

**The Pisimweyapiy Counselling Centre:
Paving the Red Road to Wellness in Northern Manitoba**

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Introduction

The Pisimweyapiy Counselling Centre (PCC), originally funded as a one-year pilot project by the Aboriginal Healing Foundation (AHF) in 2000,¹ is one of three programs administered by the Nelson House Medicine Lodge, a regional substance abuse treatment centre located on the Nisichawayasihk Cree Nation (NCN) in Nelson House, Manitoba. Designed to round out the continuum of care provided by the Medicine Lodge, the PCC is characterized as an outpatient/residential school program that has evolved in structure and function during its five years of funding by the AHF. According to the published brochure that is distributed by the Medicine Lodge to advertise the PCC, the program's mission is to "Promote and enhance wholistic healing of residential school impacts on Nisichawayasihk utilizing traditional and contemporary practices."

An elaboration of this description submitted to the AHF as part of the PCC's renewal application summarizes the purpose of the program:

The Pisimweyapiy Counselling Center is a community-based, nine (9) week, two phase outpatient counselling service. It offers services both in the Cree and English languages. The program will admit a new intake of program participants every 10 weeks. It entails individual and family therapy plus structured group sessions designed to normalize, universalize and depathologize the program participants' negative life experiences symptomatic of the residential school syndrome. The service will assist in addressing unresolved and often untreated grief characteristic of posttraumatic stress disorder.

In addition, the stated goals of the PCC are threefold:

- (a) A resourceful community healing place that maintains our Cree language, culture and spirituality.
- (b) To provide direct purposefully designed culturally appropriate community therapeutic support services.
- (c) To provide an integrated and holistic therapeutic approach to healing and wellness for individuals, families and the community utilizing western and aboriginal practices.

Finally, PCC program efforts were expected to achieve concrete outcomes:

[T]o have the program operate to its full capacity ... [with] 15 individual participants and/or their families per intake ... [To supplant] unhealthy survival patterns ... with life empowering behaviours ... [To provide] participants ... [with] an expanding network of support ... capable of responding to survivors' needs borne of the residential school legacy.

Probably no better introduction to the community-based therapeutic activities of the PCC—named for the rainbow and its inspiration of hope—might be provided at the outset of this report than a few summary descriptions offered by its staff:

We see ourselves as paving the Red Road to wellness. The imagery is significant. Paving the Red Road might be regarded by many people as heresy. "You're messing with age-old customs.

¹ The PCC was originally named as the Nisichawayasihk Healing and Wellness Program, but changed its name in 2002.

You're revamping age-old processes that have demonstrated their utility over the years." But in my humble opinion, the reason ... why our people have left in droves from the Red Road, [is] because it's hard. It's a hard way of life. It is really difficult to be an Indian. That coupled with the presumed mysticism of the Indian way of life. So paving the Red Road speaks of an attempt to demystify Indigenous processes and make it a lot easier to grapple with this monster called identity (Administrator).

I try to make people understand about the Medicine Wheel concept ... It's a philosophy. It's not something that you can carry around with you in your pocket. And ... you can use that concept ... You can use those teachings in every aspect of your life because it includes the whole universe. In the whole universe, we are but a speck of that whole universe, but we are interrelated, and we are part of that whole universe as we see it (Counsellor).

The red, white, black, and yellow. In the Medicine Wheel, each [of these colors] symbolizes something. There's an animal that sits in each direction, and it symbolizes that love, humility, and whatnot. And then there's a plant [associated with each direction]. So it shows everything is connected and interconnected, that no one is above or below another, that we're all equal, that the human is not more important than the rest of the animals and the elements of the earth. That because everyone is connected and interconnected, that we have to learn how to respect Mother Earth (Administrator).

Given its place within the service ecology of the Medicine Lodge more generally, the PCC focuses upon delivering culturally sensitive programming on an outpatient basis to Aboriginal clients. These clients typically need assistance with a host of personal challenges and difficulties attributed either directly or indirectly to the colonial legacy of Canada's residential school system. As a result, the potential clients of the PCC's holistic therapeutic services were described first as "any Nisichawayasihk member who is a residential school survivor," then as "children of parents who survived the residential school system," and finally "any member of Nisichawayasihk." This latter category was deliberately inclusive of the entire community, principally because all residents of the community were perceived as suffering from the intergenerational impacts of forced assimilation, Aboriginal religious suppression, and disrupted family relations wrought by compulsory residential school experiences. Although clients of the Medicine Lodge's other programs routinely include First Nation individuals—and occasionally a Euro-Canadian—from throughout Western Canada, in fulfilling its mandate as an outpatient program, the PCC was primarily concerned with serving the local needs of the NCN members who live nearby (either on-reserve or perhaps in the adjacent Métis settlement).

The PCC staff was comprised of three full-time counsellors and a program coordinator. During the first three years of the project, the PCC team evidenced remarkable continuity, but prior to the site visit both the program coordinator and a counsellor resigned from their positions. A new program coordinator assumed that position a few months prior to the site visit and a new counsellor was selected within the timeframe summarized by this report. All four staff positions were filled by NCN members. The program coordinator holds a bachelor's degree in social work and has over a decade of experience working in human services with Aboriginal people. She was responsible for the day-to-day management of the PCC program, including staff supervision, program development, activity scheduling, event planning, project reporting, community outreach, and other administrative tasks. In addition, an important part of her charge was to identify alternate funding for the PCC in order to ensure its continuity once the AHF's financial commitment expires. She

reported to the executive director of the Medicine Lodge as well as to the six-member Residential School Advisory Committee (distinct from the Medicine Lodge's board of directors) that provided direction to and accountability for the program.

The counsellors reported a variety of educational experiences, but routine training opportunities offered by the Medicine Lodge to its staff helped to ensure that each counsellor had earned or would be able to earn a certificate in applied counselling (equivalent to six credits of university coursework). One counsellor had worked in higher education for many years before returning to Nelson House, another had worked as a parole officer, and still another had been a cook at the Medicine Lodge before accepting a position as a counsellor-in-training; she later went on to complete her certificate with Medicine Lodge sponsorship. Counsellors were responsible for providing services to clients, including group lectures on weekday evenings, one-on-one therapy sessions as needed or desired, home visits to encourage and support clients, transportation of clients to program activities, and community education and outreach. Counsellors were expected to be flexible in their schedules (within the typical 38-hour workweek) and reported directly to the program coordinator.

Three staff members were themselves residential school Survivors, and one had spent two years in reform school as an adolescent. In terms of age, the youngest was in her early forties and the oldest was in her mid-sixties, with the remainder in their fifties. All had experienced poverty, domestic violence, physical and/or sexual abuse, family disruption, alcohol or other substance dependence, identity confusion, or cultural loss as part of their own life trajectories. All reported remarkable life events that had ultimately placed them on their own healing journey, resulting in abstinence from alcohol or drugs, improved coping skills, greater self-awareness, clearer direction in life, and renewed compassion for others. All but one emphasized the importance of Aboriginal cultural participation as fundamental to their own healing and recovery, and at least two explicitly identified themselves as traditional pipe carriers.

The PCC staff conducted many of their activities within the Medicine Lodge proper, an accomplishment in its own right following a building expansion that permitted the program to relocate its offices from a nearby trailer. Each staff member was furnished with a private office in which to counsel clients, return phone messages, complete paperwork, and so on. A large front room provided space for lectures and other group meetings for staff and clients. The location of these offices within the Medicine Lodge routed PCC clients away from the in-patient or treatment side of the facility, thereby protecting confidentiality and possibly reducing embarrassment or stigma. The building itself is striking in design, with lofty rafters, roomy spaces, countless windows, an open-air terrace, and a group dining area that overlooks the shores of Footprint Lake. As the grassy slope recedes from the Medicine Lodge towards the water's edge, a sweat lodge stands close to the lakeshore, partially hidden from view. Stands of trees adjoin the grounds, lending a pleasant and relaxing, almost retreat-like atmosphere to the surroundings. Nevertheless, a significant portion of the PCC's activities occur elsewhere, whether in various community forums, training conferences, traplines, fasting camps, medicine wheel sites, or the sibling community of South Indian Lake, not to mention routine visits to Thompson, Manitoba, the "Hub of the North," for consultations, celebrations, or supplies.

The Medicine Lodge, established in 1989,² is principally funded by Health Canada and fully accredited by the Canadian Council on Health Services Accreditation. Despite its location in the traditional territory of the NCN, the Medicine Lodge initially operated independently of band authority until interested parties agreed that program responsiveness and accountability was best served if the NCN chief and council appointed the

² For further information, see: www.medicinelodge.ca

Medicine Lodge's five-member board of directors. At the time of the site visit, the Medicine Lodge operated a 21-bed, long-term (17–20 weeks) in-patient, non-medical alcohol and drug rehabilitation program that employed a treatment team of eight individuals; the AHF-funded PCC that employed four individuals; and a National Native Alcohol and Drug Abuse Program (NNADAP)-funded prevention/referral service that employed two individuals. Finally, in addition to the professional staff, the Medicine Lodge also maintained an administrative team as well as other support staff, bringing the total personnel employed by the Medicine Lodge to approximately 25 individuals. With perhaps one or two exceptions, all of these individuals are Cree—the exceptions were First Nation individuals from non-Cree communities—and the majority of them are affiliated with NCN.

The decision by the AHF to fund the PCC was viewed with great excitement within the Medicine Lodge administration, in part, because most Aboriginally oriented substance abuse treatment programs in Canada are apparently unable to provide outpatient services. As a result, the PCC was seen as an important opportunity to develop and modify an outpatient program that could round out the community-based service delivery options beyond the prevention, referral, and in-patient offerings that were already established at the Medicine Lodge. The commitment by PCC staff to advance holistic healing by utilizing traditional and contemporary practices exemplifies the vision and mission statements of the Medicine Lodge more generally:

Vision Statement: Paving the Red Road to Wellness

Mission Statement: Medicine Wheel Firekeepers Empowering Healthy Lifestyles

These statements, officially adopted shortly before the site visit, were deliberately intended to capture the distinctive Aboriginal cultural orientation of services provided by the Medicine Lodge. One administrator elaborated further on the significance of paving the Red Road to wellness:

How are we moving towards the paving of the Red Road to wellness? The mission has been revised to state that we are medicine wheel firekeepers empowering healthy lifestyles. I mean those statements are memorable. They're imbued with the symbolism of our people. The Medicine Wheel takes in everything that we know, have known, and can accommodate what is to be known. The Medicine Wheel is that encompassing. Firekeepers are simply helpers. And that's how we view ourselves as not the keepers of the medicine wheel teachings, but rather the helpers keeping those teachings alive and well and palatable for a growing number of our people.

Much will be written in subsequent sections of this report about the significance of this approach to healing as it is understood and practiced in this setting, but for now the point is simply that the treatment philosophy of the PCC is part and parcel of the Medicine Lodge as a whole.

The Medicine Lodge itself was situated within the broader NCN community and stood as one of several important institutions concerned with the welfare of the NCN's members. NCN is located west of Thompson and northeast of The Pas in northern Manitoba. A paved highway runs from Thompson to within a few kilometers of the reserve, at which point all roads become gravel. The community itself is comprised of nearly 6,000 hectares (nearly 15,000 acres). Several housing clusters consisting of approximately 400 homes in various states of repair organize residential life in the community, and are situated on various points of land that help to outline Footprint Lake. At the time of the site visit, band membership was approximately 5,000

members, with around 2,400 residing at Nelson House and a small number residing in the sibling community of South Indian Lake farther to the north.³ Numerous buildings house the various activities of NCN, including governmental offices, an elementary school, a high school, a police station, an education centre (provides vocational counselling), a local sports arena, a café, a state-of-the-art nursing station (provides round-the-clock care for the elderly and/or disabled), and the stunning Family and Community Wellness Centre. The Wellness Centre was designed to integrate community services under one roof and includes a community meeting hall, a pre-school, a daycare, and most of the band-controlled social service programs. These programs include counselling services for community members provided by resident therapists as well as therapeutic consultations provided by an itinerant psychologist who travels to the community twice per month. PCC counsellors routinely consulted, coordinated, and supported therapists from these other programs as part of their community outreach activities. Finally, several Christian denominations have established churches at NCN as well.

The NCN population was characterized by most respondents as confronting a host of daily challenges. Like many First Nation communities in Canada, the on-reserve population appeared to experience higher poverty, lower employment, and increased prevalence of substance dependence, domestic violence, family intervention, suicide, and black market activity by alcohol bootleggers and drug dealers. Much of this community distress was attributed to the historic impact of the completion of the paved road to Thompson in the late 1960s (rendering the community less remote from the influences of Euro-Canadian society), the flooding of many family hunting and trapping territories by Manitoba Hydro, and, of course, the residential schools, which were estimated to have directly affected about 240 NCN members. The NCN chief and council recognized that economic development was crucial to the future well-being of the community. One contemporary community venture with relevance for this report was the contracting by NCN Human Resources and Development of Mr. Tulshi Sen, “one of the World’s foremost lecturers in the field of home based business development,”⁴ to train 21 community members—including four members of the Medicine Lodge staff—as life skills trainers who could then go on to educate their own people in the habits and abilities best suited for gainful employment and even entrepreneurial leadership.

Methods

The interview guides used in this research were developed by James B. Waldram, with the expectation that the standardized interview format would be adapted to the particular needs of the respective research sites. No formal modifications were necessary in this study, though interview respondents were almost never asked all of the scripted questions owing to the length of their responses to earlier questions and their unavailability for follow-up consultation. This led to a fluid give-and-take during interviews in which relevant information was solicited at appropriate points during the interview, even if the requested information was officially scripted for later in the interview sequence. In addition, routine, unscripted follow-up questions requesting confirmation or clarification of respondent perspectives was typical. All interviews were conducted by the author of this report in private settings, and all interviews were audio recorded, transcribed, and subsequently checked for transcription accuracy prior to analysis.

³ Source: NCN data provided by author.

⁴ For further information see: www.tulshisen.com

The author initially arrived in October of 2003, but due to a family emergency departed the community one week later. He returned a second time in November of 2003 and remained in the community for about three weeks before the approaching Christmas holidays began to interrupt the regular rhythms of service delivery for the PCC program. The author undertook a final site visit in May 2004. One of the difficulties that further complicated time spent in the community was the shortage of lodging at Nelson House proper. Thus, during the 2003 visits to the community, the author lodged in Thompson, requiring a commute of two hours per day just as winter was settling into the region. Fortunately, by the 2004 visit, arrangements had been made to board with an influential family in the community. Such close contact with high-profile community members in itself afforded additional observations and insights about the NCN healing context more generally. Altogether, the author spent a total of seven weeks in northern Manitoba over three visits spanning seven months to complete this study.

Through consultation with Professor Waldram in preparation for this study, it became clear that the process of review for research conducted with human subjects by university institutional review boards (IRB) in the United States was apparently much more bureaucratic and inflexible in comparison to Canadian university norms. For example, proposals to sit in with clients during confidential group sessions at the Medicine Lodge required sustained negotiations in a creative effort to identify a process suited to IRB ethics concerns as well as to study logistics. One result of this and other negotiations was the designation of the research as a program evaluation in the IRB proposal for this study (which enabled some flexibility and open-endedness for research activities that would otherwise have required advance specification in restrictive detail). Unfortunately, documents using this terminology unwittingly and erroneously signalled to the Medicine Lodge staff that the research was more evaluative than descriptive. The significance of any potential evaluation of the PCC was further pressured by the pending discontinuation of AHF funding for the program and the understandable desire within the community for either renewal from the AHF or the procurement of continued funding for the program from other sources.

Efforts to reduce this evaluation anxiety included reassurance that the AHF had already selected the PCC as one of a handful of promising programs to be studied for the purposes of identifying best practices in Aboriginal healing from the residential school legacy. This reassurance, in turn, was interpreted by some as evidence that the PCC was superior to other AHF-funded programs in regard to design, efficacy, administration, and so forth (when in fact several indicators including geographic distribution, type of service setting, and so on were used to select programs for detailed AHF description), thereby perhaps raising expectations that continued funding might be forthcoming. The research was undertaken in the context of performance anxieties and pressures that undoubtedly led staff and clients of the PCC to place their “best foot forward” and celebrate the achievements (while downplaying the limitations) of the program. As a result, access to certain aspects and realities of the program was rendered more difficult. One significant instance of this was the evident staff discomfort (communicated very indirectly) with the author’s plan to routinely observe their evening group lectures. Out of sensitivity for reducing stress in that component of their services for which PCC staff already acknowledged performance anxiety during their interviews, the author limited his observations to an occasional lecture with the most experienced counsellors.

It is important to remember that the site visit occurred within months of a major administrative transition following the resignation of the original PCC program coordinator. The result was an understandable lack of administrative continuity in regard to specific program milestones and institutional memory (e.g., precise summaries of client participation over the years, including the number of clients who recycled through the

program or the exact number of PCC program graduates, was never determined). Furthermore, the site visit coincided with the resignation of an experienced counsellor who had been retained by the program since its inception. As a result, the PCC staff was shorthanded for the 2003 portion of the site visit, though the author was able to glean invaluable insights by observing first-hand the hiring process undertaken to replace this veteran counsellor. Finally, the PCC program entered its fifth and final year of AHF funding during the site visit, which involved to some degree a shift in energy and attention away from the intensive efforts of prior years to recruit clients and engage the community toward securing a sustainable future for the program. Not surprisingly, PCC activities unfolded at a measured pace during most of the site visit, commencing with a staff sharing circle for an hour or two each morning, continuing with on-call, planning, or catch-up activities during the afternoon, and concluding with the group lectures four nights per week after suppertime.

The PCC staff was quite helpful in recruiting clients of the program for study interviews. Owing to the unavailability of personal transportation for many of these individuals, counsellors routinely embarked from the Medicine Lodge in search of respondents who could be persuaded to come in for an interview. Given the interpersonal nature of life in this face-to-face community, most respondents were known (or even related) to the staff (and each other) prior to participation in PCC activities and were perhaps predisposed to participate in the study as a result of these relationships. Generally speaking, while these respondents participated fully and willingly in the interviews, few of them seemed especially comfortable with the endeavour. In addition, interview responses were generally terse, concrete, and lacking in detail. Furthermore, despite the PCC staff's best efforts, client interviews were catch-as-catch-can, yielding a small fraction of respondents from the 162 names entered into the PCC contact database. Thus, formal interviews with other recommended respondents were undertaken, including a handful of residential school Survivors from the community who were informally associated with the program, as well as other counsellors in the Medicine Lodge programs, many of whom were seamlessly involved in the larger healing effort at NCN. In fact, the routine and comfortable interactions among counsellors, therapists, and cultural practitioners throughout the NCN, combined with PCC staff encouragement, led to an occasional invitation for other proponents of this larger community healing effort to share their perspectives and observations about healing through a formal interview during the site visit. Early efforts during the study suggested that a rich understanding of healing in the PCC was most likely to result from additional consideration of the opinions and perspectives of those who were best able to articulate and describe pertinent healing activities, namely, the therapists and service providers (along with the visionary administrators) employed throughout the community.

Thirty-three formal interviews were conducted as part of this study, including interviews with eleven PCC clients, fourteen service providers at the Medicine Lodge (including all PCC counsellors and nearly all of the service providers employed by the Medicine Lodge), three administrators at the Medicine Lodge (including the PCC coordinator as well as the current and former executive directors of the organization), one member of the support staff at the Medicine Lodge, and four additional community members with experience or expertise pertaining to healing in the community (e.g., a PCC board member, a residential school Survivor, a counsellor in another NCN agency, and a cultural practitioner with ties to the PCC program). It is important to note, however, that the author's understanding of the healing activities undertaken by the PCC program specifically, and the Medicine Lodge more generally, was crafted by routine participant observation in the daily activities of the PCC staff (including morning sharing circles, staff meetings, cross-agency consultations, sponsored community gatherings, hiring efforts, a client graduation, and various cultural activities such as sweat lodge and pipe ceremonies; the principal exception was routine access to evening group lectures for the reasons already explained). This was an especially vital source for learning about the program and the community early on, as the

community was regularly described as in crisis following a handful of suicides and suicide attempts as well as the death of an infant resulting from an attack by local dogs. Finally, an additional source of important information was the many documents and records pertaining to the PCC program and the Medicine Lodge. Due to issues stemming from the administrative discontinuity previously described, important background information on the early years of the PCC was obtained from the 2002 AHF case study report on the PCC.

Data analysis was undertaken by the author, with intermittent assistance by graduate students Carmela Alcántara and Erin Graham, as well as lively engagement with various undergraduate students in the Culture and Mental Health laboratory in the Department of Psychology at the University of Michigan. Additional funds for the laborious effort of transcribing interviews were obtained as part of the author's research fund provided for his use during his time as a post-doctoral Kellogg Scholar in Health Disparity at the University of Michigan's Institute for Social Research in 2003–04. The principal analytic technique used in this study is thematic content analysis of transcribed interview material. The quotations from interviews cited in this report have been edited to enhance clarity and protect identity in accordance with the assurances guaranteed during the consent process undertaken with all respondents.

Participant Profiles

Demographics: the median age of the eleven clients interviewed was 30 years, ranging from 20 to 62 years in age. Five of the clients interviewed were in their 20s, four were in their 30s, one was in her 50s, and one was in his 60s. Seven of the clients were male, including all five of the respondents younger than age 30. The four youngest of the seven male respondents were single, while the older three were married. Two of the four female respondents were single, the youngest was married, and the oldest was divorced. Only two of the younger male respondents reported an absence of children in their lives. At least eight of the eleven clients were graduates of the PCC program, representing a non-trivial proportion of those clients thought to have actually completed the program during its years of operation. According to the 2002 case study, 19 clients had completed the program during its first two years, and one PCC counsellor who had been with the program since its inception did not think the total was much higher by the time of the site visit.

Aboriginality: all of the eleven clients interviewed were affiliated with NCN. All reported that they spoke the Cree language minimally, and eight reported speaking the language fluently. When asked to describe their Aboriginal background, most clients were quite reticent. Characterizations of their cultural identity or community participation ranged from one word responses such as “solid” or “alright” to affirmations that they had been born in Nelson House, reared in a trapline or hunting camp or lived off the land through hunting and trapping. In response to this question, one client volunteered that he had learned the Cree language from his grandmother who had raised him, and another mentioned a brief list of traditional activities with which he was familiar. Still another replied that he was not really traditional.

Most of these respondents had lived not unusual lives on or near the community. Nevertheless, while it may be tempting to conclude that interviewed clients had thereby actively embraced and expressed affirmative Cree cultural identities, this attribution would oversimplify the dynamics of cultural awareness and participation among the resident population of NCN. Owing to the longstanding but ever-increasing suffusion of Euro-Canadian societal influences at Nelson House, including the devastating cultural impacts of compulsory residential schooling life on the community, was frequently characterized by PCC staff and administrators as requiring pervasive education and awareness in order to re-socialize the resident population into the lifeways

and thought ways of their ancestors. For example, one administrator explained that community healing will ultimately depend upon a process of creative indoctrination, the goal of which is to “indoctrinate our people in our own [Aboriginal] practices and processes without them even realizing that that’s what we’re doing.” Furthermore, the intersection of therapeutic practice and Aboriginal cultural participation that was enacted by so many of the Medicine Lodge’s service providers was additional evidence of the explicit link made in at least one segment of this community between ancestral cultural preservation and revitalization and healing. Indeed, PCC staff reported that nine traditional pipe carriers and six sweat lodge holders from the community were employed by the Medicine Lodge alone.

