SS intervention in the reduction of trauma-related symptoms using the TSC-40 as one of the outcome tools. One hundred and four women were randomly assigned to treatment, including a condensed (six-session) SS intervention or the standard chemical dependence intervention. At baseline (n=36), the mean of TSC-40 total scores of the women in the SS group was 49.86 (SD=19.49). At post intervention (n=22), the mean of TSC-40 total scores was 18.68 (SD=19.05). In comparison, the standard treatment group at baseline (n=50) had a mean TSC-40 score of 47.96 (SD=24.47) and, at post-treatment (n=18), a mean TSC-40

score of 20.83 (SD=21.71).(Ghee, Bolling & Johnson, 2009). The SS participants reported lower sexual-abuse-related trauma symptoms at 30 days post-treatment, as compared to participants who received only standard treatment (Ghee et al., 2009).

Patitz, et al., 2015), in a pilot study, investigated the impact of SS (Najavits, 2002) on trauma symptoms among 23 rural women with comorbid substance use and trauma. To assess the trauma symptoms the Trauma Symptom Inventory (TSI; Briere et al.,1995) was utilized pre- and post-intervention. The SS groups occurred over 12 weeks, and 24 sessions were offered. There were no dropouts (Patitz, et al., 2015).

The blending of Indigenous and Western research methods, knowledge translation, and program development has been called Two-Eyed Seeing (Bartlett, 2009). The concept of Two-Eyed Seeing originated through the work of Mi'kmaq Elders Murdena and Albert Marshall from Eskasoni First Nation, along with Dr. Cheryl Bartlett at Cape Breton University's Institute for Integrative Science and Health/Toqwa'tu'kl Kijijitaqnn (Iwama, et al., 2009). Two-Eyed Seeing is explained by Elder Marshall as, "to see from one eye with the strengths of Indigenous ways of knowing, and to see from the other eye with the strengths of Western ways of knowing, and to use both of these eyes together" (Bartlett, et al., 2012, p. 335). Two-Eyed Seeing recognizes Indigenous knowledge as a distinct and whole knowledge system that can exist side by side with mainstream (Western) science (Bartlett, et al., 2012; Iwama, et al., 2009). The Canadian Institutes of Health Research's (CIHR) Institute of Aboriginal Peoples' Health has adopted the concept of Two-Eyed Seeing with the goal of transforming Indigenous health and features it prominently in its vision for the future (CIHR, 2011).

The present pilot study sought to address this question: Is the integration of Indigenous healing practices (IHP) into the Seeking Safety (SS) model effective for group treatment for IGT

and SUD in Indigenous women and men? A mixed-methods approach was selected for this study. This paper presents the quantitative results; the qualitative results have been published separately (Marsh et al., 2016). The expected main outcome of this study was a reduction in the trauma scores without worsening of substance use.

Methods

IHP guided this research from inception. It was critical, therefore, to conduct this research in an honorable, honest, respectful and humble manner. Thus, cultural informants (Elders, an Indigenous advisory group, Indigenous scholars and clinicians) were invited into this process as consultants and experts. The teachings, wisdom, guidance and feedback of these experts were critical to the success of this research.

Four facilitators and two students were selected to lead the SS sharing circles for this implementation project. The Elders advised that all facilitators should be Indigenous, and have experience working with Indigenous peoples. All four facilitators had previous experience working with women and men who suffer from trauma and SUD. The facilitators were trained in group facilitation and the delivery of the SS sharing circles. The training lasted for one week, eight hours per day and consisted of didactical, experiential and small-group learning, as well as practice sessions which were video recorded. Discourse on sharing circle protocols, methods, process, therapeutic use of self, and expectations was also included.

Participants

Participants were recruited by counsellors, health care workers and health care professionals on reserves in the surrounding areas of Sudbury. A convenience sampling approach was used to recruit 24 participants (12 women and 12 men) who self-identified as Indigenous and who were willing to accept an implementation project where Indigenous traditional healing

practices were incorporated.

Most of the participants were in early recovery and connected with these treatment agencies. After referrals were made, appointments were set with prospective participants. Written consent from all participants was obtained during their initial interviews. All participants resided off-reserve in Northern Ontario and were between the ages of 24 and 68 years (with an average age of 35 years). Of the 24 participants, 16 identified as Ojibway, two as Cree, and six as Métis. Furthermore, all participants self-reported that they had IGT and SUD. Half of the participants reported substance use in the past 30 days. In this sample, there was no active psychosis, no acute withdrawal, and no current suicidality or homicidality. This study was approved by the Laurentian University Research Ethics Board in May 2013. Written informed consent was obtained from all participants.

Data Collection

The initial meeting with each participant lasted approximately 90 minutes. Participants were briefed and informed about the IHP and SS implementation project, the process, and the program details. The following instruments were administered at baseline and at the end of the 13-week treatment program: ASI-Lite, TSC-40, HLS, HLASS. Also, after every SS sharing circle, participants were given an end-of-session questionnaire to report on their satisfaction with the program (Marsh, et al. 2016; Najavits, 2002a).

The TSC-40 (Briere & Runtz, 1996; Elliott & Briere, 1992) is a relatively brief, 40-item, self-report instrument consisting of six subscales (Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbance) that measure symptoms associated with childhood or adult traumatic experiences (Elliott & Briere, 1992). Items are rated according to frequency of occurrence over the prior two months, using a 4-point scale ranging

from 0 to 3. The composite TSC-40 scores have a maximum possible range from 0 to 120, with high scores indicating worse outcomes (more symptoms). The TSC-40 has predictive validity with a wide range of traumatic experiences, including sexual and emotional abuse (Binder, McNeil, & Goldstone, 1994; Dutton, 1995; Dutton & Painter, 1993).

The ASI-Lite is a semi-structured instrument administered by face-to-face interviews conducted by clinicians, researchers, or trained technicians. It covers many aspects of a client's life, including medical history (psychiatric health, drug and alcohol use), social situation (implications with the law, family/social issues) and employment history. Given its wide scope, the ASI-Lite allows the researcher to obtain lifetime information about respondents' problem behaviors, as well as problems within the previous 30 days (McLellan, et al., 1980).

The HLC and the HLASS capture the impacts of historical trauma. The HLASS is composed of twelve items and specifies symptoms identified by participants. Response categories range from 1 (several times a day) to 6 (never). This scale has high internal reliability, with Cronbach's alpha scores of 0.94 for the Historical Loss Scale and 0.90 for the HLASS (Whitbeck, et al., 2004).

The end-of-session questionnaires were designed to capture the immediate reaction of participants to the content and traditional healing techniques in each session and were completed by participants after every session. Gender division was maintained throughout the intervention, as requested by the Elders and Indigenous advisory group. They indicated that the hallmark of this treatment was safety and healing; therefore, both men and women would feel safer this way. During these sharing circles, participants were asked to talk about their experiences (see Appendix F).

Indigenous Healing Practices and Seeking Safety Sharing Circles

The goal of providing a culturally appropriate healing method was achieved by incorporating traditional healing practices and ceremonies with the SS model. For example grounding techniques (SS) were used in the sweat ceremonies. A sweat ceremony is a cultural practice performed in a heated, dome-shaped lodge that uses heat and steam to cleanse toxins from the mind, body, and spirit. SS uses grounding and centering techniques in the group sessions. This grounding technique helps traumatized individuals connect to the present, calm the nervous system, and help with difficult memories.

Smudging was incorporated at the opening of each session with the burning of a sacred herb (sage) in a small bowl to purify the participants, leaders and the therapeutic space. Soon after, a SS topic was introduced and the sacred medicine aroma would enhance the connection with the information. Drumming, the use of ceremonial drums and songs as a way to connect with the Creator and spirit, was often accompanied by a SS quotation. The hallmark of the SS model is safety and therefore the use of sharing circles wherein all participants, including the Elders, are viewed as equal were utilized. Also, the information, spirituality, and emotionality were shared to enhance the sense of safety in the circles. The traditional healers, who use a wide range of activities from physical cures using herbal medicines and other remedies, worked closely with the SS content. For example, they encouraged psychological and spiritual healing using the ceremony blended with the self-care emphasized in the SS model. The presence of the Elders and their teachings blended well with all the SS topics. One such example was when the SS topic “anger” was discussed. The Elders teachings on this topic were about the power of the sacred fire. The Elders encouraged the participants to be their own fire keepers and to make sure that the fire brought them warmth and not destruction. (Marsh, et al., 2016; Menzies, et al., 2010; Menzies, 2014).

25 SS sharing circles were offered over 13 weeks following the initial meetings. The sessions for 12 men took place at Rockhaven Recovery Home for Men, and the sessions for 12 women took place at the N'Swakamok Native Friendship Centre. We conducted all 25 SS topics (Najavits, L. M. 2002a). The handouts were printed and given to clients at every session. Topics were scheduled as per the SS Manual and the number of participants who attended varied. During the 25 sharing circles, an average of nine participants out of the 12 registered participants attended. Beverages and a light snack were offered during every circle. Also, at the completion of the program, the participants were advised about aftercare. They were all encouraged to return to their referring treatment agencies and to continue to apply the strategies and knowledge they received. They were encouraged to use the resource list that they received at the beginning of the project. Participants were also encouraged to continue their relationship with the Elders (Marsh, et al., 2015b; Marsh, et al., 2016).

Data Analysis

Descriptive statistics were calculated on baseline characteristics and outcome measures to describe the sample. Changes as a result of the implementation project were measured by comparing scores post-intervention scores (collected within two weeks of completing treatment) to baseline scores (collected within one month before the intervention) for the subset of participants who completed at least 10 of the 25 intervention sessions. The main treatment outcomes included current (i.e., past 30 days) trauma symptom severity as measured by the TSC-40 composite score and past-30 days drug and alcohol composite scores on the ASI- Lite. Additional outcomes included historical loss and grief measured using the HLC and HLASS. The significance of changes was assessed for the outcomes using paired *t*-tests. We also compared Composite ASI Scores, at baseline, treatment completers versus non-completers.

Results

Demographics

At baseline, 12 Indigenous males ($n = 12$) with an average age of 39.0 years (S.D. 14.3) and 12 females ($n = 12$) with an average age of 37.5 years (SD 10.4) entered the 13-week IHPSS implementation project. Seventeen of the 24 participants completed ten or more sessions of the program. In the post-intervention group, the mean age of the eight retained males was 40 years (SD 14.7). The mean age of the nine females retained was 37.2 years (SD 10.8). There were no participants who self-identified as non-Indigenous. Further baseline demographic data is summarized in Table 1.

Table 1: Baseline Demographics of All Participants -- Completers and Non-Completers

(Completers are participants who completed 10 or more sessions)

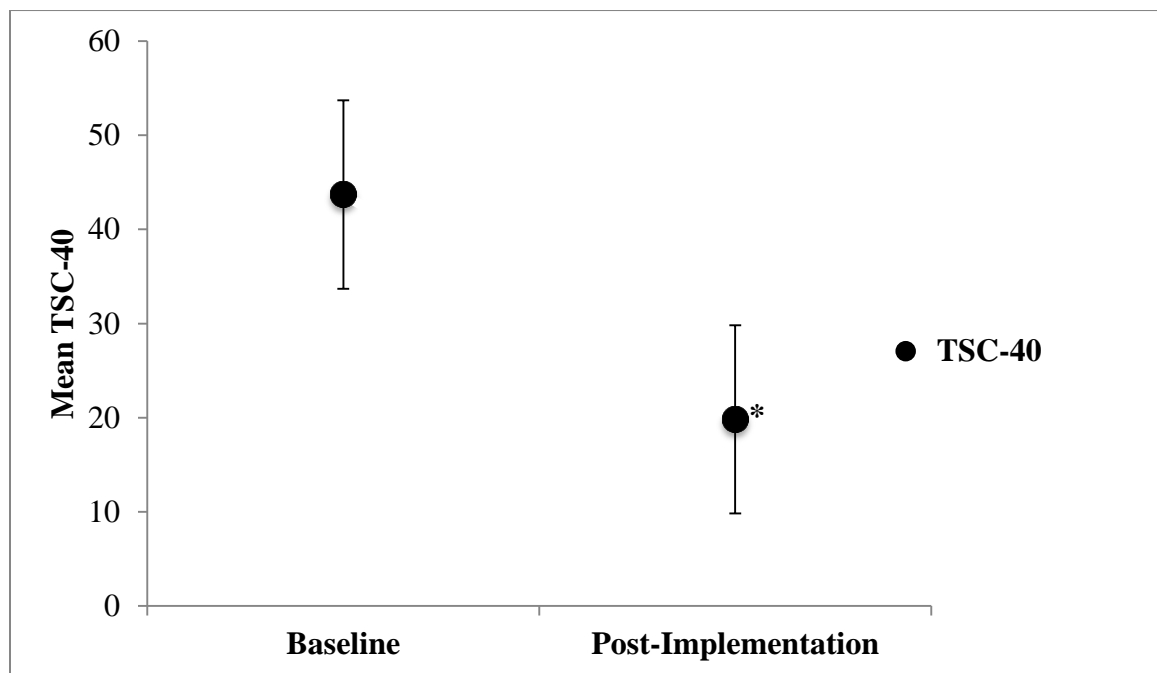
Characteristics	Baseline All (n=24)	Completers (data at baseline) (n=17)	Non-Completers (data at baseline) (n=7)
Age in years	Males (n=12) Mean 39.75 SD 14.3 Females (n=12) Mean 37.5 SD 10.41	Males (n=8) Mean 41 SD 14.68 Females (n=9) Mean 37.22 SD 10.84	Males (n=4) Mean 37.25 SD 15.31 Females (n=3) Mean 38.33 SD 11.15
Female/Male (%)	12 Female (50%) 12 Males (50%)	9 Female (75%) 8 Male (67%)	3 Female (25%) 4 Male (33%)
Relationship Status			
Single	17 (71%)	10 (59%)	7 (100%)
Divorced/separated	3 (12%)	3 (18%)	0
Married/partner	4 (17%)	4 (24%)	0
First Nation	21 (88%)	15 (88%)	6 (86%)
Metis	3 (12%)	2 (12%)	1 (14%)
Education			
Less than HS	9 (38%)	7 (41%)	2 (29%)
Finished HS	6 (25%)	3 (18%)	3 (43%)
Post-Secondary	9 (38%)	7 (41%)	2 (29%)
Employment			
Employed	5 (21%)	3 (18%)	2 (29%)
Disability			
Other Social Benefits	19 (79%)	14 (82%)	5 (71%)
<i>Legal Status</i>			
Probation	8 (33%)	2 (15.4%)	2 (15.4%)
Children's Aid	6 (25%)	5 (29%)	1 (14%)

Main Outcomes: Trauma Symptoms

The main outcome was the severity of trauma symptoms measured by the TSC-40 before and after participation in the IHPSS implementation project. The 24 participants who entered the implementation program had a total TSC-40 mean score of 40.7 (SD=20.2) at baseline. The 17 participants who completed at least 10 of the 25 sessions had a mean score of 43.7 (SD=21.6) at baseline and 19.8 (SD=15.2) at the end of treatment. The reduction in these composite scores

was statistically significant ($p= 0.001$) and is shown in Figure 1 (see page 191). The change occurred without an increase in severity of the mean alcohol and drug ASI-Lite scores, supporting the conclusion that the participants were not triggered to substantial relapse through the treatment process (see Figure 2 on page 192). The TSC-40 subscales verified a reduction in the severity of symptoms on all sub-scales: dissociation, anxiety, depression, SATI, sleep disturbance, and sexual problems. (The sub-scale results for the 17 participants who completed the 13-week IHPSS implementation project are presented in Table 2).

