

Integrating Mainstream and Indigenous Approaches in a Private Clinical Setting

by

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Abstract

This report thoroughly examines and discusses my Advanced Practicum experience. The practicum was completed from October 23rd, 2017 to March 6th, 2018 within Tremblay Counselling Services of Timmins, Ontario. The primary learning objective was to critique the applicability of certain theories and approaches such as Cognitive Behavior Therapy, which are highlighted in the literature review while reflecting on how I could integrate an Indigenous framework within my practice approach.

The Advanced Practicum offered an experiential learning experience, which was a more enriched opportunity to observe, assess, and critique the theoretical models utilized within therapy. In addition to my placement, a parenting group pilot project was also initiated. This project was an opportunity to learn about group facilitation and group processes. Primarily, the goal was to disseminate awareness and education concerning intergenerational trauma and its residual impacts on individual, familial, and community wellbeing. Essentially, the parenting group pilot project sought to fill a gap in services pertaining to Indigenous led support groups as it was discovered that culturally congruent interventions were lacking, specifically within the community of Timmins.

Throughout my practicum placement, the integration and process of reflection was a key component in fostering self-awareness and professional development, which positively shaped my identity as an Indigenous practitioner. My goals for completing the Advanced Practicum sought to enhance, build, and strengthen my clinical skillsets while gaining confidence as I am wholeheartedly drawn to Indigenous mental health social work practice.

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“All great achievements require time”

Maya Angelou

My educational journey through the Master of Social Work (MSW) program at Laurentian University has been one that required a great deal of time, dedication, and commitment, which has resulted in a great achievement. It is an achievement that I am very proud to have accomplished despite the many challenges experienced throughout the learning process. This journey also required the help of many, which I would like to take this opportunity to express my sincere and heartfelt gratitude.

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Introduction

Within Canada, mental health challenges are extremely prevalent within Indigenous¹ populations. It is well documented that First Nations, Metis, and Inuit peoples experience greater mental health issues, where suicide rates are illustrated to be five to six times higher compared to non-Aboriginal populations (Isaak, Campeau, Katz, Enns, Sareen & Team, 2010). Importantly, research indicates a strong correlation linking mental health disparities amongst Indigenous populations to macro factors such as social distress, economic inequality, and more significantly historical trauma, all of which considerably increases vulnerability of suicide and other mental health challenges (Pollock, Mulay, Valcour & Jong, 2016). Yet, despite these challenges, Indigenous people have highly demonstrated a strong resilience to the historical experiences of colonization (Gone, 2013). This resiliency is deeply rooted on the resurgence of Indigenous practices and ways of knowing as the revitalization of cultural practices provide a more enriched and meaningful framework, fostering individual and community healing. Thus, culture as treatment (Gone, 2013).

Bombay, Matheson, and Anisman (2014) defined historical trauma as “the accumulation of collective stressors and trauma that began in the past, which may contribute to an increased risk for negative health and social problems amongst contemporary Aboriginal peoples” (p. 341). Arguably, the conceptualization of historical trauma can be profoundly related to colonialism as

¹For clarity, the term Aboriginal will be highlighted within this report as the term is used collectively to describe the First Peoples of Canada, which includes First Nations, Metis, and Inuit (FNMI) (Sam, Ghosh & Richardson, 2015). The term First Nations is used to identify Indigenous peoples of Canada who are neither Métis nor Inuit. It is also a term used to replace the historical term “Indian” (Simeone, 2015). Similarly, the term Indigenous will also be expressed and acknowledged throughout this report as Rowe, Baldry and Earles (2015) indicated the term is used to describe First Nations peoples internationally (p. 296). For this report, I chose to use the term Indigenous consistently throughout my paper as the term signifies the original peoples of the land, rather a state constructed term such as “Aboriginal” (unless otherwise cited). Importantly, the term Indigenous supports reclamation of identity which is crucial for resistance of political powers and revitalization of Indigenous cultures (Alfred & Corntassel, 2005).

its implications have clearly impacted Indigenous wellness within Canada (Bombay et al., 2014). Alfred (2009) defined colonialism as “the resource exploitation of indigenous lands, residential school syndrome, racism, expropriation of lands, extinguishment of rights, ward-ship, and welfare dependency” (p. 43). Similarly, according to Dr. Yellow Horse Brave Heart’s (1998) extensive research concerning the Lakota peoples, the implications of mass trauma inflicted by colonization with European contact resulted in a long legacy of chronic and unresolved grief. Yellow Horse Brave Heart (2003; 1998) also argued that this long-standing legacy of chronic and massive trauma and unresolved grief has gravely perpetuated multi-generations of trauma, referring to the effects as historical trauma; therefore, illustrating the after-effects of colonization as visibly evident and prevalent within contemporary society, resulting in psychosocial ills (Yellow Horse Brave-Heart, 2003).

Indigenous people are vastly over-represented within criminal justice, mental health, and more specifically within the child welfare system. This extreme over-representation can be strongly correlated to the historical impacts of the Residential School system (Bombay et al., 2014; Greenwood & de Leeuw, 2012). Ideally, for change and healing to occur, a genuine understanding of the issues that have significantly contributed to this chronic over-representation requires a historical lens. Essentially, this conceptual framework emanates understanding while providing a profound insight of how dominant epistemologies of Western knowledge imposed on Indigenous ways of knowing have subjugated Indigenous approaches to healing and wellness (Cunneen & Rowe, 2014). Also, understanding power relations is paramount to ethical social work practice concerning Indigenous populations, which I will review and discuss in Chapter 3.

Literature pertaining to Indigenous epistemologies has clearly demonstrated that there are paths to creating positive outcomes and healthier pathways for attaining Indigenous wellbeing

(Linklater, 2014; Nabigon & Nabigon, 2012; Lavallee & Poole, 2010). Likewise, Indigenous methodologies that involve traditional forms of helping and healing have demonstrated to considerably improve wellbeing, in terms of holistic healing of health. This process of holistic healing involves the integration of Indigenous modalities such as the medicine wheel teachings, which have proven effective and beneficial within therapy (Lavallee & Poole, 2010; Verniest, 2006). Contrarily, it is argued that attempts made by mainstream health service providers to assist Indigenous people with drug and alcohol addictions have proven unsuccessful as differences in worldviews exist concerning help-seeking behaviour (McCormick, 2009).

To fulfill the partial requirements for the M.S.W degree at Laurentian University, I chose to complete an Advanced Practicum within Tremblay Counselling Services, a privately-owned clinical practice located within Timmins, Ontario. I felt an urge to participate in and complete a field practicum in this setting as this would offer an enriched learning experience while providing an opportunity to critique the various theoretical approaches utilized within a clinical setting. Further, this learning setting would foster reflective practice as this was paramount to exploring as to how I would integrate an Indigenous framework within my praxis approach. Importantly, the practicum would advance and build my social work skills and knowledge in terms of professional development while positively shaping and enhancing my clinical skillsets. My work experience has involved working with Indigenous people in the capacity of mental health (adult/youth), primary health, and currently within a child welfare context. The approaches that I was exposed to during my practicum will be further discussed in Chapter 1. Also through my practicum, a parenting group pilot project was prepared, presented, and approved by the Advanced Practicum Committee that aligned with completing my field

placement. This parenting group pilot project was achieved in partnership with Kunuwanimano Child and Family Services (CFS).

The aim of the parenting group project was to provide a service to clients accessing services through Kunuwanimano CFS; primarily families who had an open protection file. Generally, the project sought to fill a gap in services pertaining to Indigenous led parenting support groups. Various theories such as intergenerational trauma theory, traditional Aboriginal parenting theory, Indigenous healing practices, and two-eyed seeing approaches were utilized as frameworks for fostering understanding. Each of these theories were used as guiding tools when planning and coordinating the parenting groups as each theory would demonstrate its ability to facilitate, foster, and cultivate an environment conducive for voluntary participation to occur. With intergenerational trauma theory, the objective was to foster an understanding of how the residual effects have impacted participants from an individual, familial, and community dimension; and more so, its impact on healthy and nurturing parenting relative to contemporary Indigenous family dynamics and child welfare. The parenting group pilot project will be further discussed in Chapter 2.

In the next chapter, the literature review will discuss the various theoretical approaches that I was exposed to and learned about while completing my practicum. It will also highlight theories pertaining to the parenting group pilot project as these concepts were utilized as guiding tools. After the literature review, I include a chapter describing the Advanced Practicum setting. Next, I discuss my reflections and analysis concerning the practicum experience, mainly how I would work towards integrating an Indigenous framework within practice, specific to the mentioned models. Also, discussions of presenting themes concerning the parenting group pilot

project will also be examined. Finally, the practicum report will conclude with observations concerning implications for social work practice in general.

Chapter I: Literature Review

The literature review will discuss the various theoretical models that I was exposed to during the extent of my Advanced Practicum. Prior to commencing my placement, a review of peer-reviewed literature was completed to further enhance my knowledge concerning the various social work theories utilized within Tremblay Counselling Services. Importantly, I felt the Advanced Practicum would enrich my knowledge while gaining a visible understanding of how certain practice models were utilized within a clinical approach. Generally, this learning would generate and foster critical analysis concerning my own praxis, focusing particularly on the significance of integrating Indigenous modalities within therapy. Hence, the primary goal of the Advanced Practicum was to critique the applicability of the following theories: cognitive behavioural therapy (CBT), trauma-focused-cognitive behavioural therapy (TF-CBT), eye movement desensitization and reprocessing therapy (EMDR), and group and/or social group work therapy.

Although the above-mentioned theories were delivered from a Western lens, the key learning objective was to reflect on how I could integrate these methods within an Indigenous context. Essentially, this learning process involved deconstructing and reconstructing the theories while utilizing additional resources such as Indigenous focused research for cross-referencing. This learning experience was fundamental in shaping my professional identity as an Indigenous practitioner while building my confidence. As a child protection worker, I also felt this learning process was vital for heightening my clinical skillsets and knowledge, particularly the delivery of trauma-informed care within practice. Within the Indigenous child welfare system, the impacts of intergenerational trauma are considerably evident, which continue to impact Indigenous

family dynamics. The theories I learned about and deconstructed are described below, starting with an overview of cognitive behaviour therapy (CBT).

Cognitive Behavioural Therapy

Dr. Aaron T. Beck is credited with initially establishing Cognitive Behaviour Therapy (CBT) in the late 1960s, which was introduced into social work practice as a psychosocial intervention for improving mental health (Bennett-Levy, Wilson, Nelson, Stirling, Ryan, Rotumah & Beale, 2014; Turner, 2011). The effectiveness of CBT highly depends on the use of core techniques developed in efficacy studies, which measured its effectiveness, particularly the use of manual-based methods (Turner, Tatham, Lant, Mountford & Waller, 2014). Contrarily, Indigenous scholars critique CBT as “culturally unresponsive”, due to its regimented process and highly encourage that the use of CBT with Indigenous people requires care and expertise (Nelson, Ryan, Rotumah, Bennett-Levy, Budden, Stirling, Wilson, & Beale, 2013)

Additionally, it is argued that CBT does not fully address the needs of clients from a cultural perspective, as CBT is soundly based on a Western lens, which hinders its applicability in terms of cultural sensitivity (Bennett-Levy et al., 2014; Hays, 2014). CBT is considerably grounded on Western-based empirical evidence. And more so, it is argued that CBT approaches “ultimately undermine the social and emotional wellbeing of Indigenous people” (Nelson, et al., 2013, p. 24); however, it is noted that CBT has the potential to be culturally adapted which is highly dependent on the therapist’s skills (Nelson et al., 2013). Also, it is suggested with evidence-based approaches such as CBT, recognizing its cross-cultural limitations is essential as this provides the opportunity to explore and rethink ways to integrate culturally specific and responsive practices within therapy (Hays, 2014). Integrating culturally responsive approaches within CBT acknowledges that the client is perceived as the expert in their own experiences,

which is significant for fostering empowerment concerning Indigenous populations (Hays, 2014).

CBT focuses on teaching specific strategies as the basic principles of CBT involves social learning theory. Thus, learning is acquired partly through the actions of people that produce their environmental conditions, which in turn affects their behaviour in a reciprocal fashion (Bennett-Levy et al., 2014; Lesser & Cooper, 2001). Bennett-Levy et al. (2014) noted that “CBT provides individuals with strategies on how to think and act more adaptively while recognizing and challenging negative and unhelpful belief systems, which increase coping skills” (p. 1). Generally, the primary goal of CBT is to establish a client and therapist relationship. Through the relationship, both client and therapist work collaboratively in identifying faulty thought processes while simultaneously identifying attainable goals, which fosters a more positive and healthy way of thinking about fixations (Turner, 2011).

Faulty thought processes are alleged to stem from our core beliefs (schema). Core beliefs are described as fundamental beliefs people have about themselves, the world, and/or the future, which can be destructive and harmful (De Oliveira, 2012). For example, De Oliveira (2012) suggested “a person with the core belief, ‘I am incompetent’, will likely predict that he/she will be unable to function adequately during a job interview” (p. 328). Similarly, our thought processes are enmeshed with feelings and emotions as our thoughts significantly influence how we feel and how we think of ourselves. Further, it is noted that dysfunctional thought patterns are considerably influenced by traumatic events, which can create maladaptive coping skills insofar that the individual tells themselves what they want to hear in order to cope (De Oliveira, 2012).

According to theorists, CBT is comprised of three main assumptions that underlie

cognitive behavioural approaches, which include the ideas that (a) emotions and behaviour are determined by thinking, (b) emotional disorders result from negative, maladaptive and unrealistic thinking, and (c) by altering negative, maladaptive and unrealistic thinking, emotional disturbance can be reduced (Howe, 2009). Reaven, Blakeley-Smith, Culhane-Shelburne and Hepburn (2012) indicated that “cognitive behavioral therapies (CBT) are well-established, highly researched evidence-based treatments, and are considered as the gold standard psychosocial treatment for anxiety in adults” (p. 410). Thus, CBT has become the most dominant and favoured model of intervention for treating many disorders, due to CBT being the most researched form of psychotherapy (David, Cristea & Hofmann, 2018).

Although CBT is often referred to as the most effective treatment for psychological disorders; however, CBT models of treatment have endured a great deal of controversy concerning its claim as an evidence-based practice. Such controversies include its efficacy, its effectiveness as an approach to psychological treatment, and its allegiance to the medical model (Ougrin, 2011; Andersson & Asmundson, 2008). For these reasons, CBT has endured controversy regarding its effectiveness as researchers have questioned whether its effectiveness is primarily related to the challenging of maladaptive thoughts, or if the use of behavioral interventions alone can improve individual behaviours and health outcomes (Ougrin, 2011). Generally, CBT is usually offered on a short-term basis, leaving clinicians, practitioners, and patients to question its effectiveness, as CBT aims toward a “quick fix” due to its short duration of treatment (Bonfil, 2014).

Yet, despite the fact that CBT is evidence-based and often perceived as the treatment of choice within the mental health sector, it is suggested that CBT has its disadvantages for treating individuals. For example, it is noted that CBT does not meet the needs of all individuals,

specifically, those with complex issues. As practitioners we cannot assume what works best for one individual necessarily works well for others (Hobson, 2012). Although, CBT treatment involves challenging maladaptive thoughts and how our thoughts influence behaviours, CBT does not challenge, nor does it acknowledge the impact societal structures have on an individual's social location, the impact of oppression, and how such factors can affect one's mental health (Hobson, 2012). With respect to Indigenous people, structural and systemic oppression have profoundly impacted their cultural autonomy and individual wellbeing from an economic, health, and societal perspective (Lane & Hibbard, 2005). As it has been noted, this is distinctly evident within the child welfare and judicial system, as Indigenous people are vastly over-represented, and this is strongly connected with the impacts of colonialism and described by Indigenous scholars as "soul wound" (Blackstock & Trocmé, 2005; Duran, Duran, & Yellow Horse Brave Heart, 1998). Therefore, the use of CBT alone as a method of treatment concerning Indigenous mental health would likely not effectively address the needs of this group, due to its lack of culturally sensitive approaches.

Further, research suggests that CBT possesses cross-cultural limitations as CBT focuses on the here and now. It is argued that CBT does not acknowledge, nor does it integrate the impacts of historical trauma into its model approach, specifically when treating Indigenous individuals (Hays, 2014). Therefore, it is suggested that CBT needs to re-examine and consider its practice approach, specifically within a culturally sensitive perspective. This entails, as Hays (2014) noted, "examining how evidence-based practices (EBPs) are relevant to the needs of cultures that were not originally in the minds of the EBPs developers, which is significant in terms of its effectiveness" (p. 17). For instance, in a study conducted amongst Indigenous clients utilizing mainstream approaches such as CBT, results suggested that Westernized models of

psychological training do not work very well within Indigenous contexts. Thus, psychologists working within Indigenous contexts are required to work out their own methods based on trial-and-error. This process typically involves adopting strategies that culturally meet the needs of Indigenous people (McConnochie, Ranzijn, Hodgson, Nolan & Samson, 2012).

Furthermore, Nowrouzi, Manassis, Jones, Bobinski and Mushquash (2015) noted “CBT is very structured and typically uses written exercises to help clients learn coping strategies” (p. 34). However, within Indigenous traditions, more emphasis is placed on narratives and relational aspects of mental health care at all ages, where healing comes from within the community (Nowrouzi et al., 2015). Overall, practitioners working with Indigenous people are encouraged to learn, understand, integrate, and design best practices within Indigenous contexts, so that the needs (physical, emotional, mental & spiritual) of Indigenous people are adequately met. Therefore, it is strongly suggested that the use of mainstream theories such as CBT within practice must also draw upon traditional approaches as this provides a holistic framework for understanding whilst promoting healing and change (Nabigon & Nabigon, 2012).

Trauma-Focused-Cognitive Behaviour Therapy (TF-CBT)

Trauma-focused cognitive behavioural therapy (TF-CBT) was originally developed for children who had been sexually abused, and for their non-offending caretakers (Mannarino, Cohen & Deblinger, 2014). TF-CBT is an evidence-based treatment that is designed to address the difficulties experienced by children, youth, and their caregivers in the aftermath of traumatic events (Pollio, McLean, Behl & Deblinger, 2014). Yet, within my practicum experience, majority of Mr. Tremblay’s work consisted of working with Indigenous adults and trauma experienced resulting from the Indian Residential School era. Thus, the principles of TF-CBT were utilized within practice as the trauma experienced amongst clients occurred as children.

Therefore, the integration of TF-CBT assisted with acknowledging and learning how to work through childhood trauma experienced. While the plethora of information is written based on children who experienced sexual abuse, I did not come across literature pertaining to TF-CBT with adults. However, I felt gaining an understanding of the principles of TF-CBT was essential in constructing my knowledge regarding trauma work, specifically trauma resulting from childhood sexual abuse.

Exposure to trauma is associated with an increased risk for medical and mental health problems, and if left untreated may result in posttraumatic stress disorder (PTSD), depression, anxiety, substance abuse, and possibly suicide (Cohen & Mannarino, 2015). Similarly, Cohen and Mannarino (2015) noted “early identification is key for treatment of traumatized children, as this can prevent potentially serious and long-term negative outcomes” (p. 1). Essentially, TF-CBT involves helping the individual to identify distorted thinking patterns regarding themselves, the traumatic incident, and the world (Bisson, Andrew, Cooper & Lewis, 2014). With TF-CBT, the core principles of treatment involve three phases: (1) stabilization, (2) trauma narration and processing, and (3) integration and consolidation (Cohen & Mannarino, 2014, p. 3), which I will briefly discuss next.