The meaning of Aboriginality as expressed by the interviewed clients must be interpreted within the community context in which certain forms of Aboriginal cultural familiarity, participation, and practice characterized as sporadic by Medicine Lodge staff nevertheless served as markers of secure identity and holistic wellness. Not surprisingly, the absence of such markers in one’s personal life frequently signalled the need for outreach, education, and healing.

Substitute Care Experiences: first-hand experience of residential schooling, foster care, or adoptive placement was not typical among the interviewed clients, with six respondents disavowing placement in any of these substitute care arrangements. The two oldest respondents were the only interviewed clients to report attendance at residential school (for four and five years of their adolescence respectively), and two additional respondents indicated that one or both of their parents had attended residential schools. Three other clients reported placement in foster care, two of these on one occasion each for about three months during their early adolescence and the third for about three months at a time, twice per year, until he was adopted by a First Nations family at age twelve. This latter individual reported the only instance of adoption in the study. In contrast, all of the PCC staff reported substitute care experiences, including either attendance at residential schools or, in one instance, judicial confinement to a juvenile reform school. Although first-hand experience with the residential school system was typically associated with older members of the community (precluding many of the young adults sampled in this study), it also seemed apparent that PCC activities had involved greater numbers of residential school Survivors in the earlier years of the program.

Beginning in the late nineteenth century, perhaps 100,000 Aboriginal children throughout the nation were removed from their homes and enrolled in residential schools aimed at assimilating First Nation individuals into mainstream Euro-Canadian society. The schools were typically inhospitable institutions, at least for most Aboriginal children, and usually emphasized learning by memorization, Christian religious instruction, and preparation for agricultural and domestic trades and all sustained by a regimented routine and harsh corporal punishment. As in other kinds of authoritarian institutions, abuse and exploitation by staff members of their dependent charges were unfortunately commonplace. Upon discharge from these institutions, many Aboriginal individuals—some of them quite wounded—found it difficult to return to their home communities where life was less regimented, often economically impoverished, and structured by cultural routines that were now unfamiliar to former students. Thus, the legacy of the residential schools includes displacement and disruption of generations of First Nation individuals, sometimes resulting in substantial personal and interpersonal distress and dysfunction that has lately been referred to as residential school syndrome. Following the proceedings of the Royal Commission on Aboriginal Peoples in the mid-1990s, the federal government has attempted to reconcile with First Nation citizens, in part by redressing the residential school legacy (through the establishment of the AHE, for example). Today, many residential school Survivors harbour hopes of government initiatives that might financially compensate them for their childhood ordeals.

Based on interviews with Survivors in this study, the lifelong impact of the residential school system on the individuals who experienced it was profound. One client who experienced four years of residential school beginning at age fifteen described his experience as follows:

Oh, it affected me a lot, especially [in the] years when I came home. I was abusive myself because of what happened to me over there. I wanted to just get even with other people. That's how I felt. I was ... fed up of getting beat up all the time, couldn't do anything. Right away they'd jump you and beat you up. Even the principal was pretty strict too. I got whipped once there just for talking Cree ... You'd talk your language, the others like Saulteaux and Sioux ... when they hear you talking your language, they'd go tell the principal right away. And you'd go to the office and that's it, come out of there crying. And I was only fifteen when I went there. They'd get me a lot. It's gone now though. I try to forget about it.

This client noted, however, that forgetting about his experiences in residential school was a challenge at times:

First ten years. It's affected me a lot. Even when people yell at me, I respond right away ... But it's gone now. It's gradually been fading. I just hid it away, start missing it. [Laughs] And then I talk about it ... especially when the lawyers were here. They wanted to compensate the kids, the residential school Survivors. I had to go through all that again with the lawyer then. I thought about it for the next two months after that, came back to me, so I don't like talking about it. I just want to forget about it. It's over.

Even decades later, talking about these experiences for the purposes of obtaining possible reparations led a respondent to reiterate that he would prefer just to forget rather than go through those experiences again. Another client described her residential school experience in much greater detail, noting at the outset of her story a sense of anticipation upon her arrival to a residential school at age twelve that soon turned to loneliness and alienation:

Well, for the first three days it was exciting exploring the place where you're going to stay all that year. But then after that, everything settles down. All of the excitement turned around and I was starting to get lonely, lonely for my family. Being there and living with all these strangers, except for these people from your own hometown, it was really hard for me to adjust to that kind of environment, moving from the reserve to that residential school.

Initiation to school life among strangers was marked by persistent difficulty in finding social connections with fellow pupils from other First Nation communities.

Most of them didn't speak English. They spoke their own Native language, and I couldn't communicate with them because they speak Ojibwa, and they speak Dene ... And there was some Cree ... And it was confusing ... Fear was in with me. All these people, and I didn't understand a word they're saying. So we went into little groups. There's a Cree group, there's a Dene group, there's Ojibwa groups. Separated (Client).

Creation of new social ties for this client was extremely difficult during her years at residential school:

There's no sense of belonging ... No sense of belonging there. You all are different people. We speak Cree. They speak a language different than I speak ... And it was hard to build up those communication skills.

These differences not uncommonly led to inter-group violence.

Every night I remember I beat the shit out of the girl next to me. Even if I beat up this Dene, and I beat up this new [student]. It was crazy sometimes among us, among our own Aboriginal people. And a Dene didn't like a Cree. The Ojibwa didn't like a Cree. The Crees were in the middle of most fights. Nobody liked us. We used to fight amongst each other as Aboriginal people. "Oh, go fight that that Dene." Of course, I didn't understand the words they were saying to me, and you shouldn't when you couldn't learn their language (Client).

If violence commonly coloured peer relationships in residential school, the source of such altercations was frequently the abusive actions of the residential school staff.

I was always in fear because ... when I was going to school here, we had a teacher that was very strict and was very abusive when we did something wrong ... If we speak Cree, we would be physically punished ... And this is where I encountered all forms of abuse ... Because this priest, the form of discipline he used to give us was physical discipline. Used to get strapped, and oftentimes my hands were like this, they were numb. Other times my thumbs were just like this. It's so hurtful, and they still expect us to go to the classroom and learn, and you can't learn. I was in so much pain, can't even hold a pencil (Client).

Fleeing the school only seemed to make matters worse.

We used to run away too. I was trying to run away from that pain, and we were trying to run away from the way we were treated. But when we run away, and we were caught, they used to shave our head ... And they used to have a movie at that school. We used to sit there. [They] displayed us [as part of our punishment] ... And this priest and nuns thought it was funny putting us in front of the screen while they're watching the movies, and they would not allow us to watch the movies because that's our punishment. And the priest punished us like that too (Client).

Furthermore, harsh discipline sometimes shaded into monstrous violations.

I'm the victim of sexual abuse too by the priest. It was hurting. And I couldn't study and I couldn't concentrate across all that pain I carried there, and that hurt (Client).

Reporting such violations to other staff members could be met with wanton disregard.

I should try and tell the Sister. She says, "Oh you can't say that to this priest, he's a man of the cloth. You'll go to the chapel and say your ten Hail Mary's to be forgiven." It wasn't me that asked for forgiveness, it was that priest who did something to me that later on in my adult life would affect me (Client).

To properly appreciate the developmental consequences of this form of criminal violence upon school-aged children, it is important to remember the dehumanizing institutional context that served as the backdrop for such activities.

I remember my number was 52. I guess [it was] the year I was born. I was numbered ... I remember 52 because I'd sleep in number 52 bed. Everything we were doing, clap, clap, clap, [and] they all lined up. Line up to go to bed, and line up to go to school, and line up to go to church, and line up to go for meals. We were always in line. Going on like that for five years. The first year was the hardest (Client).

Not surprisingly, the emotional development of children in such an impersonal setting was affected in negative ways.

Why should I tell somebody that didn't believe me what was going on? "It's not nice for you to speak like that!" It wasn't even nice to express your feelings. It wasn't nice for you to cry. If you cry you'd be punished. And sometimes when you have to be punished, they shut me in the dark room. They used to give you water and bread for two days. And it was where you got sent sometimes. When I was there, that's where I used to sleep and think, when I was in the dark room ... In order to go to the washroom [you] start hollering ... You know what I did? Well, they didn't hear me knocking, knocking ... So there was the punishment [for not making it to the washroom too] (Client).

Emotional expression in the residential school setting was sometimes met with punitive measures, compounding children's sense of anger, isolation, and despair.

Nowhere to run to. No one to talk to. No one cared for us. That's how I see that residential school ... And they provide you shelter, clothing, food, but they never like to hear how you feel. There was no love (Client).

Once emancipated from years of confinement in such loveless and abusive environments, many Survivors predictably emerged with no sense of belonging that would chronically trouble their adult years. One Survivor described her troubled life as a cycle of distressed interpersonal relationships in which abuse figured prominently:

I'm divorced. I've had numerous unstable relationships. I didn't have parenting skills ... [I] became a single parent all my life. I don't want to remarry. I know that's sad for us residential school Survivors ... They get married, divorced, single parent, married, divorced. It's a cycle where we're living ... It's a cycle of abuse. Got married, became an alcoholic, divorced, remarried. Then, finally, I go through the healing journey, while I'm trying to get away from all forms of abuse (Client).

Low self-esteem, too, was described as a consequence of the residential schools.

Our low self-esteem. Go down [to its root cause], and it's fear and anger and all that emotional hurt. The mental hurt, too, that goes with it if you think about it and you feel about it. Basically, you want to punch someone? You began to be a violent person because you're so angry about

all that abuse you went through. Emotional abuse, physical abuse, sexual abuse, psychological abuse, even spiritual abuse. Meaning that they didn't want me to practice my own culture and spiritual practices (Client).

The resulting ignorance of Aboriginal cultural knowledge and practice was bitterly lamented by some respondents.

I lost my culture. In 1985, when I attended the university, that's the first time I saw a powwow. Oh, [that] was amazing to me! I was too traumatized. I was too drunk ... I never used to see sweats. It's only now, when I was about forty years old, [that] I'd seen my first sweat. It's only now [that] I start learning my culture, half a century after [residential school]. Because they taught me a religion that was in Latin. And I had to read in Latin, when the priest says Mass. I had to read in French. They wanted me to read in French. That was [the] number one subject. If you don't pass French, you'll fail your grade. They tell me to speak French, tell me to speak and write French. Today, I don't even know any French words. I don't even want to read a French word. I resented it because I was forced to learn that language, to read, to write. And once again, [what] I didn't learn was my culture. I didn't know [about] the sweat. I didn't know the meaning of the sweat. I didn't know the meaning of the symbolics of our culture, instead I know the symbolics of the Catholic faith (Client).

With regard to the residential school legacy for this latter client in particular, it is illuminating to consider the centrality of language in her narrative of her years in residential school and beyond. Her life before school was grounded in family and community where the Cree language was the principal means of communication. In contrast, her school years were dominated by seemingly any language but Cree: mandatory English throughout the routines of school life; Latin in the daily Mass and during religious education; French in class as she was prepared for future citizenship in multicultural Canada; and a host of other Aboriginal languages that characterized a contentious student life when beyond staff surveillance. Under different conditions, exposure to such linguistic abundance might have produced an accomplished polyglot, someone who speaks several languages and is at ease in cosmopolitan circles, with a range of resources for meaning-making and self-expression at the tip of her tongue. Instead, it would seem that the horror of the residential schools was that they were actively organized to suppress self-expression, indeed, to dismantle Aboriginal selfhood altogether and thereby erode the possibility for any cultural continuity in meaning-making. Unfortunately, for those Survivors contending with residential school syndrome, the legacy of their experiences may well leave them without enough fluency in any "language" (that is, a coherent system of shared meaning-making) adequate for embarking upon creative, competent, and coherent lives. It is this pervasive disruption of existence (including even spiritual abuse) experienced by some Survivors and their family members that the PCC sought to holistically redress.

Life Narratives

When asked to recount the stories of their lives up to and including involvement in the PCC program, client interview responses were as diverse as the individuals who provided them. Some offered terse, straightforward summaries of hardships they had encountered and subsequent actions they had taken without any clear resolution to these narratives of chronic distress. Others offered detailed and meandering accounts of challenging life circumstances that continue to disrupt what seem to be genuine personal commitments to sweeping changes

in lifestyle. A few recounted experiences of remarkable personal transformation that have dramatically altered their lives for the better. Respondents' life stories also varied a great deal in terms of comprehensiveness and coherence. For example, one client narrated the entire story of his life in remarkably abridged form:

[There was] just a lot of drinking when I was growing up because my parents used to drink a lot. And I started staying with my grandmother. I'm still staying with my grandmother. [I] didn't start drinking till I was thirteen years old. That's when I was in foster care. So they send you to treatment. I got alcohol poisoning, and I almost froze that year too, passed out in the bush in the winter time when I first started drinking. And I stayed there [in treatment] for about six months straight, came back, started drinking again, and I'm still drinking today ... I stopped for a couple of years, the drinking, till my grandmother passed away. The one I was staying with at first. So I started drinking again, and they sent to me [to another treatment program]. I just put myself in there. I was drinking too much. At [that program], I learned a lot there [about] sun dances, sweats. I made dreamcatchers. It was alright. At first I didn't like it, I just wanted to come home. AWOL'd a couple times and went back here. The reason I went to PCC, later on there, because it was court-ordered. I assaulted someone and I had to do that program. Ten weeks. Now [I] completed [the PCC program] and my charge got dropped. That's about it, that's all I can remember.

Keeping in mind that no single narrative can adequately represent the variety of life stories obtained in this study, this client's fairly condensed account of his difficulties contained many elements that were commonly found in interview responses: childhood family disruptions, early substance abuse, compounding consequences of substance abuse that carry over into adult life, voluntary and involuntary efforts to address substance-related problems through recurrent treatment, and exposure to Aboriginal cultural practices as part of the therapeutic endeavour.

The narratives differ the most in relation to the effects of recent therapeutic experiences on current lifestyles. For example, even though the majority of PCC clients interviewed for this study did not report formal or extensive substitute care experiences as children, almost all respondents, both clients and staff, described familial chaos at times during their formative years. One client reported trying to cope with household drinking as a child by hiding under his bed. Another client explained how she deliberately avoided placement in residential school because of all the negative things she heard about it, only to remain in a chaotic family environment while growing up:

Before [my parents] started drinking, I remember it was always happy in the house. We were always smiling and playing games and whatnot. And when I turned six or seven is when my mom and dad started drinking. Well, my dad did. And then he just changed dramatically. He was violent. He was very violent towards my mom and very abusive ... When they drank, I used to take my mom and I used to hide her in one of my tree houses there, and we used to spend the night there. Or I'd take her places, to my auntie's or cousin's or whoever, where she can spend the night [instead of] her getting beaten up ... And as I was growing up, I hated my father. I really hated him. I wanted him dead and things like that for hurting my mom. He did so much damage to her ... And I always wanted to move out of my parent's house because of my dad's drinking.

A third client was encouraged by a relative to escape his own chaotic family life, resulting in his adoption by another family, leading to a different but more manageable set of challenges:

My family was on a destructive era in their life, I guess. They were going through a lot of drinking ... And through those twelve years I was with my family, I met one of my uncles ... and he said, "You got to go, otherwise you're going to end up like us." I said, "Where do I go?" He says, "Just go up there, you'll find something." So I found a family and they adopted me.

Another client described how the local Hydro development project disrupted his family life while he was still a youth:

I remember a lot of times growing up in camp, being with my parents and my other siblings. And my father was the provider. He was a trapper and he was also a fisherman. We sort of lived off the land. And basically, they would come to town and buy the basic stuff that they needed to survive out in the bush. And every so often we'd come and live in the community. I'd seen a bit of drinking back then but it wasn't so bad. The land was nice there. It was beautiful out there. But then I started noticing a change, the water rising, and I heard elders and older men talking about Hydro. I didn't know nothing about Hydro back then, but the land was going to get flooded ... And then, I guess, basically, it gradually led on to a little bit more drinking out there ... My parents started drinking, my older brothers, and I'd seen the older adults starting to do the same thing. And they were working, bush cutting, cleaning out trees, and stuff like that. And they were making money, I suppose, and it was all right to them. But then, as the water was rising, I think there was sort of a grief and loss because a lot of times I heard my father complaining about what Hydro was doing to the land and their trapping grounds ... And I guess they sort of started to depend on the welfare system ... And to make a long story short, there were ups and downs. I'd seen some things happening that, I don't know, I didn't understand back then. And I'd seen some abuse going on. There were adults arguing and fighting and I heard guns going off that night, and there was drinking going on ... It was getting kind of depressing for me to be out there. It wasn't the same any more, once you saw the trees in the water, and there's no more places that were nice. You couldn't walk around the shore no more ... I guess the adults were grieving. Sometimes I saw the adults cry when they were drinking when the spring flooded, and I guess that was when one of my older brothers was telling me, "It's time to go back to school and get some education, because the environment is getting ruined. You can't move along or live off the land no more like in the old days" ... Sometimes I went to school hungry, but I wouldn't tell anybody. Sometimes there's still drinking going on in the morning. I wasn't too happy about that. And I would go to school and sometimes my dad would get mean and loud, and sometimes I used to see him abusing my mother and I didn't like that. I didn't like my home life.

The life narratives offered by interviewed clients frequently recounted how such early disruptions in family functioning (including displacement to residential schools in two instances) were later followed by sustained, and sometimes pervasive, personal, and interpersonal distress and dysfunction during their own adult years. Every client interviewed in this study struggled with substance abuse—often beginning during adolescence—that predictably increased the likelihood that relational and family problems first encountered in childhood would recur in the domestic arrangements of clients as they became adults.

Well, there was always abuse with my common-law ... That time when I was on probation, I didn't let him inside [the house]. I wanted to be through with him, but he didn't understand, and he kept on kicking the door ... And so he comes inside. But there was a mop there, a plastic mop. He hits me right on my nose. That's where I got this scar from. And I couldn't tell the cops because he was saying, "If you tell the cops, I'm going to say this and that about you, so you'll go to jail right away." And I was scared of jail. I was scared to go anywhere because I had my children ... So I didn't report the incident. And all this time he's been so abusive. And one time, too, my cousin stopped by to visit ... but my common-law was on the couch. We thought he was passed out. And then, it happened so fast. My cousin went under the table and I was standing there. I didn't know anything. I was just standing there, just blood all over me. This cut here, scar, he hit me with a frying pan ... And he took off ... And they took me to the nurse ... I don't know how many stitches I had. I think I had about thirteen or twelve. So he went to prison right away without even going to court [because he was already on probation] (Client).

Such domestic turmoil, in turn, could impact clients' own children in negative ways as well.

So I went out to go look for my [eleven-year-old] son, but I found him at a party, a wild party. And one of the kids that he was hanging around with was probably drunk, fighting his mom ... And I asked [my son], "Let's go home?" And then he said, "No, I don't want to go home. I want to stay here." "Why, so you can see this?" He said, "No, I was just going to sleep over." "You can't sleep over. Look what they're doing. Nobody can sleep!" ... And he didn't even want me to smell his breath, but I knew right away. His eyes were small. You see, he was stoned, and I figured he was drinking, too ... And I grabbed my son, "Let's go home!" And [he was] crying all the way, and hitting me, because I was holding him right here. So when I got to the house I told him to go to bed. "You're grounded!" ... And so I gave him a licking with my hand on the butt. And then he took off on me again. He ran out ... [I] couldn't catch him. And I guess he went to the police and said I gave him a licking with something [besides my hand] ... So the cops came over and then they said, "You're being charged with an assault" (Client).

Such cycles of substance-induced relational dysfunction typically yielded a range of increasingly severe challenges for many clients (including criminal activity, jail sentences, family interventions, and court-ordered treatment). For example, the client who was adopted as a youth reported a more recent history of chronic legal problems related to drunken altercations:

And my first charge was when I was twenty years old. I assaulted a guy who belittled my family. I come from a very poor family ... So he said something about my family, and then I just reacted without any thinking, just reacted. Boof! Scarred him up pretty good. And that was my first charge. And right up until two years ago, I was charged probably about twice a year for assault.

Sometimes such substance-related assaults could be deadly serious.

So we went to a baby shower, but I knew I had a bottle at home waiting for me. So we went home after the party, but I lost my partner, my common-law ... So I went back to my house

and then looked for that bottle. It was gone, and I got so mad that it was gone ... So I went back ... I met up with [my partner] walking [along] there, and I said, "What did you do with the bottle? Why did you?" And then ... he swung it at me, and banged my head ... But I blacked out ... And I guess I stabbed him. And I told on myself right away. I went to go phone. Where did I get this [knife]? And I was still carrying it ... And then [my partner] fell on the ground and I started screaming for help ... I almost killed him (Client).

Another client described a death within her immediate family that led to an alcoholic binge, ultimately resulting in a suicide attempt and, eventually, her children being removed from her care:

I guess it started in '96 when I lost my sister ... It was just a shock to me because we were very close, and she was my mentor, my confidante, my sister, my best friend. Just like a mother ... And then it really hit me hard, and I went on a [binge]. I think I drank for a whole year. And then in 1997, I slashed my wrist. And that's when I woke up. I thought, "What the hell? I have children. I'm young. What the hell was I thinking?" ... After I had my baby [sometime later], I just went on a drunk. And that's when I lost my kids to CFS. I didn't care. I didn't care about my life or anyone, I just went drinking almost every day.

If pervasive distress and dysfunction characterized the adult lives of most clients interviewed for this study prior to treatment, accounts began to vary when considering the effects of treatment upon current lifestyles. Most clients praised the PCC program for its therapeutic efforts—and some continued to participate in program activities and services—even as they carried on their struggle with substance abuse.

I tried following the sweetgrass route, but I put my stuff away recently. They've been wrapped up and put away because I started smoking dope again. So I put them away for the time being anyways. I haven't had a smudge in awhile. And every time I have smudge, it feels like a new day, a new beginning, of course. But I put them away because I started smoking dope ... I feel bad if I touched them if I'm smoking dope because it's kind of like abusing it. So slowly I'm trying to get back on track. I've been slipping here and there (Client).

I must have drank about three, four times since I left [the PCC program]. But I haven't touched liquor for a while now ... There's some times, I can't resist it, especially [with] friends. Yeah, it's like they're forcing you to drink, and you can't say no ... Since I graduated here, I've been back on my feet again, back on the road again, so it's been okay since. Well, occasionally I drink, but [it] doesn't bother me, except for weekends, mostly weekends, but before, it was just about every night (Client).

I was sober for two years. I recently started partying in July when [my foster kids] went back to their biological mother ... It was time for them to go home so I was in my house and I have my roommate there that drank ... So what happened is I tried everything to keep my mind off the girls, and I cleaned up my whole house ... By the time I was done cleaning up, say about four in the afternoon ... I was sitting at the table wondering what to do next. Sitting there and I thought, "Well, here's a six-pack in the fridge." And I got up, went to get a beer, held it for awhile. About an hour I held it, played with it, put it down, go to the washroom. This was going on for about an hour, go get it, look at it ... And I thought, "Well, if I drink this beer,

I'm not drinking it alone." So I had to go wake up my cousin. I said, "Get up. Come and have a beer with me" ... She sits up on the bed. "A beer?" And then she starts crying. "Why me? Everybody is going to blame me!" ... She started crying because everybody would blame her for me having a beer. Then I said, "It's nobody's fault but mine" ... She cried all through the time I opened that beer. It was funny, too. I was standing by the window and I opened that beer. As I was taking my first sip, I could see this big bolt of lightning, and it started raining. And that's what I remember, that day when I took that first drink, was that lightning and my cousin crying, bawling away (Client).