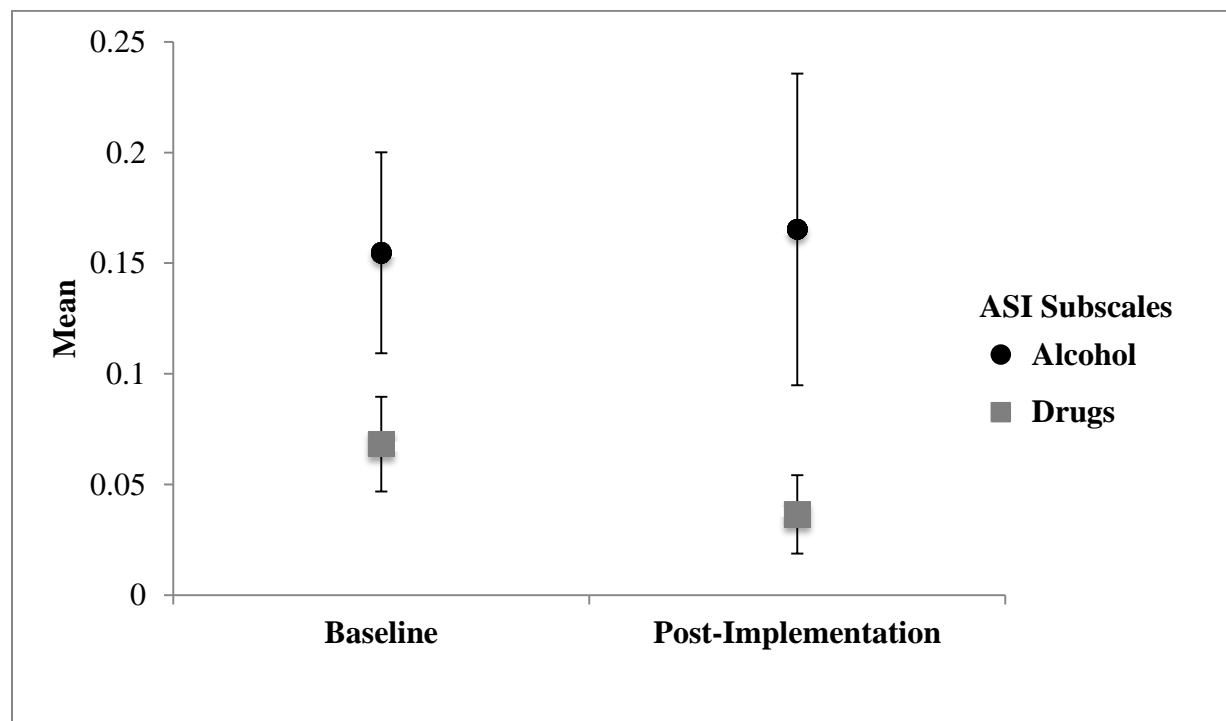
Figure 1: Composite TSC-40 Scores Pre-and Post-Implementation
(*: $p= 0.001$)



Substance Use Disorder

Alcohol and drugs use was measured by the ASI-Lite before and after the project. The composite ASI-Lite scores for the 17 participants who completed the program had a mean alcohol score of 0.16 (SD=0.19) at baseline and 0.17 (SD=0.29) at the end of treatment. Their mean drug score was 0.068 (SD=0.088) at baseline and 0.037 (SD=0.07) at the end of treatment. There was no statistically significant change in the alcohol or drug ASI-Lite composite scores (Alcohol: $p=0.90$; Drugs: $p=0.26$). An increase of 0.1 or greater would have been considered clinically significant for the ASI scores (McLellan, et al., 1980). These results are displayed in Figure 2 (see page 192).

Figure 2: Composite ASI-Lite Scores for Completers Pre- versus Post-Implementation



Specific Trauma Symptoms Improved Post-Intervention

To further understand the improvement, the subscales of the TSC-40 for each symptom group were examined. Completers of the project showed reductions in severity of all six symptom domains within the TSC-40 (see Table 2).

Table 2: Changes in Specific Trauma Symptoms for Completers Pre- versus Post-Implementation (TSC-40 Subscale scores)

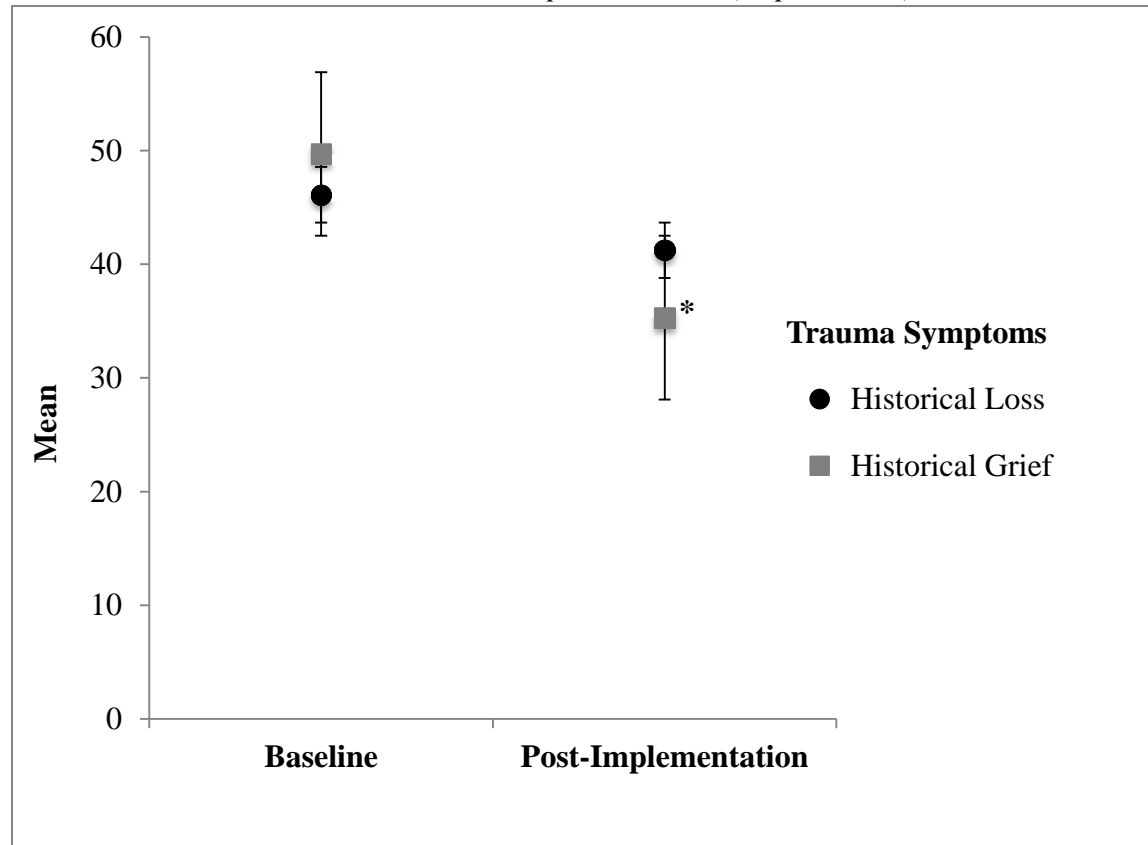
TSC Subscales	Baseline		Post-Intervention		
	M	SD	M	SD	
Dissociation	7.8	5.0	3.8	3.4	p=0.027
Anxiety	9.2	5.8	3.5	2.8	p= 0.001
Depression	11.2	5.3	4.6	3.5	p=0.000
Sexual Abuse Trauma Index	7.4	4.0	3.7	3.9	p=0.0011
Sleep Disturbance	9.4	4.9	4.6	3.4	p=0.003
Sexual Problems	5.1	4.0	2.6	4.1	p=0.037

Indigenous Context and Trauma Symptom Improvement

The HLS and HLASS were administered before and after the implementation project to explore the relationship between their historical context and the symptom expression. Completers of the project showed a reduction in the severity of the historical loss symptoms (HLS) that did not reach statistical significance (p=0.079). The reduction in historical grief symptoms (HLASS) reached statistical significance (p=0.0015). At baseline the historical loss mean scores were 46.11 (SD=16.01) and at post-implementation the mean scores were 41.23 (SD=13.52). The historical grief scores at baseline were 49.70 (SD=17.22) and 35.29 (SD=10.86) post-implementation. This aspect of the intervention was explored in more depth in

the qualitative analysis (Marsh et al., 2016).

Figure 3: Composite Historical Loss and Historical Grief Symptom Scores for Completers Pre-versus Post-Implementation. (: $p=0.0015$)*



Satisfaction with the Seeking Safety Sharing Circles

There was a high degree of acceptance of the IHPSS implementation project. All of the 24 participants who entered the program agreed on the blended implementation approach. Mean ratings on the end-of-session SS questionnaire provided information about the specific aspects of treatment that patients found most and least helpful. Participants were asked to answer six questions with six sub-questions using a four-point Likert scale, which ranged from 0 (never) to 3 (a great deal) (Najavits, 2002a). See also Appendix G for the reference for the end-of-session questionnaire. Four of the questions and four sub-questions mean scores were as follows: Overall mean rating for question one, Helpfulness of the session, was 2.76 (SD=0.56). Question two (a)

How helpful was the topic? had a mean score of 2.81 (SD=0.51); question two (b) How helpful was the handout? had a mean score of 2.81 (SD=0.48); two (c) How helpful was the quotation? had a mean score of 2.67 (SD=0.69); two (d) How helpful was the therapist? had a mean score of 2.80 (SD=0.52). Overall mean ratings for question three (a) Help with PTSD was 2.61 (SD=0.80); and mean scores for three (b) help with substance use was 2.61 (SD=0.84). Overall mean rating for question four, How much of what you learned will you use? was 2.77 (SD=0.58). Questions five and six were qualitative questions and the results are published in a separate paper (Marsh, et al, 2016).

Predictors of Dropout: Exploratory Analyses

Participants with more severe problems related to drugs as detected by the ASI-Lite composite scale were more likely not to complete the program ($p=0.027$), see Figure 4 on page 196). Differences in alcohol ASI scores did not reach significance. Treatment non-completers attended four to five sessions. Treatment completers exhibited more severe symptoms on the HLASS compared to non-completers at baseline. For example, at baseline, the 17 treatment completers had historical loss means scores of 46.188 (SD=16.015) and historical grief mean scores of 49.705 (SD=17.226). In comparison, the mean scores at baseline for the historical loss for non-completers were 44.57 (SD=13.89; $p=0.82$) and the historical grief mean scores were 30.4 (SD=9.05; $p=0.001$).

Figure 4: Composite ASI Scores at Baseline for Completers versus Non-Completers Pre-Implementation

(*:p=0.027)

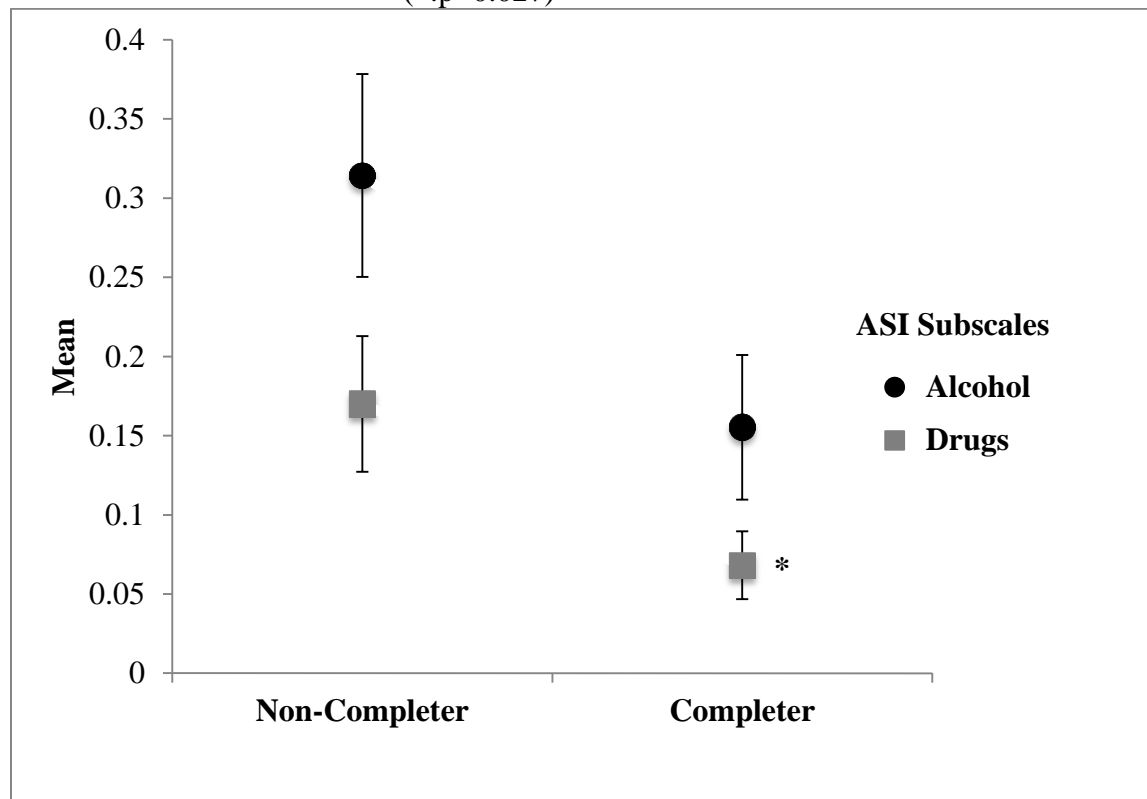
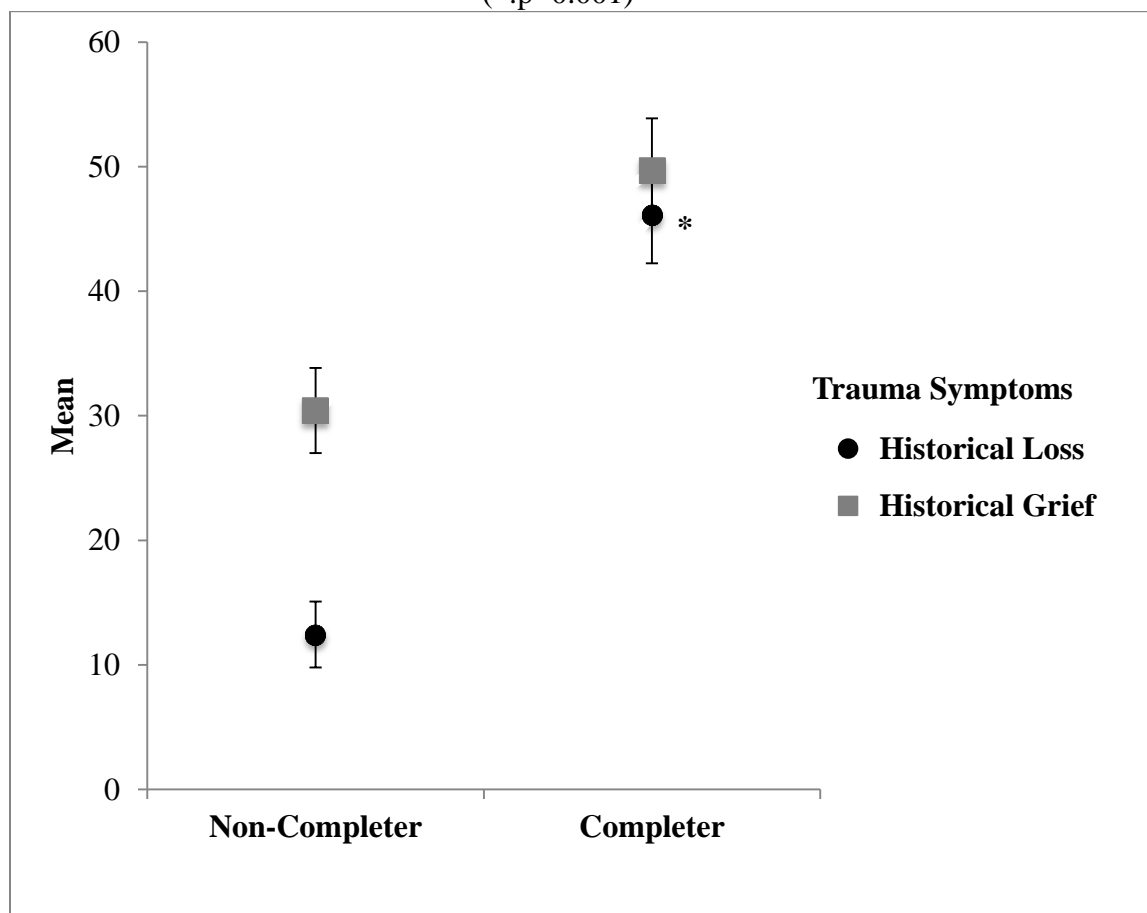


Figure 5: Historical Loss and Historical Grief at Baseline for Completers and Non-Completers Pre-Implementation
 (*:p=0.001)



Discussion

This study set out to identify whether or not Indigenous healing practices incorporated into the SS treatment model would be an effective implementation project for Indigenous women and men with concurrent IGT and SUD. This blended implementation project evidenced reduction in trauma symptoms on the main outcome measure, the TSC-40, as well as all six of its subscales in the participants who completed the program. The results of this study are similar to results in other SS studies where the TSC-40 was utilized to measure changes in the trauma symptoms (Briere, & Runtz, 1996; Ghee, Bolling and Johnson, 2009). For example, a study by

Ghee, Bolling and Johnson showed a change of 31.2 points in the seeking Safety group. These findings are very similar to 23.9 reduction reported in this study. Their drop-out rate was slightly higher at 39 % compared to 29% in this study (Ghee, Bolling and Johnson, 2009).

Results from blending IHPSS also showed a decrease in grief symptoms for completers from pre-implementation to post-implementation. Depression, anxiety, insomnia and sexual problems are all related to grief and loss (Herman, 2006; Levine, 2003; Linklater, 2010; Marsh, 2010). Brave Heart (1998) and many other researchers in this field brought forth theories and intervention models aimed at providing Indigenous people with tools and methods to address the IGT (Chansonneuve, 2007; Duran, Firehammer & Gonzalez, 2008; Kirmayer, Brass, & Tait, 2000; Kovach, 2009; Lavallée, 2008; McCormick, 2009; Mehl-Madrona, 2009; Menzies, 2014; Stewart, 2008; Waldram, 2008). Stewart (2008) further explains that these helping and healing methods and practices also need to include the involvement of local communities, Elders, and traditional helpers (Stewart, 2008). In a recent study, Oulanova & Moodley (2010) found that integrative efforts of mental health professionals in their practice proved extremely helpful for clients (Oulanova, & Moodley, 2010). Kirmayer, Simpson, and Cargo (2003) further affirm the value in offering such access to traditional ways of healing (Kirmayer, Simpson, and Cargo (2003). A study done by Lowe et al. (2012) found that Indigenous traditional healing interventions with Native American adolescents were significantly more effective at reducing substance use and related problems than non-culturally based interventions (Lowe et al., 2012).