Stabilization is a process that involves building rapport with the child/youth while encouraging the child/youth in sharing a neutral narrative for the basis of working towards trauma narrative. During the stabilization process, basic psychoeducation is provided to the parent and child, regarding the prevalence, dynamics, and the impact of child sexual abuse, which are offered and openly discussed (Cohen & Mannarino, 2015). Psychoeducation provides the youth and caregiver with education and information about the trauma impact, which assists with better understanding their symptoms while providing hope for recovery (Cohen,

Mannarinoa, Kliethermes & Murray, 2012). It also teaches the client about the symptoms (how to recognize them, what they mean, how to control them), and it decreases the client's shame, confusion, and loss of control attached to those symptoms, which is essential for empowerment and healing to occur (Fisher, 1999).

Trauma narration and processing involves the development of a trauma narrative, as this provides gradual exposure and allows the child/youth to connect to the thoughts, feelings, emotions, and bodily sensations prior to, during, and after the exposure to child sexual abuse. During this stage, the child/youth learns how to cognitively process and modify dysfunctional thought processes about themselves and others, particularly concerning the aftermath of child sexual abuse. Therefore, the child/youth is provided with cognitive coping skills that enhance thought processes while eliminating negative cognitive distortions (Cohen & Manarino, 2015).

With Integration and consolidation, this process involves in vivo exposure to a trigger, meaning the child/youth is gradually exposed to the trigger. During this stage, parents are invited to actively participate by encouraging non-avoidance and ensuring that the in vivo plans are continued outside of therapy for improving health outcomes (Cohen & Mannarino, 2015). However, during early TF-CBT sessions, practical strategies are also established to target affective distress as the goal is to help the child/youth gain mastery over trauma reminders or triggers such as feelings, smell, or a memory associated to the trauma (Cohen et al., 2012). Practical strategies entails a structured phased-based treatment as the primary goal is to enhance youth resiliency coping skills, which includes a series of eight components referred as the acronym P.R.A.C.T.I.C.E (Cary & McMillen, 2012; Cohen et al., 2012). Signs and symptoms of affective distress may include the following but are not limited to:

Affective Distress Trauma Experiences			
Cognitive	Behavioural	Physical	Psychological
Intrusive thoughts of event that may occur out of the blue	Avoidance of activities or places that trigger memories of the event	Easily startled	Overwhelming fear
Nightmares	Social Isolation and withdrawal	Tremendous fatigue and exhaustion	Obsessive and compulsive behaviours
Visual images of the event	Lack of interest in previously enjoyable activities	Tachycardia	Detachment from other people and emotions
Loss of memory and concentration abilities		Edginess	Depression, anger, anxiety, panic attacks
Disorientation		Insomnia	Guilt – especially if one lived while other perished
Confusion		Chronic muscle patterns	Shame
Mood swings		Sexual dysfunction	Emotional shock, irritability

(Cascade Behavioural Health, 2019).

Cary and McMillen (2012) noted “TF-CBT is precisely structured, manualized, involves conjoint parent/child intervention, and generally consists of sequential 90-minute weekly sessions” (p. 48). Individuals with PTSD related to childhood abuse typically experience substantial emotion regulation and interpersonal difficulties. Therefore, TF-CBT is strongly recommended to be highly effective as an efficacious treatment for PTSD in children and young people, particularly survivors of sexual abuse (Holtzhausen, Ross & Perry, 2016; Cloitre, Stovall-McClough, Nooner, Zorbas, Cherry, Jackson & Petkova, 2010). TF-CBT protocols draw on four core components emphasized in varying degrees, which include psychoeducation, anxiety management, exposure, and cognitive restructuring (Bisson et al., 2014).

In a controlled study conducted by Jenson, Ormhaug, Egeland, Granly, Hoaas, and Wentzel-Larsen, (2014), it was concluded that “TF-CBT significantly reduced symptoms, as this type of treatment appeared to play a significant role in alleviating PTSD symptoms and other mental health problems amongst participants” (p. 367). Essentially, TF-CBT is soundly recommended for the treatment of PTSD, due to compelling evidence regarding its effectiveness, and is deemed as the most widely and commonly utilized treatment amongst mental health settings (Holstead & Dalton, 2016; Kar, 2011). Additionally, TF-CBT and exposure-based interventions are beneficial and helpful when treating individuals, as they aid to “desensitize” past traumatic memories and experiences. Overall, the principles of TF-CBT is proven to provide positive coping strategies when trauma is triggered or arises (Cohen, Mannarino, & Murray, 2011).

Understanding complex trauma and its impacts on individual wellbeing is essential in providing trauma-informed care and practice, specifically when working with Indigenous people. Research suggests that complex trauma is severely disruptive and can have damaging effects concerning one’s capacity to regulate and ability to manage internal states, particularly if the trauma occurred during childhood (Kezelman & Stavropoulos, 2012). If left untreated, trajectories of trauma can lead to unhealthy coping mechanisms such as negative forms of defenses and/or addictions in adulthood, which can be detrimental to individual wellbeing (Kezelman & Stavropoulos, 2012). Importantly, Dr. Renee Linklater (2014) noted “given the history of Indigenous peoples and the traumas endured, it is important that trauma-informed approaches be used when working with people involved in substance misuse and behavioural addictions” (p. 41). Given this, it is highly suggested that trauma-informed approaches not only

serve as an essential framework in addressing critical survival issues, but also provide genuine understanding (Linklater, 2014).

Eye Movement Desensitization and Reprocessing (EMDR)

Eye movement desensitization and reprocessing (EMDR) is also used in the treatment of PTSD, as it can improve PTSD symptoms, and appears to be superior to stress management and other therapies (Kar, 2011). EMDR was first developed by Francine Shapiro in 1987 (Deville, 2002). EMDR has been referred to as a new method of therapy that employs both exposure (desensitization) and cognitive processing of the traumatic memories that involves saccadic eye movements during the treatment procedure (Boudewyns & Hyer, 1996). EMDR is an evidence-based treatment used to effectively treat symptoms of PTSD, obsessive-compulsive disorders (OCD), chronic pain, and addictions, which has received more empirical research than other new trauma therapies (Hase, Balmaceda, Ostacoli, Liebermann & Hoffman, 2017; Baldwin, 1997). EMDR consists of a structured eight-phase protocol and is typically delivered in weekly 90-minute sessions, which are guided by the Adaptive Information Processing (AIP) model (Shapiro, 1995).

According to Shapiro and Maxfield (2002) “EMDR is a structured treatment approach guided by an information-processing model which integrates elements of other psychotherapies such as psychodynamic, cognitive-behavioral, person-centered, body-based, and interactional therapies into a standardized set of procedures and protocols” (p. 933). The AIP model was developed and established by Shapiro and Maxfield and acts as a guide within EMDR therapy, which is noted to be unique and central to practice (Hase et al., 2017). Within the AIP model, it is suggested that a physiological information-processing system exists within everyone, where new information is processed to an adaptive state. It is within this adaptive state where

associations are forged with previously stored material, resulting in learning, relief of emotional distress, and the availability of the material for future use. This is essential for guiding EMDR clinical practice (Shapiro & Maxfield, 2002). Thus, the AIP model claims that mental pathology is caused by distorted, maladaptive, and faulty processed memories, where it is noted that these memories tend to get stuck in an emotional and vivid state. Therefore, EMDR assists with reprocessing these memories so that the traumatic event is no longer stressful (Shapiro, 1995).

Hase et al. (2017) indicated that “the human brain can usually process stressful information to complete integration, however, if impairment exists, it is noted that the memory will be stored in a raw, unprocessed, and maladaptive form” (p. 2). Any memory of a traumatic event causes an individual to connect to the negative feelings and cognition associated to the trauma. Therefore, the dual task components utilized within therapy (eye-movements + traumatic memory) instinctively disrupt a memory image within the working memory, thus, creating a sense of distance from the associated traumatic experience referred to as reprocessing (Hase et al., 2017; Shapiro, 1995).

Maxfield and Hayer (2002) noted “EMDR is hypothesized to facilitate the accessing and processing of traumatic memories, thus, creating an adaptive resolution, which is indicated by desensitization of emotional distress, reformulation of associated cognitions, and relief of accompanying physiological arousal” (p. 24). Similarly, Siedler and Wagner (2006) indicated with EMDR, the client is instructed to focus both on a disturbing image or memory and on the emotions and cognitive elements connected with it, therefore, once the client has established contact with the disturbing material, the therapist induces a bilateral stimulation. (p. 1515)

Bilateral stimulation is the process where the client is asked to perform rhythmic eye movements, looking left to right, while focusing on either visual, auditory, or external stimuli. For example, this may include visual tracking of hand movements within therapy or use of audio tones (Arnott-Steel, 2016). While doing so, the client is directed to concentrate on a traumatic memory for the purpose of desensitization or trauma exposure, as the aim is to stimulate the information processing systems of the brain (Maxfield & Hayer, 2002). Generally, EMDR has proven to be effective and has demonstrated efficacy in a number of well-controlled clinical trials, producing a significant reduction in PTSD and depression symptoms experienced by participants (Ironson, Freund, Strauss & Williams, 2002).

Despite EMDR is highly proven as an effective psychotherapy treatment for PTSD and other mental health issues, it is noted that studies specific to Indigenous people are very limited, leading to question its credibility amongst culturally diverse groups (Gray & Rose, 2012). However, it is strongly suggested that EMDR along with the use of other psychotherapy interventions such as CBT, dialectical behaviour therapy, or hypnosis would provide a much more therapeutic and beneficial health outcome when treating complex trauma (Arnold & Fisch, 2011).

Group Therapy/Social Work Group Therapy

Research suggests group therapy is a highly effective intervention for trauma survivors whether traumatic experiences involve interpersonal trauma (rape, physical assault, domestic violence, torture, or combat) or traumas resulting from natural disasters or accidents (Foy, Eriksson & Trice, 2001). Group intervention is a form of psychotherapy. An important goal of psychotherapy with trauma survivors is to recognize and help the survivor mobilize his or her resilient capacities (Harvey, 2007). Similarly, Mendelsohn, Zachary, and Harvey (2007) noted

that “group therapy counteracts the isolating effects of interpersonal trauma and enables survivors to connect with sources of resilience within themselves and others” (p. 227).

According to Yalom (1995), the group process is defined as “the nature of the relationship between interacting individuals, where the primary goal of group process is to utilize the interpersonal relationships amongst group members for therapeutic purposes” (p. 130).

Further, it is suggested that the fundamental conviction of group theory is that all group therapy gains its therapeutic potency from the interactions and relationships that emerge during the group process intervention (Jennings & Sawyer, 2003). Jennings and Sawyer (2003) noted “with group therapy, several types of groups exist where the foci and objectives differ as group process interventions include group-based interventions, group-focused interventions, educational groups, psychoeducational groups, group therapy, and group psychotherapy” (p. 255).

Within social group work practice, it is indicated “a group is made up of a collection of individuals who come together for a period of time for some kind of commonality-issue, problem, task, friendship, pleasure or work” (Papell, 2015, p. 241). Social group work requires facilitators to be skilled, as purposeful application of group work skills and theory enables groups to move beyond the illusion of work. For example, if the facilitator is skilled, participants won’t perceive their participation within a social group work session as mandated work; rather as an opportunity of improving oneself willingly (Papell, 2015). Whereas, non-skilled facilitators can often stall or hinder the group, or diminish the group altogether (Shulman, 1999). Drumm (2006) noted that “some of the factors that make a group a “social work group” are the awareness and employment of principles like inclusion and respect, mutual aid, stage management, use of conflict, conscious development, use and implications of purpose, breaking taboos, value of activity, and problem solving” (pp. 20-21).

Group therapy has many advantages for survivors of complex trauma as social disruption is a frequent primary effect of traumatic events. Group interventions provide significant potential to restore, empower, and rebuild social connections for trauma survivors (Mendelsohn et al., 2007). Additionally, Young and Blake (1999) noted “groups help individuals who feel overwhelmed by post-traumatic symptoms to make sense of their experiences and reactions as survivors share tools for managing intolerable symptoms” (p. 1). Therefore, group therapy is a recommended choice of therapy for trauma survivors, as it is cost effective, provides a sense of empowerment amongst group members, and provides a therapeutic approach as group members learn from shared experiences. This enables group members to acknowledge the universality of post-traumatic symptoms (Young & Blake, 1999).

Although, group therapy is highly recommended for the treatment of trauma survivors, facilitation is also significant, as group therapy must be conducted in a reciprocal fashion. For example, the group must be conducted and delivered in a communal, shared, and equal manner for group therapy to be successful. Jennings and Sawyer (2003) indicated that “the primacy of group therapy depends on the therapist’s ability to utilize and take full advantage of the power of group therapy, as the therapist must truly use the group medium” (p. 254). Nevertheless, in the event that the therapist places attention on group members one at a time, this could result in group disruption, which would diminish the opportunity to strengthen group cohesion (Jennings & Sawyer, 2003). Similarly, Burlingame, Fuhrman and Johnson (2002) noted “the primary relationships that form cohesion in the group include member-to-member and member-to-leader, as this creates bonding, structure, and a positive working alliance amongst the group” (p. 72).

Within Indigenous practices, the sharing circle is an integral and highly effective

approach to therapy or group discussions. Sharing circles are utilized as an Aboriginal healing approach to social work (Hart, 2002). Essentially, sharing circles permit participants to openly share their stories, feelings, and thoughts within a uniform and unbiased environment. A feature of sharing circles noted by Hart (2002) is its “length of process, usually, there is no time pressure for participants to contribute since they are allowed to speak freely without interruption” (p. 64). Similar to group therapy and focus groups, conductors or facilitators overseeing sharing circles must be experienced, as Hart (2002) indicated “the strength of a sharing circle depends significantly upon the conductor” (p. 72). Also, it is noted that the circle represents a long-standing methodology utilized within Indigenous practices, which is reflective of oral traditions (Lavalley & Poole, 2010). Sharing circles are also referred to as talking circles, peacemaking circles or healing circles that are deeply rooted within Indigenous methodologies (Umbreit, 2003).

Further Research

In the next section, I will discuss intergenerational trauma theory, traditional Aboriginal parenting theory, Indigenous healing practices, and a two-eyed seeing approach. These concepts were utilized and deemed appropriate when planning and coordinating the parenting group pilot project, and provided a theoretical lens when conducting Indigenous group work in the parenting group. Similarly, these concepts assisted with heightening my learning experience as the mentioned theories were essential for attaining informative groundwork. Intergenerational trauma theory is key for understanding the social ills endured within contemporary Indigenous communities, particularly for understanding its impacts on individual wellbeing and autonomy.

Intergenerational trauma theory provides a constructive lens when working with and amongst Indigenous populations, as the concept acts as a crux for comprehending how an

individual is impacted by collective trauma from one generation to the next and so forth (Wesley-Esquimaux & Smolewski, 2009). Importantly, the term assists with understanding how untreated or unresolved trauma experienced by survivors can impact individual, familial and community wellbeing. This understanding is crucial when working towards attaining and restoring Indigenous wellness. As Linklater (2014) noted “to deny the impact of colonization on Indigenous worldviews would only contribute to the solidification of a colonized perspective, which in turn can create further harm than good” (p. 28).

Further, the concept was foundational for building and fostering understanding amongst participants in the parenting group pilot project. Primarily, the goal of the parenting group was to build, create, and establish a learning environment based on a reciprocal approach – two-eyed seeing (student and therapist learning from participants and participants learning from therapist and student). Therefore, incorporating the mentioned Indigenous modalities into the literature review component was perceived as fundamental to attaining and working towards an Indigenous framework. With the parenting group initiative, this project was an opportunity to raise awareness while simultaneously disseminating education amongst participants concerning intergenerational trauma. The overall purpose was to discuss its residual effects and how it has obstructed participants’ capacities to effectively parent their own children.

Intergenerational Trauma Theory

Intergenerational trauma theory is highly related to historical trauma theory. Historical trauma was first examined and introduced by Dr. Maria Yellow Horse-Brave concerning the psychosocial ills impacting the Lakota peoples, resulting from European contact (Yellow Horse Brave-Heart, 2003). Dr. Maria Yellow Horse Brave-Heart described historical trauma as “cumulative, emotional, and psychological wounding, over the lifespan and across generations,

emanating from massive group trauma experiences” (2003, p. 7). However, the term “multigenerational trauma” and the impacts of trauma on victim/survivor populations was initially examined by Dr. Yael Danieli, who conducted in-depth research involving Holocaust survivors and their children, thus, co-founding and directing the first extensive psychotherapeutic work program for Holocaust survivors and their families in 1975 (Danieli, 1998). In her book, *Decolonizing Trauma Work*, Dr. Renee Linklater (2014) noted that “multigenerational trauma points to multiple types of trauma understood as current, ancestral, historical, individual, or collective experiences” (p. 23).

Many Indigenous scholars have suggested that the term “soul wound” existed as an integral teaching within Indigenous knowledge prior to colonization, and it is now utilized within contemporary practice to illustrate the traumatic experiences of American Indians, also referred to as “historical trauma” (Duran, Duran & Yellow Horse Brave-Heart, 1998). Dr. Maria Yellow Horse Brave-Heart’s extensive research involving historical trauma and its effects on the Lakota peoples of Americas is built on original research by Danieli, (1998) stemming from survivors of the Holocaust (Shoah, 1951). This early conceptual framework provided a concrete understanding concerning the complex dynamics of collective grief and the challenges of mourning a massive group trauma such as a mass grave loss that was noted to be parallel to the experiences of American Indians (Brave Heart, Chase, Elkins & Altshul, 2011; Bombay et al., 2009, p. 22; Yellow Horse Brave-Heart & DeBruyn, 1998, p. 65). Similarly, Thornton’s (1987) publication, *American Indian Holocaust and Survival: A Population History Since 1492*, describes the historic parallels experienced by Native Americans such as acts of aggression, displacement, and cultural suppression to genocidal acts to be in comparison to that of the Nazi Holocaust (Kirmayer, Gone & Moses, 2014).

Arguably, it is well documented that Indigenous people of North America have endured long-standing and cumulative traumatic experiences that have significantly contributed to profound individual, familial, and community distress. Also, it is noted that these cumulative traumas are visibly evident within contemporary society (Bombay et al., 2014; 2009).

Importantly, historical trauma is collective, in that the trauma is extreme and is experienced amongst a group (communal), which is evidently the case of Indigenous peoples of America. Thus, Indigenous people have experienced and endured years of colonization, forced assimilation, and acts of genocide, leading to the devastation of communities and cultures; thus morphing into a multitude of contemporary traumas (Coyle, 2014; Bombay et al., 2009).

Nonetheless, it is suggested that historical trauma comprises a multitude of concepts, and many of the concepts involved still require further clarification and research development (Evans-Campbell, 2008). Mohatt, Thompson, Thai and Tebes (2014) noted the following:

historical trauma involves three primary elements, which include (a) a trauma or wounding that is shared by a group of people, rather than individually experienced; (b) the trauma spans multiple generations such that contemporary members of the affected group may experience trauma-related experiences without having been present for the past traumatizing event(s), and (c) the trauma is distinct from intergenerational trauma in that intergenerational trauma refers to the specific experience of trauma across familial generations but does not necessarily imply a shared group trauma. (p. 128)

However, Evans-Campbell (2008) noted that historical trauma is best understood as having impacts at three levels including the individual, the family, and the community, noting “these three levels are distinct but clearly interrelated” (p. 322).