Others acknowledged a transformation in perspective, if not lifestyle, as a result of their experiences in the PCC.

And I've always been confrontational against healing and therapy and counselling. Always like, "You don't need that. It's up to the individual himself" ... So when it came to counselling, [the court] recommended it. I was like, pfft! ... And then one day they said, "Hey, listen, [you can] go to jail or you can do this, plus counselling." Sure, why not? I was like, "Oh, cool. I'm here [in the program] for [the] courts." Whatever. "Give me what you got." And I left there crying that same day. Since that day, man, it's been very uplifting, I guess, to be able to try to understand what you went through, what our ancestors went through, to be able to see what our parents went through ... So it's been great (Client).

A few respondents did report remarkable experiences of personal transformation as a result of the PCC that had set their lives upon a better course.

I started drinking beer and all that stuff [when I got back to the reserve] and I got into some trouble. I got into a couple of fights and I got charged, and that's how I got introduced to this PCC program. I got charged and it was by law for me to go there. And I'm real grateful for them sending me there ... It opened my eyes quite a bit. I see things a lot differently from the way I used to when I came back (Client).

When I look at the time I went back to university there, where I failed, because I wasn't on the healing journey 'cause I still had unresolved issues. I still had something blocking. Then I started disclosing and I learned [about] myself. I say the hardest thing I had to disclose was when I was sexually abused by the priest. That was the hardest. I cried. Today when I tell it, I can speak it. Before, I used to cry. So angry ... When I went back to the university [after treatment], I look at my marks, they're all As, Bs, B pluses. Even now I'm still going to university, learning ... It's never too late to learn and to go back to school. And whereas then I had poor marks, 'cause there was ... so much stuff in my feelings and my body that I wasn't healed. Those things kept bothering me. I couldn't read, I couldn't even concentrate. But when I started my healing journey it was just like my body was light, my feelings were light, my thinking was cleared, my spirit was really clean (Client).

Finally, even among those clients who continued to struggle with substance abuse and the associated havoc it created in their lives, the PCC had reportedly provided them with perspectives and skills that helped them to manage the chaos around them a little more effectively.

Well, I feel a lot more confident about myself. I don't feel like I'm worthless or anything like that. I don't feel like I'm never going to amount to anything because today is the only day I look at sometimes, and today's the day that I'm doing something positive. And I don't beat myself up if I can't succeed in something ... I'll just say, "Okay, I made that mistake but I can still go on." Pick myself up here. And it's given me that encouragement to just [keep] on going ... Sometimes, I guess, I'm living in the past, where I'm at a point where I start feeling hopeless. But in reality there is hope (Client).

Even in the midst of ongoing difficulties, small victories were celebrated.

My [eleven-year-old] son, my oldest, he never usually gave me a hug or a kiss or say, "I love you" to you. But all of a sudden I feel that love in him. He gives me this giant hug. "Mom, I love you." "I love you too" ... He's so happy seeing me and that I'm healing. He knows that I'm doing my best and I feel happy about that (Client).

The life narratives offered by PCC clients interviewed in this study typically detailed lengthy histories of family instability, relational dysfunction, substance abuse, violent altercations, legal problems, intergenerational impacts, and formal treatment experiences. Different clients remained in various stages of the personal change process, ranging from a few who still did not seem particularly concerned about their substance use to a few who had proven records of abstinence following transformative experiences in treatment. Most were somewhere in between, waiting to decide to quit altogether or relapsing in the face of earlier commitments. What seemed clear from the life narratives provided during the interviews was that almost none of the client respondents remained untouched in some significant way by the people and activities associated with the PCC.

Client Problems

The life narratives of PCC clients interviewed for this study revealed lengthy histories of relational turbulence and personal distress. Certainly, substance abuse figured prominently in these tales of turmoil. Even when clients abstained from alcohol or other drugs for significant periods of time, the effects of grief, loneliness, unemployment, poverty, domestic violence, and family disruption continued to batter them. Several had cycled through treatment programs prior to arriving at the Medicine Lodge, and a few had sought additional treatment as a result of personal insights gleaned during their involvement with the PCC. Several agreed to participate in PCC activities as a means to avoiding jail time or having their children back from protective custody of Child and Family Services. In the face of such pervasive and overwhelming distress, PCC staff members commenced their therapeutic efforts with at least some common understandings that guided their approach to client difficulties.

The inescapable reality that substance abuse had derailed the lives of many PCC clients was one ready point of access for counsellors as they formulated their clients' problems. After all, an emphasis on substance abuse necessarily structured the activities of counsellors in an accredited substance abuse treatment centre. Moreover, the PCC counsellors' own personal experiences with substance abuse, treatment, and recovery informed their perspectives on client problems. Thus, one common understanding of client distress emerged from the presumed reasons for prolonged client substance abuse and the bevy of attendant problems: deep personal pain and the inability to cope with such pain in adaptive ways.

So, they come to learn that they drink because they carry pain and to identify where that pain comes from ... And then they learn new skills, new tools in how to handle their lives in a more positive way. Yeah, they get an awareness [of how] that way of life, like drinking and doing drugs, isn't going to help them nor their children ... So that's what they learn here in PCC, that they need to take responsibility for their own lives. And sometimes, yes, it's good that they're forced to take a look at themselves because sometimes we have to be forced. Even the universe forces us to do things that we don't want to do. So that's what I show them anyway, that they need to take responsibility and accountability for their own lives (Counsellor).

By implication, client substance abuse problems were seen to involve more fundamental processes than drinking or drugging, including maladaptive attempts to cope with personal pain, lack of insight about the origins of such pain, and unwillingness to accept responsibility for one's actions. Once the sheer unmanageability of their lives forced them to take a look at themselves, novel practical skills and tools were offered to clients so that they may be better able to deal with life experiences in a more positive way. Thus, client problems at the individual level were seen to result from inadequate self-awareness and deficient coping skills in the face of enduring emotional pain. Not surprisingly, clients who sought help through the PCC would oftentimes have preferred immediate solutions for these problems.

They want to hear an instant solution to their problem ... They want to be able to walk out of your office and say, "Well, now that I've seen [the expert], now I know what to do." Oftentimes that's the case. And because I'm aware of that, then I'm very cautious in my approach to them. I let them know right away, right from the start, that I'm not here to solve your problems. That's not my job, that's nobody's job. That's your job. I'm only here to guide you, to give you some options, to give you some alternatives, and try things differently. If that doesn't work, try something else, because sooner or later you'll find something that will work for you ... See, what our treatment here does is equip them for the real world out there. That's all it does. Now whether it [works] for them, it's entirely up to each individual (Counsellor).

Professional guidance in discovering what learned skills work for the individual client was a goal of treatment, though the assumption of personal responsibility toward use of these skills outside of treatment in the real world was necessary as well. This formulation of client problems at the level of basic personal awareness and behavioural self-control did not seem altogether different than in substance abuse treatment more generally. Nevertheless, even the problem of substance abuse among specific clients was discussed in terms of larger community pressures and expectations.

There's a lot of alcoholism in our community, and of course, the people want them to drink and drink ... A lot of peer pressure ... Even now, fourteen-year-old [kids] see their parents drinking too, and of course they follow in their footsteps (Counsellor).

As a result of such widespread pressures, descriptions of client problems quickly became descriptions of community problems, that is, the contextual backdrop that informed the therapeutic activities of PCC staff remained distinctively Aboriginal, grounded in the history and experience of the NCN community. For example, origins of alcohol abuse and related problems in the community were attributed to alcohol's alien cultural origins.

Alcohol was introduced to our people. What I've heard over the years is alcohol wasn't meant for our people. If it was, then they would learn how to use it, but they don't. When they drink, they drink to get drunk. They don't drink just to be sociable and then know when to say, "That's enough." And then when they're drinking, there's family violence a lot of times when they are under the influence. Sometimes they end up committing a crime when they are under the influence or killing someone. The children end up experiencing scary situations, where they experience fights like I did. They go hungry because they use up their paycheque or their welfare to drink. So there's a lot of problems that go with it too, and we have to be able to try and get them away from that practice and tell them it's not a part of our culture. "Throw it away!" And we have to stop that family violence in our community. It's going to take a lot of work. And then when our people come through the treatment, we can't stop there. That aftercare is really important so they don't fall off. They need ongoing support ... It's really hard sometimes when people sober up because they get discouraged, because they think, "Well, why sober up when I don't have a job to go to, when I don't have a training program to go to?" So they get discouraged and fall back (Administrator).

This explanation for alcohol's virulent effects on the community included reference to the harmful effects of severely constrained community resources. Even when community members decide to stop drinking, local opportunities for meaningful involvement, reliable income, or upward mobility remained so scarce that discouragement may well lead to relapse. As a result, ongoing support of these individuals in the form of programmatic services was urgently required.

The nature of local social problems was frequently described in collective terms by PCC staff, focusing less on specific troubled individuals than on the community as a whole.

Well, the community needs a lot of healing. There's a lot of drinking in here, a lot of drugs, even though we have a treatment centre here ... There's still a lot of healing work for us to do for our people to also get out of that welfare dependency mode. So I've talked with [another administrator] about that, and I said, "We need to come up with a life skills program for them that has Aboriginal content." And then from there they need to take upgrading ... for their education or going to some kind of a training program. And then from there, they can go out into the workforce. That way they get out of that welfare mode (Administrator).

In addition to unresolved pain and maladaptive coping strategies, client problems were also seen to involve more general deficits in life skills conducive to healthy lifestyles and stable employment. For instance, one administrator described the kind of life skills needed by PCC clients and community members:

About family, about grooming and whatnot, about leisure activities, like how they can spend their money when they get their paycheques and to have family outings. How to take care of themselves, to eat properly, to eat nutritious meals, to exercise, to get involved in community activities and sports, things like that. I talk about [these things in lectures], to learn how to write a resume, a cover letter, to know what it's like to work, working as a team, and the different skills that employers look for, and what it's like in a workplace, to learn how to talk to somebody if you're concerned about something, not to keep it to yourself. I tell them in there to learn what the difference is between being assertive and aggressive.

Promotion of such skills was one objective of the NCN Human Resources initiative involving Tulshi Sen, which explicitly targeted community-wide limitations and deficits involving life skills.

Clearly, these and related client problems were understood to merely reflect more widespread community problems. The origins of these problems were explicitly grounded in the history of Euro-Canadian colonization, with an important goal of treatment being to educate clients about this history.

And then our lectures ... talk about the history, and what our people went through. That way they're educated and they know what happened to them, because that really helped me. I was able to know what happened, the different governmental attempts that were made, and the reasoning for that. So I also include that in our lectures ... And what the future goals and aspirations of our leaders are, in terms of trying to strive for self-government and economic self-sufficiency (Administrator).

The hope is that greater awareness of the historical origins of contemporary social problems within the community will facilitate greater cultural and political awareness that might then motivate commitments to personal recovery.

Perhaps the most significant and unambiguous expression of the colonial encounter was the residential school system, designed to assimilate whole generations of Aboriginal people into the lowest echelons of the Canadian economic system. As a result, a primary source of community social problems was seen to be the residential school legacy that the PCC was instituted specifically to address.

Every single pathology evidenced in our communities today can be linked back to the residential schools. Whatever form that pathology takes, you can implicate the residential school system ... To help [program clients] to understand why they use whatever they use, it was because of the stuff that went on in residential schools, if not the actual things that happened, the intent, the design of [what the] residential schools were [supposed] to produce ... I call them apples, essentially, people who are red on the outside but white on the inside ... We want people to understand that a people who lose their identity will be a lost people, and lost people will make some mistakes (Administrator).

The logic here was clear: as influential expressions of colonization, the residential schools succeeded in eradicating the cultural identities of their student charges while still consigning them to the margins of Euro-Canadian society. The result was a lost people, whose pathologies are best understood as the mistakes of so many reeling survivors of a ruthless existential assault.

Disruption in cultural identity, then, was perhaps the chief predisposing factor related to client difficulties in the context of widespread social problems within the community.

The single most significant opportunity for me [in this therapeutic endeavour] is that represented by, I guess, cultural identity, for lack of a better word. And that was probably best captured by our vision statement ... So paving the Red Road speaks of an attempt to demystify Indigenous processes and make it a lot easier to grapple with this monster called identity. Because I believe, and nobody has been able to convince me otherwise, that a person

who knows who and what they are simply makes healthier lifestyle decisions. So we need to find ways to allow our people to embrace their own practices, to reclaim, to make the whole process of the cultural renaissance of the Red man, if you will, more palatable to the Dick and Jane on the streets? (Administrator).

If client problems might be attributed to this “monster called identity,” its conquest will result through finding ways “to allow our people to embrace their own practices.” The official mission of the Medicine Lodge was an expression of this commitment on behalf of client recovery.

And we live in a First Nation reserve, so that in itself is unique. Even our vision statements, we wanted to make them unique to the Aboriginal. That’s why we said, “Paving the Red Road to Wellness.” That’s why we said, “Medicine Wheel Firekeepers, Empowering Healthy Lifestyles.” And we’re going to put that Medicine Wheel there because we don’t just want a vision statement that any white person can use. We want it to be unique. We want it to stand out too, so that when they read it, they’ll know it’s an Aboriginal vision statement (Administrator).

Our mission, in looking at who and what we are right now and how we are doing that, how we are moving towards the paving of the Red Road to wellness. The mission has been revised to state that we are Medicine Wheel firekeepers, empowering healthy lifestyles. I mean those statements are memorable, they’re imbued with symbolism of our people (Administrator).

Thus, reclamation of the Aboriginally unique “symbolism of our people,” along with institutional promotion of related practices, formed the basis of all activities of the Medicine Lodge in the effort to reconstitute a robust cultural identity for the entire NCN community that should, in turn, lead to healthier lifestyle decisions.

This turn to Aboriginal cultural practices yielded additional explanations for community distress that extended far beyond the conventions of formal counsellor training. Prior to the site visit, the community hosted its first ceremonial shaking tent in several decades. After consulting with knowledgeable spirit persons who entered the tent, the ritual leader identified a spiritual source of community problems.

Well, we’re doing a lot of work with our culture. Some are interested and some aren’t ... I was telling you about that shaking tent. The chief went in there himself, and he mentioned that there’s a lot of alcoholism going on in our community, a lot of suicide going on in our community, a lot of things are happening to our people, so that the Elder that was in [the shaking tent] got the message. [The Elder] was saying that, “The reason why you people are turning to alcohol, and a lot of things that’s happening, there’s a black spirit around your community ... Some other people meet him, shake hands with him, and that’s why they’re becoming alcoholics. So the best thing you can do is to have a [sacred fire].” Well, they’re going to open [the ceremony] today to get rid of that black spirit. They’re supposed to have it for a whole week during our National Drug Awareness Week. People got to offer tobacco for that fire burning. But I think they started one night, and you seen a person going around there, [his] face was black. Dressed like an ordinary person but his face was black. So they met the spirit (Counsellor).

In conclusion, PCC client problems were directly associated with substance abuse and related problems, but these difficulties were further explained with recourse to intra-personal factors (underlying pain, maladaptive coping skills, and disrupted cultural identity) as well as community-wide contextual factors (peer pressure, dark spirits, and Euro-Canadian colonization). This ready juxtaposition of the personal and the communal in conceptualizing client problems afforded treatment that grounds the call to personal awareness and responsibility within the politics of community restoration and cultural reclamation.

The Medicine Wheel Model of Healing

Throughout mid-western Canada, circular arrangements of stones known as medicine wheels have dated to prehistoric times. These wheels usually consist of a central pile of rocks surrounded by a ring of stones of several meters in diameter, often with lines or spokes marked between the central cairn and the external ring. Archaeologists who have studied these ancient North American structures acknowledge their Aboriginal origins, but hesitate to speculate on their precise significance for this continent's earliest inhabitants. Today, these ancient material artifacts continue to harbour profound significance for the Aboriginal people who reside among them. Members of the NCN community are generally aware of those inspiring structures situated in proximity to their recognized territories. Ritual gatherings at these sites in recent years seemed to be on the rise, and attention to the medicine wheel as a material expression of an age-old Indigenous philosophy is increasingly prevalent within the Aboriginal therapeutic discourse of Canada and the United States. As one administrator explained, "The Medicine Wheel takes in everything that we know, have known, and can accommodate what is to be known. The Medicine Wheel is that encompassing." A counsellor elaborated further:

I try to make people understand about the Medicine Wheel concept ... You won't find a Medicine Wheel anywhere, other than the rocks that have been placed there by ancestors to illustrate the Medicine Wheel concept. The Medicine Wheel is a concept, it's an idea, it's a philosophy. It's not something that you can carry around with you in your pocket ... You can use that concept ... You can use those teachings in every aspect of your life because it includes the whole universe. In the whole universe, we are but a speck of that whole universe, but we are interrelated and we are part of that whole universe as we see it. As we see it, and as we [do] not see it, because there's also the unseen. The spiritual part is the intangible ... It's like the teachings from the Bible. Say, for example, the Bible teaches about the good way of life. Okay, the Medicine Wheel teaches us the same thing, the good way of life, only it teaches us about all of our being, not just our mental, not just our physical, not just our emotional, not just our spiritual, but all of it.

So central is the Medicine Wheel concept to the approach and activities of the Medicine Lodge that following the site visit, the NCN community sponsored the ritual construction of a stone medicine wheel on the grounds of the Medicine Lodge.

The Medicine Wheel is a powerful metaphor for understanding human existence. Conceptually it represents the holistic balance and integration of four constituent parts within a unified whole. The emphasis on four basic constituents was linked to the very essence of Cree personhood.

I mentioned earlier this evening that a return to the Medicine Wheel teachings entails a return to everything that is, that was, and that can be known. That entails a certain open-

mindfulness about what is and what isn't Indian. It commands an understanding of the term Indian. When you look at Indian, what is an Indian? You interpret that word in any of the two hundred and fifty plus languages of Canadian Indian people, the three hundred more in the United States. Invariably it's going to become "human being" ... And in former times, an Indian person was an Indian person not by the color of their skin or by the fact that they had more than one wife or the fact that they had feathers or they wore buckskin, but they lived a certain life, they lived by certain values ... For us, we say *Naonoway* in our language, *naonoway*. When you ask a Cree speaker what this word means, ninety per cent of them will tell you "speak Cree" ... When in fact the meaning of that word is much deeper because it talks about who you are and what you are. *Naonoway*, there's a root word in there that speaks to a number, four. *Nao* in our language is four ... In other words, speak and think in the four ways of who and what you are ... What that means is we are a people who move and behave in four ways (Administrator).

Thus, the Medicine Wheel facilitates consideration of four ways within the context of a greater unity or an integrated whole.

The Medicine Wheel is represented as a circle bisected by two perpendicular lines that cross at the centre point and terminate at the outer edge. These lines yield four spokes at right angles to each other that demarcate four quadrants within the circle. The handout used in PCC lectures to introduce the Medicine Wheel to clients described the significance of the wheel:

In the way of our ancestors we are taught that everything in life is circular. We observe the change in the seasons, the travelling direction of the sun and the moon, how we develop from birth to death and the spirit world. We are one within the circle of life. The Medicine Wheel teaches us balance, to discover ourselves and our path (PCC Handout).

Thus, one significant aspect of the Medicine Wheel concept is the circular representation of life experience, whether as the cycle of day and night, or the four seasons, or the developmental path of a full human life.

In addition, however, the Medicine Wheel—also known as the circle of life—affords consideration of distinctive aspects of most of existence (usually distilling these to four components), while simultaneously acknowledging the integration of these aspects within an unbroken circle. The primary metaphorical template for such consideration is the four cardinal directions demarcated by the four quadrants of the Medicine Wheel, each with its own associated attributes and objects. For example, the eastern direction is often associated with the spring season, human birth, the color yellow, the Asian race, the sacred plant tobacco, and the eagle. The other directions harbour similar significance as well, moving clockwise to the south, then the west, and finally the north. A large, full-color poster of the associated circle of life was prominently displayed in the Medicine Lodge and other community spaces and listed, for example, the following attributes of the northern direction: wind, stars, trees, four-legged, old age, harmony, purity, and winter. In essence, the Medicine Wheel can accommodate a wide range of interrelated concepts and understandings.

It shows in the Medicine Wheel the four races in the world, the red, white, black, and yellow. In the Medicine Wheel, it each symbolizes something. There's an animal that sits in each direction, and it symbolizes that love, humility, and whatnot. And then there's a plant

[associated with each direction]. So it shows everything is connected and interconnected, that no one is above or below another, that we're all equal, that the human is not more important than the rest of the animals and the elements of the earth, that because everyone is connected and interconnected, that we have to learn how to respect Mother Earth (Administrator).

Thus, the evident metaphorical advantage of the Medicine Wheel is an explicit recognition that any element considered in detached isolation from the other three distorts reality, yielding disharmony and disintegration.

Given the ongoing significance of Aboriginal experiences of colonization by Euro-Canadians, the accommodation of race relations to the Medicine Wheel was one of the most cited applications of this metaphor among clients and staff interviewed for this study. More specifically, harmony and balance between peoples was seen as a likely outcome if only the gifts and contributions of each race were properly esteemed.

In our Medicine Wheel teachings, they teach us about the four races of the world and how each race was gifted a gift. And for our white brothers, they were gifted the reasoning, the mentality, the mind. And today it's evident through modern technology. And for the people in the East, that's the Orientals, the Asians, they were given the gift of emotion, feeling. And it's evident, like, for example ... the Chinese, and all the Asian people, they're very close-knit [in terms of] family, very disciplined. And then in the south we have the red race, which would be the Native people, and they were given the gift of spirituality, spirituality and the knowledge of creation, the knowledge of nature. And not so much prayer because prayer is for everybody. Prayer is a communication between our Higher Power. That's all it is, it's not a religion. And spirituality isn't a religion either because it's for everybody. And then in the west, we have that gift of movement, the black brothers, and it's evident that they're very athletic. So those are the gifts of all these four races as that Medicine Wheel teaches. And the responsibility that I was given when I was honoured with the [ownership of a ceremonial] pipe was to bring those four races together, because that's what we need in our individual lives. We need those four gifts in order to walk in balance, or close to perfect balance, in our lives (Counsellor).

Interestingly, in this instance, the gifts of the four races were seen not just as the foundation for interracial harmony around the world, but also as the foundation for intra-personal harmony within the individual as well: "Because that's what we need in our individual lives. We need those four gifts in order to walk in balance, or close to perfect balance, in our lives."

This application of Medicine Wheel teachings to individual lives was the most widespread use of the concept in PCC activities. More specifically, the therapeutic essence of this diversity-comprising-unity approach was the accommodation of the four basic constituents of the human being to the Medicine Wheel: "It just all boils down to mind, body, spirit, emotion. Mind, body, spirit, emotion. Those four aspects of our being have to be involved" (Counsellor). Throughout participation in the PCC program, specific attention to these basic elements of human experience guided clients and staff along their healing journey. Of course, the counsellors and administrators charged with facilitating healing at the Medicine Lodge were more articulate than clients when discussing the meaning of the Medicine Wheel, but some clients demonstrated definite familiarity with the concept following their graduation from the PCC. In response to a direct query, one client explained the meaning of the Medicine Wheel from his perspective:

Well I'm not really sure. There's a lot of different ways [that] different cultures, different people, traditional men and women perceive the Medicine Wheel. For myself, it's four directions of four nations, the white, black, yellow, and red. And from going around, it's from birth, to youth, to adult, and to an elder, in a circle. It goes on from birth until you're an elderly. From an elder you go back to being a baby, I guess. You go back to Mother Earth and the circle goes on. What comes around goes around.