An outcome of this implementation project reported in a previous paper was that five women regained custody of their children (Marsh, et al., 2016). The women reported how they had numbed themselves with substances to ease the pain of missing their children. The reduction in the IGT symptoms and the understanding of both IGT and SUD supported this outcome

(Marsh, et al., 2016). The Elders' teachings and healing that was reported by the participants during the sweat lodge ceremonies enhanced the healing energy of the blended implementation project. Sweat Lodge ceremonies represent returning to the womb of Mother Earth. In the process, participants were encouraged to release the suffering of the past and present and claim back the Spirit. The teachings and the support of the Elders and the facilitators contributed to the reduction in trauma symptoms. The hallmark of SS is to encourage safety and self-care so that a space can be created for healing from both IGT and SUD (Najavits, 2007). All of the core content in the sharing circles was delivered to promote knowledge and understanding so that the cause of the problem could be addressed. The traditional healing practices shared the same belief. These practices were implemented to help participants to heal from internalized oppression, which was causing participants to self-harm (Gone, 2009; Hill, 2009; Kovach, 2009; Poonwassie & Charter, 2005; Smith, 1999).

Today, many Indigenous mental health professionals and researchers have taken the lead in promoting traditional spirituality and healing along with culture. They concur that this approach is potentially beneficial in preventing and healing SUD, other addictions and suicide, as well as additional behavioral and developmental challenges that plague many Indigenous communities of North America, especially among the very young. Indigenous professionals have come to consider traditional spirituality and culture as the key appropriate responses to IGT and unresolved historical grief (Duran, 2006). Many Indigenous health practitioners integrate traditional spirituality and culture into their therapy or develop professional practices from within traditional culture and its spirituality. This movement is included in therapeutic interventions and individual counselling (Duran, 2006; Brave Heart, 1998; Brave Heart, 2004), small group psycho-educational interventions (Brave Heart, 1998; Brave Heart, 2004; Duran, 2006), larger

scale addiction recovery programs (Chansonneuve, 2007), and suicide prevention programs (Chandler & Lalonde, 1998).

All of the participants in this study presented with a history of traumatic experiences, including sexual abuse, family violence, multiple losses, and a history of multiple substance use. Two thirds of the 24 participants were using at baseline. Of these 16, the 9 completers all had moderate SUD, while the seven non-completers had severe SUD. These findings are not consistent with other findings in the literature which indicate that participants treated with SS were more likely to benefit if they had more severe SUD at baseline (Ghee, et al., 2009; Najavits & Hien, 2013).

This study had several limitations that deserve consideration. First, it is important to acknowledge that this study did not include a control group. Also, the sample size was small. Therefore, generalizations beyond the study participants must be made with caution. Furthermore, all of the data in this study was reported by the participants. While this is essential to obtain their perspectives, it may result in under-reporting of symptoms due to fears of stigmatization, shame and guilt connected to both disorders. Thus, the results are considered conservative, with the potential for a larger effect to be observed if these biases could be eliminated. Furthermore, differences in outcomes may have been caused by pre-existing differences in amount of use and levels of support, understanding, and education about both disorders (Marsh, 2010; Marsh, et al., 2015b; Marsh, et al., 2016). At baseline many of the participants in this study did not understand that substance use is connected to IGT symptoms. One of the strengths of this project was their increased recognition of this and their learning of specific coping skills to manage these issues. The very strong quantitative satisfaction data from this study helps speak to what we found in our qualitative results, which was that they reported

attaining new insight and knowledge, they felt validated and understood; stayed in the program, and received relief and healing (Marsh, et al., 2016). Further research with a larger sample size and a recruitment strategy design is necessary to examine the factors that affect the effectiveness of this blended approach for the treatment of both disorders. Lastly, the experiences and views of the participants may not be representative of Indigenous people elsewhere across different regions. The assessment tools are validated instruments, but it is possible that some information and cultural aspects could have been missed because of limitations in these tools.

Conclusion

Evidence from this study suggests that this IHPSS implementation project, coupled with the Two-Eyed Seeing approach and principles, could be effective in relieving Indigenous men and women from some of the debilitating effects of trauma symptoms, which were intergenerational in nature, and with no worsening in their SUD. There is a definite need for future studies to take this work to the next scientific step, such as a randomized controlled trial, so as to continue to understand the impact of Indigenous practices combined with Western treatment. Social and political awareness should inform how treatment for mental health and SUD is researched and delivered. Success has been experienced in communities that have embraced culture and spirituality, but there is also a need for further scientific efforts to inform these observations. Research focusing on factors that enhance resilience and mental health is critical as Indigenous peoples and communities continue on the pathway to Minobimaadizi, “living the good life.”

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Chapter 6: Discussion and Conclusion

The purpose of this final chapter is to shed light on and integrate the previous four chapters. Chapters 2 to 5 have been submitted for publication in separate journals with different submission criteria. This final chapter will focus on synthesizing, summarizing, and integrating the key findings of the thesis; its final section will reflect on the framework, reflexivity, positionality, and knowledge transfer. In addition, this chapter concludes with details on study limitations, opportunities for future research, and the significance and relevance of the study.

Overall, the purpose of the study was to explore whether incorporating Indigenous healing practices (IHP) into Najavits' (2002a) Seeking Safety (SS) treatment model was a feasible, suitable, and beneficial treatment for Indigenous women and men suffering from intergenerational trauma (IGT) and substance use disorders (SUD). The theoretical framework that guided and informed the development of this research was Medicine Wheel. The Medicine Wheel represents the alignment and continuous interaction of physical, emotional, mental and spiritual realities. The circle shape represents the interconnectivity of all people, including connection to the natural world (Nabigon, 2006; Menzies, 2014). Also, the Medicine Wheel is one representation of an Indigenous worldview that depicts a holistic health framework is used by many Indigenous communities across Canada (Vickers, 1992) (see Figure 1-1, p. 29). The Medicine Wheel was also applied in Chapter 3 to depict the themes that emerged from the qualitative data (see Figure 1, p. 171). An Indigenous decolonizing methodology with the Two-Eyed Seeing approach attuned well with the Medicine Wheel framework for this research process. Furthermore, this framework was utilized to honour the strengths of both Indigenous and Western knowledge, research techniques, knowledge translation, and program development (Iwama, et al., 2009).

An Indigenous Decolonizing Methodology, and the Two-Eyed Seeing Guiding Principles

As an Indigenous researcher and clinician, I chose to use an Indigenous decolonizing methodology to ensure a critical analysis throughout the research process (Smith, 1999). The Indigenous decolonizing methodology and the Two-Eyed Seeing approach were appropriately able to support the use of culturally sensitive and traditional healing practices delivered within the framework of the SS model. A decolonizing approach is a process that engages with imperialism and colonialism at multiple levels by critically examining the underlying assumptions, motivations and values that inform research practices (Smith, 1999). Similar to Smith (1999), Kaomea (2001) claims that “The process of decolonization requires our continual efforts towards questioning and revealing hidden colonial influences in past and current beliefs and practices” (p. 72).

Further support of this project’s approach was found in Friere’s (1973) work, which identifies oppression as the foundation in understanding colonization. A key aspect of his work focused on the liberation and empowerment of the oppressed. Freire (1973) espoused that both the oppressed and the oppressors ultimately benefit from a move away from exploitation, oppression, and all forms of injustice, instead working together in a more humanistic way. He viewed two-way discussions, critical reflection, and actively working together as key elements of liberation and decolonization (Freire, 1973). Similarly, Smith (1999) suggested that one of the most important decolonizing results is that the oppressed reclaim their Indigenous identity, worldviews, knowledge and power by the conscientization process, by which people achieve a deepened awareness of the sociocultural reality that shapes their lives and their capacity to transform that reality. It involves praxis and is understood as the dialectic relationship of action and reflection (Freire, 1973).

Absolon and Willett (2004) note that decolonization is “about both knowing our cultural history and having a critical consciousness about our colonial history” (p. 11). According to this definition, the process undertaken in this research project was decolonizing through the combination of critical analysis and the inclusion of culture and tradition within the research process. In this decolonizing process, there is a commitment to Indigenous peoples and their right to self-determination, not only from an economic or political viewpoint, but also with respect to research (Wilson, 2008). The design of this research included attention to the following cultural components: the use of sharing circles, the presence of Elders in circles, drumming, smudging, praying, the availability of sweat lodge ceremonies, feasting, and the use of sacred bundles. In order to maintain a critical consciousness approach, this research remained grounded in an Indigenous worldview, traditional and cultural healing practices, safety, respect and a place where all the participants could be heard. Through this approach, a space was created that enhanced awareness, self-determination, healing and liberation. Such an approach is consistent with the discussions of previous scholars on the topic of decolonization (Abdullah & Stringer, 1999; Bombay, Matheson & Anisman, 2009; Crazy Bull, 1997a; Duran, 2006; Smith, 1999; Wilson, 2008).

Summary of Key Findings

This thesis has demonstrated that the Indigenous Healing practices and Seeking Safety (IHPSS) implementation project was acceptable to many of the Indigenous participants struggling with intergenerational trauma and substance use disorder (SUD), who reported that the blended approach was appealing, empowering and healing. According to the literature, some of the most outstanding symptoms of SUD, post-traumatic stress disorder (PTSD) and intergenerational trauma include terror; fear; intrusive thoughts; destructive behaviours toward

self and others; loss of meaning of life; hopelessness; confusion; shame; guilt; isolation; and self-blame (Brave Heart, 1998; Duran, 2006; Gatz, et al., 2007; Herman, 2006; Najavits, 2009). Participants in this project reported similar symptoms (see also Chapter 4, p. 136-144). These symptoms were depicted during the initial interviews and the sharing circles, in the transcripts and in the quantitative questionnaires (see Chapter 4, p. 136-144, and Chapter 5, p. 188-197). In his seminal work on trauma, Peter Levine (2003) teaches that trauma resides in the nervous system and not in the events. Therefore, a part of the goal of this IHPSS implementation pilot project was to teach clients about the impact of intergenerational trauma and SUD on their nervous systems, helping them understand the role these symptoms play (Najavits, 2002a; Levine, 2003).

The proposed descriptive framework brought together the four core themes: (a) healing through traditional Indigenous healing methods; (b) impact, education and knowledge through sharing circles; (c) awareness, understanding, and the link between trauma, substance use, and the impact of colonization; and (d) integration and application of knowledge. The Medicine Wheel was used as a visual tool to conceptualize the integrative process and the Two-Eyed Seeing approach. Figure 1 (see page 170 in Chapter 4) illustrates how the components of the Medicine Wheel and the sharing circles influenced the participants' learning, healing, and growth. This Medicine Wheel was adapted from an article by Vickers (1992). In addition, the framework is based on the work of Duran (2006), Martin-Hill (2003), Nabigon & Mawhiney, (1996), and Nabigon (2006). There are many interpretations of the Medicine Wheel; however, for this research, an outer circle was added. This depicts the Seven Grandfather Teachings that contributed to the participants' learning, guidance, and growth throughout this implementation project.

Key findings emerged throughout the four themes which are depicted using the voices, testimonies and viewpoints of participants (Chapter 4, p. 136-144, and Chapter 5, p. 188-197). Notably, transformation and integration emerged throughout this IHPSS implementation project as particularly important. Other important findings include the shift from self-destructive behaviours, re-enactment of trauma, shame and guilt to a connection with self and others, integration of the tools and wisdom, coupled with a sense of pride (See Chapter 4 under all four themes p. 136-144). It was clear during the intake sessions, at the end of the program sharing circles and in the transcripts that many participants were neglecting themselves physically, emotionally and spiritually. In the trauma literature, this is described as a repeat of their personal history of severe abuse and/or neglect (Herman, 2006). In this way, they continue their pain and suffering and ignore their own needs (Drake, 2003; Herman, 2006; van der Kolf, 2006; Yalom & Leszez, 2005). Many program participants exhibited these symptoms and behaviours upon entering the program; yet, at the end of the program, these behaviours had changed as depicted in the transcripts and quantitative data (see Chapter 4, p. 136-144, and Chapter 5, p. 188-197, in the result sections).

Healing Through Indigenous Healing Practices

As discussed in Chapter 4, most participants experienced a connection to spirituality and traditional practices through the IHP and presence of Elders during the sharing circles. Participants felt a deep connection to the Elders during their teachings (see Chapter 4, p. 136-141, in the results section under the heading healing through Indigenous traditional healing practices) which, according to the trauma literature, allowed them to begin to regain their sense of self-worth, humanity, and wholeness, as they connected to others (Duran, 2006; Menzies, 2014). The hallmark of trauma is isolation. The presence of the Elders and their knowledge of

traditional healing practices created a sense of belonging for the participants as they became more aware of changes they experienced in their bodies during ceremony. For example, participants reported feelings changing from pain to comfort and from fear to relaxation and ease. During the sweat lodge ceremony and in discussions afterward many participants talked about the emotional relief they experienced. The hallmark of trauma is disconnection from spirit and it was clear that this connection was made as expressed by participants (see Chapter 4, p. 136-144, in the results section under all four themes) (Brave Heart, 1998; Duran, 2006; Gone, 2009; Gagne, 1998; Hall, et al., 2015; Herman, 2006; Mehl-Madrona, 2009).

For most participants, trauma was accompanied by shame and guilt. This was evident in their responses in the qualitative data (See Chapter 4, p. 136-144, the results section). Participants reported that they were able to transcend their shame through the IHP and ceremony. The sense of dehumanization caused by the trauma was replaced by the loving kindness of Elders and spirituality (as expressed in Chapter 4, p. 136-193, and Five, p. 194-195). Elders Julie and Frank brought with them a clarity as they explained to the participants how connection with spirituality, ceremony and the sacred medicines could bring connection to their roots and culture.

Furthermore, through the Seven Grandfather Teachings (i.e. wisdom, respect, love, bravery, honesty, humility and trust), the Elders shed light on the meaning of an Indigenous worldview. Both Elders talked with participants in a loving and kind way whenever they were upset and in emotional pain and therefore provided healing opportunities that were grounded in cultural practices (see Chapter 4, p. 136-141, in the results section under the heading Healing Through Indigenous Healing Practices). According to Lesley Malloch (1989), there is a strong belief that traditional principles of health prevent 'sickness,' based on the emphasis on health that is encouraged through the traditional lifestyle, and the resulting balance between the

physical, emotional, mental, and spiritual elements. Colomeda and Wenzel (2000) wrote that “for Indigenous peoples, good health includes practicing cultural ceremonies, speaking the language, applying the wisdom of the Elders, learning the songs, beliefs, healing practices, and values that have been handed down in the community from generation to generation” (p. 245). These authors noted that Elders have always played a crucial role in Indigenous health and healing by maintaining the health of the people. The Elders are the key to the healing process, as they are considered wise and responsible for their people’s education (Colomeda & Wenzel, 2000; Nabigon, 2006).

Impact, Education and Knowledge Through Sharing Circles

As noted in Chapter 5, another significant finding of this study involved the psychological changes that participants experienced during the sharing circles. Participants reported better emotional regulation and positive changes in depression, anxiety and sleep disturbances (see Table 2 in the results section of Chapter 5, p.193). In addition, participants identified better anger management, fewer self-destructive emotions, decrease in risk taking, changes in self-perception, decreases in levels of guilt and shame about substance use and losses (see Chapter 4, p. 136-144, in the results section under all four themes). These behavioral changes and experiences had a profound impact on their healing, as evidenced through the themes discussed in Chapter 4. Clinicians and trauma researchers agree that as traumatized individuals begin to understand their illness, the abuse related trauma, the patterns, thoughts, emotions, actions and behaviors, something profoundly shifts within. They begin to understand at a very deep level that it was not all their fault—and then begin to take responsibility for their future actions and behaviours. This was evident in most of the participants and linked to both

IHP and SS. (Brave Heart, 2004; Haskell, & Randall, 2009; Herman, 2007; Marsh, 2010; Najavits, 2007, 2009).

Awareness, Understanding, and the Link Between Trauma, Substance Use, and the Impact of Colonization

Another key finding was the experiences of participants with the topics and material discussed during the sharing circles. IGT and oppression stem from abuse by others; thus many of the struggles the participants exhibited related to inter- and intra-personal conflict with themselves, families and communities (Bombay et al., 2009; Brave Heart, 2004; Marsh, 2010; Najavits, 2007). Most participants struggled with issues of safety and trust in their relationships. Many were caught up in the re-enactment process and abusive power relationships. In this area, the SS topics explored the importance of the development of new supportive and trusting relationships. During the sharing circles, all of the 17 participants reported the impact of the SS approach (CBT and psycho-educational elements), particularly how they began to understand their painful symptoms of both trauma and SUD. With the understanding that their substance use was an effort to numb the pain and shame of their personal and cultural losses and the sharing of their experiences with the other participants through the IHP, they began to feel connected, understood, accepted and safe. These responses are also validated by other literature on group psychotherapy. For example, Yalom and Leszez (2005) talk about the power of shared testimonies for traumatized individuals. These researchers discussed how connection with others can restore another person's disconnected self and lead to healing. Yalom and Leszez agree with other scholars that as trauma destroys faith, decency, courage, and connection, group treatment or sharing circles, such as those utilized in this research, can provide a reawakening through

common altruism by others (Brave Heart, 2003; Drake, 2003; Duran, 2006; Herman, 2006; Marsh, 2010; Yalom and Leszcz, 2005).