Research indicates that trauma has devastating effects on individual wellbeing as trauma can occur at any time in our lives, and can have a profound effect on memory, affect regulation, and interpersonal relatedness (Connolly, 2011). For example, neurophysiological and neuropsychological research has illustrated that traumatic stress has a broad range of effects on brain function and structure, as well as on neuropsychological components of memory (Bremner, 2006, p. 455). Therefore, in individuals who experience extreme trauma that is cumulative, the development of Post-Traumatic Stress Disorder (PTSD) is more likely to result. As van der Kolk (2002) indicated, “PTSD is generally characterized by intrusive sensory recollections of traumatic life experiences whereas ordinary events generally are not relived as images, smells, physical sensations, or sounds associated with that event” (p. 382). Further, Huppert (2009) noted “psychological wellbeing is, however, compromised when negative emotions are extreme or very long lasting, which interfere with an individual’s ability to function in his/her daily life” (p. 140).

Despite the many atrocities endured by Indigenous populations (historically and contemporarily), it is noted that the implementation of Indian Residential Schools (IRS) and the Sixties Scoop imposed by Euro-Canadian government policies have arguably had the most profound and detrimental effects on individual wellbeing, specifically impacting Indigenous children (Bombay et al., 2014). Historically, Indigenous children were coerced and permanently removed from their homes and reserves, and those that attended IRS endured persistent and pervasive neglect and abuse (physical and emotional abuse). Moreover, many children were separated from their families for a lengthy duration of time, and often with child welfare, children were placed within non-Indigenous families, creating massive displacement. This mass removal of children from their homes for long periods of time debilitated the opportunity and

transmission of traditional Indigenous family values, parenting knowledge, and community behaviours between generations, thus, resulting in cumulative trauma (Menzies, 2008).

Although some have suggested that Residential Schools were primarily established to protect, save, and educate Indigenous children, arguably, the overall purpose was assimilation and annihilation of cultural beliefs, values, and knowledge (Bombay et al., 2014; 2009). Further, it is well-documented that many survivors of the IRS system suffered inter-generational effects subsequent to the abuse and disconnection experienced while attending these institutions. Research by Stout and Peters (2011) indicated that the legacy of residential schools has been referred to as “residential school syndrome, complex post-traumatic stress, collective trauma, historical trauma and intergenerational trauma, which are understood to be among the most significant factors at the root of present intergenerational social suffering among Aboriginal people” (p. 13).

While some children may have had positive experiences while attending Indian Residential Schools, notably, many more survivors have expressed that their experiences within these institutions left them torn, in the sense that they felt entrapped between two worlds. Nagy and Kaur Sehdev (2012) noted,

many former students have found themselves caught between two worlds: deprived of their languages and traditions, they were left on their own to handle the trauma of their school experience and to try to readapt to the traditional way of life that they had been conditioned to reject, having detrimental effects. (p. 67)

The transmission of intergenerational trauma occurs from generation to generation, impacting parents, grandparents, or great parents that attended Indian Residential Schools (IRS). IRS experiences are referred to as adverse childhood experiences (abuse, neglect), which

subsequently affected parenting capacities (Bombay et al., 2009). Further, Bombay et al. (2009) noted that “it is clear from studies in other populations and cultures (e.g., survivors of the holocaust during WWII) that the effects of trauma can be transmitted from parents to their offspring, just as there is intergenerational transmission of knowledge and culture” (p. 7). The Aboriginal Healing Foundation (2004) indicated that,

intergenerational trauma is transmitted when survivors have not dealt with their own experiences inflicted by the Residential School System such as sexual abuse, and are therefore more likely to transmit and convey their experiences on to their offspring without consciously knowing they are doing so (disassociation). Thus, the perpetuation of intergenerational trauma continues to the next generation and so forth. (Wesley-Esquimaux & Smolewski, 2004, p. 22)

For example, survivors of acute trauma are more likely to dissociate, meaning detachment from physical and emotional experiences, which influences one’s ability to distinguish between subjective time of memory and the objective time of history. Therefore, untreated or unresolved trauma in the parent is inadvertently transmitted to the child through the attachment bond and through the messaging about self and the world, safety, and perceived danger (Connolly, 2011). Additionally, during adulthood, parents are more likely to exert adverse effects onto their children, which profoundly impacts their ability to build meaningful narratives and relationships with their children. Thus, resulting in breakdown of family kinship networks and social structuring amongst families and communities (Bombay et al., 2014; Connolly, 2011; Yellow Horse Brave-Heart, 2003).

Similarly, it is suggested that families who have experienced traumatic events are likely to cope through denial, repression, or consciously omitting important family information (Siefert

Abrams, 1999). Bombay et al. (2009) noted “children who grew up in families in which there was no outright communication regarding the parents’ trauma such as survivors of Residential Schools, found that children of survivors reported little communication by their parents regarding their time at Residential School” (p. 22). Consequently, the impairment of traditional Aboriginal parenting styles was one of the profound intergenerational effects of Residential Schools, as Indigenous children inherited the significant traumas that their ancestors were forced to endure and undergo (Muir & Bohr, 2014; Yellow Horse Brave-Heart, 1999).

Traditional Aboriginal Parenting Theory

Within Canada, Indigenous children are chronically over-represented within the child welfare system. As the Aboriginal Children in Care Working Group (2015) noted, “within Ontario, 3% of the child population under the age of 15 is Aboriginal and that 21% of the children in care are Aboriginal children living off-reserve” (p. 7). Similarly, the National Household Survey for Aboriginal Peoples in Canada (2011) indicated “Aboriginal people represented 4.3% of the total population of Canada, while almost half (48.1%) of the 30,000 children in foster care were Aboriginal compared with 0.3% of non-Aboriginal children in care” (p. 2).

Regarding the proportionally high number of Indigenous children in care, it is suggested that inadequate parenting skills have significantly contributed to unhealthy family relationships. And more so, with the lack of parenting skills this has resulted in harmful, neglectful, or abusive situations where children were generally placed in the care of child welfare agencies (Muir & Bohr, 2014). Banyard, Williams and Siegel (2003) indicated that “child maltreatment is often correlated to notions of an intergenerational cycle where parents that experienced maltreatment in childhood go on to perpetuate abusive behaviors on to their own children” (p. 335).

Subsequently, residential schools were found to have the most detrimental effects on parenting capacities as children in residential schools did not experience healthy parental role modelling, resulting in a diminished capacity as adults to adequately care for their own children (Blackstock & Trocmé, 2005).

Residential schools were established for the purpose of the assimilation of Indigenous children as these schools were primarily operated by church missionaries (Morrisette, 1994). Indigenous children were forcibly removed from the care of their parents at a generally young age as the goal was to sever parental influences while undermining traditional child rearing practices (Morrisette, 1994). The overall goal of the Residential School system was to eradicate and eliminate the “Indianness” within children that attended these institutions. Therefore, harsh, cruel, and unjust punishment was utilized as an influential practice for enforcing, instilling and imposing Westernized ways and dominant ideologies upon Indigenous children. Sadly, this resulted in a sense of displacement, disconnection from culture, and loss of identity, which many survivors continue to struggle with today (Morrisette, 1994).

The punishment and abuse endured within Indian Residential Schools (IRS) resulting from maltreatment have been well documented and substantiated through shared personal narratives of survivors. Flisfeder (2010) noted “the first public reports of sexual abuse came in 1989 from the Mount Cashel Orphanage”, which was said to have fueled personal disclosures of the various abuses experienced within the IRS system (p. 4). Many children who attended IRS experienced continuous physical and emotional abuse for the purpose of re-socializing and ensuing Euro-Western customs. The aim was to eradicate Indians as Indians (Dalseg, 2003, p. 4). Many survivors of the IRS shared that corporal punishment was often utilized and demonstrated in the presence of other children to iterate the importance of adhering to rules, often instilling

humiliation. Initially, children who did not listen or follow rules were physically and emotionally punished, which included whippings, spankings, seclusion into dark places, or starvation as a result of their behaviours (Gauthier, 2010). Bombay et al. (2014) noted within their study that “IRS survivors’ parenting skills were most likely to be soundly influenced directly/indirectly through the modeling of negative care-taking practices observed within IRSs” (p. 326).

Historically, Aboriginal child-rearing practices valued, respected, and regarded children as having a meaningful role within their community as children were highly considered and perceived to be the centre of attention to their immediate and extended family (Kruske, Belton, Wardaguga & Narjic, 2012; McShane, Hastings, Smylie & Prince, 2009). Some authors suggested that Aboriginal child-rearing practices were communal and collective as extended family members were continuously involved, and attended to the children’s needs. The bonds between Aboriginal children and adults were multi-layered and not dyadic (Neckoway, Brownlee & Castellan, 2007). Additionally, child-rearing practices were viewed as “shared parenting” within Aboriginal cultures, meaning grandparents played a significant role in socializing, providing physical care, wellbeing, and training their grandchildren (Fuller-Thomson 2005; Neckoway et al., 2007). Generally, traditional Aboriginal family dynamics were strongly based on kinship structure consisting of clan members including mothers, fathers, aunties, uncles, sisters, brothers, cousins, and so forth (Muir & Bohr, 2014).

Sadly, the transmission of traditional Aboriginal child-rearing practices was severely undermined as parenting skills were lost due to the implementation of the Residential School System and dominant Western ideologies concerning the definition of family. Within a contemporary context, it is suggested that mainstream society and particularly the child welfare system, must consider and acknowledge the distinctiveness of Aboriginal parenting styles. Muir

and Bohr (2014) noted that “it is important to consider the cultural, social, and historical realms of Aboriginal communities when assessing Aboriginal children, predominantly within the context of child protection, as identifiable differences may exist between parenting norms in Aboriginal communities and those of mainstream groups” (p. 75). Therefore, incorporating a framework that integrates an Indigenous worldview will adequately and appropriately address the needs of families while providing a culturally safe and sensitive approach, thus fostering autonomy and wellbeing.

Indigenous Healing Practices

Traditionally, Indigenous practices and approaches were integral components for attaining and maintaining healing and wellness within Indigenous communities. These components incorporated the mental, emotional, physical, and spiritual aspects of being (Nabigon & Nabigon, 2012). However, forced colonization created profound displacement, disharmony, and disconnection amongst Indigenous peoples and their cultural practices, insofar as their belief and value systems were purposely undermined and destroyed, resulting in loss of land, loss of cultural practices, and loss of identity referred as “postcolonial suffering” (Kirmayer et al., 2014, p. 300). Colonialism is described as the practice of attaining power and control over others, which involves the oppression of one group by another often described as a form of genocide (Bourassa, McKay-McNabb & Hampton, 2004). Wolfe (2006) indicated “settler colonialism destroys to replace” (p. 388). Subsequently, this displacement generated a huge disconnect concerning ceremonial knowledge, which severed Indigenous peoples’ access to traditional ways of healing, grieving, and understanding of interconnectedness concerning balance and wellness referred as historical trauma (Linklater, 2014; Yellow Horse Brave-Heart, 1998).

Despite discrepancies between Western and Indigenous conceptualizations concerning mental health and what constitutes wellness, and how healing should occur within contemporary practices, it is noted that cultural protocols, knowledge, and understandings are significant aspects for attaining individual and community wellness (Linklater, 2014). Similarly, it is emphasized that Indigenous healing involves both an individual and community effort, due to the cumulative mass grief, and suffering endured, resulting from colonizing forces (Robbins & Dewar, 2011; Yellow Horse Brave-Heart, 2003). Thus, this disruption to cultural knowledge, practices, and spirituality requires communal healing as this promotes recovery, empowerment, and decolonization, which is essential for attaining wellness.

DeVerteuil and Wilson (2010) indicated that culture and place are integral to Indigenous health as it is suggested that “the importance of culture for understanding the links between health and place has been made especially evident through the emergence of the therapeutic landscapes concept” (p. 499). Traditional ceremonial practices such as the sweat lodge have proven effective for attaining healing, wellness, and balance. It is also indicated, “for traditional knowledge to be maintained and to develop, it must be continuously practiced” (Robbins & Dewar, 2011, p. 1). The sweat lodge provides individuals an opportunity to connect with oneself and to others while honoring the spirit world, thus, creating harmony and balance concerning aspects of the self – body, mind, the natural world, and spirit (Garrett, Torres-Rivera, Brubaker, Portman, Brotherton, West-Olatunji & Graysheild, 2011). Importantly, sweat lodge ceremonies represent returning to the womb of Mother Earth while promoting spiritual refuge for mental and physical healing to occur (Marsh, Cote-Meek, Young, Najavits & Toulouse, 2016; Marsh, Coholic, Cote-Meek, & Najavits, 2015). Within their study, Marsh et al. (2016) noted that participants who attended the sweat lodge ceremony alleged that this form of intervention

provided a sense of healing, which encapsulated body and mind as a participant noted “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” (p. 11). Notably, traditional interventions can address several areas of health and more so traditional healing promotes health from a holistic approach – mental, physical, emotional, and spiritual, which is essential for attaining and maintaining balance and wellness (Robbins & Dewar, 2011).

Rowen, Poole, Shea, Gone, Mykota, Fagas, Hopkins, Hall, Mushquash, and Dell (2014) noted,

cultural practices incorporated within healing interventions appropriately address wellness from a holistic sense and that healing involves a harmonious relationship which includes the whole person – mind, body, emotion, and spirit. Thus, emphasis on understanding the meaning of Indigenous wellness is vital for effective treatment to occur. (p. 3)

In *Decolonizing Trauma Work*, Dr. Renee Linklater (2014) emphasized “for healing and wellness to occur within an individual and community aspect, practitioners must grasp an understanding of Indigenous practices for wellness and holistic health, as these concepts are deemed as significant strategies for working towards decolonizing trauma work” (p. 100).

Moreover, within my learning experience, a need to fully comprehend and understand power relations must also be acknowledged, insofar that integrative approaches for perpetuating Indigenous wellness can be genuinely constructed relative to healing. I will further explore and discuss the importance of power relations within Chapter 3 as I felt this understanding was essential in shaping my professional identity while acting as a catalyst for Indigenous healing. Importantly, gaining an understanding of power relations is vital for mitigating further risk and

harm, so that practical methodologies for decolonizing trauma work can be adequately established. Thus, with this knowledge gained, this would ensure that Indigenous practices are central to my approach while respecting individual needs concerning one's healing journey.

Two-Eyed Seeing Approach

Incorporating two-eyed seeing approach within the literature review was integral to my practicum experience as my learning involved integrating both Western and Indigenous approaches within practice. Two-Eyed Seeing approach is defined as “an Indigenous decolonizing methodology, utilized to honour the strengths of both Indigenous and Western ‘ways of knowing’, research techniques, knowledge translation, and importantly it determines how we think and talk about a topic” (Iwama, Marshall, Marshall, & Bartlett, 2009, pp. 5-6). Moreover, two-eyed seeing provides a theoretical framework that allows all parallels of understanding to become intertwined in a manner that is respectful, valued, and acknowledged, as two-eyed seeing offers a way in which diverse perspectives might work together to provide a unified solution (Martin, 2012).

Traditionally, the concept of two-eyed seeing originated from 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 Kjjijitaqnn (Hall, Dell, Fornssler, Hopkins, Mushquash, & Rowan, 2015). Utilizing a two-eyed seeing approach highly promotes decolonization, which is paramount for supporting Indigenous healing and importantly a rite to resurgence (Marsh, Cote-Meek, Toulouse, Najavits, & Young, 2015; Iwama et al., 2009). Two-eyed seeing also provides and promotes an environment reflective of Indigenous epistemologies, which is conducive for understanding while establishing trusting relationships. This creates space for building collectiveness while establishing collaboration as

the process involves “weaving back and forth” between worldviews - Indigenous and Western (Marsh et al., 2015; Rowan et al., 2015).

Subsequently, Anuik and Battise (2010) indicated,

First Nations search for their inner knowledge, which came from the connections they had made with those physical and metaphysical elements in their territories, which has become the source of knowing that remains the core of Indigenous knowledge and the foundation of personal development and of Aboriginal epistemology. (p. 66)

Moreover, within Indigenous epistemologies, the learner is viewed as the most essential component to the learning aspect as the learner acts as a guiding principle in which lessons learned are reciprocal, and that sharing amongst one another are encouraged and meaningful (Anuik & Battiste, 2010). Therefore, a two-eyed approach promotes an environment that is conducive to learning in which participants learn openly and whole-heartedly while drawing upon the strengths of both Western and Indigenous knowledge (Rowan et al., 2015).

Summary

Although my exposure to the mentioned theoretical models within a clinic-based setting was brief, the learning experience enhanced my understanding and knowledge of the social work theories utilized within Tremblay Counselling Services. The overall goal of the practicum component was to grasp a genuine learning experience concerning the mentioned models through research conducted and observational study. Essentially, this learning experience provided an opportunity to critique, deconstruct, reconstruct, and explore how I could integrate an Indigenous framework within my practice approach.

Furthermore, the Advanced Practicum experience involved integrating trauma work conducted by Dr. Renee Linklater (2014), *Decolonizing Trauma Work: Indigenous Stories and*

Strategies. The author discusses the significance of incorporating an Indigenous framework within practice, which she indicated is essential for attaining an understanding of historical trauma and its impacts to restoring Indigenous healing and wellness (Linklater, 2014). I also explored the works of Rupert Ross (2014), *Indigenous Healing: Exploring Traditional Paths*. Ross's work provided an insight for gaining an understanding of "decolonization therapy", which the author shared is key for healing to occur as re-connecting to traditional Aboriginal worldviews is essential for prevailing from tribulations experienced by Indigenous peoples (Ross, 2014). With these resources, I was able to critically reflect on the importance of Indigenous healing, and the significance of implementing an Indigenous framework relative to Indigenous needs when deemed appropriate. In the next chapter, I will discuss and review the Advanced Practicum setting, agreements with my practicum placement, learning objectives and goals, and the practicum project. This project was an opportunity to learn, observe, and initiate group facilitation.

Chapter II: Process of the Advanced Practicum

As a partial requirement for the Master of Social Work (M.S.W.) program at Laurentian University, I completed an Advanced Practicum (SWRK 6024) from October 23rd, 2017 to March 6th, 2018. The practicum was completed within Tremblay Counselling Services, which is a privately-owned clinic-based practice located within Timmins, Ontario. This private practice is owned and operated by Mr. Michael Tremblay, who has been a practicing clinical social worker for almost two decades. Mr. Tremblay holds a Master degree in Social Work through Lakehead University and has worked extensively with Indigenous populations, mainly providing mental health counselling.

As an Indigenous social worker, I chose to complete my field practicum within Tremblay Counselling Services as this would offer an opportunity to further build and strengthen my clinical skillsets while gaining confidence. Importantly, the practicum offered the ability to critique the applicability of the mentioned theoretical models: cognitive behaviour therapy (CBT), trauma-focused cognitive behaviour therapy (TF-CBT), eye movement desensitization and reprocessing (EMDR), and group and/or social group work therapy while reflecting on how to integrate methods within an Indigenous context. Essentially, I felt this experiential learning would offer a more enriched experience concerning the importance of attaining healing and wellness as the need for culturally based services within the north is considerably lacking. Thus, an increase in culturally congruent interventions offered within Timmins and its surrounding area will ensure that applicable programs are readily accessible to Indigenous communities.

Firstly, I will discuss the process of the Advanced Practicum such as the placement setting, agreements made with Tremblay Counselling Services to fulfill my placement, and the learning objectives and goals fulfilled. I will also discuss the supervision I received while

completing my field practicum, which was essential for fostering personal and professional growth as a student. According to Barton, Bell, and Bowles (2005), “student practicums should be an opportunity for building skills and knowledge, as they play a pivotal role concerning theory and practice integration while building confidence and motivation” (p. 302).