Here was the requisite attention to four essential components that comprise a greater whole as well as cyclical movement that has no marked start or end point.

Given the importance of the "renaissance of the Red Man" for Medicine Lodge activities, it is worth noting here, too, how conventional substance abuse treatment modalities might be "re-traditionalized" as expressions of the age-old Indigenous philosophy represented in the Medicine Wheel concept.

So that's basically in a nutshell the Medicine Wheel teachings, but there's a lot more to it ... Because, just for an example, the [Alcoholics Anonymous] program, which we're all familiar with, came from the seven sacred teachings of the Medicine Wheel ... It's the same concept. I do a workshop where I demonstrate that ... And it's been proven that that's why the AA program works, because it's based on the seven sacred teachings of the Medicine Wheel. So it was the Medicine Wheel before AA, not the other way around (Counsellor).

The Medicine Wheel concept provided the central metaphor for the therapeutic activities of the PCC in particular and the Medicine Lodge more generally. Its ability to facilitate distinct consideration of the constituent elements of human existence and experience without losing sight of the ways in which they articulate and integrate into greater unities provided a holistic perspective for addressing client problems. Furthermore, conceptual representation of the many cycles that structure and govern human life grounded the Medicine Wheel in an Indigenous philosophy with continuing relevance for contemporary NCN community members. As a result, the Medicine Wheel appeared to provide an ideal metaphor for an Aboriginally distinctive approach to healing.

Therapeutic Approach

If the Medicine Wheel provided the overarching metaphor for the therapeutic services provided by PCC staff members to their clients, the actual techniques employed by counsellors were an eclectic mix of Aboriginal and Western practices (in accordance with the officially stated goals of the PCC, which included utilizing traditional and contemporary practices). The PCC program was instituted as a community-based, nine-week, two-phase outpatient counselling service within the Medicine Lodge, complementing the activities of the seventeen-week in-patient residential treatment on the one hand and the assessment and referral activities of the NNADAP prevention program on the other. The PCC aspired to enroll fifteen clients from the surrounding NCN community in each treatment cycle (which had been expanded to a ten-week duration by the time of the site visit), with an emphasis on the recruitment of residential school Survivors. Although outreach to residential school Survivors within the community was designed to involve them in program activities well beyond the scope of treatment per se, the location of the PCC within the Medicine Lodge inevitably associated PCC services with substance abuse treatment (with its attendant implications) in many people's minds. For example, immediately prior to the site visit, a telephone call to the Medicine Lodge resulted in the author being placed

on hold for a minute or so. During this hold time, the local radio broadcaster was heard to announce a PCC activity with a tongue-in-cheek flourish: "You want to quit your drinking and drug habit? Go on down there and they might be able to help you!" Countering such misconceptions about the PCC program within the community seemed to be a persistent task of the PCC staff.

Of course, most clients who participated in the PCC program did in fact have enduring problems with substance abuse as previously described. As a result, many of the structured therapeutic activities in which they engaged during their time in the program were not all that different in content from the activities that were organized for residential clients in the in-patient program. Therapeutic activities in the Medicine Lodge were generally categorized as workshops, seminars, lectures, group sessions, and one-on-one counselling. Workshops were multi-day affairs structured around a common theme or approach, including related hands-on activities.

There are workshops. And when we first started, there was only two workshops that we delivered. One of them was the inner child that you talked about, and the other one was personal portraits where they take a personal portrait of their life and childhood. And part of that fits with the intergenerational theory and the intergenerational impact. And those were the two workshops that worked well with clients. And you could tell it made a difference in their life, especially when the workshops are happening. Clients were tense during the workshop, they'd go outside for a smoke. But by the end of it, they were just really light and flying and [they] became so much more aware (Administrator).

Seminars involved intensive coverage of more focused themes for a day or less, facilitated perhaps by a guest speaker, about a wide variety of therapeutically relevant topics such as communication styles or sexual abuse. Lectures were shorter instructional presentations of treatment-related information, sometimes including a hands-on component as time allowed. Group sessions were structured opportunities for clients to share their personal experiences with one another in a supportive and confidential setting.

We deal with a variety of topics in our sessions. Our sessions consist of looking at the notes on the overhead, and then after that we would form a circle and we'll discuss what we just read off the wall either on a flip chart or on the overhead. And then following that, we have what we call a sharing circle, where we share with one another our own personal experience of whatever topic that we're on, whether it be grieving or loss, sexual [abuse], whatever the topic is (Counsellor).

One-on-one counselling involved private meetings between clients and their assigned counsellors to personalize lessons from treatment through the discussion of pressing personal matters, often of a more sensitive nature.

The one-on-one works best for confidential matters. Some examples would be sexual abuse, another example would be suicide, another example would be a death, grieving, even domestic violence ... For example, it might have been a person that contemplated suicide, and maybe even attempted, and that's why it's so meaningful to them. And they just can't bring themselves to talk about it in public in that group. But they realize that sooner or later they'll have to talk about it in order to address it. And for that reason, when they talk about it on one-on-one, then they can really lay it on the line (Counsellor).

Selecting from this palette of therapeutic modalities, the PCC program offered nightly lectures and associated group sessions, supplemented by one-on-one counselling as needed (or required for case management purposes). In accordance with common staff formulations of client problems, these activities were typically oriented to the development of self-awareness and the adoption of more effective coping skills (“new tools in how to handle their lives”).

Still, there’s that heaviness in my heart a little bit for a lot of those people out there that are still suffering in that community. I know that I reached a few ... I just gave them some tools ... And I explain that to them. They can’t do nothing without tools. A carpenter, he’s got to have a saw, hammer, and everything. “I gave you a few tools and you’ve done very well with [those tools]” (Counsellor).

Some clients explicitly acknowledged the therapeutic benefits of increased awareness and alternative coping strategies.

And the way it helped me is with the drug abuse and alcohol abuse. [Explaining] why people do their drugs and their alcohol and all this bad stuff, I guess. It tells you lots, and it tells you how to handle it, how to feel about it, how to approach it. Like when somebody puts you down, you don’t have to go fight him or anything, just walk away. It’s his problem, it’s not ours (Client).

In addition to these formal components of treatment, Aboriginal cultural activities were routinely encouraged and supported as a valued treatment modality in their own right, and elements of these were sometimes integrated into lectures and group sessions. For example, PCC clients might begin a group session with a smudging ritual in order to facilitate personal reflection and emotional expression.

The first time I smudged, it just felt different. My body felt different. All the things in you just went down. You just felt so light. Man, [I] did that and felt better about myself, and I could speak better and say whatever ... You don’t think about what you’re going to say, you say what you feel. That’s what I learned in there too, you don’t think from your mind. You just say what you feel, your emotions, how your emotions feel. Your emotion speaks for you (Client).

Most Aboriginal activities, however, were stand-alone affairs that required planning and participation outside of the lecture and group session formats.

The backbone of PCC services was the lectures (inclusive of related group sessions) offered Monday through Thursday in the evenings in a large room near the front of the Medicine Lodge. At the program’s inception, PCC activities were offered during the weekday, but over time it became clear that clients were better accommodated through evening gatherings that neither conflicted with work schedules nor required early morning awakenings. PCC counsellors might drive through the NCN community in advance of the lectures to transport clients to the Medicine Lodge. Some clients arrived early to share supper in the Medicine Lodge cafeteria, and others hired babysitters with a PCC subsidy in order to attend program activities. Once convened, a wide variety of topics—drawn from a curriculum of over 40 self-contained modules—were addressed in the PCC lectures, which typically lasted from three to four hours per evening. Lecture themes, accompanied by printed handouts and sometimes related exercises, were quite diverse, including personal awareness (e.g., anger, identity, self-

esteem, communication skills, self-care, love and relationships, sexuality, developmental stages, world view), therapeutic challenges (e.g., alcohol and drugs, depression, co-dependency, abuse, grief and loss, fetal alcohol syndrome, suicide), family relationships (e.g., family violence, marriage, parenting, divorce), and cultural practices (e.g., four directions, give-away, the teepee, powwow, songs, traditional practices).

There was some recognition by administrators that lectures were less ideal than workshops for meeting PCC client needs.

And in the client feedback, in their evaluations [of residential treatment], they said what they really liked about the program was that workshops worked well. They didn't like lecture style. They didn't like a counsellor or a worker to stand up there for one hour and talk to them and educate them ... Workshops are more participatory, where everybody's involved, and it happens usually over a three-day period. So that was what worked well. And remember, we're client-focused, and so we started doing more workshops [in residential treatment] (Administrator).

Unlike residential treatment, however, the PCC staff could expect to engage their clients for no more than half a day at a time. Given the time constraints associated with outpatient services, the PCC staff could not afford the luxury of the more participatory workshops.

The structure of the PCC treatment cycle evolved over time, but consistently included two phases spanning eight weeks. The two phases were initially intended to focus on individual and family treatment respectively, with each phase comprised of four weeks. Each week within its respective treatment phase was explicitly linked to a sacred direction and its corresponding attribute (e.g., "Week 1: South (Physical)," "Week 2: West (Emotional)," "Week 3: North (Mental)," and "Week 4: East (Spiritual)"). Lecture topics in any given week, however, were not exclusively keyed to the designated attribute. An additional week was reserved for graduation activities, which typically included a public celebration of client accomplishments marked by speeches, the presentation of certificates, a meal, and occasionally a pipe ceremony (if the graduates so desired). By the time of the site visit, the difficulties in implementing so structured a treatment cycle were evident. The integrity of the treatment cycle depended on a full contingent of new clients reliably participating in PCC activities from intake to graduation. Instead, by year four of the program, successful recruitment of new clients remained a challenge. Many who continued their involvement in PCC activities had originally begun their participation during an earlier treatment cycle, only to drift away for a variety of reasons in the interim before the PCC staff might persuade them to return. As a result, graduation from the program came to depend less on the number of weeks in attendance or comprehensiveness of the material covered, but on counsellor judgments about client readiness. Moreover, the second phase of treatment designed to involve clients and their family members together in therapeutic activities never really succeeded.

I wanted more families to come in for help ... It would be a process that would help those families recognize their own issues and be able to work them out, because you need a family. But it hasn't really worked out (Administrator).

Evidently, it was challenging enough for PCC staff to keep the actual clients consistently engaged with program activities. Adaptability to these kinds of unpredictable contingencies was an obvious strength of the PCC staff and administration.

In addition to structured lectures, groups, and individual counselling offered during the treatment cycle, other PCC-sponsored gatherings and events in the community were commonplace. Respected Elders, political leaders, and other community members were generally invited and encouraged to participate in all public PCC activities. Over the years, the PCC has sought to address the residential school legacy by coordinating annual trips for Survivors to return to these schools, now closed, for purposes of reflection, commemoration, advocacy, and healing. The PCC also sponsored seasonal fasting camps in which clients and other interested community members might collectively venture into the bush to learn and practice traditional ceremonies involving abstinence and inspiration. Furthermore, the PCC coordinated public feasts in honour of residential school Survivors as but one strategy to heighten community awareness of the residential school legacy and to educate community members about the prospects for healing. PCC staff also offered public lectures, workshops, training, and consultations to other community agencies engaged in the healing enterprise at NCN and South Indian Lake. At the beginning of the site visit, PCC counsellors joined forces with therapists in the Wellness Centre to staff a crisis hotline during a rash of suicides and suicide attempts in the community. Finally, PCC staff members were centrally involved in many local expressions of a renewed spiritual life, including participation in pipe ceremonies, sweat lodges, the historic shaking tent, and tending the sacred fire, to name but a few of these. In short, PCC staff members were engaged in a wide range of healing activities that bridged formal client treatment and informal community outreach and education as well as therapeutic pursuits both secular and sacred. Indeed, the extent to which PCC staff engaged in community outreach and interaction demonstrates the commitment of the program to healing well beyond the mere delivery of structured therapeutic services to a small portion of unusually distressed individuals.

Regarding identifiable approaches that guide and frame counselling activities, the diversity of therapeutic philosophies and techniques recognized and advocated (though not necessarily instituted for clients in every instance) by PCC staff was striking. These were typically classified as either Western or Aboriginal in origin or orientation. So-called Western therapeutic modalities included the Twelve Steps and Twelve Traditions of Alcoholics Anonymous, inner child explorations, grief exercises, anger discharge, energy work, guided imagery, meditation and visualization, relaxation training, genogram mapping, Reiki, neurolinguistic programming, acupuncture, and so on. Aboriginal therapeutic modalities included smudging, talking circles, blessing rites, tobacco offerings, pipe ceremonies, sweat lodge rituals, fasting camps, and the shaking tent (though programmatic incorporation of herbal medicines was not in evidence). Different counsellors were associated to different degrees with these modalities. At one point during the site visit, a counsellor explained that the PCC therapists maintained differential expertise with Aboriginal cultural approaches, Eastern mystical approaches, and Western therapeutic approaches respectively. The inclusion of Aboriginal cultural practices had genuine appeal for some clients.

Since I'd been going to treatment centres, and they were short term, and [I] did not know traditional things ... I figured maybe I need to find out a little bit about my Native background ... and learn a little bit about spirituality. And I was interested in learning the drums and the singing and the dancing. It appealed to me and I've been interested in it, like when you hear that drum, it sort of lifts up your spirit. It makes me feel like I want to get into it. It makes you want to dance, but you don't know why you feel like that, you just want to ... I guess I was finding myself, searching ... I figured that would give me some answers, I suppose (Client).

Among the PCC staff, these practices were understood to facilitate healing as effectively as the Western modalities.

Only our cleansing ceremonies, which oftentimes are commonly known as the sweat lodge ceremonies, it's a sacred ceremony, and it addresses all four areas of our being. It cleanses physically, mentally, and emotionally and spiritually. Because in our cleansing ceremonies, as we know them, we have that opportunity to share with one another whatever it is that's bothering us, whatever it is that's not right in our lives, that's hanging over our shoulders, so to speak, or the dark cloud above our heads. It gives us that opportunity to release that there. It gives us the opportunity to share with one another whatever teachings we've acquired in that time of our lives, the teachings that we have that have been passed down to us from our Elders. Oftentimes, if we're sincere about the ceremony itself, we come out of there feeling refreshed in all areas. The aches and pains in your body are gone ... The physical tiredness you feel, it's not like the tiredness you'd feel physically from hard labour, but it's a tiredness of releasing a heavy load, that kind of relief. Mentally, you feel okay because then you come to the realization that, "Hey, I'm not the only one with this problem. And yeah, I can see how I can work this problem out." They have a better perspective. They have a different perspective of whatever there was that bothered you when you first went in there. And then you come out with a clearer vision of how to go about whatever it is, whether it be a relationship or whether it be financial or whatever, you have a clearer picture as to how to go about it and you have the support of all those people in that ceremony, in that circle (Counsellor).

Although PCC staff were involved in promoting both Western and Aboriginal approaches, great care was taken to explain that participation by clients in Aboriginal traditions was encouraged but not forced, owing to the reality of religious diversity in the NCN community.

One of the ways [we include Aboriginal practices] is by smudging. Now we take into consideration that not all people are comfortable with that. So when we bring our smudge into our sharing circles, we ask that the people, if they're not comfortable with it, they don't have [to participate]. We don't force anything on anybody that they're not comfortable with ... Because of the Christian mentality that has been imposed on us, even to this day, we have still a lot of resistance from our own Native people [toward] our Native traditional ways. But that's understandable, so we make accommodation for that (Counsellor).

Nevertheless, one commitment of the PCC program was to educate clients and community members about traditional Aboriginal practices. In some instances, relating suppressed Aboriginal ceremonies to more familiar Christian understandings proved helpful in this educational process.

I'll explain a lot of the stuff to them first of all ... Like, in a group it's good to explain about respecting Christianity. But I'd say about seventy-five per cent of them will go into smudging. Some of them I'll give sweetgrass or cedar to burn ... And I'll explain it to them about the cloth [offerings]. I say, "Remember in the Bible?" I said, "They offered a lamb." I said, "We'd offer cloth, tobacco." So, once you get that understood, I said, "The pipe," I said, "I want to explain to you." You see them open their eyes ... "The pipe," I said, "is our crucifixion. In Christianity, [the parallel is] crucifixion," I said. "We fast four or five days. In the Bible, the Creator [sic] fasted for forty days, forty nights," I said. So there's so many similarities. Well, when I explain it that way to them, in a good way, then [I] see their eyes opening up. Some of them grasp onto it (Counsellor).

Sweat lodge ceremonies were conducted on Medicine Lodge grounds every Thursday, while occasional pipe ceremonies might be scheduled on Saturday or Sunday when routine program activities had ceased for the week. A full-time traditional counsellor was employed by the Medicine Lodge to assist with these and other cultural activities. This individual also engaged clients in more conventional counselling services, though he did so primarily through the residential treatment program.

The striking inclusion of such diversity in the therapeutic approach within the healing activities of the PCC staff was counterbalanced by the relative absence of mainstream evidence-based interventions or recognized best practice approaches to substance abuse and related problems (e.g., brief intervention, relapse prevention, motivational enhancement therapy, and so on). This was probably the case for at least three reasons. First, the culture of substance abuse treatment in mainstream society has been ideologically committed to the discourse of Alcoholics Anonymous (AA), which emphasizes a disease model of substance abuse, a spiritual program of recovery, and an anti-authoritarian, self-help approach to well-being. These assumptions, currently shared by many Aboriginal community-based treatment programs as well, have limited the role that pragmatic evidence-based interventions and training might play in substance abuse treatment in general and in Aboriginal programs specifically.

Second, a distinctive feature of the Medicine Lodge staff was that employees were all themselves Aboriginal in background and hired principally from the NCN community. Given the educational and employment disadvantages that characterize many First Nation communities, the commitment to remain as accessible as possible to an Aboriginal client population necessitated a trade-off between Aboriginal life experiences and formal education among its staff. In fact, the Medicine Lodge administration prided itself on the organization's ability to invest in the training of community members as they were hired to fill staff positions. As noted previously, such training was typically regional, part-time, and targeted to Aboriginal treatment contexts. Not surprisingly, the kinds of training opportunities described by PCC staff tended to draw more readily from popular psychology and alternative therapeutic approaches such that exposure to and expertise in mainstream or state-of-the-art treatments and interventions—including evidence-based ones—were unlikely.

Finally, the endorsement or inclusion of treatment approaches by the Medicine Lodge reflected the growing community consensus that spirituality remains at the core of healing. Indeed, this burgeoning consensus motivated the explicit commitment of the PCC to provide an integrated and holistic therapeutic approach to healing and wellness for individuals, families, and the community utilizing both Western and Aboriginal practices in the first place. As a result, secular treatments such as those developed, evaluated, and disseminated by Western researchers harboured minimal appeal in comparison to the sacred principles, unique insights, or mysterious energies that were thought to be manifested in complementary and alternative or even New Age therapeutic techniques. Reiki was one such technique.

I'm actually going to propose if I could do that, not to do the lectures but more so the hands-on healing stuff. I mean, [another counsellor] does an excellent job with [lectures]. But during the day, if they desire, if they want to come, [Reiki] is what I can do. And then they can go into the lectures with an open mind. Yeah, I mean meditations can help you with that too (Counsellor).

PCC staff members were not only open to such trendy or alternative approaches but actively pursued information, training, and even proficiency in such techniques. For example, one counsellor explained her interest in cosmotherapy:

I didn't really learn too much about that, but I learned it through [my Teacher]. It's similar to hands-on healing, but you're listening to different vibrations, different noises, different sounds and smells ... When you see a piano, it has different sounds to them, but she hits them with a noise and it just vibrates, vibrating noise, and it just goes into your body, and somehow it triggers something within your body. Wherever you're sick, it just opens it up or something like that, that's how she described it. And the smells, too, different smells can heal different parts of your body. So, it's quite interesting.

Such interest in novel approaches also accounted for the fact that several counsellors at the Medicine Lodge were learning to become life skills trainers under the guidance of economic development guru Tulshi Sen, who drew upon a variety of Eastern and New Age techniques to inspire community members to greater self-fulfillment and even entrepreneurial leadership.

In this sense, the therapeutic activities of the PCC were unusually eclectic, with staff participation in a wide variety of Western and Aboriginal approaches that frequently shared in common an overarching if somewhat imprecise spirituality. Taken together, this medley of approaches rendered an approach to treatment that was undeniably distinctive in the effort to reach and to serve an Aboriginal clientele.

Integration of Techniques

Despite incorporation of a wide variety of healing approaches and techniques, PCC staff consistently distinguished between Western and Aboriginal modalities. This is probably because many Aboriginal practices made available to PCC clients involve a ritual protocol that must be properly observed. Sweat lodges, pipe ceremonies, vision quests, and the shaking tent are all highly formalized endeavours in which powerful Grandfathers are beseeched for blessings and gifts. Owing to the very nature of these power-laden encounters, strict adherence to roles and procedures rendered formal integration of other modalities unlikely. Similarly, the contextual frame for many counselling activities served to limit the degree to which integration might occur. For example, even though every member of the PCC staff is religiously observant in some broad sense (sometimes in multiple traditions, including, say, both Roman Catholic and Aboriginal), none reported praying for or with their clients during their one-on-one sessions. Furthermore, in at least a few instances, tensions between Western and Aboriginal approaches were referenced:

I really believe in what I do ... But I question a lot of times my techniques in the field of social work because a lot of the work that I do has to do with our traditional way of life, and our traditional beliefs, our sacred ceremonies. But I have every faith in that way, not that it's any better than any other way, but it's just that it's natural ... And it's the way that we've been taught from as far back as I can remember, growing up ... With my own eyes I've seen it. I've had [contact with] the Ancient Ones they're called, the Elders that have gone into the spirit world. I've seen them, I've heard them. They've talked to me. But I know what they had to say to me wasn't only for me, it was meant for everyone that's waiting to hear. And that's why I strongly believe it, that there is a connection with the universe, that whole universe and everything is interconnected and related. And when one part of the whole is disturbed, whether it be mentally, physically, psychologically, spiritually, the rest of that whole is tampered with, it's broken. And I strongly believe that, and the Medicine Wheel teachings teach us that, and the Elders constantly remind us (Counsellor).

One client identified clear differences between the Western and Aboriginal approaches and evidently felt more comfortable with the unmediated expressions afforded by the latter:

The white man, they use the [Alcoholic's Anonymous] Big Book. It's like a Bible to them. There's the Bible too, but there's no book or Bible or anything written for traditional Native medicine, so it all comes from the heart and body, mind, spirit and soul. And the Creator, of course ... [the Spirits] can hear you instead of you writing it down, reading it, and whatnot. You just say it and they'll hear you and the message will go through. And you'll feel there's a change in you after you do a ceremony or something.

As a result, the integration of techniques in the PCC program more commonly involved routine and fluid shifts between professional and ritual contexts, both of which were valued as essential for client and community healing.

This is not to suggest, however, that instances of integration in less formalized activities were uncommon. The most prevalent of these was routine communication in the Cree language during the PCC activities conducted by the two counsellors who were fluent Cree speakers. In the instances observed during the site visit, these activities included a mix of English and Cree presentation, and even those in attendance who did not speak Cree fluently seemed to understand what was conveyed during the sessions. Other forms of integration were apparent as well; for example, smudging at the beginning of group sessions was not at all unusual, and inspirational lectures might accompany pipe ceremonies. Lectures and group sessions were typically initiated with prayer.