Most of the participants in this study were very forthcoming in expressing their feelings in the sharing circles and this helped others to understand their struggles and pain. Many took risks in trusting others in the sharing circle, by talking about their innermost feelings and fears. They expressed this connection as bonding and a sense of belonging. Many also indicated during the sharing circles that they were surprised that they were not alone in their suffering and welcomed the support and help. These subthemes reflect the traditional worldview brought to the program by the IHP and are also consistent with other SS research findings.

Participants also reported the immediate changes they experienced as the IHP and SS materials were presented in the sharing circles. They felt a sense of belonging and were comforted that the other participants understood their suffering, hurt and pain. They also felt validated, supported by the Elders and facilitators, and therefore more connected to themselves and others. This came through clearly during the sharing circles as well as during the end-of-treatment individual interviews (See Chapter 4, p. 136-144, the results section under all four themes).

Integration and Application of Knowledge

One of the most valuable findings was that five of the women regained full custody of their children. This is also reported through the themes in Chapter 4. At baseline, six (n=6) women reported losing their children to the Children's Aid Society (CAS). During the initial interviews, the women reflected on their pain from this loss, and their attempts to numb themselves with substances to ease the pain of missing their children. During the program, with the support from Elders and facilitators, coupled with the knowledge they received through the

SS information, IHP and the traditional ceremonies, they began to relinquish the guilt and shame (See Chapter 4, p. 136-144, in the results section under all four theme headings). By the end of this study, five women had received full custody of their children and, to date, are substance free and fully engaged parents. These women testified throughout the themes that the IHPSS helped them to understand their struggles, suffering and SUD.

The women began to heal as they came to understand the reason for their substance use and the impact of their trauma and activated nervous systems. They grew to understand that both trauma and SUD are no-fault diseases, and, in this way were able to relinquish much of their shame and guilt through IHP including the teachings of the Elders. There appears to be a consensus among researchers and practitioners that when participants understand the pain and suffering, they experience relief through the validation (Marsh, 2010; Menzies, 2014). Therefore, restoring traditional healing practices and knowledge is a pathway to both empowerment and health for Indigenous peoples and communities (Brave Heart, 2003; Duran, 2006; Hill, 2009; Menzies, 2014). In order to achieve this goal, the traditional knowledge once practiced in historical Indigenous societies needs to be restored and included in the intervention measures aimed at substance use, trauma, and the epidemics facing Indigenous peoples (Duran, 2006; Thatcher, 2004).

Integration of Key Findings

The IHPSS implementation project was originally designed to explore whether a blended approach could help Indigenous men and women with IGT and SUD. This blended approach relieved the symptoms and behaviors related IGT in the participants, particularly for the seventeen participants who completed the program. From the Indigenous wisdom, the key healing following the experience of residential school abuse and its intergenerational effects lies

in the area of reclaiming identity (Smith, 1999; Waldram, 1997). Reclaiming Indigenous identity means recovering traditional values, beliefs, philosophies, ideologies and approaches, and adapting them to the needs of today (Couture, 1985, Goforth, 2007; Smith, 1999). This reclamation process emerged throughout the program and this was evident through all four themes (See Chapter 4 under all four themes, p. 136-144).

This reduction in symptoms was measured by the TSC-40 before and after participation in the IHPSS implementation project. These changes verified a reduction in the severity of trauma symptoms, specifically IGT. The reduction was reflected in the total composite scores TSC-40 ($p= 0.001$) (see also Figure 1, p. 193, in Chapter 5). The change occurred without an increase in severity of the mean alcohol and drug ASI-Lite scores, supporting the conclusion that the participants were not triggered to substantial relapse through the treatment process (see Figure 2, p. 194, in Chapter 5). Also, those who completed the project showed a trend toward reduction in the severity of the historical basis of their symptoms that did not reach statistical significance (see Figure 3 and Table 5, p. 196, in Chapter 5). This aspect of the intervention was explored in more depth in Chapter 5. Trends in both the quantitative data and the qualitative transcripts indicated that the program led to a broader impact on well-being as reflected in a decrease in global symptom severity following the IHASS implementation project. To further understand the improvement, the subscales of the TSC-40 for each symptom group were examined. The completing participants of the project showed reductions in severity of all six symptom domains within the TSC-40 (see Table 2, p.193 in Chapter 5).

However, as summarized above and described in Chapters 3 through 5, the main finding from the study was that the IHPSS implementation pilot project helped participants to connect with themselves by becoming more grounded and present, which is reinforced by the IHP

embedded in the program. The project also helped participants understand the role SUD played in their lives and how treating both disorders interactively helped them heal and connect with themselves, others, and communities as a whole. Most of the participants could once again connect with Anishinaabe Bimaadiziwin (“the Good Life”).

Four core themes that emerged from the qualitative transcripts describe the impact of the IHPSS implementation program in Chapter 4, p. 136-144. Participants began to realize that their history and the loss of culture and spirituality and traditional healing practices damaged their sense of wellbeing and wellness. Brave Heart (1995), Duran (2006), Hill (2009), and Menzies, (2014) agree that restoring Indigenous traditional healing practices and knowledge is a pathway to both empowerment and health for Indigenous peoples and communities. These powerful experiences were internalized as positive somatic markers, which is an important component for healing from intergenerational trauma. Another powerful outcome was the support that participants received from each other during the sharing circles, as well as the support from the Elders and facilitators. The Elders encouraged participants to let go of painful memories during ceremony. All the IHP enhanced participants’ well-being and provided new insights about their health, trauma and SUD. As the participants reclaimed their identities, a new energy emerged as they began to experience hope, joy and peace—in other words, the good life. Kirmayer, Simpson, and Cargo (2003) further affirm the value in offering such access to traditional ways of healing. They stated that “recuperating these traditions reconnects contemporary Aboriginal peoples to their historical traditions and mobilizes rituals and practices that may promote community solidarity” (p. 89). Finally, the qualitative data and voiced experiences of both the men and women indicated that this blended implementation project enhanced the wellbeing and healing of all 17 participants. The total findings led to several implications, highlighted several

limitations, and helped clarify the need for future research.

Reflexivity, Positionality and Situating Oneself as a Researcher

Situating oneself as a researcher is important, particularly within an Indigenous research framework (Absolon & Willett, 2004; Baskin, 2005; Restoule, 2004). As a researcher, I enter a world of lived experiences of Indigenous peoples. Within most Indigenous communities, we begin to identify ourselves: who we are, where we are from, who our ancestors were (Lavallée, 2009). When we situate ourselves within the research, we embrace such principles as open and honest communication, inclusion, community connectedness, and respect; and we encourage equality in relationships at all levels. This transparency allows others to know who we are, which in turn helps to establish trust (Absolon & Willett, 2004). An awareness of being an outsider doing research with Indigenous peoples is also an important reason to situate ourselves.

As an Indigenous scholar and researcher as well as an outsider, I identified with the study participants. Although I am not a member of this cultural group, I come from a culture with a similar history of colonization, oppression, loss of land, language and culture. Generations before me suffered multiple losses, and therefore I am aware that I have been affected by intergenerational trauma. Thus, I explicitly stated that my own life experiences, biases, and personal views would influence the findings at the outset of this research (see Chapter 3, p. 92 under the heading: The Application of Two-Eyed Seeing: An Indigenous Decolonizing Approach). My interest in this research topic was ignited by my passion for helping people heal from intergenerational trauma and SUD. I believed that we could heal when we receive the proper care and treatment. As a nurse and psychotherapist with experience in South Africa and Canada, I witnessed trauma, violence and their horrific consequences. I also witnessed healing and transformation and the resilience of our nations.

Knowledge Transfer

As described in the CIHR guidelines, knowledge translation is a broad concept. It encompasses all steps between the creation of new knowledge and its application to yield beneficial outcomes for society. The concept includes knowledge dissemination; technology transfer; consideration of the ethical context; knowledge management; knowledge utilization; two-way exchange between researchers and those who apply knowledge; implementation research; technology assessment; synthesis of results within a global context; and the development of consensus guidelines (CIHR, 2011). The knowledge transfer (KT) strategy in this research project involved sharing how blending IHP and SS could serve to assist people with SUD and IGT. This idea was respected and honored through community involvement, the establishment of an Indigenous advisory group, and the presence of Elders. The following sections will explore the various approaches to KT, and describe the strategies utilized to implement the KT.

Throughout this project, strategies were implemented to enrich the research process, and the credibility of the findings. Distinct strategies for KT included: (a) consultation and working with Elders; (b) the development of ethical relationships; (c) the establishment of an Indigenous advisory group with community members; (d) training of the sharing circle facilitators; (e) settings and demographics of participants; (f) conducting IHPSS sharing circles; and (g) sharing results with participants. All of these strategies are discussed in detail in Chapter 3, p. 95-100. Near the end of the research process, the KT approach also involved a community feast, give away, and the sharing and revising of the findings with community leaders at the N'Swakamok Native Friendship Centre. In addition, all the participants who embraced this program were invited to attend the feast with their family members. Further distribution of KT will include

presentation of results at regional, national, and international conferences and publication of these findings in various journals, including peer-reviewed academic journals. A report will also be sent to all research partners, participants, and key players in the community. Finally, a website will be established to distribute the findings and a training manual will be created.

The Canadian Institute of Health Research (CIHR) is committed to KT. However, to understand KT within the Indigenous worldview and context, it is necessary to understand the concept and principles of Indigenous knowledge. These concepts and principles have been described at length in earlier sections of this thesis (Chapter 2, p. 19, and Chapter 3, p. 52 and 57). According to Absolon and Willett (2004), the legacy of invalidating Indigenous knowledge has been a disconnection of Indigenous peoples from “their traditional teachings, spirituality, land, family, community, spiritual leaders and medicine people” (p. 9). Many different ways of knowing coexist in both Indigenous and Western worlds, however, and, as seen with Two-Eyed Seeing, attempts have been made to bring about understanding and connection between the two knowledge systems.

During this entire research process, participants, leaders, community members, and Elders were encouraged to share their stories about their lives, experiences, treatments, understandings, struggles and healing. The goal was to foster healing, transformation, liberation and freedom of mind, body, spirit and soul. Many researchers and scholars agree it is important to find ways to ensure that KT can inform health policy reform and practice (AHF, 2006d; ANAC, 2002; Atleo, 2011; Buse, 2008; Linklater, 2010; Wilson, 2008). More important among these findings are the ways in which Indigenous knowledge and understandings of health care, prevention and promotion can be used to inform mainstream health-care delivery. The IHPSS implementation pilot project demonstrated that it is feasible to deliver IHP within the framework

of the SS model. This approach to respecting the strengths of both IHP and western approaches in designing and testing new service delivery models could inform Indigenous and mainstream health promotion, prevention and treatment programs in other communities in the future.

Limitations

The limitations of this research in its various stages have been discussed in the different chapters; however, it is important to have a final consolidated discussion. The following sections describe limitations of the qualitative and quantitative phases separately, with a final section presenting limitations related to the sustainability of change for Indigenous peoples in the treatment of intergenerational trauma and SUD.

There were two overall limitations of this research. First, it is important to note that all participants in this study received both IHP and SS elements within the blended IHPSS implementation pilot. It is therefore impossible to distinguish which benefits are attributable to either the IHP or the SS elements. While the participants identify in the qualitative themes that they benefitted from both IHP and SS, further studies, which compare outcomes from these elements delivered independently, would be required for accurate attribution. Moreover, as there was no untreated control group in this study, it is possible that the documented changes in symptom severity resulted simply from the passage of time (for a chronic relapsing condition) or were related to participation in the research process. This explanation seems unlikely given the time course and magnitude of the changes compared to the typical clinical course of these conditions, however further research incorporating a waitlist control group would be needed to test this possibility.

Secondly, this study had a small sample size. This limits the ability to generalize the findings beyond this group. The small sample size also results in limited statistical power to

detect changes of a small magnitude within portions of the sample (such as between men and women or completers and non-completers).

Limitations of the Qualitative Phases

Several limitations in the qualitative phase of the study were discussed in Chapter 4, p. 155. The views and experiences of the participants may not be representative of Indigenous peoples elsewhere across the different regions and provinces of Canada. This limitation could be addressed by initiating several studies at a time in different provinces in order to compare and explore the differences. Furthermore, there was difficulty with the recruitment of the men for this study, as they were not as forthcoming and interested as the women.

In this study, participants self-reported their SUD and trauma symptoms, because it was important to trust and honour their stories, as well as respect this cultural protocol as taught by the Elders. Therefore, the histories and reports may be somewhat imprecise and there could also be minimizing or withholding of information. Underreporting by this population of clients is very common with both disorders due to the shame, guilt and pain associated with both intergenerational trauma and SUD. This could be remedied by the development of culturally sensitive assessment tools that could capture a bigger picture of the challenges faced by Indigenous clients with trauma and SUD.

While I am an Indigenous researcher, I am not of Canadian Indigenous descent. Because of this, there was potential for this study to be limited by a lack of knowledge, understanding, and subtle cultural differences on my part, despite the great effort I employed in researching and understanding the culture. To address this limitation, the qualitative approach used suitable methodologies to adhere to cultural appropriateness throughout. These methodologies included

sharing circles; incorporation of Indigenous facilitators; involvement of Elders, engagement of an Indigenous advisory group; and collaboration with Indigenous research committee members. I was also mentored by Elders Julie and Frank Ozsawagosh in Indigenous culture and practice. These teachings supported and helped me to understand both the participants and the facilitators.

Limitations of the Quantitative Phase

Several limitations can also be noted in the quantitative phase of the study, discussed in Chapter 5, p. 196. Most of these limitations were related to sample size, recruitment and scale selection. This study involved only participants living off reserve in Sudbury, Northern Ontario. Most of the recruitment took place in downtown Sudbury, from various agencies supporting this population of clients. Therefore, generalizations beyond the study participants cannot be made. The participants who responded to the advertisement were already accessing services and involved in SUD and mental health programs. With this recruitment strategy, participants who could have been eligible may have been missed because they did not receive information about the intervention. This challenge was compounded by additional limitations related to the number of participants who completed the program ($n=17$). Despite these limitations, it was remarkable that 17 participants did so. This retention rate was excellent for this population, especially considering the fairly substantial time commitment required from participants (sharing circles were held twice a week for three months). To overcome this limitation, future studies with a larger sample size and a recruitment strategy designed to represent a more diverse range of participants should be used.

Most health-related studies that collect data from Indigenous communities are national in scope, and relevant information was not available for individual communities due to confidentiality and data suppression. Another limitation related to the quantitative phase of the

study was use of the ASI-Lite and TSC-40, as both of these tools are non-Indigenous scales or measures. The lack of relevant Indigenous measures of health and well-being resulted in a discussion with the Elders and the Indigenous advisory group about this gap and need within the Indigenous community.

Sustainability of Change

The IHPSS implementation project was designed as a three-month project. This was a very short healing period for this population, as both trauma and SUD require long-term support and maintenance of care. However, all participants were connected with resources at the completion of this implementation project. This was an important area to shed light on, as in this research I acknowledged the lack of follow-up and aftercare as areas that had been identified as a priority the literature (Duran, 2006; Menzies, 2014; Rowan, 2014). The participants who completed the program connected with their respective agencies, health-care providers, Elders and Friendship Centres. As the word spread about this implementation project and the impact it had on the participants, both facilitators and research sites asked for training in the blended approach.

To date, I have offered IHPSS training in nine different agencies and several Indigenous communities. Currently, the IHPSS program is offered in several Indigenous and non-Indigenous treatment agencies. I was asked to speak to students in the Indigenous Social Work Program at Laurentian university in Sudbury and presented the findings of this research at the Canadian Society of Addiction Medicine conference in Alberta in November 2015. I was also invited to offer the training program in a fly-in Indigenous community, Eabametoong First Nations, in Fort Hope, and recently offered training for the Nipissing First Nations in North Bay, Ontario. Other communities that will receive this training include Wikwemikong Unceded Indian Reserve on

Manitoulin Island and Stoney Nakoda Nation in Alberta. As well, the IHPSS program is currently offered at the Health Sciences North Hospital in Sudbury. This program has been running for over a year in the Indigenous healing lodge and the number of participants attending varies from 10 to 16 at any one time. The Iris Addiction Recovery for Women (now Monarch Recovery Services), N'Swakamok Native Friendship Centre and Shkagamik-Kwe Health Centre have also followed suit. Currently, six other agencies in Sudbury are in the planning stages of implementing the IHPSS implementation project as an actual treatment modality. These agencies are keen to begin evaluating the outcomes and are using the end-of-session questionnaires. Most of the agencies are planning to apply for funding to initiate research.