Secondly, the parenting group pilot project will also be discussed in-depth later within this Chapter as this experience was twofold, fostering knowledge concerning group facilitation and group processes while also fostering consciousness-raising. This project was in partnership with Kunuwanimano Child and Family Services (CFS), which adopted a participatory strategy. The aim of this project was to learn from each other in a reciprocal fashion, rather than a top-down approach or expert knows best perspective. As a child protection worker with Kunuwanimano CFS, I perceived this project not only fitting, but it ideally aligned with fulfilling the learning objectives outlined within the M.S.W Handbook. The parenting group pilot project was an opportunity for discussion concerning participants’ knowledge of intergenerational trauma and how participants had been impacted at an individual, familial and/or community level. The focus of the group was to disseminate awareness concerning intergenerational trauma and its implications for healthy parenting skills related to contemporary Indigenous family dynamics.

Description of the Advanced Practicum Setting

Tremblay Counselling Services is privately owned and operated by Michael Tremblay, M.S.W, R.S.W, who is a Registered Social Worker with the Ontario College of Social Workers and Social Service Workers (OCSWSSW). Mr. Tremblay holds 18 years of clinical experience within the mental health field and has worked extensively amongst Indigenous populations. Mr. Tremblay has managed his private practice over 11 years and specializes in cognitive

behavioural therapy (CBT), trauma focused-cognitive behavioural therapy (TF-CBT), eye movement desensitization and reprocessing therapy (EMDR), group therapy, and grief therapy. Tremblay Counselling Services' mandate is to provide services within a safe, comfortable, and relaxing environment.

Tremblay Counselling offers services to all service user populations within Timmins and surrounding areas, with a fee for service. However, Tremblay Counselling's service user population primarily consists of Indigenous clientele, who originate from the following First Nations communities: Moose Factory, Attawapiskat, Fort Albany, and Kashechwan (Treaty 9 territories). The majority of Tremblay Counselling Services revenue is generated through the Non-Insured Health Benefits (NIHB) program via the Indian Residential Schools Resolution Health Support Program (IRS RHSP). As well, counselling and psychotherapy services are often covered through insurance benefits or Employee Assistance Programs (EAP), which often determine a fixed amount of sessions an individual may be eligible to receive.

The IRS RHSP is a federally funded program offered in conjunction with Non-Insured Health Benefits through the Government of Canada. This program was established in 2010 for the purpose of providing mental health support services to eligible former Indian Residential Schools students (survivors) and their families (Government of Canada, 2018). Despite funding provided, psychologists, professional counselors, and social workers must be registered with NIHB to be recognized as an accredited practitioner for eligibility purposes. Because limitations exist concerning eligibility and timeframes imposed within this program, it has been notably argued that the current structure continues to undermine the process of Indigenous healing. The Assembly of First Nations (2017) argued that healing from the past should not have a set timeframe. Further, incorporating an Indigenous framework within social work practices that

acknowledge the implications of historical trauma is essential and pertinent for Indigenous healing and wellness to occur (Linklater, 2014; Yellow Horse Brave-Heart et al., 2011). Thus, the conceptualization and understanding of Indigenous healing should be acknowledged as a limitless journey, based on individual needs.

With Mr. Tremblay's extensive work experience amongst Indigenous populations, I was drawn to complete my practicum within Tremblay Counselling Services due to my work history, which involves ample work with Indigenous families, youth, and children. Despite my current work in child welfare, I am wholeheartedly drawn to work with mental health, specifically working with Indigenous people, as mental health is a determinant to Indigenous wellbeing. Within the practicum, my keen interests were primarily (a) gaining clinical skills while procuring a sound knowledge of the theoretical models utilized in practice through observation, research, and critical analysis, (b) gaining knowledge pertinent to trauma-informed practice, and (c) understanding the importance of integrating an Indigenous framework within my praxis when deemed appropriate.

Agreements with Tremblay Counselling

In August 2017, I met with Mr. Tremblay, who manages Tremblay Counselling Services, to discuss the opportunity of completing my Advanced Practicum within his private practice. Once my proposal was approved, the necessary documents and forms were forwarded by Ms. Suzanne Lacelle, Laurentian University's School of Social Work field placement coordinator, via email to ensure my placement was secured. The required documents included a *Students Declaration of Understanding* and a *Safety Orientation Checklist*. These documents were reviewed, signed, and completed prior to commencement of my Advanced Practicum within

Tremblay Counselling. A copy of each document was provided to Mr. Tremblay for his reference and for record-keeping purposes.

During the first week of my practicum, I was required to sign an *Oath of Confidentiality and Non-Disclosure Agreement* form pertinent to my role as a M.S.W student while on placement with Tremblay Counselling Services (refer to Appendix A). For the duration of my placement, it was agreed that I would shadow, observe, and participate within counselling sessions at the discretion of the service user, due to the sensitivity of reporting processes involved with Non-Insured Health Benefits (NIHB). Therefore, it was a best practice that I observe counselling sessions pertaining to the agency's NIHB clientele. Prior to conducting sessions, Mr. Tremblay would formally introduce me as his student on placement while seeking verbal consent from clients regarding whether they felt comfortable with my sitting in and observing prior to therapy sessions commencing. It was thoroughly explained to each service user the benefits of my participating in observation, as this would profoundly contribute to my learning experience. Ideally, this learning would support and enhance my skillsets while fostering professional development. Thus, most clients graciously agreed.

Learning Objectives and Goals

As a student completing an Advanced Practicum, the overall goal was to ensure that I received the most out of my learning experience while building my clinical skillsets and theoretical knowledge. Yet, despite that I was mainly shadowing, observing, and participating (when deemed appropriate) within sessions, I truly felt this experience offered an excellent opportunity to critique each approach utilized during therapy. Hence, the primary learning objectives while completing the Advanced Practicum included:

- 1) Gaining and developing clinical skills and knowledge pertinent to the theoretical models delivered within Tremblay Counselling Services while building confidence.
- 2) Critiquing, examining, and exploring ways of integrating an Indigenous framework reflective to my own practice approach.
- 3) Initiating, implementing, and delivering a parenting group project in partnership with Kunuwanimano Child and Family Services pertinent to raising awareness and education regarding Intergenerational Trauma and Traditional Aboriginal Parenting concepts.

Although the core learning objective involved the ability to critique the applicability of the mentioned models while assessing ways to integrate an Indigenous framework, reflection played a pivotal role in fostering my understanding concerning the need for culturally based methods. Essentially, it became apparent that culturally appropriate modalities should be integrated into practice when deemed suitable and fitting (based on individual needs) while respecting individuals where they are at, as both are equally significant for conceptualizing what constitutes wellness from an individual standpoint (Linklater, 2014).

With reflection, this concept fostered the ability to deconstruct and reconstruct each modality while focusing on the need for resurgence of Indigenous methods within practice, as acknowledging culture as treatment is central for attaining Indigenous wellness (Linklater, 2014; Gone, 2013). Ideally, this process involves respecting and valuing individual autonomy, which simultaneously creates space for a more deepened sense of empathy and understanding. Thus, reflection is key for fostering knowledge, particularly the importance of discerning when and how to apply Western-based and Indigenous approaches within therapy, as both prove beneficial and effective (Nabigon & Nabigon, 2012; Lavalley & Pool, 2010). In the next Chapter, I will

further discuss critical reflection as this concept was pertinent in cultivating professional development and learning while shaping my professional identity.

Given that I have fulfilled my learning objectives and goals as mentioned, I feel this experience has heightened my knowledge while positively shaping my identity as an Indigenous practitioner. Through observation, this experience has shed light on the importance of modification and tailoring, reflective of client needs and treatment therapy. As noted earlier, as practitioners, we cannot assume what works best for one individual, works well for others (Hobson, 2012). Simply, we cannot place or categorize every client to fit in the same box as this hinders ethical social work practice. Importantly, practitioners working with Indigenous people must acknowledge the importance of cultural competency while demonstrating receptiveness to Indigenous modalities integrated within treatment. Generally, cultural competency ensures that the delivery of services is safe while promoting positive dialogue, collaboration, and empowerment, which are essential for building positive working relationships relative to attaining Indigenous healing and wellness (Bennett et al., 2011).

Learning Experiences

In my experience with shadowing and observing sessions, I had witnessed that the majority of NIHB clients were affected by trauma first-hand or had experienced multi-generational trauma during their childhood. Those who had attended the Residential School system (RSS) were survivors of physical, emotional, mental, and spiritual abuse, which were in many aspects extreme or excessive. Many had referred their abuse as leaving significant emotional and mental scars, which they shared as traumatizing while impeding on their wellbeing. In their book, *Healing the American Indian soul wound*, the authors highlighted Indigenous historical experiences as subjugation, signifying these traumatic events as “soul

wound”, exacerbated from multiple traumas (Duran, Duran, Yellow Horse Brave-Heart, & Horse-Davis, 1998, p. 344).

Throughout my observations, it was noted that most survivors of the RSS expressed shame, guilt, and embarrassment associated with the abuse they had endured while attending Residential Schools. In their study, Sochting, Corrado, Cohen, Ley, and Brasfield (2007) noted, “DSM-IV field trials indicate that childhood interpersonal trauma is a strong predictor for developing complex PTSD which include alterations in self-perception manifested by a chronic sense of guilt, shame, or inflated sense of responsibility,” resulting in trajectories of abuse emerging into adulthood (p. 321). Therefore, it is evident that the implementation and aftermath of the RSS has left a very dark and detrimental legacy that continuously inhibits Indigenous wellbeing within contemporary society (Bombay et al., 2014; 2009).

Within sessions, prior to initiating therapy, Mr. Tremblay would discuss and initiate grounding techniques in the event the client felt any level of distress, particularly dissociation or the onset of anxiety due to traumatic experiences shared. Grounding techniques utilized included deep breathing exercises, seeing, touching, and feeling, which were essential for alleviating and stabilizing the client, thus facilitating client safety. With seeing, it was suggested that the client name three visible items within the therapy room and openly share. With touching, the client was asked to embrace their footing and to touch their surroundings, as this would provide the sense of being within the present ensuring a sense of safety. Overall, these exercises were discussed prior to each session taking place to create an environment that was safe and calming while ensuring the client was cognizant of the present. The overall purpose of grounding techniques was to avert the onset of self-destructive behaviors. According to Fisher (1999), the skills needed by trauma patients in order to stay stable include the following:

- grounding and centering techniques
- coping strategies for dealing with suicidal and self-abusive impulses
- contracting for safety with themselves and others
- the ability to anticipate stressful or triggering events
- learning how to calm the body and mind
- distinguishing past and present reality and how to stay "in the present"
- recognizing and making better use of dissociative abilities. (p. 5)

Moreover, in their work: *The Last Frontier – Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery*, Dr. Kezelman and Dr. Stavropoulos (2012) indicated:

when initiating trauma work, practitioners must ensure client safety is always facilitated within session. This establishes a sense of safety, which is vital for attaining self-regulation and management of internal states within the client. Also, practitioners are encouraged to foster the client's ability to self-regulate on a consistent basis, as this is fundamental for empowerment and healing. (p. 4)

Within child welfare, it is visibly evident that a growing need for culturally appropriate and culturally safe services are essential for Indigenous wellness to occur (Blackstock, Brown & Bennett, 2007). Culturally congruent services ensure that the needs of Indigenous communities are adequately addressed from an emotional, mental, physical, and spiritual aspect. As a frontline worker, a substantial need concerning education exists regarding the significance and delivery of trauma-informed services, particularly when working with minority and vulnerable groups such

as Indigenous populations. Importantly, a considerable gap also exists concerning the need for culturally congruent services within the north, as the need for such services is required to effectively address intergenerational trauma. In her book, *Decolonizing Trauma Work*, Dr. Renee Linklater (2014) highlighted the importance of understanding intergenerational trauma and its impacts on individual, familial, and community wellbeing, which must be acknowledged, as fostering an understanding is essential for attaining wellness and health. Moreover, Indigenous scholars have illustrated the continued need and on-going support for culturally responsive interventions, as Indigenous modalities have proven beneficial to attaining wellness (Linklater, 2014; Brave-Heart et al., 2011). Therefore, I truly feel more in-depth work and further education is needed for generating consciousness-raising concerning the impacts of historical trauma, particularly within a northern context.

Supervision

At the start of my practicum, Mr. Tremblay and I openly discussed supervision and what it would entail during my practicum experience. Importantly, it was agreed that the supervision process would also integrate a trauma-informed lens, as a majority of Tremblay Counselling Services clientele were survivors or extended family members of the Residential School era. I felt the integration of trauma-informed practice was fundamental within supervision as it would foster a more in-depth understanding concerning the complexity of trauma, countertransference, and also the ability to be more empathetic to the needs of the service users concerning their trauma (Knight 2015; Gibbons, Murphy & Joseph, 2011).

Moreover, trauma-informed supervision was an opportunity to deconstruct, unpack, and recognize the impacts that trauma may have on a front-line worker both at a personal and professional level. This approach was beneficial in acknowledging, addressing, and preventing

countertransference. Essentially, countertransference is interpreted as the ability to manage reactions to client material, which has been labelled as reactions concerning exposure to a patient's/participant's unbearable feelings (Hensel, Ruiz, Finney & Dewa, 2015; Holmes, 2014).

According to Bogo and McKnight (2006), supervision is defined as “a process which involves education, support, and meaningful feedback of workers. It is also recognized as a crucial aspect for a supervisees' learning process which contributes to effective practice” (p. 51). Additionally, it is noted that supervision involves three interrelated functions, which include administrative/managerial (normative), educational (formative), and supportive (restorative) components that truly assist and develop the professional capacity of the supervisee (Kadushin & Harkness, 2002). Supervision with Mr. Tremblay was consistent and on-going throughout my placement, which was insightful, invaluable, and essentially constructive. Importantly, Mr. Tremblay would encourage integrating critical reflection within my learning experience and highly suggested that reflection be integral to my practice going forward.

The supervision I received notably fostered and furthered my professional growth not only as a student, but more importantly as a practicing social worker within the field. Given that supervision is perceived and acknowledged as an essential support source for new and experienced social workers alike, it is also highly suggested that social workers fully engage in significant reflection for growth to occur (Lay & McGuire, 2010). The process of reflection allows practitioners to delve into conflicting biases such as ones' values, beliefs, assumptions, and status concerning human behaviors, which is essential for acknowledging and recognizing cultural differences, and more so, it has implications for ethical social work practice (Walker, Schultz, & Sonn, 2014; Ingram, 2013). Also, consistent supervision ensured I was on track with my tasks and learning objectives while on placement, which was essential for cultivating growth.

Overall, this continuous supervision aided in fostering and promoting empowerment while demonstrating support.

Importantly, a key component to the supervision process was the opportunity to openly immerse and learn from Mr. Tremblay as he shared a great deal of personal and professional experience. A key discussion involved the term “point of reference” and its significance to trauma work and therapy. Mr. Tremblay expressed that in order to perform genuine trauma work, the worker must have dealt with their own traumas. Unresolved trauma can lead to being triggered when clients share their trauma experiences during therapy, resulting in detrimental effects, which can impact the client, creating further harm. Further, it was highlighted that a therapist’s point of reference can also be influenced by the individual’s personality, personal history, current personal circumstances, and level of professional development. It was emphasized that integrating one’s point of reference within therapy when deemed appropriate can promote trust, as this permits the therapist to utilize his/her past experiences within sessions for the purpose of relating and/or connecting with the client on an interpersonal level. Thus, sharing personal lived experiences can foster genuine empathy and understanding, which can be fundamental within the client’s healing journey. Hart (2002) makes an indication of this process in his book, *Seeking Mino-Pimatisiwin*, emphasizing “it is important that individuals utilizing an Aboriginal approach reflect upon their own lives and be willing to share their life experiences to support the healing of others” (p. 54).

Dr. Diana Coholic was designated as my first reader and Dr. Elizabeth Carlson was my second reader throughout the duration of my Advanced Practicum. During placement, we had connected on numerous occasions through email, telephone, and scheduled video-conference meetings, as the link was provided to Mr. Tremblay and me beforehand. Since my practicum was

completed within Timmins, this mode of supervision was deemed appropriate and permitted an opportunity to review and discuss my practicum experience throughout its duration. Although academic supervision was not delivered using a face to face approach, these various modes of supervision did offer insightful direction, guidance, and support delivered via the Advanced Practicum Committee, which was provided on a continuous and as-needed basis.

Knowledge Gained

As a child protection worker, the practicum experience was beneficial as I gained pertinent knowledge concerning trauma-informed work, which many times I was able to execute and implement within my realm of practice within child welfare. For example, I was assigned an on-going protection file which was coded as a 5-3-B (Caregiver with Problem), which meets the intervention line for investigation, assessment, and ongoing support. The file involved a single-parent mother with two younger children with identified alcohol use in the home, placing the children at risk for harm due to the mother's behaviors. Upon meeting with the mother, I had discovered that she had experienced intergenerational trauma as a child, and given I felt confident to execute a trauma-informed approach, the mother openly shared her past experiences. By incorporating a trauma-informed lens within practice, I was able to cultivate trust and compassion with the client. Hence, trauma-informed practice adequately equips workers to probe appropriate questions in a way that is respectful, compassionate, and empathetic.

From that point, I was able to authentically understand how trauma hindered the client's ability to cope, which alternately impacted her capacity to effectively parent. Also, it was identified that her parents were survivors of the RSS. I felt that the knowledge gained, and confidence developed concerning trauma-informed therapy permitted me to effectively execute the skills required for effective therapy to occur. As a result, a service plan was implemented

based on the family's identified needs, specifically relative to trauma, which also facilitated client participation. Without the acquired skills, the treatment could have proceeded differently, as Harris and Falot (2001) noted "lack of knowledge pertaining to the significance of trauma can result in failures to make appropriate referrals for trauma services" (p. 4).

Overall, this learning experience and knowledge gained was paramount to self-learning, which ultimately created a more deepened sense and understanding of the importance of trauma informed care within practice. Trauma informed practice is essential for developing and fostering trust within working relationships, specifically amongst vulnerable groups such as Indigenous people, as it promotes a framework for genuine understanding.

Parenting Group Project

As a practicing child protection worker with Kuuwanimano CFS, I had discovered support services such as Indigenous led parenting classes within Timmins and surrounding areas were considerably lacking. Therefore, the parenting group pilot project was presented to the Advanced Practicum Committee and Kuuwanimano CFS, which was in favour of the project. The issue presented was the need for culturally based services as this was identified as vital for addressing and strengthening Indigenous families from a cultural aspect. Blackstock and Trocmé (2005) emphasized the importance of culturally based services, indicating "Clearly when culturally based structural supports are provided to Aboriginal children and families at risk, significant and sustained positive outcomes in child and family wellbeing can be expected" (p. 17).

Also, it was indicated that my role would mainly involve co-facilitation concerning the parenting group pilot project. Ideally, this project provided an insight and learning opportunity

concerning group facilitation and group processes. For this project, I had the responsibility of arranging and scheduling a meeting with Kunuwanimano CFS staff, as this was deemed essential for promoting and steering the project. It was also agreed that I would undertake the project's administrative roles such as creating and developing the pertinent materials. These materials included a parenting group information pamphlet (refer to Appendix B) and PowerPoint presentation slides which were used throughout the group's duration. These materials were reviewed by Mr. Tremblay and approved by him prior to distribution and dissemination.

Since I was an employee of Kunuwanimano CFS working part-time and completing a practicum, my mode of promoting the upcoming parenting group pilot project involved verbal dissemination to staff. During this process, I had provided staff with copies of the parenting group information pamphlets, discussed the referral process, and encouraged the use of work email for communication purposes pertaining to the project. These methods of communication were utilized to advertise, address, and inform staff members of the forthcoming project. An information session was scheduled for November 6th, 2017 within the Agency's family room for 10:30 AM.