Usually we would open our meetings, our sessions, with a prayer because we have different denominations in our community. We have the Catholics, we have the Anglicans, now we have Full Gospel, and then we have what we call our traditionalists. We make reference to all of these top denominations, and we make reference to the fact that no one denomination is greater than the other, but they're all equal. They're all the same and we have respect for all of them. And in our prayer, we don't pray any certain way. We don't pray the Catholic way. We don't pray the Anglican way. We don't pray any denomination. We pray in the same way that you'd be talking to a friend, that's how we pray. And we don't ask for favours, and we don't ask for miracles, and we don't ask for this and that, we just give thanks ... There's a lot to be thankful for, but we don't ask favours ... And everybody's comfortable with that (Counsellor).

Here and elsewhere, the boundary between the Western and the Aboriginal was frequently blurred or even dissolved altogether ("They're all equal. They're all the same, and we have respect for all of them"). Western group sessions and Aboriginal talking circles might afford little to distinguish them beyond the explicit framing of these activities as either secular or sacred respectively.

Furthermore, Western therapeutic approaches might be attributed to Aboriginal origins through a process of traditionalization: "The [Alcoholics Anonymous] program which we're all familiar with came from the seven sacred teachings of the Medicine Wheel." This same PCC counsellor characterized Aboriginal ceremonies in the unmistakable terms of group therapy:

And this is the way we used to do it, through ceremonies, through the cleansing ceremonies, commonly known as sweat lodges, through fasting, through vision quests and through

healing circles or talking circles, whereby we express to one another in all confidentiality as to how we really feel from our emotional aspect, from our emotional being, how we really feel about whatever it is that's on the table. Whatever it is that's the issue. Whatever our personal issues are, whether it be in a relationship, in a marriage, or any other type of relationship, or whether it be family, whether it be community, any aspect of our lives we can talk openly to one another because that trust is already there. It stays in there [through observance of confidentiality] (Counsellor).

Similarly, New Age notions of auras and energies were interpreted as expressions of age-old Indigenous understandings of power and life. Another counsellor, an enthusiastic participant in Tulshi Sen's life skills seminars, offered a brief monologue extolling the virtues of stillness, space, and gravity and the significance of the seven sacred chakras during a sweat lodge ceremony.

By far, the greatest challenge to the integration of Western and Aboriginal techniques in PCC activities was not the mechanics of the techniques themselves, but the more basic spiritual or religious significance in which these were embedded. Religious diversity prevailed in the NCN community, such that constant care was taken at the Medicine Lodge to promote Aboriginal cultural practices without disrespecting (or imposing or intruding upon) Christian beliefs and practices:

Not everybody that comes in there is traditionally oriented. And you get Christian people that are dead set against traditional ways. So we had to be open to accommodate ... our own people who were Christian-oriented. So we had to somehow respect their practices because if you want to gain people's trust, you've got to respect the way of life that works for them. We don't want to impose our way of belief on them, you've got to respect the client's beliefs (Administrator).

However, tensions between faith traditions were not always cast as Aboriginal versus Christian. In at least one instance, this led to an amusing quandary for one administrator:

When I started [here] ... I had experienced one of my first challenges as a manager. And there was a cultural clash between two nations, the Cree and Ojibwa. Okay? The traditional counsellor was an Ojibwa woman. And there was a weasel that was running around the Medicine Lodge and she just freaked out. She said, "That's an evil spirit, that's an omen that's running around, that's bad news. The Medicine Lodge is going to burn down!" And it freaked me out, and then ... when I went to start working [at the Medicine Lodge], [my relative] was already employed there. So, she was right behind this woman helping her try to kill this weasel. They're setting up traps, putting hamburger and cheese in it, stuffing it with poison, setting it up. And then this other woman [announced the opposite, stating that this weasel was a Grandfather spirit] ... And to me, these two women were elders, and I thought, "Well how am I supposed to stand up to these two women?" Because one woman is saying, "She's killing my Grandfather! You can't let her do that!" And I'd say, "Oh my gosh, what am I supposed to do?" ... I wasn't very knowledgeable in Aboriginal practices ... so I said, "Well, I'm going to go talk to an elder that I know, that I trust." And I knew her since I was a child. So I went to her cabin, her trapline, and I told her what was going on with these two ladies. They were fighting about this weasel, one saying it's an omen spirit, and the other saying that

it's her Grandfather, and I said, "What am I supposed to do?" And she says, "That's [a pelt worth] ten bucks running around the Medicine Lodge!" And I thought, "Okay, that's what makes sense to me, that's the reality." Because that's what I grew up with and it's okay. And she says, "They're harmless." She said, "Every once in awhile I got a weasel coming to visit me and they just have a job to do. They're there to kill mice and that's it, they're gone." I thought, "Okay, that is such a relief. It's not an omen spirit. It's not a Grandfather. It's a weasel." I said, "Okay, I'm just going to let them fight it out, okay?" She said, "Yeah, just let them fight it out." Because what am I supposed to do, right? Two elderly women.

However, the situation reached crisis proportions before it finally was resolved.

Then this Cree woman, she just come marching down the hallway, just stomping ... into my office. "Come here," she said, "Come here!" So I went. It was a real crisis. We're racing down the hallway [toward the kitchen]. I told the maintenance man, "Come with me, come with me." So we went. She says, "Look! Look! She killed my Grandfather!" ... So me and [the maintenance man] are looking, and it's just a real shriveled up brown thing. So [the maintenance man] had his work gloves on, so he decided he was going to pick it up. And he looked at it and said, "This is a dried carrot," he said. So that was my orientation to a culture clash with our people (Administrator).

As humorous as this episode was in the telling, there was also the hint of tragedy to be found in the story of the Medicine Lodge weasel, for ultimately the subject of such great cultural consternation was neither omen nor Grandfather, nor even a casual medium of exchange, but instead simply discarded refuse. In the context of such ambiguities, then, thorny culture clashes were understood to come with the territory in regard to the distinctive vision of programs at the Medicine Lodge.

Such cultural contestations were perhaps unavoidable in a community engaged in reclamation and revitalization of traditional practices that were all but devastated by Euro-Canadian colonization. One counsellor described the cultural situation at NCN when he initially returned from his university studies during the 1970s:

I came back, that was about 1974. And like I've mentioned before, it was like the whole community had gone to sleep. The elders weren't talking, the young ones weren't learning anything cultural, there was absolutely nil, as far as culture. We had quite a few elders still alive then, but they were being quiet ... They were not teaching us the way that our parents before them, like a generation before, had spoken to us about the culture. And then it seemed like they didn't want to have anything more to do with it, for whatever reason. But later I found that it was the total oppression of them being prosecuted for practicing that way. And there was a time when the government of the day had banned our cultural ways, it was against the law in Canada.

This counsellor was subsequently instrumental in mobilizing the ongoing revitalization effort in the community:

So how we initially started was, I initiated a Native Cultural Group, is what I called it. A Native Cultural Group, whereby I was sharing what I had learned about Native history from the West Coast, and how those people there in the West Coast were proud people. They were proud of

their heritage. They were proud of their history. They were proud of their arts and crafts, and whatnot. And it was a struggle at the beginning ... But we had some people in our community that it was a reawakening for them, in a sense that there's something here. This guy seems to know what he's talking about. So I had a few followers, started off with five young men and they were all younger than me ... Because we didn't know how to go about our own ceremonies from this north region, we invited the Elders from down south, southern Manitoba and into the next provinces, Saskatchewan, Alberta, that were knowledgeable about the cultural practices of their own region. So we more or less adopted their practices, but in the process we were learning our own Cree way, different ways of addressing the same purpose, which is spiritual.

All of the five original participants of the Native Cultural Group, according to this individual, were involved in community healing efforts of one kind or another.

The adoption of cultural practices from different regions of Canada during this community revitalization effort gave pause to some community leaders, however, who worried about the incorporation of pan-Indian orientations and traditions that might undermine distinctive Cree principles and practices. For example, ceremonial use of peyote by local practitioners was controversial, all the more so at the Medicine Lodge where lifelong abstinence from psychoactive substances was a primary treatment goal. One administrator at the Medicine Lodge considered pan-Indian cultural synthesis to be a substantial danger to community well-being:

I think another significant challenge is that of pan-Indianism. It's a major threat, I think, to the unfolding of what can be a very significant and powerful healing process that could unfold in our communities. But it's a set of beliefs and practices that are dangerous in their appearance as being Indigenous, but are, in fact, a hybrid of too many Indigenous practices that could spell disaster.

Interestingly, while this hybridity of Indigenous practices was viewed with some alarm by this administrator, the combining of Western therapeutic approaches and Cree tradition within PCC activities did not seem to trouble him at all. Moreover, the gravitation of some PCC staff toward alternative and New Age therapeutic approaches—including the principles of stillness, space, and gravity espoused by Tulshi Sen—seemed to elicit understanding rather than condemnation from this administrator: “Our people, as lost as we are, will gravitate to anything that they see as being even remotely Indigenous.”

This tendency to readily incorporate even remotely Indigenous therapeutic approaches and practices inevitably fueled contestations of culture that affected efforts at therapeutic integration in the activities of PCC staff.

Nelson House has lost [a lot of its cultural traditions]. They're getting it from people that just got into it themselves a few years ago. Like [one guy] just got into it a couple years ago, and all of a sudden he's a pipe carrier. And that's what bothered me because a lot of them are getting the improper, inappropriate teachings. You have a group of women in there ... that just go to the very, very extreme on cultural stuff ... They have followers, and they teach it ... I finally talked to one of the counsellors. I told them, “That's terrible.” I said, “You shouldn't allow those women to do that. They don't know anything ...” And so, what happens is you have in the whole community a lot of these wannabe elders ... This community is lost ... Maybe that's why there's so many [terrible] things happening in this community (Counsellor).

The ready assimilation of potentially inauthentic traditions and practices in the name of cultural revitalization within the community was seen by a small minority of Medicine Lodge staff to actively endanger the well-being of the very community that they were explicitly dedicated to healing.

In sum, the integration of therapeutic techniques in the activities of the PCC involved the routine separation of Western and Aboriginal approaches, with accompanying segregation in the more formal activities of each, but casual integration in the less formal of these. More significant for the purposes of understanding integration efforts was the spiritual or religious significance in which any given technique was embedded. Not surprisingly, given the diversity of religious practice in the NCN community, respect and accommodation for non-Aboriginal belief systems were essential even as exposure to and appreciation for Aboriginal practices were valued. The contemporary community context of cultural reclamation and revitalization involved openness by many of those affiliated with the PCC to a wide variety of cultural approaches and practices that resonated with Aboriginal tradition broadly construed. These individuals anticipated that incorporation of such practices could be put to use for community healing. For a few others, however, this ready appropriation of elements that were not authentically Cree (or even authentically Aboriginal) instead posed an active threat to the well-being of the community. Thus, cultural contestation surrounding the spiritual or religious significance of healing techniques seemed the greatest challenge to therapeutic integration within the PCC.

Liaison with Other Agencies

To a significant degree, the PCC staff coordinated their efforts with other programs and agencies in the NCN community to better facilitate healing and recovery among their clients and potential clients. One obvious venue of routine collaboration was within the Medicine Lodge itself. The PCC staff comprised just four of the 25 or so Medicine Lodge employees, but the circulation and exchange of ideas, approaches, and support was commonplace. During much of the site visit, for example, the two NNADAP prevention and referral program employees joined the PCC staff each morning for a smudging and sharing circle to inaugurate the workday. In addition, techniques in use by the residential treatment staff often filtered into PCC activities. Indeed, the director of the residential treatment program was responsible in part for the training of the PCC staff in the early months of the program. Finally, staff throughout the Medicine Lodge might be friends or even spouses, and the lateral transfer of employees across programs into unfilled positions was not unusual.

Beyond the Medicine Lodge proper, the PCC staff maintained strong ties with other wellness efforts and counselling programs throughout the community. As previously noted, the NCN Wellness Centre was the band-controlled umbrella organization for twelve human services programs, including counselling services. The counselling services program employed three NCN members who provided crisis counselling and prevention services for the community. Individuals in need of more intensive therapy might be referred to the psychologist who visits the community twice monthly or referred to the Medicine Lodge programs if warranted. An additional counsellor was employed in Human Resources to assist community members with vocational matters. Other service providers at the community nurse's station and the long-term care facility were well-known to the PCC staff as well. Given the small, face-to-face nature of NCN community life, many of these counsellors and other providers were intimately familiar with the same clients. In general, cross-agency consultations and collaborations on behalf of the wider community were undertaken as a matter of course. For example, PCC staff were on call for crisis intervention alongside the counselling services staff during the rash of deaths and attempted suicides near the beginning of the site visit. At one point, PCC counsellors were summoned to the local constable's office to evaluate an inmate for suicidal tendencies. Finally, clients who

graduated from the PCC sometimes required certification of their successful completion of the program to their parole officers or the courts, which the PCC staff handled routinely.

Although the Medicine Lodge was funded principally by Health Canada and accredited by the requisite government agency, there did not seem to be any major challenges arising from the ambitions and directives of the NCN chief and council on the one hand or the respective federal agencies on the other hand. Indeed, the administrator of the Medicine Lodge was officially detached to work for the chief and council for the duration of the site visit. Perhaps such unusually harmonious relations stem from the fact that the local chief and council appointed the board of directors of the Medicine Lodge and that the Medicine Lodge employees were largely comprised of NCN members.

Working with Clients

Beyond the organizational nuances of PCC program structure or the religious significance of diverse therapeutic approaches lay the dynamics of counsellor-client relationships; that is, the effectiveness of any program such as the PCC will depend a great deal on the ability of its staff to effectively reach out to, connect with, and inspire transformations in self and behaviour for its clientele. In addition to their participation in the PCC program, many clients reported earlier treatment experiences in non-Aboriginal settings. Most felt that the PCC was more effective in helping them than these non-Aboriginal programs. One client described a non-Aboriginal counsellor she had consulted sometime prior to coming to the PCC program:

But she was white. I wasn't comfortable talking to her. It's not that I'm prejudiced or anything, it's just that I know that she can't understand what [life is like for me]. I know she's a counsellor. I know she's educated and whatnot. I know she been going to school. She should know [how best to] diagnose me, but deep down, I figure she doesn't know how we are. She's white, I'm Native. I talked to her about three times, and I cancelled all the rest of my appointments with her because I wasn't really compatible with her.

Thus, compatibility between counsellors and their clients at the PCC was undoubtedly due in part to their shared Aboriginal backgrounds. For some clients, such compatibility was more conducive to talking.

It bears noting that the principal means by which PCC staff hoped to reach and inspire their clients was through talk, whether in the form of one-way lectures, two-way one-on-one sessions, or multi-way group sessions. One initial obstacle to effective counsellor-client interactions was reportedly the reluctance of clients to talk during PCC activities.

What I haven't come to understand is the fact that our Native people have such a hard time talking about their emotion, how they feel. And I've seen that from as far back as I can remember. And even myself, it's just recently that I've been able to talk about how I feel, not so much what I think, but how I feel. And having worked in the last ten, fifteen years in social work, that ... with our First Nation people, our Native people, I find it's like pulling a tooth out of them (Counsellor).

Such reluctance among an Aboriginal clientele was further exacerbated by the fact that the PCC program served outpatients who typically resided in the close-knit NCN community.

Even in a treatment centre, where if you have too many people from the community coming into treatment all at once, they were very reluctant to open up and to share their stories because they know each other. And ... one of the evils of our people is gossip, and that's what that fear is [about] gossip. And that's a really challenging thing to deal with. So one of the issues at the staff level, an area that we identified that needs to improve, is confidentiality. How to enforce confidentiality, even with our staff. And there are some staff that gossip, and how do you get them out of gossiping? And [alternatively] some go to the extreme of not talking about [anything], and that could hinder their health ... So I would imagine that in the PCC program, that may be a factor in the low number [of clients] (Administrator).

Despite these challenges to PCC client comfort and self-expression, distinctive measures were taken in order to nurture therapeutic relationships between counsellors and clients.

Perhaps the most important measure taken by PCC staff to reach clients effectively was the creation of a comfortable, supportive, and non-judgmental atmosphere conducive to client self-expression. Although such traits are probably common to counselling in general, they warranted even greater attention in the PCC program as a result of potential cultural discord in the face of such services within the NCN community. Thus, sensitive accommodation by PCC counsellors of clients who were simultaneously orienting to unfamiliar PCC program expectations even as they were reeling from the chaos of their unmanageable lives seemed crucial to therapeutic success. One administrator who conducted occasional one-on-one sessions described her efforts in this regard:

My approach? Well, I would try and be as humanistic as possible. I would make them feel comfortable. I wouldn't put a barrier between me and that individual that way because that shows distance and that I'm not approachable. I'd make them feel as comfortable as possible and just let them talk and tell them I'm here as a helper, to listen and to help you in whatever way I can. Then I'd listen to them in terms of what they want to talk about. And I'd use my different listening and counselling skills that I've learned, by showing them I'm listening, by paraphrasing, and using the other techniques.

In the PCC setting, counsellor approachability and client comfort seemed to go hand-in-hand. Approachability could be signalled by a variety of concrete gestures.

But I always want to make people feel comfortable. I think that's really vital. I don't want them to see me as an authority figure, as the person who has all the answers, as the person that's seen it all and knows it all. I don't want to come out like that to them ... And then I spend some time right from the beginning just to get them comfortable, for example, even to offer them a cup of tea or coffee. Because I'm from this community and I've grown up in this community, I know most of the people in this community ... And then I tell them a little about me. I don't get too personal with them, but just to make them feel safe and feel comfortable. Maybe I'd share a joke with them. Maybe I'd share a funny incident that happened to me during my recovery period. Maybe I'd share with them an incident that, when I think back about it now, it brings a smile to my face, but at the time I didn't find so funny. So things like that (Counsellor).

The willingness to share stories from their own recovery periods clearly served as a strategy for counsellors to seem more fully and fallibly human to their clients. Furthermore, such honesty probably served to pre-empt fears of counsellor censure or judgment, which seemed all the more appropriate in light of general community awareness of personal histories and reputations. One client found inspiration in such awareness:

And I've seen [these counsellors] when I was younger. When I was teenager, I've seen them drunk. I've seen them piss their pants. I've seen them down in the mud, and whatnot. And I can see them now. That's just like, "You can change. It's up to you to make a change."

Portraying such foibles in a humorous light (a funny incident) also seemed to facilitate approachability and comfort.

And with First Nations people, there's a lot of humour ... They can laugh about things that are really traumatic, because it's already happened, right, and they can talk about and laugh about it ... I mean, that's just the way we are here in Nelson House. And I'm able to converse with them in that way here in the PCC program. And we can laugh about it, but we come back to it and say, "Okay, well, what did you learn from that?" Or, "How did you feel back then?" You've got to bring them back on board, to go through that feeling, yeah, but also to be safe. That's the one thing that they lack is trust, even amongst each other. And I always tell them that, "When you come here, you're a family ... You've got to trust one another" ... like in a normal family, anyway (Counsellor).

The strategic use of humour could thus result in greater trust and openness during therapeutic activities for PCC clients.

The PCC commitment to counsellor approachability and client comfort also involved early assurances that client communications in program activities were confidential in nature.

Because right away, I established that trust and that confidentiality with my client. "Whatever you say [is confidential] ... If you don't want to [share some things], that's good. But the only way I can help you is if you share some of the things so I can give you some guidance and direction ... What you and I say here today, it stays here. I want you to know that." So once you gain that trust, that confidentiality, behind closed doors, [then you can proceed] (Counsellor).

Beyond confidentiality, ensuring client comfort also involved careful attention to even the smallest details of the therapeutic encounter.

I always tell [my clients], "If you're not comfortable here, we don't have to sit here. We can go out and have coffee or take a drive somewhere" ... So they're okay with that ... The environment I feel has a lot to do [with it]. Even the physical environment has a lot to do with releasing this pain, whatever we're carrying ... For example, in our sweat lodges, in our cleansing ceremonies, people are more free to talk about whatever. When they come to an environment like with four walls, you feel closed in, and especially in a formal setting. What really hinders counselling is for a [therapist] to walk in here in a three-piece suit, and you're just coming off the street, maybe from their trapline. And you really have this problem that

you want to unload, but it's really hard ... It's not really comfortable. So an environment makes a big difference in the field of counselling ... And also even in some offices, you go in, and there's nothing on the wall ... There's not even a picture on the wall, it's just the four walls. It also brings memories of being incarcerated, being in jail, and there's just these four walls and nothing [else]. So you'll notice in my office I have a lot of artifacts, a lot of pictures, a lot of scenery there, and even plants (Counsellor).

Thus, an offer of tea, a personal introduction, a self-deprecating joke, a picture on the wall, and assurance of confidentiality all served in the efforts of PCC staff to facilitate client comfort during treatment.

Evident in these discussions of approachability and comfort were degrees of flexibility not typically associated with formal treatment programs (e.g., leaving the premises to conduct counselling). Perhaps the most significant indicator of this remarkable flexibility was the consistent prioritizing of client needs over the dictates of time and schedule.

When we have our evening sessions, we lose track of all time ... Particularly with my session, time is of no essence. We're in a time warp, where we can go for however long until everything has been said that needs to be said and everybody is comfortable, so we don't leave that room with people feeling that there's something missing here, or we don't want them to go home feeling more depressed than they were before they come here. So, we want everybody to feel comfortable once they leave ... We make a last round [in the sharing circle] to make a check, see that everybody is okay. "Okay, you're comfortable with what we just talked about? Yeah. Okay, how are you? Comfortable. Explain that a little more?" And they explain how they are feeling ... And if there's anyone in that group that needs to just spend more time, then we'll pull them aside and we'll get them to talk to another counsellor that's available (Counsellor).

Such flexible accommodation was cast in terms of respect by the counsellors for their clients.

I always show them that respect, that I'm here to take that time for them. Time is of no essence ... I have a clock above my desk, but I don't pay attention to it because it's not important. And if it's lunchtime, well, that's okay too, because I can always have lunch later. What's important right now is this person and to give them that time, as much time as they need. I'm always conscious of that, and that's how I work with the people that come to see us (Counsellor).

Even the scheduling of PCC activities was determined by flexible accommodation to client routines.

The other thing we thought about that had an impact on programming, in terms of flexibility [was that] people don't get up at nine, eight, seven in the morning, they get up around twelve, one. So, okay, we'll start delivering the program at one o'clock and go into the evenings. Staff didn't like that but that's the community norm, so we've got to work with the community (Administrator).

In addition, PCC staff recognized the discomfort experienced by clients in treatment or other recovery contexts when they were pressured to identify themselves as alcoholics. Thus, PCC activities flexibly dispensed with this common AA-inspired practice, which clients seemed to appreciate.

It's a comfortable place where I can go talk and say things that I don't have to worry about, like just let it out, and people are there to listen and understand ... I've been through [a non-Aboriginal treatment program] too, where I have to call myself an alcoholic in order to speak ... PCC gives you a place where you can just be yourself, and it gives you the significant aspects of life, like honesty, humility, truth, courage ... And it's amazing. And it's been applied to me twice, and honestly, I could never get enough (Client).

Flexible accommodation of clients appeared to extend even to staff expectations concerning participant abstinence throughout the PCC treatment cycle.

But you're regurgitating the same [clients] over and over again ... You kick this guy out after a week, you bring him back. He gets drunk, he doesn't come back. He comes back the third time, and that keeps going on. You get many of these guys four and five times that have come back, same ones try and finish the program. Some of them were drinking while on the program, but I said, "Well, we've got to bring them back." I said, "If we don't, then we'll have nobody. If we were to kick out everybody that drank, we wouldn't have anybody." See you've got to be flexible there, you got to use the common sense approach (Counsellor).

As a result, former clients at all stages of their healing journey were invited and encouraged to avail themselves of PCC services whenever they might need them.