Because they perceived the need for this program to be high, Elders Julie and Frank Ozsawagosh encouraged it and predicted that it would grow in leaps and bounds. They also encouraged the creation of a training manual for health-care professionals. This will be done as a future project, as a way to further disseminate the knowledge, especially in Northern Ontario. Access to quality health care in rural, remote, and Northern communities is a long-standing issue in Ontario. The challenges of providing appropriate access to health care in these communities stems from multiple factors: geographic remoteness, low population densities, reduced availability of health-care providers, and inclement weather conditions (Czyzewski, 2011; King, 2009; Menzies, 2014). Building on previous planning for Rural and Northern health services that started in the late 1990s, Ontario has successfully launched a number of initiatives designed to address the access issues in rural, remote, and Northern communities in the province. These initiatives must now be actualized and programs such as blended approaches could help with the healing of intergenerational trauma and SUD (Czyzewski, 2011; King, 2009; Menzies, 2014).

Implications of the Research Findings

This research highlighted significant implications relevant to the areas of culturally appropriate treatment programs, integrating Indigenous and Western treatment models, health policy initiatives, and prevention programs. Many mainstream practitioners, agencies, and institutions are beginning to recognize the efficacy of Indigenous healing practices and blended approaches (Gone, 2009; Hill, 2009; Linklater, 2010; Rowen, et al., 2014). However, the mainstream medical models of clinical diagnoses and treatment for trauma and SUD continue to prevail in health-care policy, services, and education. This continues to affect funding, program development, and training design. There may also be resistance and challenges from both Indigenous and non-Indigenous health-care professionals, as many have accepted mainstream systems and continue to place value on these dominant structures. There is a need to advocate for integration of Indigenous and Western treatment models that recognize the positive impact of IHP. Nonetheless, Indigenous strategies are beginning to emerge in the forefront of healing initiatives as wise practices for Indigenous peoples (Abdullah & Stringer, 1999; Duran, 2006; Gone, 2009; Hill, 2009; Mehl-Madrona, 2009). Additionally, non-Indigenous practitioners and individuals are beginning to accept the legitimacy of Indigenous knowledge and are attempting to integrate new methods of working with SUD and IGT (Bombay, Matheson, & Anisman, 2009; Drake, 2003; Herman, 2006; Najavits, 2009; Rowan, et al., 2014).

Hopefully the implications of these research findings, and others into the effectiveness of IHP, will challenge health policy initiatives. Governments, treatment programs and other bodies responsible for the distribution of funding should consider the efficacy of Indigenous healing practices in consideration of health care for IGT and SUD in Indigenous peoples. This includes hospitals, universities, and health-care centres serving Indigenous peoples. In some cases,

policies do exist that recognize traditional healing methods; however, putting policy into practice is challenging. For example, a government may have a policy to improve Indigenous health through the provision of culturally appropriate health services, but a local ministry delivery agency may not allow traditional healing activities to qualify for program funding (Linklater, 2010; Gone, 2009; Haskell, & Randall, 2009; Menzies, 2014). Research should be undertaken to ensure that the programs offered are socially accountable and to confirm that the most appropriate policies and practices are in place.

The implications of research that demonstrates the effectiveness of IHP will be useful for Indigenous agencies that offer both traditional strategies combined with Western ones as part of agency programming. Today the challenges Indigenous communities face with SUD, especially the burgeoning opioid addiction epidemic, warrant integration with Western approaches (Grand Chief Metatawabin, 2012; Menzies, 2014; Stewart, 2008; Whitbeck, 2004). Globally, colonization brought separation, deception, hurt, and deep trust issues to Indigenous people. For this trust to be regained, both Western and Indigenous clinicians and researchers must find a way to work together in a good way (Duran, 2006; Gone, 2010; Marsh, et al., 2016; Menzies, 2014; Wilson, 2008). I believe that this working together is a process and that even small-steps in this direction can be decolonizing and empowering for all peoples. This pilot study is a very small step towards that direction.

Agencies can benefit by sharing and learning from other treatment agencies or communities that are using a blended approach. The present study and others which examine the combination of IHP and Western approaches may contribute to the discourse on traditional healing methods and mainstream services (Duran, 2006; Gone, 2010; Kovach, 2009; Menzies, 2014; Wilson, 2008).

We must also remember and acknowledge the strength and resiliency of Indigenous people in spite of their suffering. Barnes and Josefowitz (2008) explain that resilience is “well-known to be enhanced by strong relationships with competent and caring adults in family and community, strong cognitive abilities, good self-regulation skills, positive view of self and motivation to be effective in school, work, or social environments” (p. 4). Herman (2006) agrees with other researchers that to have resiliency is to be able to withstand trauma and terror, to be able to heal and transcend back into life and living. Furthermore, Dion Stout and Kipling (2003) remind us that “resiliency only operates in response to the presence of risk conditions and the possession of appropriate personal and social assets is not sufficient in and of itself to guarantee a positive outcome” (p. 6). I hope that this research will further inspire trauma and SUD treatment facilities, and society as a whole, to become more compassionate, proactive, and understanding toward this population.

It was interesting to note that, as information was gathered to support this research, very few non-Indigenous authors and clinicians referred to the work of Brave Heart (1998, 2003). Nor did many non-Indigenous researchers refer to Duran’s (1990, 2006) theory of the *soul wound* or his insight into the treatment of Indigenous peoples’ struggles with both trauma and SUD. This realization indicated that there is a gap between Indigenous and non-Indigenous trauma theory and practice. Gone (2010) asserts that Duran’s culturally specific psychotherapy “remains largely unavailable to Native clients owing to severe constraints with regard to its practice, training, and dissemination” (p. 213). This gap could be remedied by collaboration between Indigenous and non-Indigenous scholars and researchers, as well as specific curricula, courses, and workshops that focus on content relevant to the lives of Indigenous peoples. An increase in the number of publications of Indigenous traditional healing practices and the blending of models could also be

helpful.

Research into IHP can also support the work being done in the area of cultural competency. It is well understood that in order to understand the concept of cultural safety, one has to embark upon a journey that travels on the continuum of self-awareness (Absolon & Willett, 2004; Bishop, 2008; Brascoupé, & Waters, 2009; Dillard, 2008). According to Irihapeti Ramsden, the Maori nurse and educator who developed the concept in her doctoral thesis in 2002, cultural safety is the ultimate goal in a learning process, starting with cultural awareness of a patient's ethnicity and, in culturally safe practice, growing concerns with "social justice ... and nurses' power, prejudice and attitude" (Ramsden, 2002, p. 5). Ramsden (2002) turned the focus of cultural safety away from the cultural understanding and knowledge of the health-care worker and onto the power inherent in their professional position. She sought to redefine cultural safety from a transformative point of view of the Indigenous person receiving care; the determination of success is by the recipient, who defines the care received as culturally safe or not. Ramsden effectively combined the practical and the theoretical conceptions of cultural safety by depicting it both as an extension of cultural competence—where the knowledge and learning of the non-Indigenous practitioner continues to play a crucial part in the relationship with the Indigenous patient—and as a radical and explicit departure from it. This dual approach, stressing both knowledge (through cultural competence) and power (through cultural safety), is very attractive, as it depicts the transformation of the relationship through a combination of both conceptual and a practical change. What stood out in the stories of the research participants was that Indigenous people need options for healing, and Indigenous practitioners who are both culturally and clinically competent are most able to provide effective services to a wider range of clientele. McCormick (2009) recognizes that some clients will always prefer the traditional approaches to

healing and will seek out traditional healers, whereas others will opt for treatment via mainstream psychological therapies. According to McCormick, “Aboriginal people seeking help now have a third option: to see a therapist/healer who is able to use and combine aspects of both teachings in a complementary way” (p. 337). This can only be enhanced in clinical settings when health-care professionals, both Indigenous and non-Indigenous, can collaborate and conduct research together, because, in the end, it is about the health and well-being of the people they serve.

Concluding Thoughts

As I was writing my concluding thoughts on this study, I revisited and contemplated my initial intentions behind engaging in this pilot research project. It was with clarity, determination and passion that I embarked upon a project that would benefit Indigenous communities and help with healing from IGT and SUD. I became interested in the field of IGT and SUD because of my lived experiences in South Africa during colonization, oppression and the apartheid era. During the literature review, I learned how many nations and generations have been affected by colonization and its horrific impacts, and how these have led to psychological pain and suffering. During this project, I persevered through my own healing process. For example, I attended many sweat ceremonies, fasted, and attended silent meditation retreats, which was crucial to completing this research. I dreamt about the healing that could come, and realized that it is possible if we all join hands and continue to build healthy communities and familial connections. During this process, I also recognized the importance of reclaiming the spirituality that was lost during colonization and oppression. I was awe-inspired by the courage, resilience and strength of the participants, community members, Elders and facilitators.

Throughout this project, I implemented strategies to help me use my experiences to

enrich my work. These included consultation with Elders, the establishment of an Indigenous advisory group with community members, and the development of relationships with all people involved in this research and analysis. All of these processes enhanced credibility, trustworthiness, and rigor of the study. Because of my experiences with Indigenous Elders and community members, I became more attuned to their cultural values, morals, beliefs and traditional knowledge. This research project also challenged me to recognize the importance of staying present to the here and now, remaining honest, being patient and trusting, and honoring spirituality. I learned much about myself, how my past affected the present, and was reminded that we are constantly learning, growing and changing. The Elders challenged me to explore myself as an Indigenous woman and this helped me to appreciate both my strengths and weaknesses. As an Indigenous researcher and professional, I brought with me not only my own humanness and humility, but also became a co-creator of new wisdom, knowledge, understanding and healing that may benefit others. Lavallée (2008) claimed that researchers experience growth and personal transformation from the research undertaken. I saw my involvement in this process as a privilege and honour.

All the people involved in this research showed compassion and love that shone like a bright light, which I was drawn to as I witnessed their capacity and ability to endure challenging circumstances with loving-kindness. I humbly experienced their strength and resilience first hand, and this was revealing for me as an Indigenous research student. The strength of the nation continues despite the array of challenges they deal with on a daily basis. To this day, as I visit Indigenous communities, I witness the compounding impacts of IGT, multigenerational grief, loss and pain related to colonization, the stolen generation, racism and discrimination, and cultural dislocation. Elders Julie and Frank Ozawagosh and the facilitators taught and

demonstrated this strength and resilience and encouraged me to place resilience in the center of the Medicine Wheel, so that it could be seen by all.

It was important that I utilized an Indigenous research paradigm and therefore I chose Two-Eyed Seeing as it aligned well with decolonizing and Indigenous research methodologies. The application of the Two-Eyed Seeing approach as a guiding principle was intended to bring together the strengths and understanding between Indigenous and Western treatments, practices and healing from IGT and SUD, yet it brought these gifts to me as well. Today in Canada, Two-Eyed Seeing has emerged as a guiding principle for Indigenous research and my understanding, interpretation and utilization of this approach contributed to this research.

Wilson (2001) suggested that an Indigenous methodology implies talking about relational accountability, in the sense that the researcher is fulfilling his or her relationship with the world around and with others. In this process, I continued to learn and enhance my knowledge about Indigenous ways, and respected the multiple roles I had as researcher, clinician, woman, supervisor, and mentor. This self-reflection, honesty, and openness are integral requirements in the Indigenous research process and I lived and practiced these throughout this process.

The findings of this study were presented through the stories and experiences of the research participants and the teachings of the Elders, as well as the wisdom of the facilitators. The research participants came from difficult, challenging backgrounds, yet embraced both Western and Indigenous traditional teachings and incorporated them into themselves, took the tools and resources and moved into a place of healing and wellness. Their contributions to this research left me in awe and often filled with humility and gratitude.

Furthermore, I hope that this research will shed light on the impacts of IGT the connection between IGT and SUD, and the importance of an integrated treatment approach. I

also hope that this knowledge can bring understanding to caregivers about spirituality as a foundation of Indigenous traditional healing, and that this aspect needs to be respected in the care of this population. As this population continues to decolonize and heal from the terror and atrocities that visited them, they as Indigenous peoples, can travel on a healing journey, blanketed in culture, traditional practices, and ceremony while encouraging our future leaders, our youth, and generations to continue on the same path.

In Summary

This was the first pilot study to report blending of IHP with SS. The quantitative results showed a reduction in the trauma symptoms on the outcome measure, the TSC-40. The 17 participants who completed the program had a mean score of 43.7 (SD=21.6) at baseline and 19.8 (SD=15.2) at the end of the IHPSS implementation project. The reduction in these composite scores was statistically significant ($p=0.001$), as shown in Figure 1, p. 191, in Chapter 5. Also, these changes occurred without an increase in the severity of the mean alcohol and drug ASI-Lite scores (see Figure 2, p. 192, in Chapter 5).

The HLS yielded ($p=0.079$) and the HLASS yielded ($p=0.0015$) and reached statistical significance. (See also Figure 3, p. 193, in Chapter 5). There was a high degree of acceptance with the IHP sharing circles as measured by the end-of-session questionnaire. The details are discussed in Chapter 5, p. 193-194. Furthermore, through the voices and viewpoints of all the participants, as depicted from the transcripts, the IHPSS implementation pilot project brought relief of symptoms, spiritual healing, safety, connection, cultural renewal, empowerment and liberation to all the participants. (See also Chapter 4, p. 136-144).

Finally, I believe that this research highlighted the fact that Indigenous knowledge and ways of knowing, and the strengths of Western knowledge and ways of knowing, can co-exist in research methodologies and helping/health practices. My final thoughts as I came to the end of writing up this study is that: “ *we are all born to heal and that this Source, Spirit and energy is alive in us all. Aboriginal peoples are deeply connected to this Source and this was evident in the sharing circles, the ceremonies, the teachings of the Elders, the carries of this ancient wisdom.* ”

Miigwech, gakina nindinawemaaganag—thank you, all my relations.

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Appendix A: Research Information for Participants

Study Title:

Exploring how Traditional Healing Methods and a Western Treatment Model “Seeking Safety” can Co-exist in Assisting Aboriginal Peoples to Heal from Trauma and Addiction

Principal Investigator:

Teresa Naseba Marsh, Ph.D. (Candidate)

Supervisors:

Sheila Cote-Meek, Ph.D., Associate Vice-President, Academic & Indigenous Programs,
Laurentian University (Supervisor)

Diana Coholic, Ph.D., Associate Professor, School of Social Work, Laurentian University
(Supervisor)

Miigwech (thank you) for your interest in participating in my research study. My name is Teresa and I am a Ph.D. student at Laurentian University in the School of Rural and Northern Health. The research study is titled “Exploring how Traditional Healing Methods and a Western Treatment Model ‘Seeking Safety’ can Co-exist in Assisting Aboriginal Peoples to Heal from Trauma and Addiction.”

By doing this study, I want to see if a Western program, *Seeking Safety* that treats addiction and trauma, and traditional Aboriginal healing methods can assist Aboriginal peoples to heal from trauma and addiction. Trauma means that you were exposed to something so threatening that it gave you very strong feelings; for example, even believing that you could have died. In some cases trauma can happen over and over, for example, when someone is sexually or physically abused. The problem with trauma is that it affects some people long after the original

event by making them feel depressed, anxious and even suicidal. Sometimes people drink and use drugs to cope with these feelings and memories. I am hoping that by using a Western treatment and Aboriginal healing methods we can assist with the healing of these feelings and thoughts (symptoms).

Twenty-five sharing circles will be offered twice a week for 90 minutes a session. The sessions for 12 men will be take place at Rockhaven Recovery Home for Men, from September 2013 to November 2013, every Tuesday and Wednesday from 6 pm to 7:30 pm. The sessions for 12 women will take place at the N'Swakamok Native Friendship Centre every week, from September 2013 to November 2013, every Tuesday from 5:30 to 7 pm and Thursday from 1 to 2:30 pm. At the end of the 25 sessions of sharing circles, I will have one more sharing circle with the women and men to find out what they learned, experienced, thought and felt about the sharing circles, and what else helped during the three months.

In the Western *Seeking Safety* model, sharing circles gather to learn new and healthful coping skills to replace unhealthful behaviors caused by trauma and addiction. The word '*safety*' is used to mean working on healing from cravings and desire to use alcohol and other drugs, thinking less about suicide and acting out less about suicidal thoughts, reducing self-harm, and getting out of unhealthful relationships and situations. Aboriginal counsellors and Elders will teach coping skills with the help of storytelling, talks or teachings with Elders, smudging, drumming, sweats, bringing of sacred bundles, teachings about the history of the Aboriginal peoples, and the Seven Grandfather Teachings.

You will not have to share detailed stories about your trauma or addiction. The discussions in the sharing circles will focus on the unique problems you struggle with and you have to share only when you are comfortable.

Next Steps:

If you are interested in taking part in this study and program, or if you have any questions about your role in this study, please contact me, Teresa Naseba Marsh, at (705) 626-3367 or tmarsh@laurentian.ca.

Ethics

This study has been reviewed and approved by the Laurentian University Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

Robin Craig, Ph.D.