The purpose of the scheduled meeting was to provide information to staff members relative to the parenting group pilot project. In the meeting, we sought to discuss the eligibility criteria, an overview of the project, learning objectives and goals, and the vision of the project. Also, staff members were informed that the parenting groups would be overseen by Mr. Tremblay and myself. It was also discussed and iterated that during my time on placement, I was considered a student completing a practicum through Laurentian University. I felt this clear distinction was needed to clarify my role while on placement so that it did not conflict with my

role at work. The parenting group project was assigned the term “*Parenting From the Heart*”, as Mr. Tremblay and I deemed the term appropriate and fitting concerning its vision.

On November 6th, 2017, Mr. Tremblay and I meet with Kunuwanimano CFS staff members to discuss the upcoming parenting group project, “*Parenting From the Heart*” via PowerPoint presentation. Staff members were informed the first initial group was scheduled for November 28th, 2017 from 12:00 to 2:00 PM within the Agency’s family room. It was indicated that lunch would be provided, and Kunuwanimano CFS agreed to cover costs through its prevention services program. It was highlighted that participants must be survivors or have a family member identified as a survivor of the Residential School System for eligibility purposes. Mr. Tremblay noted that he was recognized through NIHB as an accredited therapist, therefore the groups would be overseen by Tremblay Counselling Services. Also, staff members were provided with Mr. Tremblay’s business cards in the event staff needed to contact his office regarding potential participants or share them with participants who were interested in attending the group and felt comfortable contacting him directly.

The aim of the parenting group was to raise awareness and knowledge about effective parenting practices while fostering self-awareness. The following theories were utilized within sessions: Attachment Theory, Social Learning Theory, Western Parenting Styles, Traditional Aboriginal Family Theory, Intergenerational Trauma Theory, and Sensorimotor Psychotherapy. Importantly, Mr. Tremblay and I wanted to ensure that the project incorporated an Indigenous framework when conducting groups, as this permitted participants to make connections and interrelate their experiences from a cultural aspect. The methods for the parenting groups were as follows: Group Processes, Sharing/Talking Circles, Narrative Therapy, and Storytelling.

Ideally, we felt these concepts were important and meaningful when conducting the groups as these approaches integrated an Indigenous approach to learning that was respectful and was delivered within an equitable manner. Essentially, this provided an opportunity for every participant to be heard, understood, and make connections with others within the group, which was vital for group cohesion. Prior to sessions taking place, we asked that an Elder be present to provide an opening prayer followed by a smudging ceremony. Most participants expressed that they felt a sense of comfort and ease when these methods were exercised prior to and after sessions.

The parenting group projected adopted a participatory strategy as the aim was to learn from each other in a reciprocal fashion, rather than a top-down approach, which we felt was not conducive for participation to occur. As well, the purpose of the parenting group was to have participants reflect, draw upon, and conceptualize how their parenting skills and knowledge were influenced by their past experiences. In her book, *Decolonizing Trauma Work*, Dr. Renee Linklater (2014) indicated “In essence, being grounded within an Indigenous worldview is to be connected to the Indigenous world – the past and the present. It is an important component to Indigenous ways of knowing” (p. 28).

Moreover, we encouraged participants to explore and examine traditional practices that were passed on directly and/or indirectly from their parents, grandparents, or extended family members concerning contemporary parenting practices. The key objective of the parenting group project was to foster knowledge while cultivating and encouraging self-awareness as the purpose was to integrate teachings from Indigenous perspectives; self – emotional, mental, physical, and spiritual. This was fundamental for participants to acquire understanding and to make vital connections to Indigenous culture and self.

Further, by integrating a participatory strategy within the delivery of the parenting group project, our goal was to ensure that participants were able to make viable connections to their past experiences and the present. This was significant for addressing the importance of practicing cultural continuity, and for how traditions, customs, and culture need to be practiced on a continuum. These concepts are key for fostering identity and sense of belonging, particularly amongst Indigenous populations. Kirmayer, Holton, Paul, Simpson, and Tait (2007) noted, “cultural continuity can be expressed in many ways, but all depend on a notion of culture, as something that is potentially enduring or continuously linked through processes of historical transformation with an identifiable past of tradition” (p. 77).

Essentially, the parenting group project was an opportunity for building a foundation of participants’ knowledge of intergenerational trauma and understanding how each participant had been impacted from an individual and/or community level. The project provided a framework for exploring how the implications of trauma impacted healthy parenting skills and practices relational to contemporary Indigenous family dynamics. When conducting this group, it was initially important to articulate the impacts of historical trauma within a meaningful and safe manner.

While literature suggests that historical trauma has severely impacted Indigenous health and welfare, adversities experienced by Indigenous people profoundly continue to compound their wellbeing (Bombay et al, 2014; Yellow Horse Brave Heart, 2003). This is visibly illustrated within child welfare as the chronic over-representation of Indigenous children in care is well documented (Greenwood & de Leeuw, 2012; Blackstock & Trocmé, 2005). Grandparents are assuming the parenting role due to the current high rates of Indigenous children in care, which is indicated to have considerably surpassed the Residential School era. The Winnipeg Free Press

argued that “Aboriginal children in care have doubled” (Winnipeg Free Press, 2011). Therefore, it is soundly suggested that education, awareness, and knowledge are key components for fostering consciousness-raising while working towards attaining and restoring wellbeing. I felt the parenting group initiative was a profound opportunity to transmit, disseminate knowledge, and understanding while creating space for genuine learning. With awareness, participants would gain knowledge in understanding how social factors have also contributed to Indigenous wellness, particularly from a familial lens. Primarily, the aim was to create and foster an understanding amongst participants because the more we know, the better equipped we become in understanding ourselves, children, family, and community.

On November 28, 2017, Mr. Tremblay and I attended Kuuwanimano CFS, specifically the Agency’s family room, to prepare and set up prior to the initial parenting group commencing. Lunch was provided through prevention services. Also, bannock was presented and donated by a staff member within prevention services as it was expressed that traditional foods should also be integral to the parenting group. Historically, bannock signifies a culturally embedded practice within Indigenous cultures; as Cyr and Slater (2016) noted: “bannock represents a distinct part of Aboriginal cultural identity” (p. 60).

November 28, 2017 – Parenting Group Session I

The main goal of the first group meeting was to acquaint ourselves with participants while enjoying a meal, which was an opportunity to “break the ice.” Once lunch was completed, participants were directed to the seating area. The family room was quite large, and it was suggested PowerPoint presentations be utilized for each parenting group session as this would act as a guiding tool while respecting time frames.

Our first session entailed introducing ourselves amongst group members as the goal was to become familiar with one another while establishing a sense of comfort within the group. The group consisted of six participants who shared that they were required by their workers to complete a parenting group class as part of completing their service plan. The majority of participants felt obligated to attend the group, yet each shared they were willing to learn and participate. This communal sharing was a starting point for recognizing and acknowledging clients' strengths while discussing the groups' commonality amongst participants. As Papell (2015) indicated "groups are made up of a collection of individuals that come together for a period of time for some kind of commonality issue" (p. 241).

Also, discussions involving the significance of attendance was discussed with participants as we wanted to ensure that their attendance was optimal, which was pivotal for fostering learning. Another key component discussed during the commencement of the parenting group project was the significance of confidentiality. It was emphasized that confidentiality plays a vital role concerning group cohesion and trust amongst participants, and that participants had the responsibility to uphold privacy. The purpose of establishing rules and expectations was to ensure that participants had a clear understanding of their responsibility as a participant; and the importance of abiding by the rules would ensure that participants felt safe, respected, and comfortable while exercising a non-judgmental environment. Also, it was suggested that the parenting group sessions would take place every Tuesday from 12:00-2:00 PM, and that participants were responsible for presenting on time. However, in the event of absences, participants were instructed to contact either Mr. Tremblay or myself to notify us of their non-attendance, as this signified responsibility and respect.

Mr. Tremblay and I reviewed what the group sessions would entail and discussed the learning objectives involved with each session. During this time, I discussed my role as a student and the purpose of the parenting group project amongst participants, and what we hoped to achieve with the upcoming sessions. Mr. Tremblay and I briefly discussed the various models that would be implemented within sessions and explained why each framework was significant to the learning experience. We also discussed the importance of making connections to culture and discussed the various tools that would be integrated within each group session. Discussions involved the significance of culture and identity, and why an Indigenous framework was essential for promoting self-awareness. We had encouraged participants to openly share their knowledge or experiences with the identified tools such as the medicine wheel, grandfather teachings, sharing circles, and storytelling. Each participant had a definite knowledge of the medicine wheel and its versatile use within Indigenous cultures. Also, most participants had participated in a sharing circle at some point in their lives, which most expressed they were comfortable with utilizing within the group. Most were aware of the seven grandfather teachings; however, most lacked the knowledge regarding the teachings.

The majority of participants shared they had ancestral/familial roots from the following communities: Moose Factory, Attawapiskat, and Fort Albany, thus identifying as having Cree ancestry. In Timmins, a majority of Indigenous people identify as either Cree or Oji-Cree, indicating that their learning of their Indigenous culture drew upon the Cree teachings. I note that the seven grandfather teachings originated from Anishinaabe teachings (Ojibway) and a majority of Indigenous people within Timmins and area have strong ancestral roots to Cree, and that traditional teachings tend to differ depending on the nation/community. However, this is not to say that specific cultural teachings cannot be implemented into therapy or utilized in various

helping situations, however, dissemination of these teachings that follow and support Indigenous perspectives is key as it promotes respect while creating a receptiveness to learning.

During this session, participants openly shared their involvement with Kuuwanimano CFS as most had multi-layered issues which hindered their ability to effectively parent and optimally provide for their children. Most indicated that their children were currently being cared for by either a family member such as a grandparent, aunt or uncle, an extended family member, or that their children were placed in the care of the Agency. Those whose children were in the care of the Society indicated that they did not have a family member who was willing or capable to care for their children due to risk factors such as alcoholism, drug use, or concurrent disorders. This sharing amongst the group was groundwork concerning the residual effects of intergenerational trauma.

To initiate further meaningful dialogue, I found myself openly sharing my personal experiences of intergenerational trauma, which created feelings of normalization and trust with the group. Therefore, the discussion focused on intergenerational trauma as this was an opportunity to discuss its residual effects, particularly from an individual, familial, community, and national lens. The use of the medicine wheel was implemented within the group, which highly supported discussions amongst participants, particularly encompassing trauma. Prior to wrapping up the session, Mr. Tremblay and I ensured that participants were in a good place prior to closing as we asked for a go-around which gave participants an opportunity to share how they felt and what they hoped to achieve with the parenting group. Upon closing the session, we had invited an Elder to end the session with a smudge as we felt this was conducive to what was shared and discussed.

December 12, 2017 – Parenting Group Session II

During this session, we had two individuals join the group, which increased the group to eight participants in total. Mr. Tremblay directed the focus of the group to the last session as discussions of intergenerational trauma were introduced into the group session. Mr. Tremblay discussed codependency and trauma, and how both concepts interrelated. Importantly, discussions focusing on the impacts of trauma and how the body tends to keep the score concerning unresolved trauma and/or grief was reviewed. Also, unhealthy coping strategies and destructive behaviors resulting from unresolved trauma were also discussed with the group. Essentially, discussions were directed to what unhealthy coping mechanisms involved and their impact on individual wellbeing and parenting capacities.

A short video via YouTube was suggested, *Gabor Mate: What is Addiction?* A brief overview was provided to the group. This video explained the root causes of addiction and how individuals overcome addiction as individuals must learn to deal with the underlying issues, through support and compassion. Also, the use of a PowerPoint presentation was utilized, which outlined Intergenerational Trauma Theory in terms of its definition, contributing factors (historical and contemporary), behaviours associated with intergenerational trauma, Residential Schools, and supports available for healing from an Indigenous context.

The use of the medicine wheel was incorporated within the session and we discussed how trauma impacts all levels of the self – mental, emotional, physical and spiritual. Within the session, participants had shared their experiences amongst one another, revealing how trauma has impacted them throughout their lifespan, particularly concerning their childhood. Mr. Tremblay discussed the importance of connecting to past experiences relevant to the present. It was discussed that healing occurs when we acknowledge our past experiences while making connections to the present as this honors our ancestors. Importantly, we had highlighted the

importance of culture and traditions and inquired what tradition(s) were passed on to participants from their childhood to the present, and more so, as parents themselves.

Also, during this session we had an Elder attend the session to discuss and review her experiences with residential school and child welfare, and how traumatic events had impacted her ability to effectively parent. The Elder shared that she is currently caring for her grandchildren due to the residual effects of residential school and discussed the importance of healing. The Elder shared that healing involved both individual and communal levels as she shared that healing is everyone's responsibility. The Elder also shared that healing was a journey and that healing takes time and the ability to learn from past experiences. The Elder discussed the importance of culture within her healing journey and encouraged participants to take the opportunity to learn about their Indigenous cultures, as she indicated that culture truly helped her achieve wellness.

Prior to closing the session, we asked that participants explore and examine their family traditions within their familial structure, and how traditions have played a pivotal role in shaping their identity. At this time, it was agreed that the group would convene in the New Year due to the holidays approaching. It was agreed that the group would meet on January 9th, 2018. Upon closing the session, we had invited an Elder to end the session with a smudge, which all participants openly took part in.

January 9, 2018 – Parenting Group Session III

The group convened at Kunuwanimano CFS family room. At this time, four participants attended the scheduled session. A meal was provided for participants to enjoy prior to the session commencing. Once lunch was completed, the group convened at the seating area. Mr. Tremblay

reflected on the last session held on December 12th and briefly touched upon the topics discussed. Mr. Tremblay inquired whether participants had any questions pertaining to discussions or thoughts regarding previous discussions, and the participants indicated that they did not.

At this time, the focus of the group was directed to the importance of traditions and its role in shaping our identity and sense of belonging. The group openly discussed the importance of language, the use and significance of moss bags, and the role of extended family when raising a child. Most participants described this responsibility as an innate feature or featured characteristic within Indigenous cultures. Majority of participants shared that the use of moss bags or Tikinagans was a tradition passed on to their children as infants. Each participant shared their knowledge and teachings about the Tikinagan, which had been passed down to them by way of oral traditions. However, during open discussions and dialogue amongst the group, the cohesion was interrupted on several occasions as staff members were observed to have entered the room unannounced. Hence, this interruption created a disturbance while severing meaningful dialogues with participants. Due to these disruptions, participants expressed feeling unsafe, vulnerable, and chose not to openly share.

Despite notifications being posted on all entrance doors informing of group sessions taking place, staff continued to present in the room unexpectedly, creating further disharmony amongst the group. At the end of the session, it was suggested that future sessions would take place at Tremblay Counselling Services, which was located down the hallway from Kunuwanimano CFS. Participants unanimously agreed to the suggestion. Upon closing the session, we had invited an Elder to end the session with a smudge, and all participants openly took part.

January 16, 2018 – Parenting Group Session IV

Prior to the session beginning, we had met our participants at Kunuwanimano CFS to oversee lunch as lunch was provided by prevention services. Once lunch was completed, we had directed the participants to Tremblay Counselling Services, which was ideally located down the hall from the Agency. We felt this setting was deemed more conducive for ensuring participants' safety, confidentiality, and anonymity. Also, this setting was favourable for participants to openly share amongst each other. Altogether, the session had four participants in attendance.

During this session, Mr. Tremblay briefly checked in with participants and suggested a go-around, so that participants could share where they were at and any thoughts about the parenting group thus far. Participants indicated that it was a learning experience and that they enjoyed the sessions and teachings implemented within the group. During this session, Mr. Tremblay reviewed and discussed Attachment Theory and its correlation to positive child rearing, particularly its role in promoting healthy child development. Also, Social Learning Theory was explained amongst participants and its connection to positive child-rearing practices. A PowerPoint presentation was utilized to describe and explain each theory. A short video was implemented, which outlined attachment theory via YouTube - *The Attachment Theory - How Childhood Affects Your Life* (Sprouts, 2018).

After viewing the video, we encouraged participants to make connections concerning their childhood experiences, and we asked whether participants felt comfortable participating in an activity. Mr. Tremblay and I explained that the activity involved reflecting on one's childhood. It was explained that a series of questions would be asked while participants were encouraged to have their eyes closed during this activity as this would allow participants to truly reflect on their childhood and make connections. Also, for each question asked, we would pause

for a couple of minutes, prior to prompting the next question as this would provide efficient time to think and reflect on each question. The questions were as followed:

- 1) Think back to a time when you were young, picture who you were living with at that time; your parents, grandmother, or whoever raised you.
- 2) How would you describe your parent's parenting styles – the way they raised you.
- 3) What was your relationship like with your family? Were you close to your parents, grandparents, extended family?
- 4) How would you describe your childhood experiences?

After concluding this activity, we encouraged participants to openly share their experiences as children amongst the group, and most participants indicated they were part of the child welfare system due to their parent's inability to effectively parent. It was discussed amongst participants the disconnection children experienced and endured within the Residential School system. Generally, it was reviewed that the residential school experience created destructive impacts on contemporary parenting skills referred to as intergenerational effects (Bombay et al., 2014; 2009).

Again, Mr. Tremblay directed the session to the importance of acknowledging our past experiences, insofar as they shape our ability to move forward in a positive and meaningful way. Also, for individual healing to occur, healing needs to be restored from within; he referred to this process as resilience. The use of the medicine wheel was integrated within the session as discussions concerning balance and attaining balance is key for achieving individual wellbeing. The medicine wheel was an integral component to the parenting group project as it permitted participants to connect to Indigenous ways of knowing and its importance for promoting and

attaining Indigenous wellness, particularly from an individual perspective. Prior to closing the session, it was suggested that we go-around amongst participants to ensure that group members were in a good place prior to ending the session. The session ended with a smudge.

January 23, 2018 – Parenting Group Session V

During this session, participants did not show up for the scheduled parenting group project. However, Mr. Tremblay and I were informed from each participant's assigned workers that participants were unable to attend due to other commitments. The agenda for this session was to discuss Traditional Aboriginal Parenting Theory versus Westernized Parenting Styles. The goal was to discuss traditional parenting and how historically it was perceived as a communal responsibility. Within the sharing circle, we had planned to re-reflect on the importance of positive attachment and have participants share their experiences as a child. This activity would allow participants to analyze and make connections to the past and how they can work towards rebuilding their parenting capacities in the present.

January 30, 2018 – Parenting Group Session VI

During this session, one participant presented to Tremblay Counselling Services for the scheduled parenting group. However, due to no other participants presenting to the office, the participant requested to meet with Mr. Tremblay for an individual counselling session. At this time, the participant requested to meet in private with Mr. Tremblay during the scheduled parenting session, as the participant declined my presence within the session.

February 6, 2018 – Parenting Group Session VII

Prior to conducting this session, it was my responsibility to contact each participant via telephone or email to confirm their attendance. Despite my efforts, I did not receive any response

from participants concerning confirmation of attendance. Therefore, Mr. Tremblay decided that he would continue with one-on-one counselling sessions during the scheduled time frame due to lack of confirmation. During this scheduled parenting session, participants did not attend, nor did we receive an update from the assigned workers regarding each participants' attendance. Therefore, it was decided that Tremblay Counselling Services would no longer proceed with parenting groups going forward due to lack of participation demonstrated and the fact that my field practicum was nearing its completion.