But it doesn't stop there because we do follow-up, and it's ongoing. It's always ongoing. And we have a revolving door policy, like once they leave here, it doesn't mean that we don't bother with them anymore. They always know that they always can come back. So, with that knowledge we do have people that come back, and we do follow-ups ... A lot of times, see ... people come in for the wrong reason, so naturally it doesn't work. So we find a lot of people fall by the wayside. And when that does happen, we don't give up on them [then] either. And sooner or later we've had successful stories of people that have gone through our program that are doing well now in their relationships and their jobs, and they're contributing to the community (Counsellor).

Thus, programmatic flexibility extended even beyond the boundaries of the treatment cycle. Accommodations to client needs were rather far-reaching as PCC staff sought to encourage the sustained engagement of clients not just in program activities but in productive relationships with their counsellors. Such efforts met with remarkable success. One client described an effective one-on-one session with her counsellor:

I had that urge to go to the bottle, but I said, "Never mind. Not this. I'll just go run to [my counsellor]." And I came to [him] and I think I cried a little when I talked to him. And then he said, "Well, it's a good thing you came." But he understands because ... he knows us for a long time, me and my partner, and he knows that there's abuse. So ... he made me feel better, like, "Yeah, I think it's time for you to move on with your own life." I'm not saying he pushed. He talks to me real good, and he made me feel better. I don't have to turn to the bottle, I always have people around me that can help.

Another client observed that such comfort extended even to group sessions:

And [the counsellor] closes his eyes and listens to you talk. And he was doing that that day. And I even told the people that were present [in group] sometimes, I said, “Hey, you seen this [kind of experience]?” ... And what I really look back on was the comfort that was given, the comfort that was given as soon as you walked in, even if you’re hard-nosed. I’m the hardest-nosed ... on this reserve, man. If they can help me, they can help anyone.

A third client explained how the comforting “vibe” created by PCC staff led to his enthusiastic participation in program activities:

When I first began [the program] it was an uplifting deal. It was so uplifting, encouraging. I was there half an hour early every day ... And it’s a comfort ... Through vibes, you get vibes. Comfort, like this, and it’s amazing. That’s what they gave me. When I spoke, I spoke from the heart. I didn’t think of what I was going to say before I said it ... So I spoke from the heart. What I tell people is if they want to go in there [to the program], give it a shot. That’s best thing, give it a chance. You give everything else a chance, why not give healing a chance? And when you do that, speak from the heart. Don’t think about what you’re going to say or don’t try to say what they want you to say, speak from the heart. And that’s the best thing you can do ... I’ve never been a spiritual person, but you’ve got to believe in something too ... I’ve come to believe in a higher power, and it allowed me to make more responsible decisions.

As intended, PCC staff efforts to ensure client comfort yielded in this instance an infectious enthusiasm for the program, resulting in authentic self-expression, responsible decision-making, and promotion of the PCC within the community.

Once a comfortable therapeutic relationship had been established between PCC counsellors and their clients, a variety of counselling skills were employed in the pursuit of client well-being. Such skills were obtained by counsellors through ability, exploration, training, and experience. Given the programmatic emphasis on client self-expression, it should come as no surprise that such skills frequently were employed to facilitate mutual communication and understanding. One of these skills was keeping clients engaged in the here and now.

I’ve come to be able to detect if the person is sincere, if the person is hurting but not talking about it, if the person is troubled about something. Because you can always tell by the shifting of the eyes, the fidgeting, the restlessness ... And not really being here [in the therapeutic encounter], but being somewhere else, your mind being somewhere else, and not really concentrating on what’s happening here. The here and now. I can always detect that. And when I see that happening in a person, I always try to bring them back to the here and now (Counsellor).

Another important counselling skill was careful questioning or gentle probing to facilitate client participation.

Most counsellors have a knack of recognizing things, so they’re able to ask the right questions at the right time. So that, in turn, is to me ultimately up to the individual him or herself. As for me, I’m grateful for the way it worked out for me. Yeah, like I said, I was one hard-nosed guy, and if healing, counselling, and therapy can help me, believe me, everybody in this world can be helped. And with other people present, I was able to use them as instruments for [helping] myself (Client).

Part of the skill involved in such questioning was taking care not to “come on too strong,” thereby creating client resistance and discomfort.

When [one counsellor], through the sessions, he didn't come on too strong, not like other people [in other programs who say], “Come on, you got to spill it out! Let it out! Let it out!” Like, “I just got here anyway! I don't hardly know you guys” ... My problems. It's like come right out, sort of like they want me to brag about it. But people like to talk in there (Client).

Once clients did start to talk, active listening was another invaluable counselling skill. Clients emphasized the ability of PCC counsellors to attend to what they had to say:

And they'll help. So they'll help you the best they could. That's better than nothing ... Because [I'm] pretty sure nobody else would listen. Because that's what they're there for, to listen and help the best way they could (Client).

I think a lot of times my counsellor has been patient. I know she had some other things to do, but she gave me that time, she gave me her listening ear. She was understanding, very encouraging. A very polite woman, considerate, and she wasn't critical. She wasn't being judgmental and stuff like that. She was there just to listen, listen to me, what I have to say. Sometimes I would speak, and she wouldn't cut me off. Some counsellors do that in the middle of your sentence, they cut you off. You never get to finish your story, and after a while you don't want to talk no more. She wasn't like that (Client).

In some instances, considerable patience was required to ensure that client communications were not cut off.

I think we can get down to their eye level, don't try to dominate [the interaction]. And I think that's probably the unique way that a lot of non-Aboriginal people don't understand. A lot of non-Aboriginal people don't understand the silence. It goes as long as a minute even ... “Do you have anything to say? Do you want to say anything? Do you want to think about it a little bit more?” Let's take, for example, one person that I've spoken about. And I looked at my watch, about forty seconds. “Do you want to think about it a little bit more?” I thought that she wasn't going to say anything, and then she just nodded her head, “Yeah.” So I let it go for another forty and she started talking. “Do you want to talk?” “Yeah.” So, there's [time for] thinking ... You're taking [your time], because once they're listening and you've got them, then you got your audience here. And the hand motions, use hand motions. You just sort of maybe even exaggerate a little bit sometimes to make them [understand you]. That's the unique way with a lot of Aboriginal people (Counsellor).

Thus, familiarity with the patterns of spoken interaction unique to Aboriginal people was an essential ingredient to effective counselling with PCC clients.

Beyond the initial facilitation of client self-expression, and the subsequent esteem and validation conveyed through active listening, additional skills were also required by counsellors for determining how best to respond to their troubled clients. One therapeutic hazard, of course, was that desperate clients might expect counsellors to provide simple and unambiguous solutions to their problems.

And I make it well-known, well ahead of time, right at the beginning, that I don't have answers to any of their problems, but I can help them. I can guide them and that's all I can offer, and the rest is up to them (Counsellor).

Thus, explicit clarification of the counsellor role was one method of reigning in understandable, though inappropriate, client expectations. Another method used to counter these expectations was to distinguish between offering clients guidance as opposed to advice.

On the one hand, [advice is where] I'm telling a person what they should be doing. On the other hand, [guidance is where] I'm making them realize what they've known all this time, but they've missed out for whatever reason because they've only been concentrating from one point of view. They've only been concentrating on the other person and not concentrating on themselves. And once they can do that, then yeah, you can see where you can make changes (Counsellor).

Guidance was seen as superior to advice as a therapeutic response, in part, because guidance might facilitate insight, empowerment, and responsibility instead of client dependency on the counsellor. Furthermore, care to avoid the giving of advice seemed to have cultural precedence.

But then you go talk to an Elder. An Elder wouldn't say, "Do this" ... He or she will tell you a story, and in that story you have to pick up what it is he's trying to tell you ... So they don't give advice, but they will just tell you a story and you got to listen. But in a Western style, you listen when they give you suggestions. They suggest in the Western style ... Whereas in the Aboriginal style, they tell a story, and from that story you've got to [figure out] what he's trying to tell you. You've got to pick up words he's trying [to convey], and it's usually done in Cree because it's more meaningful. That's the Cree way, to speak your own language, more meaningful than using all these technical terms in the Western style (Client).

One key to understanding this cultural mode by which elders offered guidance to others may be the reluctance of these older individuals to risk infringing on the personal autonomy of others. In any case, counsellors' guidance of their clients might lead to innovations in interest and behaviour: "And another thing she gave me was an opportunity to explore and try different ideas, try different resources, talk to other people" (Client). Counsellor responses to client self-expressions required skillful navigation in their own right if therapeutic progress was to be facilitated rather than endangered.

In working with clients, PCC staff made every effort to cultivate trusting and secure relationships and used a variety of counselling skills to facilitate client self-expression in PCC activities. In short, effective counsellor engagement in these processes may well have determined therapeutic outcomes for clients engaged in treatment. What then were the qualifications that best positioned an individual to perform effectively in the counsellor role? One clear prerequisite was seen to be relevant life experience.

To me [the PCC program's] backbone is the people conducting the healing. Right now, that's been their [achievement], to me anyway, with the counselling. It's our culture. It's our way of life. It's there and nobody can change it. It's how we conduct ourselves as to other people that are in the desire to heal, because they themselves are healing as well (Client).

Recovery from difficult life experiences produced counsellors whose own healing journey could inspire PCC clients to a better lifestyle.

As a result, PCC staff, as well as Medicine Lodge employees in general, served as significant role models for both clients and community members of how to live stable and functional lives. One administrator elaborated on the significance of role modelling by Medicine Lodge staff:

The easiest way not only to lead a horse to water but to make him drink was first to make him thirsty. You've got to make him thirsty and that's where the role modelling comes in. People will see ... [my wife] and I. I make no bones about the fact that I love this woman. I'm always touching her, I'm always kissing her, I'm always complimenting her, and I'm sober. And true, people can do those kinds of things when they're drunk, but having the courage to do that when you're sober, it just, I think, makes it more real. So I think the role modelling that we try to do [is significant]. I carry myself the way I carry myself because that's who I am. I don't think I'm vain ... I'm proud of who I think I am, let's put it that way. And I think I'm an Indian man who's come to know a little bit about himself and his culture and his history and his traditions and his practices and defend those things and live those things (Administrator).

The commitment to employing staff that might serve as role models for the community was so important that it could seem unforgiving at times.

And part of that [Medicine Lodge abstinence] policy is because of the value, I guess, to be a positive role model. If you want people to change, you've got to be able to model that behaviour. There's some good in it, but on a negative side [is] the nature of the programs and services that the Lodge offers. We're there to help people, but when our staff violates this [abstinence] policy, they're immediately terminated from their job (Administrator).

During the site visit, one staff member was in fact terminated through the enforcement of this policy.

Specific qualities of effective counsellors were solicited during the site visit, yielding a handful of rather comprehensive lists describing the ideal counsellor candidate.

A lot of them don't have the life experience. And I would look for, probably the biggest one, is honesty. They must be honest. And the next thing is, are you sensitive? ... When you're interviewing people, my skill is eye and body language. Eyes can tell you a lot, body language [too]. Not too many people have that skill ... So you want to get a person like that who is serious. Or even if you don't, and you have someone that was really willing and wanting to learn, and then that's the kind of person you want, right? ... Of course, that person would be alcohol, drug-free ... You can have one that doesn't have the academics, but [still is] an excellent counsellor, a lot of the experience. And then you're going to have one that's very educated that doesn't have the life experience of maybe the other person, but has good ideas. Yeah, young, more than willing to learn. So that's a tough [choice] ... You should have at least grade twelve. If you don't then you're fighting an uphill battle ... [Another] thing you see with counselling, too, is you can't become a good counsellor if you haven't got your own act together. You can take all the courses you want in counselling, but if you don't got your act

together, then how can you help somebody if you can't help yourself. So you got to look at those things (Counsellor).

Here, the ideal counsellor evidenced honesty, sensitivity, interpersonal acuity, seriousness, willingness to learn, abstinence, at least a grade twelve education, and some combination of academics ("good ideas") and life experience while having one's own "act" together. One administrator offered an even more thorough catalogue of ideal counsellor qualities:

Ideally, it would be an elderly person who is very personable, who is both an [elder] and a healer, who is very people-oriented, very in-tune with their own culture and their own identity, who is not judgmental. One who, on the other hand, is very mindful of the demands of the funding agency in terms of administration, administrivia, not only being able to do the person-to-person work, but also able to do the administration stuff. To be able to do the treatment planning, and the aftercare, and the follow-up, and the lectures. To lead the ceremonies. To bring the person kicking and screaming, and ultimately laughing and crying with joy, to the end of a treatment program, and to send them out into a world of supports that they've identified in treatment and that they've nurtured in treatment ... The person would have to know the Cree language as well ... Because so much of that is hidden in the language, the spirituality, the intonations, the tools. There is some esoteric knowledge that comes into play in ceremonies that is just not fodder for everyday discussions. So this person would be aware of those kinds of things ... And it could be a man or a woman, easy to laugh. As for training in the Western world, well, they would have to have some but it wouldn't be the deciding factor ... If my choice was [between someone with Western training or cultural expertise], I'd definitely go with the Cree-speaking, non-university-educated individual.

Obviously, these ideal counsellor candidates were larger than life and embodied so many skills and abilities that probably no human being could ever measure up to them. Nevertheless, as idealized abstractions, they provided important insights into the variety of qualities that would make for both effective counsellors as well as effective employees in the programs of the Medicine Lodge. In fact, given the size, history, and location of NCN, what seemed most remarkable was the degree to which so many members of the Medicine Lodge staff exhibited these desirable qualities.

One emergent quality of an effective PCC counsellor that was not listed in the above citations was more difficult to pinpoint. More specifically, this quality seemed to involve an overarching sense of calling or purpose to engage in therapeutic work with other Aboriginal people. One counsellor described this larger sense of purpose:

And I think that's the responsibility of this generation to address the seventh generation from now, and the seventh generation from before us because that's what it's all about. To put it simply, we're not here for ourselves, we're here to be of service to others. It took me almost a lifetime for that to click in, but through the persistent teachings of our Elders and through their patience, I have come to understand what that teaching's all about. And, yeah, it's simple. Sometimes it's too simple for academic and professional minds, and we overlook that. We overlook many things in our everyday lives in our fast pace to get ahead. To get ahead where? The only place we need to get is here, now. And that's basically all it boils down to.

Other PCC staff members also invoked a spiritual or religious significance for their own journey of suffering that had been more recently transformed into a journey of healing:

What I was told, and what I have learned, is that a lot of times the Grandfathers and Grandmothers and Creator will choose someone who has suffered a great deal in life, because they would be more compassionate and would have a better understanding of the work that they have to do to help in healing. And I really, truly believe that was the reason I was chosen (Administrator).

I think the Creator brought me to this point in my life to sort of slow down and really reflect on my life now. And I always knew, even as a child, that I would become a helper somehow, to be of service to Creator, to humanity. And I think I've been well-prepared for that. Throughout my childhood, I've endured a lot of pain and suffering. But out of that, it has made me a very strong woman today. I find myself to be very strong now, more so now that I've begun my journey of healing, to find out who I really am. So finding out who I am, like I'm part of this creation, right? (Counsellor).

It was perhaps this larger sense of purpose that distinguished healers from therapists in the eyes of at least one PCC graduate, who was herself then training to be a counsellor:

A healer is a person [pause] I don't know. A healer has [pause] I'm not sure. But it has to be a gift ... And what do you call a therapist? Like he went to school, it was learned by books and written down. But a healer has a gift, it just comes out naturally for that person. But that therapist went to school years and years.

In the end, it would seem that a calling or gift for helping others, a revelation that often comes while on one's own personal healing journey, was the most significant qualification for effective work with PCC clients. Whatever the precise recipe for effective work with PCC clients, the resultant effects were sometimes quite impressive.

Labelling myself as an alcoholic, as a drug addict, to me, honestly, was uncomfortable. In PCC you don't have to label yourself. You come in here and you learn from what they have to teach you, and then you throw back at them what you think they've taught you and how you feel with the current subject, relationships, suicide, grief, stuff like that, whatever the subject may be that week ... I've seen guys in this program that never spoke a word, never unless they're drinking alcohol, speak for an hour straight, just with the atmosphere that's [been created] ... It's good, counselling is good ... If you desire spirituality, then you will go through PCC instead of [a non-Aboriginal program] ... But that's what they give you, that's what they show you, but they never, ever reject anybody, doesn't matter who it is. But they'll give them a chance. So with [the non-Aboriginal program], it was too set [on certain] things. It was always set. And that's the comfort I got from here, that's why I came back here (Client).

In conclusion, working with PCC clients involved a great deal of sensitivity and accommodation to the Aboriginal life experience of these vulnerable individuals. Cultural responsiveness to Aboriginal (and perhaps even Cree) patterns of communication and interaction was essential to therapeutic effectiveness, requiring

counsellor approachability, flexibility, skill, and perhaps above all, a higher-order therapeutic purpose. Taken together, these qualities combined into a formidable force for healing within the NCN community.

Staff Stress

The PCC program was in existence for almost four years prior to this study. Throughout that time, it had maintained a stable staff of three counsellors and one coordinator until mere months in advance of the site visit the coordinator resigned to return to university. She was efficiently replaced by another social worker who was instrumental in founding the Medicine Lodge some fourteen years earlier. Additionally, immediately prior to the site visit, a counsellor resigned his position, which was filled a few months later by a counsellor with thirteen years experience in the NCN family services program. In sum, the majority of the PCC staff consisted of experienced human services providers with long track records in Aboriginal settings. Burnout did not seem to be a pressing issue at the PCC, though the management of staff job-related stress was an organizational priority within the program.

PCC staff stress was a result primarily of the existentially (and even spiritually) significant but emotionally exhausting activities undertaken with vulnerable, and sometimes desperate, community members. Because such work was fundamentally interpersonal in nature, it was recognized as being culturally fraught with potential relational dangers (sometimes described as energy, possibly owing to New Age refraction).

Our elders, they always caution us, walk softly, walk softly. And that's what they mean, to be careful, be careful how you approach people, be careful how you address people, or even how you think about them. And that's the reason, too, because it is a killer, envy, all this negative energy, plus we send off negative energies even in our thoughts because our thoughts are energy (Counsellor).

Negative energy, then, represented a potential hazard to counsellors from their clients as well as a potential hazard to clients from their counsellors. As one means of mitigating these hazards, the PCC staff observed a collective morning ritual "to take away the negative energy, so as we don't carry it with us today in our work."

We have a good working relationship in the fact that we have this daily ritual where we smudge. We cleanse ourselves with our medicine herbs: sage, tobacco, cedar, and sweetgrass. And what that does in our belief is it cleanses our mind, it cleanses our body, it cleanses our feelings, it cleanses our spiritual being. So it cleanses the negative energy that we come here with at the end of a day or the beginning of the day. So once that's out of the way, then we have the opportunity to share with each other how we are today ... If there's anything bothering us right now, if there's something that we may have a disagreement with, that we want to table that, and we want to be rid of that, so as we don't carry it with us. We don't carry any grudges or any resentment towards one another. If there's something that I've done that the other people may question, then it gives them the opportunity to ask me. And by the same token, I will ask them of their behaviour ... So it gives us that opportunity to clear the air that way (Counsellor).

This ritual, which might endure for 60 to 90 minutes each morning, was observed to be relaxing, supportive, engaging, and encouraging for staff members who otherwise spent their time confronting the chaos of client lives.

In addition to this daily activity, the PCC staff was able to retreat into the community on some occasions as well as from the community on others. Retreat into the community through the numerous activities sponsored by the PCC for the NCN population afforded routine breaks from direct client engagement. Withdrawal from the community through Medicine Lodge staff retreats, trainings, celebrations, seasonal cultural events and activities, and even travel to South Indian Lake for outreach and consultation afforded at least some personal relaxation and rejuvenation. Additionally, some PCC staff obtained leave for personal devotion or ceremonial participation that might even take them to other provinces, sometimes with financial support from the Medicine Lodge.

Through these and perhaps other mechanisms, PCC staff seemed able to keep their own lives in balance, a genuine challenge given the limited availability of counselling resources in the community for other counsellors.

But what my friend found when she came here is that a lot of the professionals here, they work. But then they have a hard time to say no to their relatives that need their help, their support. And she said, "The professionals here need support too. They need to talk to someone when things aren't going well in their lives and there should be people available for them." And I said, "Yes, I agree with that" (Administrator).

In response, this administrator committed to making herself available for counselling to other service providers within the NCN community. Clearly, the PCC staff seemed effective not only in managing their own personal and professional stress, but also in assisting other counsellors in the community to manage their stressful lives as well.

The Meaning of Healing

The therapeutic activities of the PCC were designed to empower healthy lifestyles for clients and other NCN community members through an integrated and holistic therapeutic approach to healing and wellness. Thus far, this report has considered the nature of PCC client problems and the approach to therapeutic intervention adopted by PCC staff. The conceptual wellspring of the PCC approach to addressing client problems was the Medicine Wheel, a compelling Aboriginal representation that, in therapeutic contexts, symbolizes the holistic balance among the four constituents of personhood: mind, body, emotion, and spirit. Both Western and Aboriginal techniques were valued by PCC staff as indispensable for facilitating the individual pursuit of intra-personal balance by clients. Such pursuit, routinely referred to as one's healing journey, was generally assumed to yield some measure of healing over some period of time. With these parameters in mind, it is now appropriate for more direct consideration of the meaning of healing in the therapeutic activities and interactions of the PCC.

Many respondents, both staff and clients, were asked to explain the meaning of healing as they had come to understand it in the context of PCC activities. Clients discussed shifts in attitude and orientation that required sustained attention:

Healing? Well, I guess it's learning to appreciate life, learning to appreciate myself and my surroundings, and learning to appreciate other people ... Not to be so critical and say, "At least I'm not like that." And also other people's beliefs. Not be so judgmental, not to be so self-righteous, and not to be too proud (Client).

Healing to me, honestly, is understanding your past. Trying to accept the things that you can't change and dealing with things face to face, not ignoring them, not putting them aside, and dealing with them in the wrong way by blaming people, by reacting violently, [or] taking those short-term stimulants, like alcohol and drugs ... To me, healing is just trying to get to know who you really are, who you can be, what it is in life that you are here for, your purpose. And that to me is healing, living a comfortable life, not a perfect life, cause it's not perfect. Nobody can be perfect (Client).

Well, healing, eh, it's not something you can just go to and stop right away and say, "Oh, I'm healed." Healing's an everyday process thing, it keeps on going. Healing can take years, decades even, for a healing process to happen, to finish, right? And it's forever going on and on, it's an everyday thing. You just can't heal someone just like that overnight or in one day, two days, it doesn't work that way ... And the only way you can get healing is that if you want it, not because somebody tells you to, it's because if you wanted what's in [this program], if you want to do it yourself, you want it for yourself to be healed, that's the only way it'll work. It's the only way anything works is if you want to do it for yourself, not because somebody tells you to do it. If you want to be healed, you'll be healed (Client).

Within these descriptions, several qualities of healing were identified. Healing was seen to involve a cultivation of appreciation and a rejection of judgmental self-righteousness. Healing entailed an understanding of one's past, an acceptance of difficult realities, dealing with problems head-on, getting to know oneself, and finding one's purpose in life. Finally, healing was understood as an ongoing process that first required the expression of individual agency in the form of personal commitment ("not because somebody tells you to do it"). PCC staff echoed these descriptions of healing, but added qualities that pertained to the counsellor-client relationship more specifically:

I mean, healing is a lifelong journey. You walk through this journey of life, and then you experience all kinds of things in your life and you need some sort of support. And this is a support place for people to come, to come and find some healing for themselves, somebody that they can turn to for one-on-one, someone who they can trust (Counsellor).