Laurentian University Research Office

E-mail: ethics@laurentian.ca

Telephone: 1-705-675-1151, ext. 3213 or 1-800-675-1151, ext. 3213

Appendix B: Consent Form – Participants

Study Title:

Exploring how Traditional Healing Methods and a Western Treatment Model “Seeking Safety” can Co-exist in Assisting Aboriginal Peoples to Heal from Trauma and Addiction

Principal Investigator:

Teresa Naseba Marsh, PhD (Candidate)

I am interested in learning how helpful a 13-week sharing circle program is for Aboriginal Peoples with substance use and trauma – the program brings together the Western *Seeking Safety* program with traditional Aboriginal healing methods. If you agree to take part in this program, you will:

- Meet with me (Teresa, the researcher), to fill in four questionnaires in an introductory meeting before the group begins. I will help you with the forms if needed. At this meeting, we will talk about your past trauma and addiction history and the issues or difficulties you have in your life today.
- Go to *Seeking Safety* sharing circles, for 1.5 hours, twice a week, for 13 weeks.
- Complete a one page questionnaire at the end of each *Seeking Safety* sharing circle.
- When you have done the 25 sharing circles, we will meet again for a one-on-one interview to talk about what you think of the program. This interview will take about one hour and will be recorded on a digital recorder so that I can learn what worked well and what we need to improve about the program.

- At the end of the program, you will do one more sharing circle that will give you another chance to talk about the program and your experiences. This circle conversation will also be recorded.

Important information

1. You will have the chance to attend 3 sweats. The Elder giving the sweats will give teachings about going into the sweat lodge and the risks involved before you decide if you want to go to the sweats. If you don't go to a sweat, you can still come to the sharing circles.
2. When you come to the sharing circles, you might feel nervous, stressed, or have other uncomfortable feelings during or between the circles. If that happens, you can talk to one of the sharing circle counsellors or the Elder about this, or you can talk with the counsellor who told you about the program and he/she will make sure you have someone to talk to about how you are feeling. It's important to talk with someone if you feel you need to. You could also contact a person or place listed on a resource list that will be given to you or talk to me.
3. We want you to know that taking part in this research is your decision and no one will force you to be involved. We don't want you to do anything that you don't want to do. We only want you to agree to participate if you really want to. If you decide to be part of the research, and then later change your mind, then you can stop coming.
4. All of the information that we collect will be kept confidential. This means that only Teresa, and the researchers who are part of her supervision team can see the information. Everything will be locked up by Teresa at the university. Once the research is done, she will get rid of it.
5. We will want other people to know about the success of the research so that others with trauma and addiction can receive the treatment too, but when we tell people about our work

with you, we will never tell anyone that you were part of the research or give anyone information that would let them know who you are.

6. I will be offering you tobacco before we start, and you will receive a gift for participating.
7. If you need to travel or have childcare, we will pay for it. At each sharing circle, we will share food.

Participation Benefits

By participating in this project, you will:

- Receive knowledge about how the trauma and addictions of the generations before us can affect us.
- Participate in the sharing circles and hopefully gain a better feeling of belonging.
- Get to know other people who have trauma and addiction similar to yours and bear witness and affirm each other's stories and feelings. This helps to develop trust and good feelings towards others.
- Have a safe place and space to share struggles and pain.
- Be reminded of or learn more about your culture and history.
- Have the chance to heal and gain knowledge that can be transferred to help your family, friends and community.

We hope that the work you do to help us in this research and the results you experience will encourage treatment centers and Aboriginal programs to think about using this program to assist Aboriginal peoples with their health and healing. Once the project is done, I will share the results with you and the community at a feast.

By signing this form, you agree to take part in our study and you are letting us know that you understand everything on this form. You will receive a copy of this form that you can keep.

Date _____

Participant's Signature _____

For further information, please contact: Teresa Naseba Marsh
Ph.D. Student, School of Rural and Northern Health
Laurentian University
E-mail: tmarsh@Laurentian.ca
Tel: (705) 626-3367

Ethics

This study has been reviewed and approved by the Laurentian University Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

Robin Craig, Ph.D.

Laurentian University Research Office

E-mail: ethics@laurentian.ca

Telephone: 1-705-675-1151 ext. 3213 or 1-800-675-1151 ext. 3213

Appendix C: Consent Form – Facilitators and Students

Study Title: Exploring how Traditional Healing Methods and a Western



Treatment Model “Seeking Safety” can Co-exist in Assisting Aboriginal Peoples Heal from Trauma and Addiction

Principal Investigator:

Teresa Naseba Marsh PhD (Candidate)

Hello, my name is Teresa Naseba Marsh and I am a Ph.D. student at Laurentian University in the School of Rural and Northern Health. I will be conducting a research study entitled “Exploring how Traditional Healing Methods and a Western Treatment Model “Seeking Safety” can Co-exist in Assisting Aboriginal Peoples to Heal from Trauma and Addiction.”

I am interested in knowing if Aboriginal women and men with trauma and addiction can experience greater healing from the *Seeking Safety* program when it co-exists in an integrated fashion with traditional Aboriginal healing methods such as storytelling, talks or teachings with Elders, smudging, drumming, sweats, bringing of sacred bundles, teachings about the history of the Aboriginal peoples, and the Seven Grandfather Teachings. I will gather information from what the participants say, think, and experience during some interviews and the sharing circles from 12 Aboriginal women at the N’Swakamok Native Friendship Centre, and 12 Aboriginal men at Rockhaven Recovery Home for Men in Sudbury.

Your participation as a facilitator and your input and experiences with the sharing circles would be of great value to this project. If you agree to be a facilitator and co-researcher in this study, you will:

- Complete a 6-day training that I will provide to enable you to facilitate the program with a co-facilitator and 12 client participants.
- Co-facilitate with another counsellor, and sometimes an Elder, group discussions during meetings we will call *sharing circles*. They will take place twice a week for a period of 13 weeks.
- Help participants complete a sharing circle questionnaire after each circle.
- Be present at 3 sweats throughout the treatment period to provide additional support for participants who need it.
- Meet with me, the researcher, for approximately 1 hour for a semi-structured interview at the end of the program. During the interview, I will ask you about your experiences as a facilitator of the sharing circles as well as your experiences with the healing of the participants. In addition, I will ask you for feedback about the supervision and support you received from me. With your consent, the interview will be audio-recorded.
- Participate in an additional sharing circle at the end of the program to help me establish the advantages of using this combination of models.

Important information

1. Know that any records or reports, with the information you provide during the interview will be kept confidential and anonymous by replacing your identity with a code name and any agency identifiers will be removed in published materials.
2. All research materials will be kept in a locked file at the university for a minimum of 5 years. Once the research is complete, the data will be destroyed.
3. I will be providing you with supervision throughout the study.

4. Some of the questions and discussions during the sharing circles pose minimal risk of emotional distress or discomfort. During the training from me before the commencement of the sharing circles I will help you identify how to minimize this risk. However, should you experience distress or discomfort while participating in the sharing circle, you can indicate this to your co-facilitator and then discuss this with me afterwards in order to debrief.
5. You will also have a debriefing session after each circle.
6. Elders Julie Ozawagosh or Frank Ozawagosh will be available to you any time you feel the need to talk and learn more about the traditional healing methods.
7. You will not receive any compensation for participating in the study, but I will be offering you and each participant tobacco before we start the research. (You mention a gift a little earlier!)

Participation Benefits

By participating in this project, you will:

- Receive knowledge about IGT and addictions.
- Facilitate the gaining of a better feeling of belonging by participants.
- Have the opportunity to share and support others who have undergone similar traumas and trials and bear witness and affirm the stories and feelings of participants. This helps them to develop trust and good feelings towards others.
- Receive training and certification in the facilitation of the *Seeking Safety* model which will allow you to integrate this method into your practice, if you so choose.
- Be reminded or learn more about your culture and history.

- Finally, as you know, the healing and knowledge that is gained through the program will give you greater opportunity to transfer that help to your family, friends and community.

I hope that the information we gather from the research will be used to identify the advantages of using an integrated Western and Aboriginal healing model to treat and assist Aboriginal men and women with trauma and addiction and that the results of the study will encourage treatment centers and Aboriginal programs to consider a combined approach that can bring health and healing to Aboriginal peoples. The study findings will be shared with all who participate and their communities at a feast when the research is completed. The information obtained from this study will also be reported in the form of published papers as part of my thesis and as a requirement for the Interdisciplinary Ph.D. in the School of Rural and Northern Health program at Laurentian University.

I understand that by signing this form I have consented to participate in the above mentioned study. I understand that my participation is voluntary and that I may withdraw at any time. I understand that I will benefit from my involvement in the study and that a copy of the consent form has been provided to me. I voluntarily consent to participate in this study.

Date _____

Participant's Signature _____

For further information, please contact: Teresa Naseba Marsh, Ph.D. Student,
School of Rural and Northern Health,

Laurentian University,

E-mail: tmarsh@Laurentian.ca,

Tel: (705) 626-3367

Or:

Robin Craig, Ph.D.

Laurentian University Research Office

E-mail: ethics@laurentian.ca

Telephone: 1-705-675-1151 ext. 3213 or 1-800-675-1151 ext. 3213

Appendix D: Signed Research Approval



APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New X / Modifications to project / Time extension	
Name of Principal Investigator and school/department	Teresa Naseba Marsh (PhD Rural and Northern Health)
Title of Project	Exploring how Traditional Healing Methods and a Western Treatment Model “Seeking Safety” can Co-exist in Assisting Aboriginal Peoples Heal from Trauma and Addiction
REB file number	2013-04-08
Date of original approval of project	May 24, 2013
Date of approval of project modifications or extension (if applicable)	
Final/Interim report due on	May 24, 2014
Conditions placed on project	Final report due on December 31, 2014

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate REB form.

In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best of luck in conducting your research.

A handwritten signature in black ink that reads "Susan James".

Susan James, Chair, Laurentian University Research Ethics Board

Appendix E: Research Ethics Completion



FORM FOR ANNUAL REPORT, REPORT COMPLETION, AND REQUEST FOR CHANGES TO A PROJECT for research projects involving human participants

File #	2013-04-08		
Title of Project	Exploring how Traditional Healing Methods and a Western Treatment Model “Seeking Safety” can Co-exist in Assisting Aboriginal Peoples Heal from Trauma and Addiction		
Principal Investigator and Supervisor (if applicable)	Teresa Naseba Marsh and Sheila Cote-Meek		
Is this a multi-year project? (Yes/No)	Yes		
Date of original ethics approval	May 24, 2013		
Date project completed (if applicable)	Dec 31, 2013		
For incomplete projects, tentative date of completion of project.			
For incomplete projects, date of next report (no more than 1 year after this report)			
Date This Report Submitted	April 22, 2015		

“Completed” means having terminated all contact with potential or actual participants for the purposes of the project, except for final feedback of the project’s results.

SECTION A – NOTICE OF COMPLETION OF PROJECT

1	How many subjects participated in the project?	24
2	Were some subjects removed from the study? How many, and for what principal reason?	0
3	Did some subjects leave the study after they agreed to participate? How many, and for what principal reason?	Yes. 8 subjects lost-to-follow-up for final outcome assessment
4	Specific issues or problems that arose (e.g., difficulty in recruiting, unexpected or serious events, ambiguities, etc) and how you handled them.	Nil
5	How are you ensuring data security during storage?	All data (on computers, laptops, USB storage) is stored in locked cabinets of Teresa Naseba Marsh in a locked area of her home office. No personal or identifying information will be included in the electronic database. Participants will be assigned unique identifiers (an alphanumeric code).

SECTION B – REQUESTING TIME EXTENSIONS OR CHANGES TO A PROJECT

	<i>Briefly describe the changes proposed. Please re-submit your full revised project to REB for evaluation, highlighting any changes in a different colour, and attach any new letters/forms that have been changed.</i>	
6	Time extension	
7	Recruitment methods or types of participants	
8	Procedures	
9	Forms: letters, consent etc.	
10	Other changes not listed above	

Signature of Principal Investigator

Date

	April 21, 2015
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Revised September 2010

Return by mail or email (PDF signature scan is acceptable) to the Research, Development and Creativity Office (L-313) on or before the date indicated for the final report on the original Ethics Approval Form.

Appendix F: Post-treatment Sharing Circles Question Guide

1. What did you find most helpful about the *Seeking Safety* group topics?
 - a. Least helpful?
2. What aspects of the traditional healing approaches did you find most helpful?
 - a. Least helpful?
3. Is there anything in the sharing circles that impacted you in a positive way?
 - a. In a negative way?
4. What do you remember most about the sharing circles?
5. How can you apply and use the knowledge and skills gained in your day-to-day life?
6. Can you describe any changes that you experienced within yourself during the sharing circles
7. Is there anything in the sharing circles that can be done differently in the future?
8. Would you recommend this treatment to others?
9. Is there anything else that you would like to tell me about your experience in the group?

Appendix G: Post-Treatment Semi-Structured Interviews Guide

1. What did you find most helpful about the *Seeking Safety* group topics?
 - a. Least helpful?
2. What aspects of the traditional healing approaches did you find most helpful?
 - a. Least helpful?
3. Is there anything in the sharing circles that impacted you in a positive way?
 - a. Negative way?
4. Please describe any changes that you experienced in yourself during the sharing circles
5. In your opinion, was the training received in facilitating the sharing circles adequate?
6. Is there anything that can be done differently in the training sessions?
7. What did you find most helpful about the supervision sessions?
 - a. Least helpful?
8. Is there anything that can be done differently about the sharing circles in the future?
9. Would you recommend this treatment to other communities and agencies?
10. Is there anything else that you would like to tell me about?

Appendix H: End-of-Treatment Individual Semi-Structured Interviews with Participants

The following questions will guide the end of treatment interviews with the participants.

1. What did you find most helpful about the *Seeking Safety* group topics?
 - a. Least helpful?
2. What aspects of the traditional healing approaches did you find most helpful?
 - a. Least helpful?
3. Is there anything in the sharing circles that impacted you in a positive way?
 - a. In a negative way?
4. What do you remember most about the sharing circles?
5. How can you apply and use the knowledge and skills gained in your day-to-day life?
6. Can you describe any changes that you experienced within yourself during the sharing circles?
7. Is there anything in the sharing circles that can be done differently in the future?
8. Would you recommend this treatment to others?
9. Is there anything else that you would like to tell me about your experience in the group?

Appendix I: Demographic Questionnaire

Demographics	Answer (e.g. n/a not applicable; w/n wish not to answer)
What is your marital status (e.g. single, married)?	<input type="checkbox"/> Single <input type="checkbox"/> Separated/Divorced <input type="checkbox"/> Married/Partner <input type="checkbox"/> Other _____
What level of education have you completed?	<input type="checkbox"/> Primary School <input type="checkbox"/> Secondary School <input type="checkbox"/> College Degree <input type="checkbox"/> University Degree <input type="checkbox"/> Post-Graduate University <input type="checkbox"/> Other: _____
What is your spouse/partner's level of education?	<input type="checkbox"/> Primary School <input type="checkbox"/> Secondary School <input type="checkbox"/> College Degree <input type="checkbox"/> BA University Degree <input type="checkbox"/> Post-Graduate <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A
What is your total family yearly income?	<input type="checkbox"/> less than \$10,000 <input type="checkbox"/> \$10,000 - \$19,999 <input type="checkbox"/> \$20,000 - \$29,999 <input type="checkbox"/> \$30,000 - \$39,999 <input type="checkbox"/> \$40,000 - \$49,999 <input type="checkbox"/> \$50,000 - \$59,999 <input type="checkbox"/> \$60,000 - \$69,999 <input type="checkbox"/> \$70,000 - \$79,999 <input type="checkbox"/> \$80,000 or more <input type="checkbox"/> Don't know
What is your gender?	<input type="checkbox"/> Female <input type="checkbox"/> Male
If you have a spouse/partner, what is their gender?	<input type="checkbox"/> Female <input type="checkbox"/> Male
How old are you?	<input type="checkbox"/> 18-29 <input type="checkbox"/> 30-39 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50-59 <input type="checkbox"/> 60-69
How old is your spouse/partner?	<input type="checkbox"/> 18-29 <input type="checkbox"/> 30-39 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50-59

	<input type="checkbox"/> 60-69
How many years are you living in Northern Ontario?	<input type="checkbox"/> Born in the North <input type="checkbox"/> Two years <input type="checkbox"/> 10 years <input type="checkbox"/> 20 years <input type="checkbox"/> Other: _____
What primary language is spoken at home?	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Ojibway <input type="checkbox"/> Cree <input type="checkbox"/> Other: _____
Were you able to ask your questions in your preferred language?	
Were your questions answered satisfactorily in your preferred language?	
Which best describes where you currently live?	<input type="checkbox"/> On Reserve <input type="checkbox"/> Off Reserve <input type="checkbox"/> Rent home/apartment <input type="checkbox"/> Own home/apartment <input type="checkbox"/> Other: _____
Which language do you prefer to read?	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Ojibway <input type="checkbox"/> Cree <input type="checkbox"/> Other: _____
To what ethnic or cultural group do you most identify with as a Canadian? (alphabetical order)	<input type="checkbox"/> Anglophone <input type="checkbox"/> First Nation <input type="checkbox"/> Francophone <input type="checkbox"/> Inuit <input type="checkbox"/> Métis <input type="checkbox"/> Other, please specify _____

Thank you for completing this questionnaire.