Overall, my role in overseeing these parenting groups involved planning and coordinating the content within each session, and co-facilitation with each session when deemed appropriate. Also, I had ensured brief PowerPoint slides were completed prior to each parenting group session. With PowerPoint slides, this allowed highlighting learning goals for each session, along with providing an informative review of the theoretical models utilized in session. Also, my role was to ensure that the necessary tools such as the medicine wheel and activities were implemented in each session, as the purpose was to promote participation and learning amongst participants.

On February 6, 2018, Mr. Tremblay and I had a scheduled meeting via videoconference with the Advanced Practicum Committee, as this was an opportunity to provide an update regarding my field practicum since the last scheduled meeting. At this time, the parenting group project was reviewed, and factors were discussed that contributed to the diminishing project. The Advanced Practicum Committee suggested highlighting these contributing factors within my practicum report regarding the project. Factors such as the environment setting, lack of support demonstrated from staff and management, and inconsistent cohesion hindered the project's ability to move forward in a meaningful manner. These presenting themes will be reviewed in

the next Chapter. Despite the shortcoming of the parenting group pilot project, the Advanced Practicum Committee suggested perceiving the project as a learning experience rather a disappointment. Also, it was suggested that I reflect on this learning experience concerning implications for social work practice.

Summary

Although the parenting group pilot project was not as successful as I had envisioned it to be nor did it achieve the desired results, however, it was truly a genuine experience in terms of learning the significance of group processes. This experience provided an opportunity to build my knowledge and confidence regarding group work, as directing groups in a manner that is cohesive creates interpersonal learning amongst group members and facilitators simultaneously. As well, for groups to be successful, it requires a great deal of skill from the facilitator, as direction and management of the group is needed for effective collaboration to occur.

Moreover, for groups to be successful, groups need to be perceived as relational, meaning that every member within the group needs to contribute equally, as each plays a pivotal role in the success of the group. Importantly, the cohesion of support groups is highly contingent to the environment, as group members need to feel safe, particularly in highly controlled environments such as child welfare agencies. In the next Chapter, I will discuss critical reflection and analysis of my Advanced Practicum experience. Also, discussions concerning the applicability of the theoretical models will be discussed relational to an Indigenous framework. As well, discussions concerning the parenting group pilot project and presenting themes will be explored.

Chapter III: Critical Reflection and Analysis of the Advanced Practicum

Mental health challenges are profoundly prevalent amongst the Indigenous populations, which continues to hinder Indigenous wellness. This is soundly evident within literature and more so through my observational learning while completing a field practicum within a private practice-based setting. Through literature, it is suggested that implementing Indigenous healing and practices within therapy proves beneficial for attaining wellness (Linklater 2014; Nabigon & Nabigon, 2012; Lavalley & Poole, 2010). In this Chapter, I will discuss critical reflection and analysis of the Advanced Practicum. This discussion will be divided into two sections as I will discuss the following: (1) The applicability of the theoretical models to an Indigenous helping approach, and (2) The parenting group pilot project and discussions regarding the presenting themes. Prior to these discussions, I feel it is imperative to highlight critical reflection and discuss the importance of understanding power relations, as both concepts played a pivotal role in fostering my understanding, and importantly, shaping my professional identity.

Critical Reflection

Critical reflection is key for promoting professional development and growth, which also facilitates lifelong learning (Lay & McGuire, 2010). It also allows practitioners to dissect and deconstruct underlying assumptions that may be deeply embedded through learning experiences, values, and beliefs. As Lay and McGuire (2010) noted, “these assumptions may become a rationale for implicit acceptance or rejection of knowledge, which ultimately influences practice” (p. 541). This notion of reflective practice drew upon the work of Schön (1983), *The reflective practitioner: How professionals think in action*, who indicated that the theory of reflective practice involves (a) knowing in action (observation and analysis) and (b) reflection on action (retrospective thinking), which ideally generates new meaning. Thus, this new meaning promotes

a profound understanding in terms of what we do as practitioners and who we are (Hickson, 2011). Arguably, critical reflection promotes exploration of the self as this process involves unearthing our identities and social location (privilege), which aides with deconstructing power structures that hugely influence our assumptions and belief systems concerning others (Nadan & Stark, 2016).

Reflective journaling was also an integral component of my learning experiences while completing the Advanced Practicum. According to Hubbs and Brand (2005), “the rationale for using reflective journaling in higher education is grounded in general learning theory, adult learning theory, experiential learning theory, and in the importance of counseling a student's personal growth and professional development” (p. 61). Reflective journaling also fostered self-evaluation and self-discovery, reflective to my professional development, which was paramount in shaping my identity as an Indigenous practitioner. Similarly, this practice generated an opportunity to interweave back and forth between reflecting in and on action while nurturing self-awareness and personal growth. I chose to journal within a notebook as I felt this form of exercising reflective practice would offer a far more beneficial learning capacity in terms of creating a deeper understanding relational to the field placement and within my current practice. In a study conducted by Toros and Medar (2015), they concluded that social work students who engaged in reflective journaling found that journaling (written words) was an efficient form/technique for self-reflection, which they argued “generates competence and quality of social work services” (p. 94).

Moreover, with reflective practice, it was imperative to integrate and comply with the code of ethics pertaining to ethical social work practice set out by the Canadian Association of Social Workers (CASW) to minimize and eliminate ethical dilemmas that may have presented

during the Advanced Practicum. An area of importance that Mr. Tremblay and I reflected on frequently throughout the duration of my placement was the concept of client autonomy. It was highlighted that client autonomy is integral within clinical practice as it plays a vital role in fostering self-determination while promoting empowerment. Client autonomy ensures that a service user has the right to make informed decisions based on relevant information received from the practitioner. Also, it was emphasized that client autonomy was extremely important concerning the clientele Tremblay Counselling serviced, as the majority are Indigenous service users. Importantly, understanding the impacts of historical trauma and imposed government policies and structures that continue to undermine the autonomy of Indigenous people generates a framework for genuine understanding (Linklater, 2014 & Rowe et al., 2015). Thus, client autonomy creates a solid foundation for effective practice while building and fostering trust.

Also, reflecting on my own experiences of trauma was equally important for acknowledging the effects of intergenerational trauma, and how it has impacted me from an individual, familial, and community standpoint. This self-reflection was significant for cultivating understanding while nurturing my growth process as this acquired learning ensured the promotion of ethical social work practice from a power with approach, as opposed to power over. Importantly, the role of social work involves helping those in need while acting as an advocate, thus, self-reflection is key for ensuring one's optimal health and growth. In *Indigenous healing: Exploring traditional paths*, Ross (2014) discussed the meaning of a healthy person in the context as helpers, as he stated:

A healthy person is thus someone who understands that he is a nested component of that complex web of interconnections, who acknowledges fundamental dependence upon

them, who is aware that he has been given significant responsibilities within those responsibilities and who is determined to fulfill them as best he can. (p. 229)

As an Indigenous practitioner, I also felt that integrating an Indigenous framework was essential for my own grounding purposes and understanding. Essentially, this learning experience assisted with acknowledging the importance and continued need for resurgence of culturally appropriate services within practice. Linklater (2014) noted “Indigenous strategies for helping and healing are most successful in supporting Indigenous individuals, families, and communities, as this promotes meaningful and profound ways to healing” (p. 132). Also, this acquired understanding positively assisted in forging a profound insight for me in terms of the much needed and on-going education and awareness concerning the impacts of colonization and intergenerational trauma.

Understanding Power Relations

The legacy of colonization and its ongoing effects continue to undermine the wellbeing of Indigenous peoples from a mental health aspect as literature highlights suicide rates are predominantly elevated amongst Indigenous populations, being five to six times higher relative to non-Indigenous peoples (Isaak et al., 2010). Moreover, research concerning mental health disparities amongst Indigenous peoples of Canada have been conducted by Westernized practitioners using colonial and non-Indigenous epistemologies (Nelson & Wilson, 2017). Essentially, within the mental health sector, theoretical frameworks for attaining mental health are primarily overseen by Westernized epistemologies, which often discredit and ignore Indigenous ways of knowing and Indigenous practices (Duran, 2006).

Historically, Western worldviews and approaches to Indigenous wellbeing were perceived as standard practice; however, these modalities of treatment continued to undermine Indigenous autonomy and cultural practices altogether. Hart noted that “Indigenous helping practices have not been well regarded by mainstream services and health organizations, they also risk perpetuating the colonial oppression that Indigenous peoples have experienced” (Menzies, Lavallee & Harper, 2014, p. 82). Arguably, most theoretical approaches utilized in health treatment settings, specifically evidenced-based practices (EBPs) were developed from a Westernized context, which continues to subjugate Indigenous frameworks, healing practices, and ways of knowing as approaches for healing (Goodkind, Gorman, Hess, Parker & Hough, 2015; Cunneen & Rowe, 2014; Hays, 2014). Importantly, it is well documented that mainstream practices hinder Indigenous autonomy; as Rowe et al. (2015) indicated “Western approaches fail to sufficiently give voice to the perspectives and subjectivities of Indigenous peoples” (p. 297).

In *Decolonizing Trauma Work*, Dr. Renee Linklater (2014) emphasized that Indigenous peoples have experienced deep-rooted oppression and suppression for many generations so that the concept of wellness has become something rather foreign, insofar that attaining wellness is an inconceivable notion. Essentially, social factors that have profoundly contributed to mental health disparities amongst Indigenous populations can be strongly correlated to governing policies and structures such as the Residential School System (Pollock et al., 2016; Lavallee & Poole, 2010). Also, Dr. Renee Linklater (2014) highlighted the work of Chansonneuve, indicating that forced institutional settings within modern and contemporary treatment settings such as hospitals replicate that of the Residential School environment, thus, creating a profound resistance causing Indigenous peoples to feel vulnerable and re-victimized. Thus, instilling a profound sense of fear, which considerably inhibits one’s ability to reach out for supports and

services. As Linklater (2014) noted: “the history of forced institutionalization deters countless Indigenous people from accessing potentially helpful services” (p. 102).

Within Westernized approaches to mental health, the Diagnostic and Statistical Manual (DSM) is a central framework for practice and diagnosis, which often pathologizes mental health struggles as an illness/disorder based on symptomology (Linklater, 2014). Although it is argued that the current DSM fails to acknowledge complex post-traumatic stress as a disorder (Linklater, 2014), it is also noted that this diagnostic tool lacks cross-cultural applicability (Thakker & Ward, 1998). Linklater (2014) highlights that diagnosis “often pathologizes the person, which can diminish identity development” (p. 160). Further, Ross (2014) highlights the work of Herman, indicating that “the diagnoses of post-traumatic stress disorder, as it is presently defined, does not fit accurately enough. In survivors of prolonged, repeated trauma, the symptom picture is far more complex” (p. 116). Further, many Indigenous scholars have noted that Indigenous conceptualizations of mental health have been referred to as distress; as being caught between two worlds (Indigenous/non-Indigenous), characterized as acculturated stress (Vukic, Gregory, Martin-Misener & Etowa, 2011). Therefore, it is argued that acculturative stress highly contributes to mental health disparities amongst Indigenous people, as interventions and programs considerably ignore the cultural, historical, and social-political contexts, which often continues to deter Indigenous wellness (Vukic et al., 2011).

Arguably, many Indigenous scholars noted that the foci of prevention and treatment amongst Indigenous communities have been considerably grounded and centred around post-traumatic stress disorder (PTSD), which fails to capture the historical traumatic experiences of Indigenous peoples altogether (Linklater, 2014; Gone, 2013; Yellow Horse Brave-Heart, 2003). Gone (2013) emphasized that clinicians tend to address the traumatic experiences of Indigenous

peoples as PTSD, based on symptomology. However, it is argued that the impacts of colonial trauma are far more complex than post-traumatic pathology, thus, highlighting that Indigenous experiences of trauma requires a historical trauma approach. This framework was constructed and introduced in the mid-90s by Yellow Horse Brave-Heart and DeBruyn's (2003; 1998) groundwork concerning the Lakota peoples (Gone, 2013). Essentially, mental health issues impacting Indigenous people require redressing, where Indigenous practices and culture emerge as promising approaches for attaining Indigenous wellness, which Gone (2013) emphasized as "culture as treatment" (p. 696). For example, in a study conducted by Brave Heart et al (2011), it was highlighted that the use of culturally congruent interventions for grief resolution and trauma mastery proved effective for treating elevated psychosocial issues (p. 286).

For Indigenous people, health and mental health are perceived as holistic, which also encapsulates the physical, emotional, and spiritual aspects of being while acknowledging humanity, nature, and spirit. All are fundamental for understanding our existence and connections to others, which Hart referred to as our "relations" (Rowe et al., 2015; Menzies et al., 2014, p. 75; Verniest, 2006). Ross (2014) highlighted that the concept of relationships is an integral teaching within the Indigenous culture as relationships help us to understand how everything is relational to one another, and that one simply cannot exist without the other. Ultimately everything has meaning. In his book, *Indigenous healing: Exploring traditional paths*, Ross (2014) noted, "all things work together in an interdependent fashion, forming an interconnected web of integrated wholeness. Through each part is a recognizable unit, it only has meaning when in relationship to the whole" (p. 28). Generally, it is argued that the terminology and language specific to psychiatry fails to articulate the experiences and understandings of Indigenous people concerning mental health and that the notions of Westernized treatment are

not conducive to Indigenous worldviews for attaining healing (Linklater, 2014). Although power relations exist, Ross (2014) noted that colonization has truly eradicated the Indigenous culture, leaving many as Christians and true to their faith, while others are holding on to traditional beliefs; whereas others are simply lost in translation. Nonetheless, Indigenous worldviews genuinely aid with understanding how relationships are significant to self and others, land, families, language, spirit, which must be maintained as these relationships significantly contribute to the optimal health of Indigenous peoples (Linklater, 2014).

Decolonization is perceived as a path for reclamation and reconciliation concerning the Indigenous culture; as Cornassel (2012) noted,

decolonization offers different pathways for reconnecting Indigenous nations with their traditional land-based and water-based cultural practices. The decolonization process operates at multiple levels and necessitates moving from an awareness of being in struggle, to actively engaging in everyday practices of resurgence. (p. 89)

Importantly, Wesley-Esquimaux (2009) highlighted that decolonization happens at home, with our children and families, indicating that meaningful discussions with our children need to take place. Thus, this allows for the resurgence of oral traditions. Storytelling permits women to articulate narrative experiences about the Indigenous culture while acknowledging our ancestral past (Wesley-Esquimaux, 2009). Essentially, decolonization facilitates self-determination and more importantly, Walters and Simoni (2009) argued that decolonizing approaches provide “a vital link to improving the health and wellness of tribal communities” (p. 573). Similarly, social inclusion is noted as vital for collective healing to occur rather treating individuals in isolation. Collective healing enhances and strengthens ethnocultural identity, which is imperative for

improving wellbeing amongst the Indigenous populations and communities alike (Dionne & Nixon, 2014).

Simultaneously, prior to applying a decolonizing approach, it is highly suggested when working with Indigenous people that their worldviews be examined due to many different Indigenous ways of being that exists within the Indigenous culture (Hart, 2002). Similarly, Linklater (2014) highlighted the importance of acknowledging Indigenous people's perspectives and worldviews as this is essential for understanding and respecting the individual's preference concerning therapeutic approaches (providing options to clients). Decolonization is perceived as difficult, due to resistance to recovery; as Wilson and Cavendar (2005) noted "some of the greatest resisters to the recovery of Indigenous knowledge are our own native people, who, having internalized racism, now uncritically accept ideologies of the dominant culture" (p. 259). Nonetheless, Linklater (2014) indicated that the process of decolonization involves challenging mainstream ideologies and that healing in the context of self-determination also involves community. Cunneen and Rowe (2014) argued "in a sense, Indigenous approaches to healing are unique because they seek individual change within a collective context" (p. 59). Hence, research indicates Indigenous healing; particularly healing from trauma entails collective recovery, as collective recovery allows the community to heal from community-based approaches created by its members, which instills empowerment and self-determination (King, Bokore & Dudziak, 2017). Generally, it is highly noted that decolonizing is integral to effective healing work (Mohammed, 2010). Importantly, a significant factor that must be considered concerning collective recovery is that communities often have different understandings of traditional healing and more importantly the needs of the community may also differ (Robbins & Dewar, 2011).

The Applicability of the Theoretical Models Relational to an Indigenous Approach

Throughout my practicum, the theoretical approaches that I was exposed to were generally delivered from a Westernized approach. Although Mr. Tremblay identified as a non-Indigenous practitioner, he shared that he was quite familiar with Indigenous ways of knowing and healing practices. Moreover, he indicated he was very open to incorporating Indigenous modalities within therapy when deemed appropriate. An important keynote he discussed was the importance of connecting and establishing relationships within the community concerning knowledge keepers and Indigenous resources, as this promotes options, specifically when the practitioner lacks knowledge of services. In a study conducted by Oulanova and Moodley (2010) involving clinicians concerning integrating Indigenous approaches within therapy, participants responded that “they do not initiate the use of traditional healing elements, believing that such practices need to be instigated by clients” (p. 351). Nonetheless, during my observations within sessions, I did identify various situations in which examining individual worldviews could have been initiated. Indigenous methodologies such as the medicine wheel, storytelling, and cultural applications of the mentioned theories could have been positively implemented and beneficial within session. Thus, a best practice would include exploring if a client has a traditional orientation and what he/she would perceive fitting within their plan of care as providing options is significant in attaining one’s optimal health.

The overall objective while completing the Advanced Practicum was to analyze and critique the applicability of the theoretical models that I was exposed to during field placement, and to assess how I could integrate an Indigenous framework concerning each approach. Essentially, the integration of Indigenous healing within practice involves embracing and practicing, which Duran (2006) described as hybrid psychotherapy. Hybrid psychotherapy involves practitioners/clinicians creating space for the expression of diverse forms of knowing

and healing while acknowledging the client's beliefs, perceptions, and experiences as legitimate and valid. Hence, these expressions represent authoritative sources of truth and knowledge (Beaulieu, 2011). Next, I will discuss the applicability of each theoretical model beginning with Cognitive Behavioural Therapy (CBT).

Integrating an Indigenous Modality within Cognitive Behavioural Therapy (CBT)

Despite that cognitive behavioral therapies (CBT) are widely favoured and referred to as the gold standard in psychotherapy for treating mental health issues (Reaven et al., 2012), CBT has received much criticism in terms of its applicability for some populations. For example, it has been argued that CBT falls short when treating Indigenous people experiencing mental health issues as CBT fails to integrate culturally sensitive approaches, particularly acknowledging the impacts of historical trauma (Hays, 2014). Importantly, CBT is strongly based on a Westernized framework, which ignores the needs of Indigenous peoples from a cultural and social aspect.

Thus, for clinicians to acknowledge and ensure cultural differences inform therapy, particularly within modalities of therapy such as CBT, Van de Vijver and Tanaka-Matsumi (2008) argued that practitioners must acknowledge the following: (a) client's cultural identity and acculturation; (b) conflict with values; (c) client's own idiom (expressions) of distress; (d) client's causal explanatory model of presenting problems; (e) metaphors of health and wellbeing in the client's cultural group; (f) client's motivation for change; and (g) client's social support group (p. 476). Further, Mitchell and Maracle (2005) noted: "mainstream health interventions directed towards Aboriginal populations are often developed outside of a historical, cultural framework rather focusing on the emotional, cultural, mental, and spiritual aspects of health" (p. 19).