That's my sort of interpretation of healing oneself. And I try to teach that because on the reserve, as I indicated before, there is so much damage done to some of those people in there ... So, having said that, you try to help these people to heal, to disclose, to gain that trust, that honest trust. And once you get that good honest dialogue, one-on-one, for me, that's my interpretation of healing. Then you're starting to dig [into people's issues], you're starting to probe [their unspoken pain], and I have those skills. And once you get to the [therapeutic] opening, then not to rush into it (Counsellor).

Here, gaining that "honest trust" with supportive others was seen as necessary for clients to find "some healing for themselves" through one-on-one encounters wherein they might be encouraged to disclose their personal pain.

Other PCC staff members emphasized the distinctive aspects of healing for Aboriginal people in particular. One counsellor indirectly invoked the Medicine Wheel concept in his description of Aboriginal healing:

In the way I have come to understand about healing is that in order for a person to heal, we have to be able to work on all four levels of our humanness. By that I mean we have to concentrate from the mental, physical, emotional, and spiritual, in all those areas. So to me that, in a sense, is the way I understand healing. And for Aboriginal people, that is very unique and the only culture that I know of that practices the healing in that respect. For instance, for a physical ailment, we'd go see a doctor, an MD that practices medicine. For the mental aspect, we'd go see a psychologist or psychiatrist. But there's no one in particular that we could go see for our spiritual well-being other than maybe the church or whatever denomination that we believe in. But when we work from our Native perspective insofar as healing, we address all those areas. And so that's how I believe [regarding the meaning of] healing in the full sense of [the] word.

For this individual, the cultural impetus to work on all four aspects of personhood was unique to Aboriginal healing contexts. Another staff member explained how the unique Aboriginal experience of Euro-Canadian colonization required this sort of unique approach to Aboriginal healing:

Well, in terms of our people, I think that their healing has to be different from mainstream [healing], because there was so much through history that was done to our people that it's important that the healing be different and unique. And with our people, because they have a culture, that it should be based on that to help them to heal. Because a lot of our people, we believe, were brainwashed. They were made to believe that their culture, their traditional practices, were evil. And then I remember in the boarding school they used to call us heathens and savages, they used to use those words. And then they wanted to make us into what they call ... [white men.] And that's why there's that saying by Chief Sitting Bull that in the eyes of Creator, I am good. That Creator made me who I am, why would I want to change? And then, it more or less says you can't change an eagle into a crow ... Besides that, our people, their first language here is Cree, and the second language is English. So a lot of times when our people talk to clients, they'll talk to them in Cree, they'll counsel them in Cree. That's why it's unique and different (Administrator).

Thus, Aboriginal healing in particular was seen to require unique therapeutic attention "in all those areas" of the person as but one expression of a more general approach based on cultural reclamation. Such reclamation, in turn, would foster healing through renewed tribal identities and cultural pride. Once "this monster called identity" had been subdued, healthy lifestyles would follow. One administrator described the connection between identity and lifestyle succinctly: "Because I believe, and nobody has been able to convince me otherwise, that a person who knows who and what they are simply makes healthier lifestyle decisions." In essence, healing was described as a process of positive existential transformation stemming from activities and insights that effectively linked the imperfect and vulnerable self to a more hopeful and compelling sense of purpose. Such purpose, it was assumed, is conducive to valued and meaningful engagement in the world.

In terms of activity and approach, the PCC staff's commitment to provide an integrated and holistic therapeutic approach to healing and wellness by drawing upon both Western and Aboriginal traditions, respectively, seemed well-suited to the promotion of healing as described above. Nevertheless, keep in mind that this summary portrait of healing is a synthesis of many perspectives and experiences—no one individual interviewed for this study ever described healing in such an abstract or comprehensive way. In some sense, healing remained

an idiosyncratic and amorphous concept, evoking from individual respondents those qualities that resonated with their own personal and sometimes professional experiences. There was another sense in which healing was implicitly understood and latently practiced in the PCC that was shared by nearly everyone involved, whether as clients, counsellors, or administrators. In this latter sense, healing indexed the power of talk to purge personal pain toward the refashioning of a more functional self.

In describing PCC activities, everyone talked about talk. Perhaps the most difficult challenge for new clients entering the program was the dilemma of verbal self-expression. One counsellor discussed such reticence as being characteristic of Aboriginal people in general. He went on to describe the ability of his own parents to discern when something was bothering him and to support him without direct discussion of the matter:

See, if I had an emotional problem, I couldn't go to my parents because I just didn't see it done. At the time, I didn't realize that it was being done in another way. For example, I remember times when I would be hurt emotionally by something that happened, or [that I had] witnessed, or something that I had been bothered with, but I couldn't tell my parents. I just couldn't find the words to describe how I felt, so I couldn't tell them how I felt. But somehow, they knew that something was bothering me even though I couldn't put it into words. So what they would do, and I remember especially my mom, she would take me out in the bush. And she'd start telling me about a certain herb, even though I wasn't paying attention, and what this herb is used for and how to prepare it. And then she would be walking along in the bush and then would see a little animal, say, a squirrel. And then she'd tell me about this squirrel. [As if] I was interested in it, okay? What it's for, what it does, what it eats, how it survives, and how it sustained life for another animal ... And she'd tell me all about these birds. Who cares? And then pretty soon, I have all this new knowledge about all these animals. I forget about my problem. And then it made me realize that, hey, my problem's not so great. This little bird can get killed any time in a second. This little bird has no choice, but me, I could choose to feel this way or I could choose not to feel this way, and yeah, my problem's not as great as theirs. That's what it made me realize. And then all this time, what she was doing was making me realize that, hey, your problem's not so great and you can work your problem out ... What it did [was] it put my problem in a different perspective, in a way that, hey, it's not so bad.

This cultural inclination for indirect communication undoubtedly functioned well in the context of compassionate interpersonal interactions, but yielded a different result altogether in chaotic relationships wherein individuals were not bothering to attune to the interpersonal needs of others. Many clients described past romantic, family, and school contexts in which self-expression to significant others, particularly involving emotion-laden subjects, was neither desired nor allowed.

And I can't even talk to my dad about [the fact that he didn't take care of me]. He can't explain anything why he had to do that, give me up like that [for my grandmother to raise me]. And sometimes I want to talk to him, but he doesn't give me a chance because he knows I'm telling the truth of everything, and he can't hack the truth. He'll just get mad (Client).

Why should I tell somebody [about the abusive priest] that didn't believe me [about] what was going on? "It's not nice for you to speak like that!" It wasn't even nice to express your feelings. It wasn't nice for you to cry. If you cry you'd be punished [at the residential school] (Client).

And why people are like this today because of residential school and all that. And why white people are like that, wouldn't let them speak our language. And that's why people are like this today, our Native people. It's bitter like that, because they're angry about the past. And I always want to ask people about that, but they don't want to talk about it. Just the people that I know really good and I ask them about it. They don't answer anything (Client).

Basically, I experienced some abuse in my school over here ... from my teacher. I remember one particular time it was in grade two. He was humiliating me in front of the class. Because of the problems I was having back at home, I didn't tell anybody. I wouldn't share with anybody what was going on. Sometimes I went to school hungry, but I wouldn't tell anybody. Sometimes there's still drinking going on in the morning, I wasn't too happy about that, and I would go to school, and sometimes my dad would get mean and loud. And sometimes I used to see him abusing my mother and I didn't like that. I didn't like my home life. But back then, I could not disclose myself to anyone because I figured that it was only happening to us ... [Now] sometimes I have trouble with authority figures ... I can see myself like I'm a little kid again and that I'm still seeing that teacher, he scared me, and that's how I feel sometimes. And [I] want to talk back and I can't seem to say what I say because I get a bit upset and I start shaking, and words don't come out right. So maybe to calm me now, my head has to be clear, then I can be able to sit down and talk to someone, ask them what I really want, like I need this and that, just like everybody else (Client).

As a result, especially in regard to difficult life experiences, substance abuse became a primary means by which PCC clients not only sought to escape their pain, but also to verbally express it.

Before I used to just keep [things that were bothering me to] myself and hold a grudge, eh. Then when I get drunk I just [got violent] ... Just only the time I'd talk was if I was drunk (Client).

And I don't like [my relatives] bitching at me when I'm sober and they're high. They just let it all out. And when we're both sober, they don't say nothing, not one word ... It brings out your emotional, what you feel about it because alcohol makes you mighty, I guess, with your words and all that. So that's the problem with that anyway (Client).

We're grieving so much on this reserve, and nobody wants to hear how anybody feels. The only time they bring out their grieving and their frustrations is when they are drinking, and that's not right. They shouldn't do that ... And I like to reach out to them and, like, "It's okay, talk about it, we'll help you," instead of you bringing it on when they're drunk ... It doesn't help because they don't know what the heck they're saying. They don't feel it because it's not their feeling, it's the alcohol taking over their feelings (Client).

Although intoxication might result in emotionally expressive talk, such talk was not thought to be helpful in purging personal pain. On the contrary, substance abuse seemed to compound personal pain.

I drink to get drunk and rid me of that pain that I felt, that confusion that seemed to be there all the time. And drugs came along ... They actually allow me to escape reality at times, not feel the pain. But when you're done [with] those drugs and alcohol, [the pain] is still there (Client).

In the end, some combination of Aboriginal cultural preference and dysfunctional developmental history produced clients who, in the face of PCC expectations regarding both expressiveness and sobriety, struggled to talk.

There is no question that verbal self-expression was seen as the initial, and perhaps even the primary, means to healing. Its therapeutic utility was grounded in the belief that PCC clients in particular and NCN community members in general carried deep personal pain as a result of traumatic or devastating experiences earlier in life, oftentimes during childhood. These experiences frequently were attributed in some fashion to colonial disruptions of community life. One client explained that the pathologies of the community originated "from the Western society, colonizationists, Europeans." The resultant emotional burdens—absent cathartic expression and introspective resolution—were understood to weigh heavily upon client lives, continually overloading or derailing individual efforts to find serenity and happiness.

That's how [we get] our low self-esteem. Go down [deeper], and it's fear and anger and all that emotional hurt. The mental hurt, too, that goes with it if you think about it and you feel about it. Basically, you want to punch someone. You begun to be a violent person because you're so angry [at] all that abuse you went through, emotional abuse, physical abuse, sexual abuse, psychological abuse, even the spiritual abuse ... I never disclosed that I was abused. It was kept inside me and this negativity kept on piling up in you, and [you] may have destructive behaviour or you have criminal behaviour (Client).

And what we do is we take the former students from our community to their former [residential] schools ... And in a lot of cases, we have people that won't even want to go there. We have cases of people that are resistant about going there for whatever reason. And we have a lot of people yet that can't open up. Whatever happened over there, they just as soon leave it over there. But the thing is it doesn't stay over there, it stays with them. And that's what they have to realize that it doesn't go away until they deal with it, face it head on. And yeah, we've had people break down. I've had people that are so overcome by emotion that they go into convulsion. We've had people like that. And that's how powerful this experience about residential school is. There's a lot of cases where a lot of psychological damage was done. And a lot of it will probably never be touched upon or even revisited there. People have gone to their graves with a lot of grief, a lot of sorrow, a lot of hurt, a lot of pain (Counsellor).

As a result, healing required first and foremost the release of painful emotional burdens through the acknowledgement and confession of past ordeals. There was utter consensus at the PCC on this point: therapeutic relief was obtained through disclosure and the resultant emotional catharsis.

The PCC staff were the chief proponents of this principle. All of the PCC counsellors offered personal instances in which their own healing had involved such cathartic disclosure:

Growing up, we were very seldom asked how we felt about anything ... Very seldom would we be asked, "Well, how do you feel?" if we were crying for whatever reason, this is as a child growing up, very seldom, I remember. And so I grew up not talking about my feelings, not knowing how, not really wanting to. So I was numb in that area, and having gone through the residential system, that made it even worse, because then I had a lot of reason to feel that way, not to be able to talk about whatever it is that happened, whatever anybody done to me there, whatever anybody said to me there. It had to stay there. I just carried it, and I carried my sexual abuse for forty years before I was able to talk about it. And I can imagine a lot of our Native people today are carrying a lot of heavy, heavy stuff that you can't unload. And then we wonder why you turn to alcohol. That's the reason why I turned to alcohol, to numb the pain, because that's what it does, it numbs the pain. And so today we address social problems, and oftentimes right away we label it, "Well it's an alcohol problem or a drug problem." Personally, I don't see it that way because there's something far beyond that. That person has an alcohol problem for another reason, for something bigger than that, for something greater than that. You have a drug problem, not by choice, but because of something greater than that (Counsellor).

And still I'm on my healing journey too, by letting out my stuff. Before, oh, I used to have a very difficult time to speak in public, I was very emotional. But I've been sexually abused myself, and I guess that's why that part of it all built up inside me. That's why I got so emotional to talk ... I used to wonder why I was like that. But being sexually abused, I guess that's a part of it, to me, anyway. But so the next day, I gave it another try, so it was much easier. Then after that, the third day, it's nothing (Counsellor).

I find that pain and that not disclosing is buried inside you. And if you want to keep it there and let it always bother you then that's [your choice]. But if you disclose it, it's your healing. It's your healing, but if you bury it, and don't want to say nothing about it, then it's going to affect your life, I think. It affected mine. The funny thing about mine ... is I had buried it so deep. And there's just an exercise in social work training that we're doing ... And I don't know what happened, but something dug way down inside and triggered for me to just almost bluntly disclose ... I just got very, very emotional, my breathing, everything, shaking all over ... After I had said that [I had been sexually abused], I could have jumped on the fence and flew over the building (Counsellor).

But in terms of looking at myself and, I guess, finding out where this trauma happened and actually taking me back to that trauma in the process, because everything is a process in life. So it was a process, where they took me back into my childhood to actually look at it and reopen it in a calm, safe environment, which is where our clients are right now, right? They want to know that they are going to be safe, this is going to be a safe environment for them ... So I was comfortable and I was safe to be able to look back into my childhood and go see what had happened and to let it go, I mean, it was a step-by-step process (Counsellor).

PCC staff aimed to reproduce these sorts of experiences for their clients. As a result, a substantial amount of energy and attention had been devoted to countering the emotionally crippling effects of deep personal pain that remained undisclosed.

And [our clients] just can't bring themselves to talking about [their pain] in public, in that group, but sooner or later they realize that they'll have to talk about it in order to address it. And for that reason, when they talk about it one-on-one, then they can really lay it on the line and say, "Yeah, I've experienced that and this is how I did it and this is what happened, and this is how I feel." So they are able to address all those areas. And then once they do that, then they're okay with it (Counsellor).

But I still have that fear. I hope to goodness I don't go have a relapse. I have that fear because other people, they stay sober for many years and all of a sudden they have a relapse, and I got that fear of that. Now, we explain to the clients about that, too. When I do lectures, I always give myself as an example because I'm still doing my healing, but ... I asked them, first, if it's alright if I can use myself as an example. Then they start sharing [about] themselves too, because I say, "This is part of your healing, you've got to talk about yourself, what you have done, that's part of your healing by sharing with other people" (Counsellor).

I knew that I was helping somebody, especially ... with men, with the amount of abuse that happens in the community in the men. I've gotten a lot of men that disclosed for the very first time. You know [then that] you're doing your job. Sixty-four years old, one guy told me. Had a guy forty-five years old, first time [he] disclosed it was to me. And we went through the breathing exercise [after disclosing to calm him down] ... And the funny thing was, the sixty-four-year-old guy said ... "I can fly right away." He said, "I can fly." And the other guy that I had to assess was a forty-five-year-old ... a quiet guy, a humble sort of guy, and he said, "Hey man," he says, "I just feel like flying." That tells me that they got a lot of crapola out of their [system] and I relieved them, because I know when I disclosed, I could have stood on a [fence]rail there and flew off into the trees here. That's how light-headed I was. I had to carry stuff with me for forty, fifty years (Counsellor).

Because of the different life experiences that people had in residential school, some of them were very, very negative, where they experienced emotional, mental, physical, and sexual abuse ... Because of those experiences, a lot of them never recovered. A lot of them had turned to alcohol as a means of escape. A lot of them didn't get the counselling they needed because the counselling services weren't available in their reserve, or the mental health or the psychologists that come in now. They never dealt with their issues. Some of them ended up becoming alcoholics, really severe alcoholics. And you will meet some of those people that live in our reserve ... And some of them have never had an opportunity to talk about what they experienced and they may end up crying when they're talking to you ... because they need to be able to talk about it. A lot of them didn't talk about it, they kept it inside, and then it just built up like a pressure cooker (Administrator).

So fundamental was this notion to healing discourse that traditional ceremonial practices were interpreted in light of the therapeutic benefits of cathartic disclosure.

Because in our cleansing ceremonies, as we know them, we have that opportunity to share with one another whatever it is that's bothering us. Whatever it is that's not right in our lives, that's hanging over our shoulders, so to speak, or the dark cloud above our heads, it gives us

that opportunity to release that there. It gives us the opportunity to share with one another whatever teachings we've acquired in that time of our lives. The teachings that we have that have been passed down to us from our elders. Oftentimes, if we're sincere about the ceremony itself, we come out of there feeling refreshed in all areas. The aches and pains in your body are gone. They're not there no more. The physical tiredness you feel, it's not like the tiredness you'd feel physically from hard labour, but it's a tiredness of releasing a heavy load. That kind of relief (Counsellor).

Clearly, the message that deep personal pain required cathartic verbal expression if it was to be remedied got through to the PCC clients. As a result, all but one of them explicitly conveyed this point during their interviews for this project. Several examples should serve to further illustrate this aspect of PCC healing discourse:

It's good to talk about things that you normally can't talk about with other people that are close to you ... It's just the release, the release of the tension or the burden that you're carrying. For instance, my father when he was hitting my mom, I said, "Sometimes I thought it was my fault," but it wasn't and then I talk about it. But when I cry, it releases it so that it's gone. It's not totally gone, but that you dealt with it, because just knowing that you dealt with an issue helps you (Client).

And that's the only thing that really affected me was [that] I wasn't there when [my mother] died. That she was alone. And I couldn't really get rid of that guilt until I really talked about it with the counsellors at the [PCC]. The PCC really helped me in this one session we did where you had to write a letter to a loved one that had passed away. And I wrote to my mom and I told her I'm sorry I wasn't there for her the day she died ... So I read it out loud, I let them hear it, [my counsellor] and my cousin and his wife and myself. Four of us were there. I read it out loud. And something lifted out of me because it was always in there. I've never told anybody how I felt, so it was good, I just felt so good after that (Client).

What I found most helpful was, I guess, the one-on-one with that counsellor, that way I was able to share some things that I couldn't share with the group. And another thing it taught me was that she encouraged me to take some risks, even if some story sounds silly, just to talk, bring it out, even if I felt it wasn't necessary to talk about this story or that story, just to bring it out ... Well, for one thing, I always felt silly about that story I just told you about, about being [sexually molested by a nurse] in the hospital ... that one, and then being in school and how it was there, I didn't really talk about those things before ... And I guess the one thing was also that she was the one that helped me get through my grief. I never really showed anyone in the group the real me. Showed my feelings. I'm always trying to be like, "I'm strong, you can't hurt me, nothing has hurt me." No one knows the kind of guy I was, always trying to keep a straight face, like [I'm] really strong, not to show any emotion or anything like that. But it taught me how to express that, and express how I really felt inside me and bring it out, and that really helped. It took a lot of weight out of my shoulders and I felt lightened after that, when I was finally able to cry in front of people without even being ashamed or stuff like that, without even being shy. It just went to show that I'm human, just like everybody else (Client).

Because the first time I smudged [in a group session], it just felt different. My body felt different. All the things in you just [receded], you just felt so light. Man, [I] did that, and it just make me feel better about myself. And just, I could speak better and say whatever ... You don't think about you're going to say, you say what you feel. That's what I learned in there too, you don't think from your mind, you just say what you feel, your emotions, how you're emotional feels you. Your emotion speaks for you (Client).

For myself, I was grieving for my grandfather. He passed away seven years ago and I never got over it until I went to that program. And it was always locked in my closet. I just never let it out. I didn't share with nobody. And I went there, I expressed myself, and now I don't have a problem talking about it ... I accept it as it happened, the way it is, because that's just life (Client).

Thus, given the wide prevalence of cathartic disclosure in the interviews of PCC staff and clients alike, it would be difficult to identify a more central component of the meaning of healing in this setting than that involving the verbal expression of deeply painful experience in service to emotional catharsis. In sum, one counsellor said it best: "A lot of those people [out] there need one-on-one counselling. Talk to [me], let's dig it out ... Let's begin our healing journey." Of course, none of the PCC staff and clients claimed that disclosure and catharsis was the sum total of healing.

But it takes time, I mean, you just can't go over there, touch the person and talk to the person, [and then] sail off into the sunset [as if] they're going to live happily ever after. Unfortunately, it doesn't work that way ... So you've got to take it step by step, to slowly heal (Counsellor).

In other words, cathartic self-expression was expected to inaugurate a process of self-examination and searching reflexivity that could sustain positive and ongoing transformations of self. Looking at oneself seemed an obvious prerequisite.

So when they started this Medicine Lodge here, that's where I learned everything. I thought it was only just to maintain your sobriety, that was good enough for me. That was my thinking, "Well, okay, I'm sober," good. But little did I know that I had to go further. To have that healthy lifestyle you've got to look at your attitude, your thinking, your behaviour, and you've got to look at yourself emotionally, mentally, physically, and spiritually in order to have that balance of living (Client).

I just have to look after myself, worry about this [inner child within me]. This is where I learned, too, [about] that inner child, because your feelings may be [arrested] at only about twenty years old while you're [actually] fifty. The way you behave ... And sometimes I act like that because, I don't know, I'm still starting to heal (Client).

But I realize now I can't handle every problem. I can't [always] help people out, I've got to help myself first. I was trying to help people all the time and I wasn't even looking at myself (Client).

So that's what they learn here in PCC is that they need to take responsibility for their own lives. And sometimes, yes, it's good that they're forced to take a look at themselves, because

sometimes we have to be forced ... And once they're able to look at where they came from ... they learn different ways on how to cope (Counsellor).

Such searching self-examination could only yield deeper insights in service to positive self-transformation. In essence, then, a refashioning of self became the therapeutic project that required consistent attention, inspiration, and insight.

But over time, when I got to working on myself and getting better, getting well, it became easier. It became easier because I could honestly talk about meaningful issues in any relationship and truthfully talk from my heart instead of pretending or making up long stories or just for the sake of sounding good (Counsellor).

But I guess the one thing this program's taught me is that to learn to believe in myself, to learn to believe that I can do it, that this day's not the end yet. I don't really have to worry about tomorrow, because it's not here yet, and yesterday I can't really do nothing about it because it already happened. And it's to live that I have to work on. That's how I look at it basically sometimes (Client).

[The Medicine Lodge is] a place to heal. It's ... somebody that they can talk to. It's a place where they can get the support, where they're not judged ... It's a safe place ... because it is a place where they can get support. And I guess to encourage their own personal development ... That's what it is, it's support, it's help, providing the supports for people that want to work on themselves. Those are the more successful clients are the ones that come there because they want to be there, and they want to learn something ... yeah, it just creates self-awareness for them (Administrator).

Another administrator invoked this notion in discussing the ideal qualities of counsellors: "They've worked on their own personal issues." Thus, working on oneself, one's issues, or one's life was emblematic of the healing journey that signifies a lifelong process of introspection, insight, transformation, and fulfillment.