Appendix J: Recruitment Flyer



Are you an Aboriginal man or women currently struggling with Trauma & Addiction?

If you are interested in participating, I will offer you a **13 week program that will run like a SHARING CIRCLE** as The part of a **research study** that will examine how this type of Sharing Circle can help and give you **TOOLS** and **SUPPORT** to deal with **TRAUMA & ADDICTION**.

For any questions about your role in this study, please contact the researcher for this project: **Teresa Marsh (705) 626-3367** or tmarsh@laurentian.ca.

The title of the research study is:

Exploring how Traditional Healing Methods and a Western Treatment Model "Seeking Safety" can Co-exist in Assisting Aboriginal Peoples Heal from Trauma and Addiction

- This is an opportunity for you to engage in a 13-week program that has the potential to help in your healing from trauma/PTSD and addiction.
- This study will explore how traditional healing methods and a Western treatment model, "Seeking Safety", can co-exist in assisting Aboriginal Peoples heal from trauma and addiction. The research will gather your experiences through your voices, viewpoints, and sharing circles.
- There will be women's **sharing circles** at the N'Swakamok Native Friendship Centre, and the men will meet at the Rockhaven Recovery Home for Men in Sudbury, Ontario.
- We really value your time and input. **Participation is completely voluntary.**
- Please accept my invitation to participate in an interview to take part in this research project where I will inform you about the healing approach and details about your commitment to participate.

Appendix K: Addiction Severity Index – Lite

Addiction Severity Index *Lite* - CF

Clinical/Training Version

Thomas McLellan, Ph.D.

John Cacciola, Ph.D.

Deni Carise, Ph.D.

Thomas H. Coyne, MSW

Remember: This is an interview, not a test

Item numbers circled are to be asked at follow-up.

Items with an asterisk are cumulative and should be rephrased at follow-up.*

*Items in a double border gray box are questions for the interviewer.
Do not ask these questions of the client.*

INTRODUCING THE ASI: Seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological. All clients receive this same standard interview. All information gathered is confidential.

There are two time periods we will discuss:

1. The past 30 days
2. Lifetime Data

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.

The scale is:

- 0 - Not at all
- 1 - Slightly
- 2 - Moderately
- 3 - Considerably
- 4 - Extremely

If you are uncomfortable giving an answer, then don't answer.

Please do not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/clarification notes are preceded with "•".

HALF TIME RULE:

If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS:⇒ Last two items in each section.

- ⇒ Do not over interpret.
- ⇒ Denial does not warrant misrepresentation.
- ⇒ Misrepresentation = overt contradiction in information.

Probe and make plenty of comments!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers of medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsman, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeman, chef, electrician, fireman, lineman, machinist, mechanic, paperhanger, painter, repairman, tailor, welder, policeman, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

Alcohol: Beer, wine, liquor
Methadone: Dolophine, LAAM
Opiates: Pain killers = Morphine, Dilaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups = Robitussin, Fentanyl
Barbiturates: Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal
Sed/Hyp/Tranq: Benzodiazepines = Valium, Librium, Ativan, Serax, Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, Quaaludes
Cocaine: Cocaine Crystal, Free-Base Cocaine or Crack, and "Rock Cocaine"
Amphetamines: Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis: Marijuana, Hashish
Hallucinogens: LSD (Acid), Mescaline, Psilocybin (Mushrooms), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy
Inhalants: Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

Just note if these are used: Antidepressants,
Ulcer Meds = Zantac, Tagamet
Asthma Meds = Ventolin Inhaler, Theodur
Other Meds = Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions look at two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days. However if the client has been incarcerated for more than 1 year, you would only gather lifetime information, unless the client admits to significant alcohol /drug use during incarceration. This guideline only applies to the Alcohol/Drug Section.

- ⇒ 30 day questions only require the number of days used.
- ⇒ Lifetime use is asked to determine extended periods of use.
- ⇒ Regular use = 3+ times per week, binges, or problematic irregular use in which normal activities are compromised.
- ⇒ Alcohol to intoxication does not necessarily mean "drunk", use the words felt the effects, "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 5+ drinks in one setting, or within a brief period of time defines "intoxication".
- ⇒ "How to ask these questions:
→ "How many days in the past 30 have you used....?"
→ "How many years in your life have you regularly used....?"

Addiction Severity Index *Lite* - Training Version
GENERAL INFORMATION

G1. ID No.:

G2. SS No.: - -

G3. Program No:

G4. Date of Admission: / /

G5. Date of Interview: / /

G8. Class: 1. Intake 2. Follow-up ☐

G9. Contact Code: 1. In person 2. Telephone (Intake ASI must be in person) 3. Mail ☐

G10. Gender: 1. Male 2. Female ☐

G11. Interviewer Code No.:

G12. Special: 1. Patient terminated 2. Patient refused 3. Patient unable to respond ☐

Name

Address 1

Address 2

City State Zip Code Tel. No.

G14. How long have you lived at this address? Years Months

G16. Date of birth: / /
 (Month/Day/Year)

G17. Of what race do you consider yourself? ☐
 1. White (not Hisp) 5. Asian/Pacific 9. Other Hispanic
 2. Black (not Hisp) 6. Hispanic-Mexican
 3. American Indian 7. Hispanic-Puerto Rican
 4. Alaskan Native 8. Hispanic-Cuban

G18. Do you have a religious preference? ☐
 1. Protestant 3. Jewish 5. Other
 2. Catholic 4. Islamic 6. None

G19. Have you been in a controlled environment in the past 30 days? ☐
 1. No 4. Medical Treatment
 2. Jail 5. Psychiatric Treatment
 3. Alcohol/Drug Treat. 6. Other:
 · A place, theoretically, without access to drugs/alcohol.

G20. How many days?
 · "NN" if Question G19 is No. Refers to total number of days detained in the past 30 days.

(Clinical/Training Version)

M1. How many times in your life have you been hospitalized for medical problems?

• Include O.D.'s and D.T.'s. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of *overnight* hospitalizations for medical problems.

M3. Do you have any chronic medical problems which continue to interfere with your life? 0 -No 1 - Yes ☐

- *If "Yes", specify in comments.*
- A chronic medical condition is a serious physical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

M4. Are you taking any prescribed medication on a regular basis for a physical problem? 0 - No 1 - Yes ☐

· *If Yes, specify in comments.*

· Medication prescribed by a MD for medical conditions; **not psychiatric medicines**. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

M5. Do you receive a pension for a physical disability? 0 - No 1 - Yes ☐

- If Yes, *specify in comments.*
- Include Workers' compensation, exclude psychiatric disability.

M6. How many days have you experienced medical problems in the past 30 days?

☐ ☐

☐ Do not include ailments directly caused by drugs/alcohol.
☐ Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions M7 & M8, ask the patient to use the Patient Rating scale.

M7. How troubled or bothered have you been by these medical problems in the past 30 days?

- Restrict response to problem days of Question M6.

M8. How important to you *now* is treatment for these medical problems?

- Refers to the need for *new* or *additional* medical treatment by the patient.

Is the above information significantly distorted by:

M10. Patient's misrepresentation?	0 - No 1 - Yes	<input type="checkbox"/>
M11. Patient's inability to understand?	0 - No 1 - Yes	<input type="checkbox"/>

[illegible]

EMPLOYMENT/SUPPORT STATUS

E1. Education completed:
 • GED = 12 years, note in comments.
 • Include formal education only.

Years Months

E2. Training or Technical education completed:
 • Formal/organized training only. For military training, only include training that can be used in civilian life, i.e., electronics or computers.

Months

E4. Do you have a valid driver's license?
 • Valid license; not suspended/revoked. 0 - No 1 - Yes ☐

E5. Do you have an automobile available?
 • If answer to **E4** is "No", then **E5** must be "No". 0 - No 1 - Yes ☐
 Does not require ownership, only requires availability on a regular basis.

E6. How long was your longest full time job?
 • Full time = 35+ hours weekly; does not necessarily mean most recent job.

Yrs / Mos

E7. Usual (or last) occupation? (specify) _____ ☐
 (use Hollingshead Categories Reference Sheet)

E9. Does someone contribute the majority of your support? 0 - No 1 - Yes ☐

E10. Usual employment pattern, past three years? ☐

1. Full time (35+ hours)	5. Service
2. Part time (regular hours)	6. Retired/Disability
3. Part time (irregular hours)	7. Unemployed
4. Student	8. In controlled environment

• Answer should represent the *majority* of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents more current situation.

E11. How many days were you paid for working in the past 30 days?
 • Include "under the table" work, paid sick days and vacation.

EMPLOYMENT/SUPPORT COMMENTS

(Include question number with your notes)

For questions E12-17: **How much money did you receive from the following sources in the past 30 days?**

E12 Employment?

- Net or "take home" pay, include any "under the table" money.

E13 Unemployment Compensation?

E14 Welfare?

- Include food stamps, transportation money provided by an agency to go to and from treatment.

E15 Pensions, benefits or Social Security?

- Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

E16 Mate, family, or friends?

- Money for personal expenses, (i.e. clothing), include unreliable sources of income (e.g. gambling). Record **cash** payments only, include windfalls (unexpected), money from loans, gambling, inheritance, tax returns, etc.).

E17 Illegal?

- **Cash** obtained from drug dealing, stealing, fencing stolen goods, gambling, prostitution, etc. **Do not** attempt to convert drugs exchanged to a dollar value.

E18. How many people depend on you for the majority of their food, shelter, etc.? □ □

· Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

E19 How many days have you experienced employment problems in the past 30 ?

· Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

E20 How troubled or bothered have you been by these employment problems in the past 30 days? ☐

· If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems.

E21. How important to you *now* is counseling for these employment problems? ☐

- The patient's ratings in Questions E20-21 refer to Question E19.
- Stress help in finding or preparing for a job, not giving them a job.

E23	Patient's misrepresentation	0-No 1-Yes	<input type="checkbox"/>
E24	Patient's inability to understand?	0-No 1-Yes	<input type="checkbox"/>

[illegible]

Route of Administration Types:				
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV				
• Note the <u>usual</u> or <u>most recent</u> route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.				
		Past 30 Days	Lifetime (years)	Route of Admin
D1	Alcohol (any use at all)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D2	Alcohol (to intoxication)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D3	Heroin	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D4	Methadone	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D5	Other Opiates/Analgesics	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D6	Barbiturates	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D7	Sedatives/Hypnotics/ Tranquilizers	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D8	Cocaine	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D9	Amphetamines	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D10	Cannabis	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D11	Hallucinogens	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D12	Inhalants	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>
D13	More than 1 substance per day (including alcohol)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>

D17. How many times have you had Alcohol DT's?

· *Delirium Tremens* (DT's): Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation, fever, , hallucinations, they usually require medical attention.

[illegible]

How many times in your life have you been treated for :

D19* Alcohol abuse

D20* Drug abuse

- Include detoxification, halfway houses, in/outpatient counseling, and AA or NA (if 3+ meetings within one month period).

How many of these were detox only:

D21. Alcohol

D22. Drugs

- If D19 = '00', then question D21 is "NN"
- If D20 = '00', then question D22 is "NN"

How much money would you say you spent during the past 30 days on:

D23 Alcohol

D24 Drugs

- Only count actual **money** spent. What is the financial burden caused by drugs/alcohol?

D25 How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days? · Include AA/NA

How many days in the past 30 have you experienced:

D26. Alcohol problems?

(D28). Alcohol problems? ☐

(D30). Alcohol problems? ☐

(D27). Drug problems?

--	--

How troubled or bothered have you been in the past 30 days by these

How important to you *now* is treatment for these:

CONFIDENCE RATINGS

(D34. Patient's misrepresentation? 0-No 1-Yes ☐

[illegible]

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 - Yes ☐

• Judge, probation/parole officer, etc.

L2. Are you on parole or probation? 0 - No 1 - Yes ☐

• Note duration and level in comments.

How many times in your life have you been arrested and charged with the following:

L3* Shoplift/Vandal	<input type="text"/>	L10* Assault	<input type="text"/>
L4* Parole/Probation	<input type="text"/>	L11* Arson	<input type="text"/>
L5* Drug Charges	<input type="text"/>	L12* Rape	<input type="text"/>
L6* Forgery	<input type="text"/>	L13* Homicide/Mansl.	<input type="text"/>
L7* Weapons Offense	<input type="text"/>	L14* Prostitution	<input type="text"/>
L8* Burglary/Larceny/B&E	<input type="text"/>	L15* Contempt of Court	<input type="text"/>
L9* Robbery	<input type="text"/>	L16* Other: _____	<input type="text"/>

• Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult.
• Include formal charges only.

L17* How many of these charges resulted in convictions?

• If L03-16 = 00, then question L17 = "NN".
• Do not include misdemeanor offenses from questions L18-20 below.
• Convictions include fines, probation, incarcerations, suspended sentences, and guilty pleas.

How many times in your life have you been charged with the following:

L18* Disorderly conduct, vagrancy, public intoxication?

L19* Driving while intoxicated?

L20* Major driving violations?

• Moving violations: speeding, reckless driving, no license, etc.

L21* How many months were you incarcerated in your life?

• If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated.

L24. Are you presently awaiting charges, trial, or sentence? 0 - No 1 - Yes ☐

L25. What for?

• Use the number of the type of crime committed: 03-16 and 18-20
• Refers to Q. L24. If more than one, choose most severe.
• Don't include civil cases, unless a criminal offense is involved.

L26. How many days in the past 30, were you detained or incarcerated?

• Include being arrested and released on the same day.

LEGAL COMMENTS

(Include question number with your notes)

127 How many days in the past 30 have you engaged in illegal activities for profit?

· Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with Question E17 under Employment/Family Support Section.

For Questions L28-29, ask the patient to use the Patient Rating scale.

L28. How serious do you feel your present legal problems are?

· Exclude civil problems

L29. How important to you *now* is counseling or referral for these legal problems?

· Patient is rating a need for *additional* referral to legal counsel for defense against criminal charges.

Is the above information significantly distorted by:

(L31) Patient's misrepresentation? 0 - No 1 - Yes ☐

(L32) Patient's inability to understand? 0 - No 1 - Yes ☐

[illegible]

F1. Marital Status:
 1-Married 3-Widowed 5-Divorced
 2-Remarried 4-Separated 6-Never Married
 • Common-law marriage = 1. Specify in comments.

F3. Are you satisfied with this situation?
 0-No 1-Different 2-Yes
 • Satisfied = generally liking the situation. - Refers to Questions F1 & F2.

F4. Usual living arrangements (past 3 years): ☐

1-With sexual partner & children	6-With friends
2-With sexual partner alone	7-Alone
3-With children alone	8-Controlled Environment
4-With parents	9-No stable arrangement
5-With family	

• Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

F6. Are you satisfied with these arrangements? ☐

0-No 1-Indifferent 2-Yes

F7.	Has a current alcohol problem?	0-No 1-Yes	<input type="checkbox"/>
F8.	Uses non-prescribed drugs?	0-No 1-Yes	<input type="checkbox"/>

F9. With whom do you spend most of your free time? 1-Family 2-Friends ☐
 Alone

- If a girlfriend/boyfriend is considered as family by patient, then they must refer to them as family throughout this section, not a friend.

F10. Are you satisfied with spending your free time this way? 0-No 1-Indifferent 2-Yes ☐

- A satisfied response must indicate that the person generally likes the situation. Referring to Question F9.

	0 - No	1 - Yes
F18) Mother	<input type="checkbox"/>	<input type="checkbox"/>
F19) Father	<input type="checkbox"/>	<input type="checkbox"/>
F20) Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>
F21) Sexual Partner/Spouse	<input type="checkbox"/>	<input type="checkbox"/>
F22) Children	<input type="checkbox"/>	<input type="checkbox"/>
F23) Other Significant Family (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
F24) Close Friends	<input type="checkbox"/>	<input type="checkbox"/>
F25) Neighbors	<input type="checkbox"/>	<input type="checkbox"/>
F26) Co-workers	<input type="checkbox"/>	<input type="checkbox"/>

• "Serious problems" mean those that endangered the relationship.

• A "problem" requires contact of some sort, either by telephone or in person.