Importantly, Nabigon and Nabigon (2012) noted that “CBT approaches are particularly beneficial in providing specific tools to change thought, heal negative emotions, understand things from different viewpoints while promoting new behaviours” (p. 50). Conversely, scholars have noted that CBT can be adapted by culturally competent therapists as CBT is highlighted as extraordinarily versatile due to its self-empowerment, philosophy, and focus on skill acquisition (Nelson et al., 2014). Also, Nelson et al (2014) argued that the principles of CBT appear “consistent with the Indigenous principles of self-determination, recovery from adversity, and resilience” (p. 24). Further, in a study conducted by Bennett-Levy et al (2014) they indicated that CBT could be a highly adaptable pragmatic therapy utilized amongst the Indigenous population as CBT techniques prove to work well with Indigenous clients.

According to Waldram (2005), the medicine wheel is used as “a pedagogical tool for helping clients understand, visually as well as conceptually, how to lead a balanced and healthy lifestyle” (p. 22). The use of the medicine wheel within therapy aides in helping Indigenous clients to clearly visualize the areas that they need to strengthen for attaining wellness, which is essential for attaining balanced relationships with self and others (Nabigon & Nabigon, 2012; Verniest, 2006). Generally, the medicine wheel is perceived as a beneficial tool within therapy as it guides and helps clients to visualize the areas where strengthening is needed, thus, creating balance and promoting wellness. Importantly, the medicine wheel is central to Indigenous healing and is noted to hold individuals accountable in their healing journey, as Waldram (2014) emphasized “the Medicine Wheel shows...personal responsibility, and personal responsibility is making the right choices” (p. 378). Also, the medicine wheel is noted to encompass the fundamental concept of wholeness, which includes the four dimensions of health: physical (body), mental (mind), emotional (heart), and spiritual (spirit) (Hart, 2002). Integrative

approaches to CBT are discussed within McArthur's work (2018), as the medicine wheel is demonstrated and highlighted as an integrative approach to CBT from an Indigenous framework perspective.

Thus, the medicine wheel is one modality that could easily be integrated within mainstream therapy such as CBT, due to its versatility and adaptability when combining Western and Indigenous approaches within intervention. For another example, Owen (2014) highlighted the versatility and integration of the medicine wheel within interventions such as the Twelve Step program concerning addictions. Within treatment the medicine wheel was introduced, as this form of intervention illustrated individual responsibility, which overall proved effective. However, successful integration of both worldviews (Indigenous/non-Indigenous) is highly contingent and dependent on the therapist's skillsets (Nelson et al., 2014). In essence, the medicine wheel helps individuals understand what aspects of the self are out of balance and what steps need to be taken to essentially restore the self, which is fundamental for attaining individual wellness (Hyatt, 2013). Overall, the medicine wheel is central to the Indigenous cultures as it represents holism and illustrates the importance of balance, which encapsulates an Indigenous conception of health (Beaulieu, 2011).

Integrating an Indigenous Modality within Trauma Focused - Cognitive Behaviour Therapy (TF-CBT)

With trauma focused-cognitive behaviour therapy (TF-CBT), trauma narration and processing are highly intended to reduce distress, as this process entails gradual exposure while resolving maladaptive thoughts, feelings, and emotions associated with trauma-related memories (Cohen & Manarino, 2015). Research demonstrates that in individuals who experienced a traumatic event, the memories associated with the trauma become distorted and disorganized

(Bisson et al., 2014). Therefore, narrative interventions allow individuals to formulate and integrate one's experiences through storytelling, which is demonstrated to positively aide in trauma recovery (Anderson & Wallace, 2015). Narratives permit individuals to make sense of their experiences as narrative meaning-making is expressed through internal state language. Thus, individuals who are better able to express themselves and explain their cognitive and emotional states through expressive narratives that fits their unique experiences have higher levels of physical and psychological wellbeing (Kirmayer et al., 2014; Bohanek & Fivush, 2010).

TF-CBT is evidence-based and highly suggested for treating children and youth in the aftermath of trauma-related experiences, particularly survivors of sexual abuse (Holtzhausen et al., 2016; Pollio et al., 2014; Cloitre et al., 2010), and it is also noted that the applicability of TF-CBT is easily adaptable, flexible, and highly versatile. Deblinger, Mannarino, Runyon, Pollio, and Cohen (2018) indicated,

TF-CBT is designed for families of diverse ethnic, racial, religious, and cultural backgrounds. TF-CBT encourages clinicians to utilize their talents and creativity to adapt the psychoeducation, skill-building, and trauma narration/processing activities to optimally serve the child and his/her family reflective to their needs. (pp. 13-14)

In a study conducted by Deblinger, Pollio, Runyon, and Steer (2017), it was noted that results replicated prior randomized studies indicating that children who participated in TF-CBT illustrated increased personal resilience and positive coping skills. However, in a study concerning PTSD diagnosis amongst children conducted by Cohen and Scheeringa (2009), they emphasized that child researchers voiced that “too many children who have been chronically and repeatedly traumatized, abused, and/or neglected are not being diagnosed with anything because they believe that their symptoms do not fit PTSD” (p. 93). Hence, this misleads clinicians to treat

comorbid conditions rather properly treating the trauma syndrome, which often places children at further risk (Cohen & Scheeringa, 2009).

Within Indigenous cultures, storytelling plays a role for community, identity, and self, as Indigenous ways of knowing are taught and learned through storytelling and sharing circles, which noted as being “fluid and experiential, thus adaptable over time” (Senehi et al., 2009, p. 318). Importantly, storytelling is reflective of oral traditions which are essential for Indigenous existence and connections to self, ancestors, and generations to come (Sium & Ritskes, 2013; Lavallee & Poole, 2010). Indigenous scholars have noted that the power of narratives for healing has proven successful in terms of disrupting the transmission of intergenerational trauma as narratives promote the reclamation of knowledge, which is highly conducive for healing (Beltrán & Begun, 2014). However, Calabrese (2008) indicated that for narratives to be meaningful, narratives must be tailored to the individual patient’s life history. Therefore, therapists must use a nondirective approach while working collaboratively and drawing upon significant narratives. Similarly, in *Decolonizing Trauma Work*, Dr. Renee Linklater (2014) emphasized the significance of “talk therapy” which entails “going back into the past of their memories, their childhood, of what they recall and just have them tell their story” (p. 146). Thus, talk therapy permits the practitioner to help the client where they get stuck and assists with reconnecting to their memory while integrating cultural approaches as this positively aides with clarifying individual experiences (Linklater, 2014).

Although the process of healing and recovery is illustrated as a painful journey, particularly concerning the historical impacts and experiences of Indigenous peoples, it is highly suggested that the integration of storytelling and narratives within therapy is perceived as extremely powerful and meaningful. Storytelling gives voice to individual experiences (Sium &

Ritskes, 2013). Essentially, Leyva (2003) noted “for indigenous communities, confronting the effects of trauma through storytelling/re-telling is an emancipatory process that can lead to spiritual, psychological and eventually physical liberation” (p. 192). Likewise, narratives allow individuals to reframe their life experiences in ways that demonstrate cultural and social contingency as this process is led by the individual, thus, placing personal responsibility on the client. Wesley-Esquimaux (2009) indicated “narratives promote individual responsibility to become healed rather than focussing on being perpetually victimized (or perhaps being in a perpetual state of healing)” (p. 26). Further, Kirmayer et al. (2014) noted that “the processes of healing in clinical interventions include narrating suppressed or inchoate experiences, to give it form” (p. 312), highlighting this also provides a construct and a way to enter into individual stories of suffering, to locate causes, ascribe responsibility while valorizing personal struggle (Kirmayer et al., 2014).

Storytelling can be recognized as a vital tool within therapy concerning the integration of Indigenous frameworks within practice, specifically trauma-focused therapy. This method allows individuals to acknowledge, understand, and process traumatic experiences while making connections to self, which is essential for recovery and healing. As an Indigenous practitioner, storytelling would be a fundamental and beneficial framework to implement within practice as it would promote meaningful dialogue while exploring and learning about client strengths. Storytelling provides validation and empowerment, which are fundamental for decolonizing trauma work as this allows the client to direct the therapy, which can be perceived as utilizing a power with approach. Sium and Ritskes (2013) noted: “stories are open-ended processes for speaking reclamation and resurgence, dialogue and contestation, they are part of a cycle of renewal and recreation” (p. 6).

Integrating an Indigenous Modality within Eye Movement Desensitization and Reprocessing (EMDR)

Although EMDR has received more empirical research than any other new therapies (Hase et al., 2017), and is referred to as the new method of treatment for psychological trauma (Boudewyns & Hyer, 1996), and is superior in treating PTSD (Kar, 2011), much controversy exists concerning its efficacy. Importantly, research concerning the applicability of EMDR amongst Indigenous peoples is noted as limited; therefore, questioning its credibility concerning cross-cultural competency (Gray & Rose, 2012). EMDR is highly grounded on the Adaptive Information Processing (AIP) model (Shapiro & Maxfield, 2002), which is central to practice (Hase et al., 2017), as AIP strongly focuses on emotional and cognitive experiences. Moreover, it is highly suggested that EMDR be ethically utilized by licensed mental health professionals or that interns be supervised by EMDR-trained clinicians due to its complexity and intense therapy sessions (Parnell, 1996).

Given that EMDR is highly based on the therapist's skillsets, Mr. Tremblay did identify he received extensive training and is specialized in EDMR therapy. Arguably, EMDR is most effective for treating single-event traumas and is highly suggested that prior to utilizing EMDR within therapy, individuals who have experienced multi-layered trauma must also be cleared for symptom relief (Parnell, 1996). Mr. Tremblay noted that EMDR is only used within session, given that the client is ready and motivated to change, and importantly if the client has participated in previous healing as the optimum success of EMDR is highly contingent on the client's willingness to change and openness to experiencing uncomfortable feelings and disturbing thoughts (Parnell, 1996). Essentially, limitations that exists with the use of EMDR can be relative to, but not limited to the therapist's skill and experience, which includes their level of

training and experience, the extent of practice, and that EMDR may not be the treatment of choice in most cases, specifically treating complex trauma (Parnell, 1996).

While EMDR therapy is one of the most widely used and preferred therapy of choice for treating mental health issues such as PTSD (Holstead & Dalton, 2016; Kar, 2011), it is noted that within EMDR, bilateral stimulation is key where the therapist will move his/her fingers in front of a client from side to side. While doing so, the client is directed to watch the therapist's fingers while he/she is encouraged to visualize a memory in relation to their trauma, thus, allowing the emotions to flow through, which promotes desensitization (Deville, 2002; Boudewyns & Hyer, 1996). Given that Mr. Tremblay adopted a Westernized approach to therapy, his mode of bilateral stimulation within therapy involved the use of auditory equipment, which proved effective during observational study. However, it is noted that the use of waving a hand (fingers) may be perceived as threatening (negative association) as Indigenous peoples have experienced a great deal of abuse and tyranny from a hegemonic context such as residential schools, which can re-victimize or make the client feel vulnerable (Gray & Rose, 2012). Therefore, an Indigenous practice within mainstream therapy such as EMDR may include the use of a prayer feather as this allows the client to focus on something that represents a cultural and spiritual aspect while promoting cultural competency within practice (Gray & Rose, 2012).

Despite my learning experience and exposure to EMDR within a clinical setting being brief, my observational learning fostered the ability to understand the core principles of EMDR within therapy. The core principle of EMDR is diffusing adverse thought patterns and feelings associated with trauma which is highly contingent on the use of rapid and rhythmic eye movements while instilling positive experiences which fosters future adaptive behaviours (Shapiro & Maxfield, 2002). As noted earlier, this process is highly dependent on the therapist's

skillsets. During observation, when EMDR was initiated, Mr. Tremblay was able to direct and successfully guide the individual within therapy, particularly during difficult memory and thought processes as grounding techniques were initiated during session while instilling positive thought patterns.

During sessions, I did observe the opportunity for other modalities of grounding techniques such as smudging which could have proved beneficial as a resource tool within EMDR therapy. Smudging provides a form of cleansing, and more importantly grounding, where traditional medicines such as sweetgrass, cedar, sage, and tobacco are burned for purification while allowing the individual to connect spiritually (Beaulieu, 2011). Essentially, smudging permits individuals an opportunity to release negative energy/thoughts which in many ways can be empowering and emancipating while grounding the individual.

Overall, given that I prepared and reviewed numerous peer-reviewed literature articles pertaining to EMDR (Hase et al., 2017; Devilly, 2002; Shapiro & Maxfield, 2002; Parnell, 1996; Shapiro, 1995) and how it works within therapy, and given I had the opportunity to observe EMDR conducted within sessions, I still felt reluctant concerning its use with Indigenous people. However, Mr. Tremblay noted that EMDR takes a great deal of training in order to confidently execute its applications within therapy, which is consistent with Parnell (1995) who noted this as crucial to the success of EMDR within treatment. Thus, Mr. Tremblay encouraged that if any opportunities presented themselves in the future regarding training specific to EMDR, it was strongly suggested that I invest my time and willingness to advance my clinical skill in this area.

Integrating an Indigenous Modality within Group Therapy/Social Group Work

Group therapy is described as a form of psychotherapy, which has proved efficacious for treating trauma survivors (Foy et al., 2001). Importantly, Mendelson et al (2007) highlighted that “group therapy counteracts the isolating effects of interpersonal trauma which enables survivors to connect with sources of resilience within themselves and others” (p. 227). Knowing the histories of Indigenous people and the impacts of colonization on Indigenous wellbeing, Indigenous scholars have referred these experiences as “historical trauma” (; Bombay et al, 2009; Yellow Horse Brave-Heart, 2003; 1998), as previously discussed in this thesis report. Historical trauma was defined as “cumulative, emotional, and psychological wounding over the lifespan and across generations” (Yellow Horse Brave-Heart, 2003, p. 7). Essentially, this framework assisted me in understanding intergenerational traumatology and more significantly its effects on Indigenous wellbeing (Evans-Campbell, 2008).

Arguably, overcoming collective trauma requires collective recovery (King et al., 2017), which must be highly rooted within cultural and holistic healing practices such as talking and/or sharing circles as the circle promotes communal sharing of experiences (Lavallee & Poole, 2010). Thus, sharing circles posit collective healing as they emanate long-standing Indigenous methodology and practices (Lavallee & Poole, 2010). Similarly, Dionne and Nixon (2014) illustrated that for Indigenous healing to occur, healing also entails social inclusion, which is fundamental for attaining Indigenous wellness. Within placement, Mr. Tremblay provided group therapy for residential school survivors through the Indian Residential School program, which consisted of no more than eight participants as this ensured group cohesion and trust amongst members. Also, the Assembly of First Nations (1994) noted that individual/communal healing begins with allowing residential school survivors to tell their stories (Dionne & Nixon, 2014). Dionne and Nixon (2014) indicated “telling their stories gives them permission to become

emotionally unencumbered; it is in this acknowledgement that the freedom from oppression and healing begins” (p. 338).

Importantly, sharing circles demonstrate empowerment and self-determination by providing a non-judgemental and uniform environment (Dionne & Nixon, 2014; Lavallee & Poole, 2010). As previously highlighted, sharing circles must be led by experienced conductors as the effectiveness of the group is contingent on the conductor’s skill (Hart, 2002). Also, in his book, *Seeking Mino-Pimatisiwan*, Hart (2002) indicated that sharing circles are perceived as a ceremonial practice within Indigenous populations, which should only be conducted by those trained in overseeing such approach to healing, usually knowledge keepers and/or Elders. Also, Linklater (2014) noted the importance of connecting with Indigenous knowledge keepers and resources within one’s community is equally significant for providing clients with options, specifically Indigenous modalities within treatment.

Essentially, group therapy is noted as cost-effective and efficacious, however, group therapy is highly dependent on the skills of the facilitator (Papell, 2015), as non-skilled facilitators can diminish group processes, thus, creating harm (Shulman, 1999). Within social group work practice, it is indicated that a group consists of individuals who share the same commonality-issue (Papell, 2015), which highly assists with making sense of one’s experiences, however, with the benefit of collective support (Yalom & Blake, 1999). Thus, the integration of sharing circles within group therapy would effectively promote a cultural approach to therapy.

Parenting Group Pilot Project and Presenting Themes

The parenting group pilot project was initiated as an integral learning component in conjunction with my observational learning of the mentioned theoretical models (as discussed in

Chapter 1) while completing the Advanced Practicum. Prior to initiating and launching this project, a proposal outlining its anticipated goal was prepared and presented to the Advanced Practicum Committee for approval. As a student on placement, the parenting group initiative also offered an opportunity for experiential learning concerning group processes. This project was achieved in partnership with Kunuwanimano Child Family Services (CFS). The aim of this project was to provide a service to clients accessing services through Kunuwanimano CFS, primarily families who had an open protection file. Overall, the parenting group pilot project sought to fill a gap in services pertaining to Indigenous led parenting support groups offered within Timmins and area. As noted earlier, child, family, and community resiliency are symbiotic, which are highly dependent on cultural and holistic approaches to healing (Blackstock & Trocmé, 2005).

As discussed in Chapter 2, the project entailed integrating various Indigenous theories within the parenting group pilot project, which facilitated constructing a conceptual framework while building groundwork concerning participants' knowledge of intergenerational trauma. Importantly, as previously highlighted the goal was to foster learning on the residual impacts of intergenerational trauma at individual, familial, and communal levels. This was fundamental for nurturing self-awareness and education relational to contemporary parenting practices. Moreover, the project sought to foster connections to the Indigenous culture and its significance to individual healing while cultivating an environment conducive for experiential learning amongst participants. Overall, the objective was to increase participants' awareness while enhancing their parenting skills.

Although the parenting group pilot project did not emanate the results that I expected or envisioned, it truly was a good learning experience in terms of understanding the difficulties

entailed with group processes. Next, I will discuss the presenting themes individually that I felt impeded on the success of the parenting group project. Prior to formulating the presenting themes, Mr. Tremblay and I debriefed and thoroughly discussed factors that we felt contributed to diminishing the group. Thus, the following themes adversely affected the success of the parenting group pilot project: environment, lack of support demonstrated from staff and management, and inconsistent cohesion of the group, which I will discuss, beginning with the environment. Also, I think it is important to emphasize that committing to an eight-week parenting group session demonstrated a challenge for participants, therefore, committing to a short-term group perhaps would encourage attendance, therefore, fostering group success.

Environment

One of the limitations contributing to the success of the parenting group pilot project was the planned environment, which we felt played a pivotal role in determining its success. The groups were conducted within Kunuwanimano CFS on a weekly basis, which we felt may have initially infused negative emotions amongst participants at its starting point. Mr. Tremblay noted that Children's Aid Society (CAS) workers are inevitably perceived as "agents of control", which naturally instills negative reactions, specifically amongst Indigenous families. These inherent reactions (mistrust) are profoundly correlated to the historical impacts inflicted by mainstream child welfare agencies such as the intergenerational effects of the sixties scoop (Bombay et al., 2009; Blackstock & Trocmé, 2005).

Consequently, during scheduled group meetings, the group experienced numerous disruptions as child welfare workers were observed entering the family room unexpectedly, despite notifications being posted and verbal dissemination provided beforehand. Hence, these interruptions created disharmony as participants expressed that they felt unsafe, vulnerable, and

in a sense, intimidated. Paquin, Miles, and Kivlighan (2011) illustrated when group members feel vulnerable the likelihood of a member returning to the group is interrupted, thus, impacting attendance and group cohesion. Essentially, these interruptions generated resistance and deterred meaningful dialogues to occur amongst participants. Given that environments need to be safe and that the anonymity of participants is vital, environments such as child welfare agencies are positioned as highly controlled environments, thus, instilling feelings of uneasiness. Linhorst (2002) indicated ethical issues that may arise when conducting groups including “the location of the setting, particularly when dealing with highly sensitive topics” (p. 219). Similarly, with group work the concept of structure must also be considered as Papell (2015) indicated “the concept of structure may seem less vital to us, though we ought to be quite well grounded in system as metaphor for perceiving the environment of the persons with whom we are working” (p. 245).