Within the historical context of Euro-Canadian colonization and subsequent Aboriginal cultural reclamation, therapeutic self-transformation and self-fulfillment were very likely to involve connections to a compelling sense of purpose that was shared by other Aboriginal people, especially those with whom one shares kin and culture. Thus, healing in some sense was seen to be truly about the restoration of a shattered people, the revitalization of an ailing community, which in turn required a resurgent Cree identity, a fierce national pride, and a flourishing cultural renaissance.

So with our people, that's why identity's really important. They need to be proud of who they are first [in order] to become united and healthy as a nation. Our people need to relearn their cultural practices and traditions in order to be proud of who they are, to be proud of their identity, to be proud about the Cree way of life. And that's why the healing has to be unique (Administrator).

It should be noted that a possible divergence in therapeutic discourse and cultural reclamation was observed in PCC activities, namely that the therapeutic emphasis on verbal self-expression may well run counter to the

culturally traditional norms of verbal restraint in Cree interaction. In an illuminating discussion of this tension, one administrator explained the complexity of cultural politics in regard to Aboriginal survival over time:

So I think a people that come to that [cultural] intersection that you speak of with a good grasp of who and what they are, will not be easily swayed by eastern or western or northern or southern mystics. But they are a people who, in estimating the relative value of a new practice or process, will have the capacity to assimilate that or to turn their back on it, or to take a chunk of it. I mean, that's how we've survived as Indian people. As new things came to our land, we didn't turn our backs entirely to everything or else we wouldn't be here. We have to move with change, we have to be flexible. It's the nature of the Indian way of life. We're not static beings. I mean, if we were, we would have died out a long time ago. I mean, our very way of life compels us to be open, right? To be guarded, yeah, to be mindful of life, and the forces of life, and what will sustain us, what will sustain our people.

In conclusion, the meaning of healing as it was understood and practiced by PCC staff and clients might be summarized as an ongoing process of positive self-transformation—fueled by introspection, reflexivity, insight, disclosure, catharsis, dealing with one's problems, working on oneself, and finding one's purpose as an Aboriginal person—that ultimately reoriented fragile and sometimes damaged selves toward a more meaningful and compelling engagement in the world.

Treatment Effectiveness

Appraising the outcomes of treatment at the PCC was an informal process. No standardized evaluations of treatment outcome were employed nor standardized criteria that might define effective treatment were enumerated. Perhaps the most rough and ready measure of treatment effectiveness would have been the graduation rate for PCC clients; but owing to the rather recent transition in administration of the program, PCC staff were unable to identify the number of clients who had earned certificates from the program. No one disputed, however, that the number of actual program graduates was but a tiny fraction of the number of clients served in various capacities over the years, with a graduation rate almost certainly equalling less than ten per cent of the total.

Given the nature of healing discourse at the PCC, one could be sure that effective treatment did not result in complete healing. In fact, mistakes, relapses, and backslides were both common and anticipated. As one client explained, "You don't heal completely in your life, it's only when you die and you go to a spiritual [place], then you heal completely." At best, successful clients were observed either to initiate or extend their healing journey as expressed by a variety of changes in their lives. Such changes, observed by PCC staff as well as the clients themselves, seemed to be the sole source of information by which to gauge treatment effectiveness.

Asked how he knew whether healing had occurred among his clients, one counsellor described several visible expressions of what he attributed to enhanced self-esteem:

Oh, it's an easy question. The eyes. The way they talk. What you do is you almost bring back their self-esteem, even the way they dress. For example, the one lady, her hair was always messy. It looked like she just didn't know what part of the day it was. She looked like she just woke up. After I had chatted with her and ... talked to her about self-esteem, talked about

the healing, and the sexual abuse that happened to her, in six months, I think, I could just see [it in] the way she dressed, she transformed her hair. She went back drinking again, but she has a little bit of that self-esteem now because she disclosed some of that stuff. But she should be counselled more and more ... There was another fellow, the fellow there that disclosed to me the sex abuse when the [perpetrator] died. [It happened] when he was ten years old. The dress and self-esteem. He still continues to drink. He still got separated from his wife. He's found a job. So it's all those little things that tell you that they're starting to heal, but they've got to spend time with you ... not just this one [time], [as if] you get a certificate and graduate and sail off into the sunset.

Thus, despite a separation from a spouse or even a return to drinking, the therapeutic benefits of client disclosure during their time at the PCC were observed in the improvement of one's appearance or the securing of a job. Not surprisingly, the PCC clients themselves had the most to say regarding the therapeutic benefits of treatment, including renewed outlooks, re-established coping, restored functioning, repaired relationships, and refound purpose in their lives. Renewals of outlook or perspective were a common effect of treatment reported by PCC clients.

If it's raining [outside] it was miserable [for me] and [everyone else] says, "Oh well, it's raining, the Creator is watering his plants." That's positive, whereas I used to be so negative when I wasn't on the healing journey. I hated everything ... Now it's a chance to smile ... And those are the challenges that I look at myself and, hey, maybe I had to change those things, my behaviour and my thinking and my attitude, my feelings ... and those are the defects in character I have to overcome. I have to challenge them, silence that negativity, so it becomes positive. And sometimes I go off the road, [and need to] get back on track still (Client).

It's helped me a lot to come to this program because I'm a jealous person, I admit that, I get jealous so easy. I don't anymore. It's just what I think in my head ... In this program, it tells you how to be positive and negative ... ignore the jealousy and just think positive, think about good things (Client).

I don't feel like I'm worthless or anything like that. I don't feel like, "Oh I'm never going to amount to anything," because today is the only day I look at sometimes, and today's the day that I'm doing something positive. And I don't beat myself up if I can't succeed in something. I don't say, "Oh, stupid." I mean, I don't go around trying to [worry], "How could I have done it better? What could I do?" And just being regretful. I'll just say, "Okay, I made that mistake, but I can still go on, pick myself up here." And it's given me that encouragement to just to keep on going, keep on trying, not to give up. Sometimes it's just too easy to give up (Client).

Such alterations in outlook and orientation were just one indicator of a more general re-establishment of coping skills for PCC clients.

I find that I'm more patient, yeah, right now, I'm more patient. I listen and I don't judge people like I used to. I don't know, [there's] a lot of things that I never used to do that I do now that the PCC had showed me, and one of them was to forgive ... people that have hurt me. So it really helped me a lot. It really made me see [that] there's more than partying (Client).

Just recently, I felt kind of lonely. So I went to visit the Elders, and they kind of lifted my spirits. I see them sitting around there. I was laughing when I was talking to them. And I go there for my breaks and things, go sit with my Elders, with the Elders, have a cigarette with them ... Just knowing that you [talked to] somebody that's older than you and wiser than you [brings comfort]. They give you a little advice. "It's okay to feel that way," they sometimes say. "It's natural, and Creator's always there and listening" ... But when I get that feeling, when I feel that urge to drink, I go for a walk or I do something. I wash the walls or something. I keep busy ... Keep my mind occupied instead of dwelling on whatever is bothering me and think of something else positive and do something positive (Client).

The PCC gives you what you call the significant aspects of life, like honesty, humility, truth, courage, and stuff like that. And it's amazing, since it's been applied to me twice. And honestly, I could never get enough ... This place is like a second home to me now. I come in here, I meet people, it's great. And they're more than welcoming, because there is nothing wrong with healing ... It's allowed me to grow in ways that I never thought I could grow ... It's been a great beginning to my healing, and it's only been two years. And I know I got a long ways to go. There's ups and downs, I fall, but what they say is, so long as you can try, get back up (Client).

Skills involving patience, forgiveness, engagement, distraction, or persistence together signalled for PCC clients a restoration of functioning in their lives. One PCC client had pulled her life together so dramatically that she was close to obtaining counselling credentials of her own:

And when I came here for the treatment that time, all these things I learned. This is where I learned my culture too, and this is where I started healing. And last year when I completed the program, then that's when I returned to university. And here when I started working, I became a probation officer, a parole officer, foster care, and therapy. I work here [in the community] as a therapist.

In addition to these intra-personal effects of treatment, PCC clients also reported beneficial effects in their relationships with others. One client described a former enemy who participated in PCC activities with him:

Because there was so many people in these courses, that PCC program ... I had one of my worst enemies in there ... But today, we walk around the streets like it was never like that ... You couldn't even tell that we were enemies at one time. And now we're the best of friends ... And it's thanks to this program. It made us both look at life a different way ... It's unreal, man.

Another client described the relational outcomes of confronting friends and family members about the pain they had caused in her past:

But I was verbally and physically and mentally abused, and sometimes it still hurts, but I dealt with that. I dealt with that pain because I confronted the people who hurt me. They apologized to me. They gave me a hug and [it was] as if that burden just lifted from me when they apologized to me, especially my brother. He's the one that I needed his apology in order for me to go on. I resented him ... He hurt me ... and I didn't like that. I didn't like to carry that feeling all these years. It was good when he apologized to me. Even my friends, back in

school, they used to throw snowballs at me or whatever because they knew my father was abusive, and they probably thought, "Oh, she was being abused, let's abuse her too" ... So most of my friends from grade school apologized to me because they knew that I've been seeking some kind of inner peace, because I was angry, I guess, angry at everybody and at the world, but they knew that I was seeking for some kind of assurance, I guess. I wanted to straighten out my life, and most of them came and apologized to me.

A third client described the transformation in her relative's marriage following the couple's participation in PCC activities:

I find them closer now, and I find that they talk to each other more, right now, yeah. And I haven't seen my [relative] hit his wife. Also, it must have helped them, too, because he used to always fight her ... And I haven't seen him hit his wife since [completing treatment at the PCC].

Beyond repaired relationships, PCC clients also described refound purpose in their lives as a consequence of their participation in treatment. One client described a reorientation so radical that it seemed to qualify as the very kind of self-transformation the PCC program aspired to achieve in its clients:

It's a hell of a lot different [for me now], big time, man, I mean, big time. I used to drink lots, I don't drink no more. I used to smoke lots, I don't smoke no more. I used to fight lots, I haven't fought since I started that program. I was never into my traditional lifestyle, but I'm getting back into it again. And I look at people differently, I can talk to anyone I want now. More people come up to me and talk to me, lots ... ever since I stopped drinking and smoking and causing trouble and stuff like that. I've been working more. And all these things have just been coming to me, people coming to me with their problems and stuff. And for some reason, I just have the answers for whatever they have ... like to show I'll do what I can for them.

Frequently, such refound purpose included transformations in identity and expressions of cultural reclamation.

I used to be ashamed for being an Indian, oh yeah, because they used to call me a dirty Indian. "You lazy Indian." I just said I would be white. It's a good thing my skin was white ... because I didn't want to be an Indian, I was too ashamed ... Little did I know, I'm proud to be a Native now, I'm proud for who I am. I know my identity, I don't care if anybody calls me a dirty Indian, lazy Indian, you no-good, uneducated Indian. So what? I'm still a human being, I'm proud to be who I am (Client).

I really had a resentment towards the priest. He was bringing all that pain I carried all my life to the age of forty. And when I was forty years old, this is where I learned all my culture, this is where I started my healing journey, and this is where I practiced my Native culture. I go to sweats, I go to fastings, I go to powwows and participate. It's a good feeling when you're starting to find your identity, to have that sense of belonging, to have that empowerment, and to have that identity in the purpose of life. It makes me feel good (Client).

So it helps, especially when I was in sharing circles and the pipe ceremonies. It's really helpful. And I got my sister and then my brother into this program ... And my sister-in-law, I asked her to come with me to a pipe ceremony. "You'll love it. You'll have a good experience. [Whatever] you're hiding or what's in you, you'll feel better if you talk about it," I told her. And it does help to let things out (Client).

Even with Aboriginal practices, clients might still experience ambivalence about their healing.

I met [with] one medicine man [who gave me a medicine bundle] ... Of course, I still have that bundled-up package. I'm supposed to write down twenty negative things and twenty things I'd like to change. In twenty days, I'm supposed to go to a secure place every day and write out those twenty negative things that are bothering me, and twenty things that I want to happen to me. During that twenty days, in that bundle, I'm supposed to boil [what it contains] and drink it during those twenty days, and it's supposed to purify or cleanse me or something, with all the negative thoughts and negativity or whatever happened past in my life or in the present. That's what that medicine man told me, but that was a year ago and I still haven't opened that because I don't feel like I'm ready. I'm just starting to grow and I'm just learning about these things. So that bundle is still over there, still at home, still in the package (Client).

Nevertheless, the realization of healing through cultural reclamation remained a potent indicator of PCC treatment effectiveness that resonated with one counsellor's vision from many years ago:

And in my vision some twenty-five years ago ... I seen this rainbow, a full-circle rainbow. An outside circle was a rainbow ... In our Cree language, pisimweyapiy, it means rainbow. I seen this complete circle of a rainbow, and inside was an incomplete circle but a rainbow incomplete. And when I mentioned that to the Elder, the way he explained it to me was this healing process going on in our Native communities everywhere. You travel the whole country, you go to the States, you go to Canada, anywhere in the world, there's healing going on with our First Nation communities and it's quite evident today. And that complete circle represents those people that are walking on their healing journey, whether it be in the AA program, whether it be in their traditional ways, whatever works for them, whether it be Christianity, whatever, whatever works for that individual. There's lots of those people the world over, and if they were to come together in one place, there's probably not a city big enough to hold them, that circle (Counsellor).

While it appeared that PCC treatment effectiveness was not measured or recorded in any systematic way, observations by staff and clients together attested to the changes, and occasionally even the transformations, that were wrought in client lives. Such evidence was certainly sufficient for issuing a sweeping invitation to the NCN community. As one enthusiastic client frequently stated in his promotions of the PCC program: "Give it a chance, you give everything else a chance, why not give healing a chance." Just as the rainbow attests to sunlight scattering the storm, so it is the hope for healing to proliferate within and beyond the NCN community—ultimately encircling the entire world in a rainbow of wellness—that sustains the spirit of the Pisimweyapiy Counselling Centre.

Conclusion

When asked about the intended outcomes of therapeutic efforts undertaken at the Nelson House Medicine Lodge, one administrator set forth a remarkably ambitious agenda:

Oh, nation building, I think its people building, I think its community building, I think its spirit building. Without getting too [self-important], I think we're trying to fix people, and I think we're trying to help ourselves by helping others. I think we, through our various journeys, have come to realize that this way of life demands that we seek out others who are of like mind and like intent and put our heads together to see if we can come up with a life that we all want. I don't think anybody that comes to that program wants a community mired in the range of pathologies that exist in the community. They want change, and we're just change agents. That's all we are.

As the Medicine Lodge program most directly engaged with the surrounding reserve community, the Pisimweyapiy Counselling Centre similarly aspired to "pave the Red Road to wellness" for the people of the Nisichawayasihk Cree First Nation. Acting as "Medicine Wheel Firekeepers Empowering Healthy Lifestyles," four PCC staff members consistently sought to honor, guide, model, inspire, and transform life in the Nelson House community. Acting merely as change agents in this process, their ultimate vision anticipated a vast circle of individuals harmoniously united by their movement along that healing journey. As it appeared in these dreams, life in the NCN community may one day vindicate their efforts.

The prediction for Nelson House is that it's going to become a model community. It's going to heal, and I've been telling people that since I came back. I tell them, "Don't give up on your community. One day our community is going to heal," and they'll ask us, "How did you do it?" and we'll say, "This is how we did it" (Administrator).

One purpose of this study was to document the aspirations, approaches, and activities of the PCC program in anticipation of this future moment.

As a community-based outpatient treatment program, the PCC confronted numerous challenges. Its clientele was battling chronic distress and dysfunction and was frequently compelled to participate in PCC activities by family services or by order of the courts. Its staff was professionally isolated and lacked ready access to state-of-the-art training, materials, and other therapeutic resources. Its community was relentlessly beset by a chronic range of pathologies originating in poverty, residential schooling, and other legacies of the colonial encounter. Its tentative existence was utterly contingent on the continuation of AHF program funds initially received in 2000. And yet, in the face of such challenges, the PCC mustered its resources and marshalled on. Its clientele reported alterations and even transformations of self that yielded renewed outlooks, re-established coping, restored functioning, repaired relationships, and refound purpose in their lives. Its staff, comprised entirely of NCN members, persisted in facilitating healing through lectures, group sessions, one-on-one counselling, cross-agency collaboration, public education, community outreach, and ritual involvement. Its community supported the vision and mission statements of the Medicine Lodge, restrained itself from unwarranted political interference in the organization's affairs, and remained open to the healing summons of the PCC. Its enduring existence was assured by parliamentary reauthorization of the AHF through the year 2012, though the Medicine Lodge staff continues to pursue supplementary and alternative funding in

preparation for an uncertain future. In sum, the PCC program modelled the very adaptability and resilience that Aboriginal communities desperately require if their members are to “put our heads together to see if we can come up with a life that we all want.”

This study of the PCC program was explicitly concerned with models and metaphors of healing in First Nation treatment contexts. The models of healing employed by PCC staff were comprised of a variety of Western and Aboriginal approaches and techniques. Western therapeutic modalities included the Twelve Steps and Twelve Traditions of AA, grief exercises, anger discharge, inner child work, guided meditation, relaxation training, energy manipulation, genogram mapping, Reiki, acupuncture, neurolinguistic programming, and other complementary, alternative, and New Age therapeutic techniques. The appeal of such techniques was their apparent origination in spiritual principles, mysterious forces, or esoteric energies that were sometimes accommodated to Cree tradition. Aboriginal therapeutic modalities included smudging, talking circles, blessing rituals, tobacco offerings, pipe ceremonies, sweat lodge rites, fasting camps, and the shaking tent. Aboriginal herbal medicines were not employed in official PCC activities; peyote rites were deliberately excluded from Medicine Lodge services. Other forms of cultural contestation were evidenced in the community as well, such as explicit concerns about the polluting effects of pan-Indian appropriations. Given the diversity of religious practice in the community, programmatic exposure to and appreciation for Aboriginal practices was counterbalanced with explicit and routine accommodation for non-Aboriginal belief systems.

All of these therapeutic models were subsumed under the central metaphor of the Medicine Wheel, which conceptually represented holistic balance and integration of constituent parts within a unitary totality. Oriented to the four directions, the Medicine Wheel concept facilitated successive consideration of the four basic elements of human personhood—mind, body, emotion, and spirit—along with explicit recognition that these elements articulate and integrate into the larger unity of human experience. Furthermore, this ancient Indigenous representation was seen to portray the cyclical nature of human development and existence. Thus, the Medicine Wheel afforded a developmental and holistic perspective for working with PCC clients, and it seemed an ideal metaphor for organizing healing in an Aboriginally distinctive manner. Additional metaphors of healing that were evident in PCC activities included the carrying of painful burdens from a hurtful past, the excavation (digging or probing) of deeply buried personal pain in the effort to purge its toxic effects, the release of emotional pressure through cathartic talk, and the commitment to looking at and working on oneself as a therapeutic project. Finally, the meaning of healing, as abstracted from a variety of assumptions and approaches endorsed by PCC staff and clients, appeared to involve a process of positive existential transformation that therapeutically linked the vulnerable and imperfect self to a more optimistic and compelling sense of purpose more conducive to meaningful engagement in the world.

Clearly, this distinctive integration of Western and Aboriginal approaches to healing, united by the overarching philosophy of the Medicine Wheel, was compelling for many PCC clients. Treatment outcomes were not assessed by PCC staff in any formal or systematic way, but among the PCC clients interviewed for this study, a virtual consensus existed regarding the unique appeal of the program’s distinctive offerings, yielding in some instances a remarkable transformation in client orientation and behaviour. Even clients who continued to struggle with substance abuse and related distress acknowledged some progress toward improved coping with life’s challenges. Some even became outspoken advocates of the PCC within the NCN community at large. What then might be concluded regarding best practices for healing within Aboriginal reserve community contexts? Keep in mind, first, that best practices are typically derived from stringent experimental or quasi-experimental research designs in which cause and effect relationships between intervention and outcome can

be determined. This study was not designed to explore causal relationships, and thus it cannot suggest best practices in this increasingly pervasive sense of the term. Nevertheless, several anecdotal lessons from the PCC experience might be drawn.

Operations: community-based outpatient treatment programs must find a sustainable balance between responsive internal organizational administration and external community oversight and accountability. For instance, the appointment of an independent board of directors by chief and council seemed an effective means to attaining such balance, though the Medicine Lodge also maintained a quasi-independent status as a regional service provider funded by Health Canada. In addition, therapeutic programs and services should be client-centred, offering programming that engages clients effectively and doing so at times and structured by schedules that accord with the local routines of client life. For instance, the PCC conducted lectures and group sessions in the evenings to better accommodate clients who worked or rested during business hours. Furthermore, staff must be widely available to clients for consultation, support, or crisis intervention. Obviously, banker's hours will not effectively meet client needs. Staff must also be afforded regular opportunities for debriefing, decompression, planning, coordination, and mutual support. The treatment facilities should be inspiring, with Aboriginally significant decor and a friendly and casual atmosphere. For instance, the Medicine Lodge constructed a Medicine Wheel on its grounds and posted the appropriately colored flag at the exit from each wing of its building in the four cardinal directions. Traditional ceremonies sponsored by the program and conducted in or near the facility should be routine and open to the public. The community must come to realize through these and other hosted events and celebrations that the treatment program and its facilities are not just for those with alcohol or drug additions, but for all community members interested in a better life for themselves and their children.

Staffing: community-based outpatient treatment programs must employ primarily Aboriginal counsellors or those who are otherwise acutely and empathically sensitive to the needs and experiences of Aboriginal clients. Staff must be able to draw upon first-hand experience in serving client needs in empathic ways. Both education and experience were seen to be valuable, though life experience may well be more important than knowledge in the abstract. In addition, at least some staff should be familiar and proficient with a range of locally meaningful Aboriginal practices, including fluency in the local language and be able to promote interest in these cultural practices in a sensitive and non-threatening manner. Furthermore, beyond language fluency in and of itself, staff must be familiar with and sensitive to local styles of communication that would impact Aboriginal self-expression and interpersonal interaction. Particularly in close-knit First Nations communities, staff must be vigilant guardians of client confidentiality in order to ethically promote therapeutic self-expression. Both men and women with esteemed local reputations should be on staff, though a preference for middle-aged or older individuals may correspond to greater therapeutic effectiveness. Staff commitment to healing should be comprehensive and enduring and ideally grounded within an overarching sense of vibrant purpose. Staff should be selected for their ability to inspire and model for others a walking illustration of the good life.

Treatment Model: community-based outpatient treatment programs must afford the means for clients to avail themselves not just of Western modalities and techniques, but also of Aboriginal rites and ceremonies that effectively link treatment to compelling, community-based existential frames of reference. Consultation of, or even contracting with, authoritative "culture carriers" might help to manage or moderate local contestations of traditional practice. Overarching Aboriginal symbols or metaphors should be employed to guide client progress and understanding. Therapeutic activities should draw as widely as possible on available treatment approaches, perhaps even Western best practices, in order to determine what works best locally. Treatment

planning that tailors available approaches and techniques to specific client needs is warranted. Creative flexibility in accommodating client needs should be harnessed toward improved coping, expressive talk, restored functioning, repaired relationships, and refound purpose. Healing should be discussed as an unfolding process in which client slips, lapses, and breakdowns are to be expected. In the face of such distress, clients should be reminded that they will always be welcomed back for continued treatment or aftercare. Coordination with related agencies and programs to ensure seamless integration of client care is ideal.

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