Did anyone abuse you?		0- No	1- Yes
		Past 30 days	In Your Life
F28.	Physically? • Caused you physical harm.	<input type="checkbox"/>	<input type="checkbox"/>
F29.	Sexually? • Forced sexual advances/acts.	<input type="checkbox"/>	<input type="checkbox"/>

[illegible]

<p>How many days in the past 30 have you had serious conflicts:</p>	
<p>F30) With your family?</p>	<input type="text"/> <input type="text"/>
<p>For Questions F32-34, ask the patient to use the Patient Rating scale.</p>	
<p>How troubled or bothered have you been in the past 30 days by:</p>	
<p>F32) Family problems ?</p>	<input type="text"/>
<p>How important to you now is treatment or counseling for these:</p>	
<p>F34) Family problems</p>	<input type="text"/>
<p>· Patient is rating <i>his/her</i> need for counseling for family problems, not whether the family would be willing to attend.</p>	
<p>How many days in the past 30 have you had serious conflicts:</p>	
<p>F31) With other people (excluding family)?</p>	<input type="text"/> <input type="text"/>
<p>For Questions F33-35, ask the patient to use the Patient Rating scale.</p>	
<p>How troubled or bothered have you been in the past 30 days by:</p>	
<p>F33) Social problems?</p>	<input type="text"/>
<p>How important to you now is treatment or counseling for these:</p>	
<p>F35) Social problems</p>	<input type="text"/>
<p>· Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems.</p>	

Is the above information significantly distorted by:

F37	Patient's misrepresentation?	0-No 1-Yes	<input type="checkbox"/>
F38	Patient's inability to understand?	0-No 1-Yes	<input type="checkbox"/>

[illegible]

How many times have you been treated for any psychological or emotional problems:

P1.* In a hospital or inpatient setting?

P2.* Outpatient/private patient?

- Do not include substance abuse, employment, or family counseling.

Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days.

- Enter diagnosis in comments if known.

P3. Do you receive a pension for a psychiatric disability? ☐

0-No 1-Yes

		0-No	1-Yes
P4.	Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with daily function?	<div style="text-align: center;">Past 30 Days</div> <input type="checkbox"/>	<div style="text-align: center;">Lifetime</div> <input type="checkbox"/>
P5.	Experienced serious anxiety/ tension, uptight, unreasonably worried, inability to feel relaxed?	<input type="checkbox"/>	<input type="checkbox"/>
P6.	Experienced hallucinations-saw things or heard voices that were not there?	<input type="checkbox"/>	<input type="checkbox"/>
P7.	Experienced trouble understanding, concentrating, or remembering?	<input type="checkbox"/>	<input type="checkbox"/>

P8.	Experienced trouble controlling violent behavior including episodes of rage, or violence?	<input type="checkbox"/>	<input type="checkbox"/>
P9.	Experienced serious thoughts of suicide? • Patient seriously considered a plan for taking his/her life.	<input type="checkbox"/>	<input type="checkbox"/>
P10.	Attempted suicide? • Include actual suicidal gestures or attempts.	<input type="checkbox"/>	<input type="checkbox"/>
P11.	Been prescribed medication for any psychological or emotional problems? • Prescribed for the patient by MD. Record "Yes" if a medication was prescribed <i>even if</i> the patient is not taking it.	<input type="checkbox"/>	<input type="checkbox"/>

P12. How many days in the past 30 have you experienced these psychological or emotional problems?

- This refers to problems noted in Questions P4-P10.

P13 How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?
 • Patient should be rating the problem days from Question P12. ☐

P14 How important to you *now* is treatment for these psychological or emotional problems? ☐

Is the above information significantly distorted by:

P22. Patient's misrepresentation? 0-No 1-Yes ☐

P23. Patient's inability to understand? 0-No 1-Yes ☐

[illegible]

Appendix L: Trauma Symptom Checklist - 40

Trauma Symptom Checklist – 40

(Briere & Runtz, 1989)

How often have you experienced each of the following in the last month? Please circle one number, 0-3.

Symptom	Never ----- Often			
	0	1	2	3
1. Headaches				
2. Insomnia				
3. Weight loss (without dieting)				
4. Stomach problems				
5. Sexual problems				
6. Feeling isolated from others				
7. "Flashbacks" (sudden, vivid, distracting memories)				
8. Restless sleep				
9. Low sex drive				
10. Anxiety attacks				
11. Sexual overactivity				
12. Loneliness				
13. Nightmares				
14. "Spacing out" (going away in your mind)				
15. Sadness				
16. Dizziness				
17. Not feeling satisfied with your sex life				
18. Trouble controlling your temper				
19. Waking up early in the morning				
20. Uncontrollable crying				
21. Fear of men				
22. Not feeling rested in the morning				
23. Having sex that you didn't enjoy				
24. Trouble getting along with others				
25. Memory problems				
26. Desire to physically hurt yourself				
27. Fear of women				
28. Waking up in the middle of the night				
29. Bad thoughts or feelings during sex				
30. Passing out				
31. Feeling that things are "unreal"				
32. Unnecessary or over-frequent washing				
33. Feelings of inferiority				
34. Feeling tense all the time				
35. Being confused about your sexual feelings				
36. Desire to physically hurt others				
37. Feelings of guilt				
38. Feeling that you are not always in your body				
39. Having trouble breathing				
40. Sexual feelings when you shouldn't have them				

Appendix M: Historical Loss Scale

Historical Grief-Losses – Adult Form

Our people have experienced many losses since we came into contact with Europeans (Whites). I will read you types of losses that people have mentioned to us, and I would like you to tell how often you think of these.

1	2	3	4	5	6	9
Several times a day	Daily	Weekly	Monthly	Yearly or only at special times	Never	Don't know/Refused

1. The loss of our land
2. The loss of our language
3. Losing our traditional spiritual ways
4. The loss of our family ties because of boarding/residential schools
5. The loss of families from the reservation/reserve to government relocation
6. The loss of self-respect from poor treatment by government officials
7. The loss of trust in whites from broken treaties
8. Losing our culture
9. The losses from the effects of alcoholism on our people
10. Loss of respect by our children and grandchildren for elders
11. Loss of our people through early death
12. Loss of respect by our children for traditional ways

Appendix N: Historical Loss Associated Symptoms Scale

Historical Grief-Associated Symptoms – Adult Form

Now, I would like to ask you about how you feel when you think about these losses.

1	2	3	4	5	9
Never	Seldom	Sometimes	Often	Always	Don't know/ Refused

How often do you feel...

13. Sadness or depression
14. Anger
15. Like you are remembering these losses when you don't want to
16. Anxiety or nervousness
17. Uncomfortable around white people when you think of these losses
18. Shame when you think of these losses
19. A sense of weakness or helplessness
20. A loss of concentration
21. Bad dreams or nightmares
22. Feel isolated or distant from other people when you think of these losses
23. A loss of sleep
24. Feel the need to drink or take drugs when you think of these losses
25. Rage
26. Fearful or distrust of the intentions of white people
27. There is no point in thinking about the future
28. Like it is happening again
29. Like avoiding places or people that remind you of these losses

Appendix O: Healing from Anger: Example of an Indigenous Healing Seeking Safety Sharing Circle

From the Seeking Safety Manual (Interpersonal session): Anger is explored as a valid feeling that is inevitable in recovery from PTSD and substance abuse. Anger can be used constructively (as a source of knowledge and healing) or destructively (a danger when acted out against self or others). Guidelines for working with both types of anger are offered.

Session Format

1. Complete a quick check-in, approximately five minutes per client. This allows clients to share how they are doing, identifies issues to discuss during the main session, and provides a consistent start.
2. Link quotation to session (briefly). Today we will focus on anger. Ask clients what they think the essence of the quote is.
3. Relate the topic to clients' lives in-depth via the handouts.

Indigenous: *Participants mix and mingle and enjoy the treats and drinks. The facilitators create a circle with the sacred bundle in the centre and encourage participants to place any of their sacred items on the bundle cloth. The circle is opened with a prayer and smudging. One of the participants or the facilitator will walk around with the smudging bowl. The facilitator may drum and sing a sacred song.*

Western: The Seeking safety session starts with a check-in. A list of the check-in questions are sent around and the questions include:

1. How are you feeling?
2. What good coping have you done?
3. Any substance use or other unsafe behaviour?
4. Did you complete your commitment?
5. Community resource update?

After the check-in, one of the facilitators will give everyone a handout of the day's session and then announce the session. This is then followed by the quote: Example:

Quotation: "A loving heart is the truest wisdom."—Charles Dickens

- Handout 1: Exploring anger
- Handout 2: Understanding anger
- Handout 3: Before, during and after: Three ways to heal anger
- Handout 4: Safety contract: Protecting yourself and others

The facilitator will then ask a few people to comment on what the quote means for them and invite dialogue. Usually four or five people will contribute. The facilitator will then give a brief explanation of what anger is and how it affects us. Each participant gets an opportunity to read some of the core content.

Indigenous: *If an Elder is present, an Indigenous teaching will be given at the beginning or at the end of the discussion of the literature. Many of these examples are discussed in Chapters 3 and 4. The facilitators can incorporate a teaching and sometimes the teaching can also come from one of the participants. At times when participants get activated by the content as they relate it to their story, the facilitators will smudge and leave the smudging bowl at the feet of the upset participant (discussed in detail in Chapter 3).*

Indigenous teaching example:

The Elder would talk about anger as a fire burning inside of us. She would teach about the positives and negatives of our fire. She would also talk about how we have to be our own fire keepers.

Western: Once all the material has been worked through, the facilitator will talk about the commitment and decide to take an example from the Seeking Safety handout. Alternatively, he or she may come up with an Indigenous commitment. For example, “Read the Seven Grandfather Teachings daily and practice.” An example of a Seeking Safety commitment for this topic: Imagine you are teaching a child about anger: What would you say?

Western: the facilitator now informs the participants that they will move to the check-out and will start first. Then, the facilitator will hand the sheet to the next person. The check-out questions include:

1. Name one thing you got out of today’s session (any problems with the session).
2. What is your new commitment?
3. What community resource will you call?

Indigenous: *The facilitator will ask one of the participants to say a prayer or drum. Alternatively, the entire circle could sing a Sacred Song.*

Western: **The facilitator will then distribute the end-of-session questionnaire.**

Indigenous: *Participants will enjoy the rest of the treats and will take the leftovers home for their children or families.*

Appendix P: 25 Seeking Safety treatment topics

Seeking Safety treatment topics

Domains (cognitive, behavioral, interpersonal, or a combination) are listed in parentheses.

<p>(1) Introduction to treatment / Case management This topic covers: (a) Introduction to the treatment; (b) Getting to know the patient; and (c) Assessment of case management needs.</p>
<p>(2) Safety (combination) Safety is described as the first stage of healing from both PTSD and substance abuse, and the key focus of this treatment. A list of over 80 <i>Safe Coping Skills</i> is provided, and patients explore what safety means to them.</p>
<p>(3) PTSD: Taking Back Your Power (cognitive) Four handouts are offered: (a) "What is PTSD?"; (b) "The Link Between PTSD and Substance Abuse"; (c) "Using Compassion to Take Back Your Power"; and (d) "Long-Term PTSD Problems". The goal is to provide information as well as a compassionate understanding of the disorder.</p>
<p>(4) Detaching from Emotional Pain: Grounding (behavioral) A powerful strategy, "grounding", is offered to help patients detach from emotional pain. Three types of grounding are presented (mental, physical, and soothing), with an experiential exercise to demonstrate the techniques. The goal is to shift attention toward the external world, away from negative feelings.</p>
<p>(5) When Substances Control You (cognitive) Eight handouts are provided, which can be combined or used separately: (a) "Do You Have a Substance Abuse Problem?"; (b) "How Substance Abuse Prevents Healing From PTSD"; (c) "Choose a Way to Give Up Substances"; (d) "Climbing Mount Recovery", an imaginative exercise to prepare for giving up substances; (e) "Mixed Feelings"; (f) "Self-Understanding of Substance Use"; (g) "Self-Help Groups"; and (h) "Substance Abuse And PTSD: Common Questions".</p>
<p>(6) Asking for Help (interpersonal) Both PTSD and substance abuse lead to problems in asking for help. This topic encourages patients to become aware of their need for help and provides guidance on how to obtain it.</p>
<p>(7) Taking Good Care of Yourself (behavioral) Patients are guided to explore how well they take care of themselves, using a questionnaire listing specific behaviors (e.g., "Do you get regular medical check-ups?"). They are asked to take immediate action to improve at least one self-care problem.</p>
<p>(8) Compassion (cognitive) This topic encourages the use of compassion when trying to overcome problems. Compassion is the opposite of "beating oneself up", a common tendency for people with PTSD and substance abuse. Patients are taught that only a loving stance toward the self produces lasting change.</p>
<p>(9) Red and Green Flags (behavioral) Patients are guided to explore the up-and-down nature of recovery in both PTSD and substance abuse through discussion of "red and green flags" (signs of danger and safety). A <i>Safety Plan</i> is developed to identify what to do in situations of mild, moderate, and severe relapse danger.</p>
<p>(10) Honesty (interpersonal) Patients are encouraged to explore the role of honesty in recovery and to role-play specific situations. Related issues include: What is the cost of dishonesty? When is it safe to be honest? What if the other person doesn't accept honesty?</p>
<p>(11) Recovery Thinking (cognitive) Thoughts associated with PTSD and substance abuse are contrasted with healthier "recovery thinking". Patients are guided to change their thinking using rethinking tools such as <i>List Your</i></p>

Options, Create a New Story, Make a Decision, and Imagine. The power of rethinking is demonstrated through think-aloud and rethinking exercises.
(12) Integrating the Split Self (<i>cognitive</i>) Splitting is identified as a major psychic defense in both PTSD and substance abuse. Patients are guided to notice splits (e.g., different sides of the self, ambivalence, denial) and to strive for integration as a means to overcome these.
(13) Commitment (<i>behavioral</i>) Making and keeping promises, both to self and others, are explored. Creative strategies for keeping commitments, and feelings that can get in the way, are described.
(14) Creating Meaning (<i>cognitive</i>) Meaning systems are discussed with a focus on assumptions specific to PTSD and substance abuse, such as <i>Deprivation Reasoning</i> , <i>Actions Speak Louder Than Words</i> , and <i>Time Warp</i> . Meanings that are harmful versus healing in recovery are contrasted.
(15) Community Resources (<i>interpersonal</i>) A lengthy list of national non-profit resources is offered to aid patients' recovery (including advocacy organizations, self-help, and newsletters). Also, guidelines are offered to help patients take a consumer approach in evaluating treatments.
(16) Setting Boundaries in Relationships (<i>interpersonal</i>) Boundary problems are described as either too much closeness (difficulty saying "no" in relationships) or too much distance (difficulty saying "yes" in relationships). Ways to set healthy boundaries are explored, and domestic violence information is provided.
(17) Discovery (<i>cognitive</i>) Discovery is offered as a tool to reduce the cognitive rigidity common to PTSD and substance abuse (called "staying stuck"). Discovery is a way to stay open to experiences and new knowledge, using strategies such as <i>Ask Others</i> , <i>Try It and See</i> , <i>Predict</i> , and <i>Act "As If"</i> . Suggestions for coping with negative feedback are provided.
(18) Getting Others to Support Your Recovery (<i>interpersonal</i>) Patients are encouraged to identify which people in their lives are supportive, neutral, or destructive toward their recovery. Suggestions for eliciting support are provided, as well as a letter they can give to others to promote understanding of their PTSD and substance abuse. A safe family member or friend can be invited to attend the session.
(19) Coping with Triggers (<i>behavioral</i>) Patients are encouraged to actively fight triggers of PTSD and substance abuse. A simple three-step model is offered: change <i>who</i> you are with, <i>what</i> you are doing, and <i>where</i> you are (similar to "change people, places, and things" in AA).
(20) Respecting Your Time (<i>behavioral</i>) Time is explored as a major resource in recovery. Patients may have lost years to their disorders, but they can still make the future better than the past. They are asked to fill in schedule blanks to explore issues such as: Do they use their time well? Is recovery their highest priority? Balancing structure versus spontaneity; work versus play; and time alone versus in relationships are also addressed.
(21) Healthy Relationships (<i>interpersonal</i>) Healthy and unhealthy relationship beliefs are contrasted. For example, the unhealthy belief "Bad relationships are all I can get" is contrasted with the healthy belief "Creating good relationships is a skill to learn." Patients are guided to notice how PTSD and substance abuse can lead to unhealthy relationships.

<p>(22) Self-Nurturing (<i>behavioral</i>) Safe self-nurturing is distinguished from unsafe self-nurturing (e.g., substances and other “cheap thrills”). Patients are asked to create a gift to the self by increasing safe self-nurturing and decreasing unsafe self-nurturing. Pleasure is explored as a complex issue in PTSD/substance abuse.</p>
<p>(23) Healing from Anger (<i>interpersonal</i>) Anger is explored as a valid feeling that is inevitable in recovery from PTSD and substance abuse. Anger can be used constructively (as a source of knowledge and healing) or destructively (a danger when acted out against self or others). Guidelines for working with both types of anger are offered.</p>
<p>(24) The Life Choices Game (<i>combination</i>) As part of termination, patients are invited to play a game as a way to review the material covered in the treatment. Patients pull from a box slips of paper that list challenging life events (e.g., “You find out your partner is having an affair”). They respond with how they would cope, using game rules that focus on constructive coping.</p>
<p>(25) Termination Patients express their feelings about the ending of treatment, discuss what they liked and disliked about it, and finalize aftercare plans. An optional Termination Letter can be read aloud to patients as a way to validate the work they have done.</p>

From: Najavits, L.M. (2002). Seeking Safety: A New Psychotherapy for Posttraumatic Stress Disorder and Substance Abuse. In *Trauma and Substance Abuse: Causes, Consequences and Treatment of Comorbid Disorders* (Eds. P. Ouimette & P. Brown). Washington, DC: American Psychological Association.