Due to these voiced concerns, it was suggested that the remainder of the parenting groups be conducted within Tremblay Counselling Services, which was located down the hallway from Kunuwanimano CFS. Mr. Tremblay and I felt the proposed new location would provide a safer environment conducive for participation and open sharing, and more so it would eliminate feelings of powerlessness amongst participants. Thus, going forward, Mr. Tremblay strongly suggested for future learning, if I or the Agency planned to initiate future parenting groups that the location would need to be situated elsewhere other than hosting groups within the Agency. Hence, conducting groups outside of Agency would ensure that clients felt safer, thus, creating cohesion, which is essential for successful group processes.

Lack of Support Demonstrated from Staff/Management

Given that child welfare is extremely demanding and challenging as a student on placement and working part-time as a child protection worker with Kunuwanimano CFS, another limitation that I felt contributed to the diminished group was the lack of support demonstrated by the staff. Despite that the prospective parenting group was much approved by upper management, I also felt that management demonstrated lack of support as the promotion of the parenting group pilot project was not properly disseminated to staff and service users alike. As a student on placement, this project was allocated to management and staff well in advance prior to initiating the group, however, we felt the project was not well received despite its aim. Also, families who have an open protection file are in most cases obligated to participate in parenting classes, specifically when their lack of parenting capacities place their children at risk of harm.

For future learning, some areas for improvement might include taking essential steps that would ensure that everyone involved is accountable regarding roles and responsibilities. For example, perhaps drafting protocols and procedures with administrators would have been ideal as this could have possibly contributed to a more successful outcome as they might have been more supportive if they had input into the process. Also, providing copies of such protocols to management bodies and administrative staff would ensure accountability, which would hold those responsible to their role concerning projects or assignments overseen by future placement students. Overall, perhaps these steps would ensure that projected assignments have an opportunity to be successful while benefiting the Agency or projected audience.

Inconsistent Cohesion

Throughout the progression of the parenting group project, potential participants were referred on an inconsistent basis by their assigned workers, which created unpredictability. Thus, this unpredictability impacted group cohesion. At one point, Mr. Tremblay had made it

clear to staff that in order to build and ensure group cohesion, referrals from Kunuwanimano CFS staff needed to discontinue, so that the established group could adequately proceed. Yalom (1995) indicated that for group work to be successful, the therapist must create and maintain the group while building group culture and norms of behaviours. Perhaps earlier within sessions, Mr. Tremblay or I could have inquired if the suggested timeframe (Tuesdays 12:00 PM – 2:00 PM) worked well for group participants. By obtaining feedback, modifying the group sessions based on client availability could have possibly fostered group cohesion and increased attendance, therefore, resulting in a successful outcome.

On December 12th, 2017, Mr. Tremblay decided to proceed with the group we had initially established, which comprised of six original group members, with eight in total. From this point, we were able to effectively develop group cohesion while ensuring that group participants felt comfortable and safe amongst each other for the purpose of establishing and building trust amongst members. The group met accordingly as outlined within group rules and expectations, which was on a weekly basis. With the established group, Mr. Tremblay and I discussed amongst participants what group sessions would look like in terms of learning objectives and goals. Mr. Tremblay and I reviewed and discussed the theories which would be implemented within each session, in which PowerPoint presentations would be provided. It was indicated that particular theories that would be applied within the groups would generate and act as guiding tools for creating a space for learning while fostering self-awareness. These included the effects of intergenerational trauma and its impacts on individual and/or community wellbeing, also understanding codependency. All theories were pertinent for framing a conceptual framework relational to an Indigenous approach to learning as the aim was to foster connections to the Indigenous culture and its importance to and restoring wellness.

Given that group cohesion is highly dependent on unity (Yalom, 1995), an area that Mr. Tremblay and I should have considered was the significance of setting a deadline regarding referrals concerning potential participants. Ideally, a projected deadline for referrals should have been set as this could have ensured group cohesion while ensuring the success of the parenting group altogether.

Based on the outcome, some factors that may have contributed to group cohesion and group attrition might have included the length of the group sessions as this might have influenced each member's ability to fully commit to the group. Perhaps, some members experience time management issues which might have created difficulties attending groups during the proposed time frame. Also, members may have experienced life issues as this was made clear to me after completion of my placement. Since Timmins is a small community, on a couple of occasions after work hours I had come across previous group members within public facilities who voiced they had to drop out due to a life event occurring which interrupted their ability to attend the group to its projected end date. Therefore, being mindful that possible factors can arise during group processes can affect attrition of the group, however, exploring ways to retain the group earlier in its stage may decrease attrition and enhance group success.

Some areas that could be modified for future learning concerning group processes and group attrition would be obtaining feedback from participants as this would promote a sense of cohesion in terms of what works best for participants based on individual needs. Perhaps it would have been a good idea to initiate discussions around what participants envision the group to be, and what they would like to learn from the group in terms of learning experiences which would increase motivation amongst members. Also, as a facilitator, it might be helpful to consider that not all members of the group are ready to make the effort to change and grow.

Summary

Given that it is well documented that Indigenous healing practices and ways of knowing implemented within therapy create positive pathways to attaining wellness (Linklater, 2014; Gone 2013; Nabigon & Nabigon, 2012; Lavalley & Poole, 2010), it is argued that Indigenous practices must be practiced and maintained (Linklater, 2014; Robbins & Dewar, 2011). Essentially, for healing to occur within Indigenous communities, this requires collective recovery from trauma as social inclusion is highly suggested for strengthening ethnocultural identity, as opposed to treating individuals in isolation (Dionne & Nixon, 2014). Importantly, a historical trauma lens provides a framework for understanding the impacts on health disparities concerning Indigenous peoples, which is imperative for understanding the injustices and cumulative effects on individual, familial, and community wellbeing (Linklater, 2014; Yellow Horse Brave-Heart, 2003). Thus, decolonizing trauma work involves a collective framework for healing from traumatic experiences endured by Indigenous peoples as this promotes individual healing while fostering Indigenous sovereignty on what constitutes wellness (Linklater, 2014).

The parenting group project truly enhanced my knowledge concerning the difficulties associated with group processes and ethical dilemmas that may arise during group cohesion. Prior to placement, I had minimal experience with conducting groups; however, my experience was more from a co-facilitator lens. Essentially, this experience created a transformation in terms of acknowledging that the profession of social work involves much more than one on one work, as its realm of practice involves a wider context. The field of social work varies and its practice is not linear as social work encompasses a wide range of meaningful and purposeful work, which in many instances can be rewarding, despite desired outcomes. Although the parenting group project did not illuminate the results that I anticipated or had initially hoped for, the experience

was constructive in terms of learning and building my skillsets concerning group processes. Importantly, the Advanced Practicum experience truly enhanced my personal and professional growth as the opportunity to reflect during placement was conducted on an on-going basis, which has nurtured and fostered self-awareness while shaping my professional identity.

All these learning components were abundant and imperative to my Advanced Practicum experience as these experiences facilitated fostering my personal and professional development. Importantly, throughout the duration of my placement, the concept of critical reflection acted as an integral and central component to instilling ethical practice while providing a framework for understanding myself in the context of helper. In *Decolonizing Trauma Work*, Dr. Renee Linklater (2014) discussed the importance of self-reflection, indicating she had immersed herself within this process prior to writing her book, as she expressed this was fundamental for grasping a genuine understanding of historical trauma and its implications to helping others.

Implications for Social Work Practice

The primary learning objective of the Advanced Practicum was to critique the applicability of the following theories: cognitive behaviour therapy (CBT), trauma-focused cognitive behaviour therapy (TF-CBT), eye movement desensitization and reprocessing therapy (EMDR), and group and/or social group work therapy, while reflecting on how I could integrate an Indigenous framework within my practice approach. To enrich my knowledge and enhance my learning, I had engaged in reviewing peer-reviewed literature pertaining to the theoretical models utilized within Tremblay Counselling prior to commencing my placement. I participated in an Advanced Practicum from October 23, 2017 to March 6, 2018, completing 450 hours in the field. As part of my placement, a parenting group pilot project was also initiated, which fully aligned with the learning objectives outlined within the MSW Handbook. Given my placement was twofold, observing and reflecting on the applicability of the mentioned theories and initiating a parenting group pilot project, I will discuss the implications of my experiences concerning the Advanced Practicum in general.

First, I chose to complete an Advanced Practicum as I sought to build, enhance, and strengthen my clinical skillsets regarding the mentioned theories. Although I was mainly shadowing and observing clinical sessions due to the sensitivity of reporting processes with Non-Insured Health Benefits (NIHB), this learning process offered an enriching experience. Through observation I discovered that ethical social work practice is highly contingent on modification and tailoring of theories, as we cannot assume what works well for one individual works well for others (Hobson, 2012). Additionally, prior to integrating Indigenous modalities within therapy, practitioners should openly explore and offer options when deemed appropriate as Indigenous worldviews differ, depending on nation and culture. Importantly, if the practitioner is not

qualified, it is suggested that connecting clients to services would be best practice, and more so this process should be essentially instigated by the client (Oulanova & Moodley, 2010).

Generally, as practitioners we must acknowledge the importance of Indigenous peoples' perspectives and worldviews, and also be receptive and understanding of individual preferences concerning therapeutic modalities within treatment (Linklater, 2014). Overall, best practice would include taking into consideration that different worldviews exist within the Indigenous culture; therefore, as practitioners we must willingly examine individual worldviews prior to integrating Indigenous modalities within treatment (Hart, 2002).

Importantly, cultural competency also plays a pivotal role in the delivery of culturally safe and congruent interventions within practice as this creates a space for receptiveness and allows practitioners to reflect on the significance of culture within therapy. Essentially, this promotes and fosters empowerment, autonomy, and respect (Bennett et al., 2011) rather than pathologizing the individual, which is essential for attaining healing and wellness amongst Indigenous populations (Linklater, 2014). Indigenous healing also entails community involvement as opposed to treating individuals in isolation, as this promotes and instils ethnocultural identity (Dionne & Nixon, 2014). Obtaining a genuine understanding of the concept of historical trauma is vital when working with Indigenous populations as this provides a conceptual framework in understanding how trauma impacts an individual at all levels (emotional, physical, mental, spiritual). Importantly, understanding the neurological impacts of trauma on the human brain is also essential in grasping an understanding of how trauma can result in psychosocial ills and adversities later in life. If left untreated, trauma could have detrimental effects on an individual's wellbeing and social functioning altogether.

Given my placement was conducted within a private practice, the learning that I received from Mr. Tremblay was abundant and practical. This experience truly fostered and cultivated personal and professional growth, which aided in shaping my identity as an Indigenous social worker in the field. Since Mr. Tremblay works independently, one observation and question I had prompted to Mr. Tremblay was, if he had the opportunity for his own supervision and debriefing, which are both essential for self-care and continued growth. Lack of supervision may have implications for one's social work practice. Mr. Tremblay shared that he had many mentors in the community who he often sought guidance from, as this provided the opportunity to debrief and reflect on issues that arose during practice, which he noted was fundamental for his wellbeing. Also, it was shared that disclosing to his mentors genuinely provided an opportunity for grounding as he noted this was integral to his practice and was essential for fostering ethical social work practice while ensuring he upheld his responsibilities. In his book, *Indigenous healing: Exploring traditional paths*, Ross (2014) discussed the importance of being a healthy worker and acknowledging our responsibilities as helpers, which is a key component to ethical practice.

Critical reflection and supervision truly aided in developing and enhancing my growth as a student practitioner as it provided the opportunity to soundly critique, unpack, and delve into my own biases, which is essential for unearthing our identities as practitioners while being cognizant of our privileges (Nadan & Stark, 2016). This is profoundly significant when working amongst vulnerable populations such as Indigenous people as understanding power relations promotes meaningful practice that is genuinely ethical. Essentially, understanding power relations aids with grasping how dominant epistemologies have undermined and continue to dismantle Indigenous ways of knowing (Goodkind et al., 2015). Indigenous healing practices

have been well documented for promoting wellness (Linklater, 2014; Nabigon & Nabigon, 2012; Lavallee & Poole, 2010), which aids in creating modalities that truly support individual autonomy. This framework is essential for understanding the injustices and cumulative impacts affecting Indigenous wellness (Yellow Horse Brave-Heart, 2003). Thus, as practitioners if we do not educate ourselves and embark in reflection, this can truly impede and create implications to social work practice, which can generate more harm and dismantle working relationships.

Supervision allows for debriefing while providing support, which fosters empowerment. I am truly grateful that Mr. Tremblay provided supervision that was constructive, insightful, and consistent as I felt this learning was soundly important in shaping my professional identity. I am also grateful that Mr. Tremblay implemented a trauma-informed lens within supervision as this concept was significant to my learning. Given that a majority of Tremblay Counselling clientele were Residential School survivors, trauma-informed practice was essential to my learning as this provided a conceptual framework for understanding the importance of trauma informed care while recognizing the neurological impacts of trauma. Importantly, the supervision process allowed for reflection to occur, which fostered personal and professional development.

Second, despite that the parenting group pilot project did not lead to the results I had envisioned or hoped, this experience was truly insightful concerning group facilitation and group processes. Some recommendations that could have potentially increased the success of the parenting group project could have included: (1) Breaking groups into segments, (2) Conducting drop-in groups, and (3) Providing participants with an honorarium to acknowledge their participation, which I will briefly discuss next.

Breaking groups into segments might have included implementing a more shorter-term commitment, such as having participants attend four groups rather eight in total as the original

plan included implementing eight parenting group sessions. Perhaps, this suggestion could have fostered and minimized feelings of feeling overwhelmed amongst participants, which I feel somewhat contributed to the lack of participation demonstrated by participants. Thus, with a short-term commitment this could have possibly increased participation while transitioning the focus from being less of an obligation. Overall, perhaps this suggestion could have shifted participants' mindsets regarding the group as this may have fostered perceiving the group project as a learning opportunity rather a task enforced by Children's Aid Societies. Conducting drop-in groups may have also increased participation as this could have provided participants an opportunity to decide what sessions were relevant to their learning experience while fostering the right to make informed decisions, which is essential for cultivating client autonomy. Importantly, this would promote power within while nurturing empowerment and fostering autonomy as child welfare is deemed as embodying privilege and power over. Thus, providing clients with options could emanate a sense of power rather than feelings of powerlessness. Finally, providing participants with honorariums could have also enhanced participation altogether as this practice would be an opportunity to acknowledge their participation while valuing their contribution to the group.

Conclusion

Given that Indigenous methodologies have proven successful for attaining Indigenous wellness, it is strongly recommended that increased research concerning the continued development and evaluation of healing interventions within treatment also be conducted (Brave Heart et al., 2011). Further, decolonizing trauma work involves the ability to acknowledge the importance of culture within treatment while ensuring that the service user has options concerning his/her treatment plan. Importantly, creating partnerships and collaborating with

various Indigenous knowledge keepers, Elders, Indigenous agencies within one's community is soundly significant as referring clients to ceremonial and cultural resources is paramount to their healing journey (Linklater, 2014).

As an Indigenous practitioner, this experience has truly advanced my learning concerning the need for resurgence of culturally relevant and congruent interventions, specifically from a northern context. With reflection, this truly provided the opportunity to delve into my professional interests concerning mental health and the need to provide viable options to clients as this promotes autonomy, which is central to ethical practice. Additionally, mental health amongst Indigenous populations is exceedingly over-represented, which has been correlated to historical impacts and lack of cultural resources within contemporary practice. Thus, this self-awareness has sparked a new-found and meaningful learning within myself, essentially the importance of reconnecting to culture as culture instils identity and sense of being, which are essential for shaping who we are as individuals and importantly our connections to one's self. Essentially, to immerse oneself in his/her culture, truly ignites and instils a sense of self, which is fundamental for wellbeing (Linklater, 2014).

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APPENDICES

APPENDIX A – Confidentiality Form



Tremblay Counselling Timmins

38 Pine Street South, Unit 110
Timmins, ON P4N 6K6

www.tremblaycounselling.com

**CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT STUDENT FIELD
PLACEMENT – TREMBLAY COUNSELLING TIMMINS**

1) I _____, a student completing a field placement at Tremblay Counselling (“field placement”), acknowledge that during my field placement I may have access to sensitive and confidential information which is discussed, created or owned by Tremblay Counselling. Such sensitive and confidential information may be accessed or received in the form of conversations, counselling sessions, electronic documents, computer files, emails or other forms of record keeping. As a condition precedent to the commencement of my placement and the receiving/accessing of such sensitive and confidential information I agree to the following:

- (a) I will hold all information received during my field placement as sensitive and confidential. I will hold such information in the strictest confidence and exercise reasonable care to maintain the confidentiality of such information;
- (b) I will not use, copy, transmit, reproduce, summarize, quote, or otherwise use any sensitive or confidential information or my recollections of such information;
- (c) I will not disclose sensitive or confidential information to any person except as directed and authorized by my field placement supervisor at the Tremblay Counselling;
- (d) I will limit my access to sensitive or confidential information to the extent necessary to perform in my field placement at Tremblay Counselling;
- (e) I will not permit unauthorized access to sensitive or confidential information.

Confidentiality & Non-Disclosure Agreement After Completion of Placement

- 2) I acknowledge that the restrictions on use and disclosure of sensitive and confidential information as outlined above in this agreement will remain in effect following completion of my field placement, and indefinitely thereafter.
- 3) I acknowledge that failure to comply with this confidentiality requirement can and may result in termination of my field placement with Tremblay Counselling and/or personal liability.

I have read and fully understand this agreement between the placement student and Tremblay Counselling:

Signature of Student

Signature

Print name of Student

Print name

College/University/School Attending

Title

Date

Date

APPENDIX B: Parenting Group Information Pamphlet

“The knowledge of First Nations traditional and contemporary approaches to raising children and youth and their understanding of their own family dynamics lies within First Nations”
 (Stairs & Bernhard, 2002)

**Tremblay
Counselling
Services**



**101 Mall, 38 Pine Street North
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Parenting

Although parenting can be one of life’s happiest and most rewarding experiences, everyone goes through stress, hassles and demands that make life as a parent sometimes overwhelming.
 The stress of caring for kids can sometimes make parents angry, anxious and stressed. While this is a normal fact of life, parents do need to learn coping mechanisms so that they don’t feel overwhelmed by their role as a parent.
 Children need have a balanced environment in order to grow up as well rounded, secure individual.



Tremblay Counselling will be offering parenting classes to eligible Kunuwanimano CFS clients.

What Parenting Classes Will Offer

Participants will learn different theories and how to integrate these learnings into culturally positive parenting practices. As well, participants will learn the importance of historical trauma concerning First Nations population and its effect on Aboriginal families. Knowledge will draw from some of the following psychological theories:

- Attachment Theory
- Social Learning Theory
- Western Parenting Styles
- Traditional Aboriginal Family Theory
- Intergenerational Trauma
- Sensorimotor Psychotherapy

The Format Will Include:

- Group Processes
- Sharing/Talking Circles
- Narrative Therapy
- Storytelling

Eligibility for Parenting Groups
 Tremblay Counselling offers services through Non-Insured Health Benefits – Indian Residential School and Health Support Program or other insurance providers.

If you, your parents or extended family members are survivors of the Indian Residential School era, you may qualify for services.

To Register for the Upcoming Parenting Classes, Participants May:

- Contact Micheal at 705-268-7162

Services are offered within a safe, comfortable and relaxing environment.